COMMONWEALTH OF AUSTRALIA

# Proof Committee Hansard

# SENATE

## SENATE SELECT COMMITTEE ON HEALTH

(Public)

TUESDAY, 4 NOVEMBER 2014

LAUNCESTON



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**SENATE**

**SENATE SELECT COMMITTEE ON HEALTH**

**Tuesday, 4 November 2014**

**Members in attendance:** Senators Cameron, McLucas, O'Neill, Polley, Whish-Wilson.

## Terms of Reference for the Inquiry:

To inquire into and report on:

a. the impact of reduced Commonwealth funding for hospital and other health services provided by state and territory governments, in particular, the impact on elective surgery and emergency department waiting times, hospital bed numbers, other hospital related care and cost shifting;

b. the impact of additional costs on access to affordable healthcare and the sustainability of Medicare;

c. the impact of reduced Commonwealth funding for health promotion, prevention and early intervention;

d. the interaction between elements of the health system, including between aged care and health care;

e. improvements in the provision of health services, including Indigenous health and rural health;

f. the better integration and coordination of Medicare services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic, dental and allied health services;

g. health workforce planning; and

h. any related matters.

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**WATSON, Dr Judith, Chair, Tasmanian Medicare Local**

**Committee met at 09:01**

**CHAIR (Senator O'Neill):** I open this public hearing of the Senate Select Committee on Health. This is a public hearing and a *Hansard* transcript of proceedings is being made. The hearing is also being broadcast via the Parliament House of Australia website. Before the committee starts taking evidence, I remind all witnesses that in giving evidence to the committee they are protected by parliamentary privilege. It is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to a committee and such action may be treated by the Senate as a contempt. It is also a contempt to give false or misleading evidence to a committee. The committee generally prefers to hear evidence given in public, but under the Senate resolutions witnesses have the right to request to be heard in private session. If a witness objects to answering a question, the witness should state the grounds upon which the objection is taken and then the committee will determine whether it will insist on an answer, having regard to the grounds which are claimed. If the committee determines to insist on an answer, a witness may request that the answer be given in camera. Such a request may, of course, also be made at any other time.

I now welcome Mr Phil Edmondson and Dr Judith Watson from the Tasmanian Medicare Local. If you wish, you may commence with a short opening statement and then the senators will have questions.

**Dr Watson:** We also have some documents to table. Would you like them distributed now? They are single-page illustrations.

**CHAIR:** Yes. That is moved and accepted.

**Dr Watson:** Many thanks for the opportunity to address this inquiry. We, the Tasmanian Medicare Local, acknowledge the findings of the John Horvath review and his recommendations that have been accepted by the government. We also acknowledge the opportunity for change is a positive one and we stress that we are under no misapprehension as to the fact that our current system's processes or activities are perfect or beyond change. We welcome the opportunity to do a range of things differently if successful in any quest to establish the new PHN and have been working closely with stakeholders, members and partners to scope and plan such changes.

Going from Medicare Locals to a Primary Health Network is a significant change. Its implementation could be seen as largely disruptive with a somewhat wholesale approach which appears dismissive of the work to date of the Medicare Locals across Australia. By any means, two and half years of life of a new and national infrastructure is not a significant period and certainly not significant enough upon which to base a fair or reliable assessment of its long-term benefit or value.

What Medicare Locals were always intended to be about was major system business change, primarily to bolster the power of the primary sector to keep people well and out of hospital—the most economical and sustainable use of the health dollar and better for all Australians. We will be doing this by changing the way in which primary and tertiary sectors interact to service the health needs of the communities, by changing the way in which primary health providers work, communicate and engage to provide the best possible care to all of their communities and by changing the expectation, utilisation and understanding of what communities can and should expect from their primary care system. None of these things happen overnight; indeed, it takes many years of intensive effort of trust and collaboration to achieve many of the changes necessary to effect such changes in balance and focus. We must now may make the most of this opportunity to do our best to preserve the service continuity within our state.

By way of some historical perspective, when the Tasmanian Medicare Local was formed it underwent by any national comparison a significant and complex change. It was formed from an effective amalgamation of four existing organisations in Tasmania. TML was required to shift from a small regional focus to a whole-of-state unit. Inherent in such change has been complex cultural reform and refocus. It required extensive work across and between communities associated with ensuring the right balance and focus within the whole state that contained both urban capital, major regional cities, along with some tiny remote and many isolated small regional communities—many of whom see things quite differently from each other. This was not always comfortable or simple and it was far from a happy marriage, but it was one which Medicare Local has worked hard to establish and successfully maintain. This challenge is the major task ahead for most of the large interstate Primary Health Networks. So we are fortunate that we have gone through a lot of that pain.

We might therefore justifiably question the logic of applying a one-size-fits all approach in areas such as Tasmania and the ACT, where the boundaries, the stakeholders and the service partners such as state governments

will be exactly the same under the PHN structure as under the Medicare structure. Tasmania as a state is undergoing some major transformations at the same time, and primary care needs to be a stable player in that process. Further uncertainty flows from the simultaneous review processes of mental health, Indigenous health and after-hours. Those are unlikely to have been completed prior to the time of the tender process. The current future of e-health and the personally-controlled electronic health record is also uncertain. Electronic health communications are an important foundation to the future system's sustainability. A successful PHN will need to know the scope of its operating responsibilities at the point of submission. We look forward to an early resolution to these uncertainties and to a timely and quick release of their findings and the government's response in order to prevent unintended service capacity loss, community anxiety and concern, and partner and stakeholder loss of confidence.

**Mr Edmondson:** To finish off there, if I might just give you a quick overview of highlights of our current service responsibility so that you get an understanding of where we sit in relation to the service provision role within the state in the primary care sector. We have a strong and well-defined service footprint across the entire state, and we have worked hard to maintain that. This is achieved through a combination of commissioned and purchased direct health services through local government, other agencies, private providers and the NGO sector. This is to an annual total cost in 2014-15 of in excess of $20 million. So I would stress that $20 million worth of service goes out through external service partners; it is not delivered directly by us. We do provide some directly delivered services in some of Tasmania's most difficult to service remote and rural areas and we also provide a whole range of provider support services to individuals and organisations across the state who provide primary care services.

Tasmania, like many rural jurisdictions simply does not and, I would stress, is probably unlikely ever to have the capacity to privately delivered or purchased services in all disciplines or regions. I think in that respect some level of what I know you are interested in, some definition of market failure, is likely to apply long-term. TML has also been granted through to June 2016 some $60 million of additional money under the Tasmanian Health Assistance Package, which is not received by other Medicare locals nationally, although the nature of that contract is obviously up in the air with regard to the shift to PHNs. This was to design and embed major new services designed to prevent avoidable admissions and avoid preventable readmissions post discharge. This work is designed to make Tasmania's health system more sustainable. It includes delivery, through partnership and commissioned arrangements, of care coordination to almost 5,000 of Tasmania's elderly and complex chronic care population this year. It is delivering through the THO and health department partnership—THOs in Tasmania are the equivalent of the local hospital networks—the internationally successful and nationally popular HealthPathways program, which is aimed at improving patient flows, communication and transfer of care between general practice and primary care and the hospital and tertiary care sectors.

TML is successfully implementing the HealthPathways collaborative. It is important to understand in the context of that collaborative that it is work that is being undertaken across and between jurisdictions, as well. We share work and activity with other Medicare Local jurisdictions nationally. We are also commissioning comprehensive work with eight of Tasmania's most disadvantaged communities to build community capacity to address the social determinants of health. That is a term that is often thrown around quite liberally but is one that is very difficult to take action on. Fortunately, through the resourcing that was made available through the Tasmanian Health Assistance Package some quite intensive work is now underway.

We partner with the NGO sector to address smoking rates across the whole population. We are partnering with Quit and Cancer Council Tasmania to ramp up quite significantly the whole-of-population messaging and support around quitting smoking. We are also partnering with NGO organisations across the state to look at harmful alcohol and drug use amongst young Tasmanians and at issues associated with access to fresh fruit and food and with healthy eating at the community level. We also doing work to improve health literacy at the service provider level in priority targeted areas as a precursor to whole-of-population and health literacy activity. We are also implementing a successful exercise treatment initiative, which is aimed at improving community management of chronic disease as well as pre-imposed surgical conditions, to aid in recovery times.

We work with the vast majority of general practices, whom we still fund for the comprehensive delivery and support for delivery of community accessible after hours care. We re-established and commissioned the highly successful GP Assist program that was recognised nationally for its ability to support rural general practitioners, in particular, to avoid the impost of 24-hour, seven-day-a-week after-hours care requirement. This is working closely in concert with the national Healthdirect service.

We are working intensively in partnership with the University of Tasmania and the state government in the implementation of Tasmania's clinical redesign program. This is another of the foundation stones for a

reorientation of a system that, in its current form and current practice, is largely recognised as being reasonably unsustainable. We are also helping with the university's establishment and embedding of the virtual Tasmanian Academic Health Science Precinct approach to reform of the health services research sector. Together with the AMA, RACGP, the Australian College of Rural and Remote Medicine and the Rural Doctors Association, we have also established the Tasmanian General Practice Forum to source and help represent a united voice of general practice on key issues and key challenges in Tasmania. We believe that we demonstrate the characteristics of a contemporary primary healthcare organisation and we certainly hope that, in the next iteration of the federal government's investment in primary care, some of these wins and characteristics are able to be carried through into the new organisational structures, whoever might be running those.

We already are a single Medicare Local for a single state with a single state government, a single set of state-wide stakeholders in the NGO and community sector, and so we already have what we would consider to be a very highly attuned boundary to the amalgamation of service provision in the primary care sector within the state. We have developed arguably the strongest and most robust relationships with state government, and it is probably by nature of that single jurisdictional boundary sharing that we have. This is represented from minister down through the ranks within government and the Medicare Local.

We have a strong and broad knowledge and an unequivocal role as a system change embedder, and certainly in the context of the work that the Tasmanian health system is currently undertaking to reform itself. We are seen as a strong player with regard to a partnership with the state government. We were, prior to its demise, recognised as an essential partner by the Commission on Delivery of Health Services in Tasmania. That was recently disbanded as a result of some of these changes, but we were seen as an important cog in the refocusing of the system by them.

As I have said, we have almost $21 million of service delivery annually contracted through general practice and other private sector providers, we have more than 200 current contracts with Tasmanian health service providers and agencies to deliver joined up primary healthcare services and we employ 150 staff—almost 40 per cent of whom are clinicians—with a combined primary health system expertise of more than 1,000 years if you want to chuck in a nice little analogy statement. We stand ready to work with the government in relation to its goal of uniting the health system, and we believe we are well placed to do so.

One further comment I would like to make just prior to finishing is that another concern we have is with regard to the National Partnership Agreement on Preventive Health and the potential impact that some of these other changes that have not yet flowed through the system might have in this time of change. We are also concerned to ensure that some of those changes are supported by primary healthcare organisations and the impacts on communities are both understood and addressed.

**CHAIR:** Thank you, Dr Watson and Mr Edmondson, for those opening remarks.

**Senator McLUCAS:** Thanks so much for coming and giving us evidence today on Melbourne Cup Day. You said, Mr Edmondson, that the Tasmanian Medicare Local was the amalgamation of four organisations. Can you tell us what they were please?

**Mr Edmondson:** There were three former regional divisions of general practice and one state based organisation. Tasmania is a remarkably parochial state, and this was no small feat. Each of the states had its own state based structure supporting its divisions of general practice under the former but one system, and the formation of the Medicare Local brought together those four organisations in what I might say was a pretty collaborative exercise. That was achieved in the first tranche, so the first group of Medicare Locals that went through. Many of the first tranche Medicare Locals were single organisations transitioning to single Medicare Local. We were one of the few who had a multiple organisational amalgamation.

**Senator McLUCAS:** So we can look to you for experience on how to do this.

**Mr Edmondson:** You can certainly look to me for scars!

**Senator McLUCAS:** No, not you personally, Mr Edmondson. I want to go to the question of market failure and your direct services. What proportion of your services are direct services would you estimate?

**Mr Edmondson:** I would not want to put a number on it at the moment; I have not actually calculated that. In the context of service delivery it would probably be around 20 per cent, I would say, of our service delivery programs deal in areas of market failure. Those are principally—and our primary area of own-delivered services being the mental health services area—where securing, holding and retaining the skills and expertise required in those various facets of mental health service delivery have been extremely challenging over a long period of time. Successive governments, both state and federal, have recognised and faced this problem, and so we have opted, by nature of a requirement to do so, to provide some direct services ourselves. I find it very difficult to see in the

foreseeable future how we can possibly move to an environment where external providers can pick up 100 per cent because we are talking about some extremely small rural and remote areas where simply the context of provision of service delivery is both uneconomical and unattractive to the private sector.

**Senator McLUCAS:** The time frame that we had from the department was that on 1 November the request for tender would be issued. Has that happened?

**Mr Edmondson:** No, it has not. Our understanding from the latest advice is that the tender documentation should come out at some stage this month. We are anticipating that that will be towards the end of the month rather than the beginning.

**Senator McLUCAS:** Is that formal advice or have you just heard that?

**Mr Edmondson:** I think it is pretty reliable advice. We have not received a date in writing yet, but we have been advised that it is likely to be towards the end of the month.

**Senator McLUCAS:** Are you still hearing that the response time is about six weeks?

**Mr Edmondson:** There has been some discussion, with the extension over the Christmas period, that that would be slightly extended. Obviously it is all in the hands in the government; we can only speculate at this stage. Six weeks was the official figure given, but we are of the opinion that the government recognises that that may create some challenges for applicants.

**Dr Watson:** To our knowledge, all other time frames remain as they were put in place originally. So the start dates and the transition dates remain unchanged.

**Senator McLUCAS:** Thank you. That is the question I was going to ask. Going to mental health programs, you are a partner agency in Partners in Recovery, not the lead agency; is that correct?

**Mr Edmondson:** That is correct. We took on more of a facilitative role in the implementation of the Partners in Recovery process. We brought Tasmania's mental health provider base together over two to three meetings, and over that time we agreed, collectively as a group of providers across the state and agencies, that the approach would be slightly different here in Tasmania. All the providers agreed on two optional lead agencies. My understanding is that two submissions went in and one of those submissions was successful. That was a universally agreed process which was more of a facilitative role.

**Senator McLUCAS:** And you are not mentioned on the contract between that lead agency—

**Mr Edmondson:** No. We do some work with them but we do not have any contractual relationship with the government in relation to Partners in Recovery.

**Senator McLUCAS:** What other mental health programs are you running?

**Mr Edmondson:** We run the Access to Allied Psychological Services Program statewide. We also provide a range of services for refugees, and some of those services also extend into the mental health space, although that is on a case by case basis. We also have been involved in the mental health nursing initiative, but that has since shifted in relation to negotiated arrangements we have had with the state government to move some of those nurses into the state government sector to support and work more closely with the community based mental health teams. We also provide a range of services for the Indigenous community in the mental health space as well.

**Senator McLUCAS:** But that mental health nurses program is the one that was ceased in the budget. Is that the one you are talking about?

**Mr Edmondson:** The mental health nursing initiative?

**Senator McLUCAS:** Yes.

**Mr Edmondson:** Yes, I believe that is slated to cease, although I am not certain of the detail.

**Senator McLUCAS:** It was not extended in the budget. It was cut. The Tasmanian Health Assistance Package was an extra amount of money, and that finishes in June 2016.

**Mr Edmondson:** That is correct.

**Senator McLUCAS:** Was there ever contemplation that that would be renegotiated for continuance?

**Mr Edmondson:** Our understanding, and the basis on which we worked, is that the package itself was not going to continue—that it would not continue beyond June 2016. But the work involved in the activity that is being undertaken as part of that package was designed to bring about some changes that may well result in reconfiguration of the way in which service is provided. So the upshot of the whole package is that it is there to assist in system redesign. The actual outcome with regard to what might be put to government as a result of some

of the findings from the evaluation of that is not yet clear, but certainly we believe there are better ways of doing business more efficiently and effectively in the interests of the health needs of Tasmanians.

**Dr Watson:** One of our Tasmanian Medicare Locals key focuses is on sustainability, because I think most of us have been around long enough to have seen programs come and programs go. One of our reasons for being slightly slower than we might have preferred in getting things going was how could we embed this in the existing capacity of our state providers in order that it could be sustainable after any major funding ceased. I think we have been quite successful in that, but obviously the funding would be appreciated, if it could be continued.

**Senator McLUCAS:** I think the most important thing you have talked to us today about is the uncertainty that this brings. Let's hope that the process we are going through will resolve itself by the end of June.

**Senator CAMERON:** We had evidence yesterday from the AMA arguing strongly that the budget cuts—I think the changes to Medicare Local are part of the broader budget parameters, as well as some ideology—are untenable and unsustainable. Have you given any thought to the implications of the budget cuts for Launceston?

**Mr Edmondson:** I raised the Preventative Health Agency cuts—the cuts to the preventative health programs. We believe that there are going to be some quite significant impacts across the country. I am not yet certain how the quantum of those cuts is going to impact on a variety of services across Tasmania, either in the tertiary sector or the primary sector, because a lot of the detail, as you know, is tied up in review processes et cetera. Until we get the outcomes of some of those review processes it is really difficult for us to quantify what impact that may directly have. What we do know, however, is that the socioeconomic status of the Tasmanian population—its rurality, its decentralisation—is a factor that impacts negatively on access to service. By nature of that understanding, it is probably quite likely that the effects of any budget cuts would be magnified.

We also know that in the context of the states own management of its budget there are currently underway some major cuts to the Tasmanian health budget, which again are going to significantly impact. So we have probably two levels of cuts, two levels of changes, that have yet to wash through, but will inevitably impact quite significantly, I would assume.

**Senator CAMERON:** I think you are being quite diplomatic. You are saying it will impact quite significantly but the AMA go further and say that it is untenable and unsustainable. Would you have any difference from the AMA on that analysis?

**Mr Edmondson:** Our view at the moment is that the current system is untenable and unsustainable. I think we are talking about degrees of untenability and unsustainability. Realistically, any change, any cut, is going to make things worse.

**Senator CAMERON:** So you are saying the current system, without the budget changes, is untenable and unsustainable.

**Mr Edmondson:** In Tasmania it is widely recognised—

**Senator CAMERON:** So the budget cuts will make that even worse for people in Launceston?

**Dr Watson:** It will exacerbate it.

**Senator CAMERON:** Can you give me some examples of how it would exacerbate it?

**Mr Edmondson:** Again, this could play out in a number of different ways. Access to private health services at the present time is limited across a number of disciplines, particularly in rural Tasmania. Any cuts to, for example, the funding of community based allied health services will significantly impact rural service access and therefore impact on community based care. The tendency to centralise services at times of budgetary risk is one that is, again, going to further impact on those who are most distant from service centres. Costs associated with access to services, either through transport or other payments, almost certainly are going to negatively impact on the health of Tasmanians.

**Dr Watson:** If money is not spent on primary care and prevention it will only end up costing the community more money in the end, both financially and also in terms of poorer health outcomes for the community. Tasmania already has the poorest outcomes of most states—the oldest population and the sickest population—and that can only be exacerbated by any further reduction in funding.

**Senator CAMERON:** Do you have any idea what the bulk billing rate is in Launceston.

**Dr Watson:** The bulk-billing rate is not as high as the national average. There has always been quite a substantial shortage of general practitioners and we have not had the IPNs, the bulk-billing clinics, that do the 4- to 6-minute medicine. General practitioners in Launceston have generally seen people for 15 to 20 minutes and charged accordingly.

**Senator CAMERON:** I cannot say this for sure, but I assume you are a member of the AMA?

**Dr Watson:** No, I am not a member of the AMA. I am unaligned.

**Senator CAMERON:** You are unaligned. The AMA argues strongly, in a lot of the submissions we have, to put the local GP at the centre of primary care. I do not think anyone argues about that; but what I have been concerned about is that in an area like Launceston—or an area that I know pretty well like Tamworth in New South Wales, where people have written to me—people say they cannot get a bulk-billing doctor. These are pensioners. The letter I have here is from one woman with chronic illness. She is 74 years old. Her husband has some chronic illnesses. They are both pensioners living off the age pension. When they go for a level C surgery consultation, they have to find $105 for one of them—that was for her husband. Then for the woman herself, a level B surgery consultation is $70. So a pensioner has to find $175, then go and try to get some of that back, if possible, because they do not reimburse you on the spot. You do not get much of that back. Then they have to go and find money for prescriptions. So this argument about putting the GP at the centre of primary health care—isn't that flawed if you do not have enough GPs or if the market has failed so badly that people who need access to health care cannot get into a doctor either because of a shortage of doctors or because the doctors are charging so much they cannot get there?

**Dr Watson:** It is very important to be aware that general practice is a small business. If you take the analogy of going to Harvey Norman or Coles or Woolworths and you are a pensioner, that small business does not differentiate whether you are a pensioner or not. General practice is a small business and therefore what they charge is considered to be fair value for the service that is provided. Therefore I think it is important to be aware that when a pensioner gets charged a certain amount of money, they go to the government to get the rebate—what the government considers their care is worth. On one hand you could say it is what the doctor charges; but on the other hand you could say it is what the government is prepared to pay to support that person who has higher needs than someone like myself, who is considered to be wealthy. It is very important to be aware that the private business is taking a substantial cut in what it considers to be a fair fee for its service for one person because they are a pensioner, if they choose to bulk-bill them, but not for another person who is considered to be wealthy enough to pay. The government, on the other hand, provides the same rebate for both those people. There are other countries around the world which actually provide a differential rebate from the government to support people who have lesser means.

**Senator CAMERON:** If you cannot afford to buy a wide-screen television, you do not die. If you cannot afford to see a doctor you could die. I think a comparison between a doctor and Harvey Norman is not a really good comparison, to be honest.

**Dr Watson:** Okay. Coles is a much better comparison, then, because you need food to maintain yourself.

**Senator CAMERON:** You can keep trying, Doctor, but I do not think you are going to convince me.

**Dr Watson:** I do feel—

**Senator CAMERON:** The market cannot just be allowed to rip in terms of health care.

**Dr Watson:** I think rip is an unfair word, Senator.

**Senator CAMERON:** In Tamworth—I am not sure what it is like in Launceston—people cannot get access to a bulk-billed doctor. You and I might not agree on these things from a philosophical point of view, but let me now turn to Medicare Locals. Medicare Locals, as I understand it, were designed to do everything Professor Horvath's recommendations go to, other than some of the political recommendations.

I do not think the Horvath inquiry report, quite frankly, is a very robust report. I think it is a political report designed to give cover to the Abbott government's destruction of Medicare Locals. That is clearly what Horvath is about. When you look at that report and you look at what you guys do across a range of areas, I cannot understand what the big disconnect is between Medicare Locals and what Horvath is saying.

They had PricewaterhouseCoopers have a look at the effectiveness of the financial management, and Deloitte said there are no significant issues. Basically the Medicare Locals got a clean bill of health. Then Professor Horvath comes in and says: 'Well, that's fine. There was no major problem. But let's dig in and look at all these little inconsistencies. You spend a little bit more here. a little bit more there.' But you guys were really under the establishment phase, weren't you?

**Mr Edmondson:** Definitely.

**Senator CAMERON:** Can you explain some of these criticisms by Horvath?

**Mr Edmondson:** I am not going to set about criticising Horvath nor the motivation behind the review process. We recognise that successive governments make decisions, and they are entitled to do that. Our challenge I guess

is to try and understand what it is that the government is attempting to seek out of this process, and ensure that the process delivers on that.

The reality is that Medicare Locals were established to respond to local needs. Therefore, by nature, the very makeup of them, the set of responsibilities that each has, is going to be quite distinctively different and it is going to be based upon the needs of the communities that they serve. So I guess there was an understanding in there that Medicare Locals were always going to be different—in fact, their difference was their strength. The capacity to respond locally and work with their communities was their strength.

We would certainly hope that, in the context of the next iteration, that is a preserved capability. Indeed, we would hope that potentially some of the restrictions that might have existed around a range of different things might be lifted in this process and that there might be a greater opportunity from the outset to respond locally, insofar as the funding allows et cetera. We certainly see that as a strength.

I just want to touch briefly on a comment you made before in respect of putting the GP at the centre. Our view of 'putting the GP at the centre' is not that the GP does everything. The GP is a person who has a helicopter view of what it is that a person needs and is in a position to work with a range of other providers around them in order to ensure that that person gets what they need. So, without entering into a debate around the affordability of doctors' services, what we would see is that this offers an opportunity for a much better utilisation of the service system that works closely with general practice to ensure that people get what they need locally, in a timely, effective and efficient fashion.

**Senator CAMERON:** So they are not gatekeepers; they are more analysts.

**Mr Edmondson:** I guess the gatekeeper role can be defined in a range of different ways. Being a gatekeeper in the current funding system is probably an inherently reality; a referral is required in order to access a range of service. And that gatekeeper role is an important one. But so to is understanding the range of services that sit around the outside in order to make the best use of it.

**Senator CAMERON:** There are so many questions I have—

**CHAIR:** Last question.

**Senator CAMERON:** Are you aware of Mr Martyn Goddard?

**Mr Edmondson:** Yes.

**Senator CAMERON:** He is an expert in analysis on health issues.

**Mr Edmondson:** Yes.

**Senator CAMERON:** He presented a paper from the University of Sydney—I am not sure if you are aware of that paper—which says that the cost of the budget changes would impact a family of four, with two children under 16, is $184; for a self-funded retired couple without a concession card, it is $244; and for a couple on the age pension with concession cards, it is $199. How can Medicare Local help these people? Take the aged couple. It is similar to the people in Tamworth who I got the letter from. They are, say, another $200 down the tube because of this budget. That is just an age-pension couple. How can they get medical help and support if they cannot afford the system as it is without another $199 on top of it because of the budget? How can Medicare Local help?

**Mr Edmondson:** I am not sure that there is an answer that can be quantified into a specific dollar figure like that, but I absolutely understand what you are getting at. The reality is that the role of Medicare Locals is largely a system-reform role. Its job, in the current policy structure, is to work with the system to ensure that the system delivers more, more effectively, and in a more timely and efficient manner. So our job is actually to try to look at how we can work with system providers to get more out of the current system. Ultimately, any increases in efficiency will have benefit in relation to the type of circumstance that you are looking at. It might be more timely access. It might be access provided to services in a regional or a rural area where those people live and find it very difficult to get access and therefore, by choice, often do not, until things are too late. So our belief is that primary care very much is the point at which investment needs to be made, in terms of thinking, relationships and structure, to actually resolve the long-term issue that you are talking about—that is, a burgeoning systemic cost for healthcare service delivery. A dollar invested in primary care is going to be far more efficiently utilised, long-term, than a dollar invested in a hospital. But the two things have to be properly supported to provide an effective and efficient system.

**CHAIR:** Yet we have cuts to the health budget for the hospital and we also have the abolition of the national preventive health organisation. They are hits on the system at its most vulnerable points from this Abbott government. I will go to Senator Whish-Wilson.

**Senator WHISH-WILSON:** I just wanted to follow, perhaps, in my line of questioning, Mr Edmondson, what you were just saying then, about how the dollar can be targeted. Do you feel that that whole philosophy around preventive health care and targeting issues locally is what the government is attempting to change, or is it that they feel that can be done in a different structural manner? Are you too local?

**Mr Edmondson:** It is probably a little bit too early for me to make a judgement about what the government, long term, is intending to do. Having said that, in an environment of cuts to everything else, the fact that the quantum of funding that the government is choosing to apply to primary health care remains the same and everything else is taking significant hits we believe is a very strong support for the value and benefit, long term, of primary health care. I think it would be a hard argument to make against that, when all of the successful first-world economies that have really good, functional, sound, successful systems are recognising and making those investments, and I think this is, hopefully, leading towards the same ends.

**Senator WHISH-WILSON:** As to the Medicare Local concept that has evolved and the increasing prominence of preventive health care, which is a fairly recent development: what sort of time do you think you need across a lot of outcomes to show that it is essentially going to be a cost-saving thing for the government if they can get on top of preventive health?

**Mr Edmondson:** I think there is plenty of evidence already that shows that that is the case. This is not something that has not been researched already. And I think that is probably indicative, in the fact that this decision has been made to continue resourcing in this particular area. So I think the argument is already there. As to the specific structure required to deliver on that, at community, regional and local level, I guess that is part of the process that we are involved in at present—trying to arrive at what might be the best structural mechanism to help support that.

**Senator WHISH-WILSON:** On that question of structural mechanisms: you have mentioned the words 'market failure' several times, and you just talked about resourcing; can you explain to us why you believe there is market failure in the provision of these types of services?

**Mr Edmondson:** Market failure across rural Australia is a quite commonly understood phenomenon in relation to access to service providers. Small communities cannot sustain some of the service specialties that are required in specific areas. So that might play out in terms of access to GPs; it might play out in terms of access to rural health or allied health services. There are a range of things that could be impacted by that notion of market failure.

We would also define market failure in a variety of ways. Market failure may well be the incapacity to deliver a service for anywhere within a margin that is considered a reasonable cost. For example, a provider being flown in from the mainland via some mechanism to deliver a service in a rural location in Tasmania is inherently going to have a much higher cost per service than would be considered by anybody to be reasonable. So it is important to look at what other mechanisms might be applied in order to get that service accessible to that community for a more reasonable and rational cost.

**Ms Watson:** It is to do with equity, really. It is what is required for the individual and the population, not necessarily what the dollar cost is.

**Senator WHISH-WILSON:** And the role of government in correcting for that market failure.

**Ms Watson:** A perfect example would be a dietician who is required to see somebody in Rosebery, for instance. That cost will be quite substantial per service but it is still incredibly important for the community to provide that equitable opportunity.

**Senator WHISH-WILSON:** I totally agree.

**Mr Edmondson:** The important thing around service delivery in areas of market failure is that two things happen. One is the fact that you might actually supplement service for a period; but the other thing is that you are actually looking at service modelling in that environment to look at whether or not there is a longer term solution that can be brought into play to take over from services that might be directly delivered. That certainly features in respect of service delivery that we have been providing directly.

**Senator WHISH-WILSON:** Just on that: how much of your service delivery across the board is delivered by—for want of a better word—private contractors. I know that in your submission you did talk about conflicts of interest and having to streamline that.

**Mr Edmondson:** We contract out about $21 million a year worth of direct service.

**Senator WHISH-WILSON:** What is that as a percentage of your overall entitlement?

**Mr Edmondson:** That is around 50 per cent of our total budget, but again not all of our budget is applied to direct service delivery. There are a whole range of other responsibilities that Medicare Locals have that are not about direct services to individual community members.

**Senator WHISH-WILSON:** I am trying to get an idea of how much extra business you could do through private contractors. I am worried about the government's agenda in wanting to just facilitate business and corporatise as much as they can, including the healthcare services. I am wanting to know in your situation how much would be a natural role for government to play in terms of funding versus how much could potentially be done by commercial operators. I note you also said in your submission that the private health insurers were looking to move into this space in a big way as well, which concerns me.

**Mr Edmondson:** I would only iterate what has been published nationally in that respect. We have no specific evidence at this stage of major entry into that market. I do not believe it would be widely supported and nor do I believe that the current funding models within the healthcare system necessarily support that.

**Senator WHISH-WILSON:** Would that be because it would not be profitable for them to come into a place like Tasmania, given the challenges that you face?

**Mr Edmondson:** One would suggest that, if the current private market struggles in some areas, any private market would struggle in respect of that. Again, it is a question of looking at the service delivery model and whether or not the service delivery model can be tweaked or altered in order to accommodate the needs of specific regions or areas.

**Senator WHISH-WILSON:** I notice in your submission that you talk about a broad range of planning processes that the government wanted TMLs to focus on, including risk factor resource development for communities, partnership with mental health and wellbeing agencies. Have you had much to do with the alcohol and ice epidemic that we have seen in some of our communities? Is that part of your brief?

**Mr Edmondson:** No. As I mentioned in our initial opening, we do deal with alcohol misuse by young people, and that is through a partnership with one of the local youth agencies in Tasmania and through Headspace. We have had no direct engagement in relation to ice.

**Senator WHISH-WILSON:** Obviously there are the side effects in terms of your focus at a local community level—

**Mr Edmondson:** A variety of providers and agencies have carriage for those sorts of things. We certainly have interaction with those agencies and organisations. At this particular stage, my understanding is that it has not been raised by any of them as being a major priority issue.

**Senator WHISH-WILSON:** Thank you.

**CHAIR:** I am sure that is of concern to people in the north-west—particularly given the evidence we heard yesterday that cutting access to GPs, by putting a $7 GP tax in place, is a disincentive for people to seek health care early. The evidence leads everyone in Tasmania and, indeed, around the country to believe that people will end up in emergency departments much more ill than if they were able to see their doctor without the $7 co-payment. For young people in particular, who are so much a feature of the questions the senator was just asking, any gap between you and your doctor is a very big problem. For people in the northern part of Tasmania, I am sure that is of great concern. I am sure Senator Polley will have questions.

**Senator POLLEY:** Yes. I really appreciate the evidence you have given us. I now turn to somewhere like the east coast—St Helens. I visited a nursing outreach service in Hawthorn in Victoria. They are delivering a service, via the National Broadband Network, to keep people in their homes but supervise their blood pressure, insulin levels et cetera. Why do we have to rely on a service in Victoria to do that when Tasmania was the first port of call for the National Broadband Network, even though the government has stopped it from being rolled out to the extent it should be? How are you embracing telehealth in your service delivery?

**Mr Turner:** My understanding in relation to those particular broadband projects is they were trial projects for the way in which the broadband network could be utilised across a range of different areas. Tasmania has a number of broadband trials. We have intensive work in relation to end-of-life care, for example, through the 4C project in the north-west. There is a range of different things happening across the country. Obviously the rollout of broadband is not yet complete, so our ability to rely on it as a unilateral system at the present stage is not quite there even in Tasmania with its advanced rollout process.

There are a whole range of things tied up in that. The whole e-health agenda in respect of things like the personally controlled electronic health records—we have been heavily involved in the rollout of that. Tasmania, I believe, is right at the top of the list both in terms of the number of people who have been registered—and we

have played a very strong role in that process—and the number of providers ready to use that system. We certainly hope that a decision around the continuation of the e-health record and the e-health program is made in the not-too-distant future and we certainly hope that would feature in respect of primary health networks into the future.

There are a whole range of things tied up both in specific types of service delivery, from telehealth for mental health services delivery to the islands—which we utilise as an adjunct service to monthly or bimonthly visits that help supplement and provide a reasonable service access—to things like utilisation of phone based referral processes or systems to secure consultations for patients with their GP, and on through to specialists in a variety of areas. All of those mechanisms are currently used. We certainly welcome the opportunity for that to be extended further and we would look forward to an environment where that mechanism was supported both through funding for the practitioners involved as well as through the telehealth capability to make those services work.

**Dr Watson:** Tasmanian Medicare Local has only been able to undertake the work required for the contracts that we run. We would love to be more responsive to what we see as local needs but, because we have been tied to our contracts, we can only do what we can do. One of the components of the Tasmanian Health Assistance Package is the coordinated care of older people and people with chronic disease. Certainly those care coordinators, who are pretty much just starting to be on the ground now, are doing that coordination of care. It may not be true telemedicine but their involvement with these people with higher needs, in their homes, is definitely becoming quite a useful component of what we can offer our community. As Phil said, there are nearly 5,000 people who will be involved with that system, whereby they get personalised care coordination from a coordinator. That is similar to what the telehealth people are providing but in actual fact much more personalised and more responsive to older people and people with chronic disease requirements—that is, it is a more physical, human approach to that involvement.

**Senator POLLEY:** I have visited a Brisbane hospital just to see where specialists are doing projects, as you said, that are rolled out. Not only is it a cost saving to every government—we know that we have not felt the full effects of the state government's cut to health and we have not yet seen the introduction of the $7 copayment—but the reality is that as health costs increase the demand for services is going to be so much greater. If you have somebody on the west coast of Tasmania who just needs to be supervised in a recovery exercise program, monitoring their blood pressure et cetera, that can be done in their own home without the need to travel, so you have to save money there. I would be very interested to see how you deliver, for instance, your services in aged care, because that is my area of responsibility. I notice that physio is one of the requirements. Couldn't that also be used with a fast medical-grade broadband to make it more cost-effective in a better in-house or residential care facility?

**Mr Edmondson:** I think the opportunities are endless. One of the things we are doing is working with the HITLab at the University of Tasmania to look at how we can make better use of high-end technology to have work happen in patients' own homes in partnership with them. I think this is a huge opportunity opening up before us. Certainly, it is inherent upon any organisation structure, whoever is in this particular space from next July, to be looking to those as the system reform solutions, which I was talking about before, that will help us get more efficient service, more effectively provided, in people's environments of residence in a more timely manner.

**Senator McLUCAS:** What role did the Medicare Local have in the Tasmanian Health Assistance Package agreement?

**Mr Edmondson:** The Medicare Local was consulted a couple of times during the development of that process.

**Senator McLUCAS:** Are you contracted in that process?

**Mr Edmondson:** We are, definitely. We have $60 million worth of contracts through the Tasmanian Health Assistance Package directly with the federal government. They are schedules to the multiprogram agreement with the Commonwealth and therefore they fall under the ceasing programs category from June next year. The former contract will still have one year of life left. Therefore, it is of great interest to us what the intention in relation to those contracts is beyond June.

**Senator McLUCAS:** What is the name of your organisation?

**Mr Edmondson:** Tasmanian Medicare Local.

**Senator McLUCAS:** Incorporated?

**Mr Edmondson:** Yes.

**Senator McLUCAS:** TML Inc. is the organisation?

**Mr Edmondson:** Yes. It is a company limited by guarantee.

**Senator McLUCAS:** If you are unsuccessful in receiving the PHN contract, what happens to the remnants of that $60 million?

**Mr Edmondson:** That is the government's decision.

**Dr Watson:** It seems likely that the PHN would be transferred the responsibility for rolling up those projects.

**Mr Edmondson:** We would hope that would be the case but there is no certainty around that.

**Senator McLUCAS:** We don't know that, Dr Watson, and with the way this government operates I would be very nervous about the future of that money. That has only struck me now. How much will be left at the end of this financial year?

**Mr Edmondson:** I believe it will be around $17 million.

**Senator McLUCAS:** For the 2015-16 year?

**Mr Edmondson:** For the final year, 2015-16, yes.

**Senator McLUCAS:** What is that programmed to deliver?

**Mr Edmondson:** It is programmed to deliver, under three principal contract areas, social determinants of health and health-risk factors; care coordination for complex chronic patients and the elderly; and streamlined discharged care, which is work with the Tasmanian health organisations and the hospital sector to look at streamlined processes for discharge, to prevent avoidable readmissions and ensure avoidable admissions initially.

**Senator McLUCAS:** The website of the federal Department of Health website says:

The Tasmanian Health Assistance Package was an initiative of the previous government.

That is it. It does not describe it at all. It continues:

The current Australian Government is working closely with the Tasmanian Government—

not the Tasmanian Medicare Local—

to improve the effectiveness, efficiency, and long-term sustainability of Tasmania's health system.

That is why I jumped, Dr Watson, when you said you expect it will be transferred. If they are not negotiating with the Tasmanian Medicare Local or the potential replacement I would be a bit concerned about that $17 million and where it might go.

**CHAIR:** We should note the deep breath that Mr Edmondson took then. The reality is that this state is definitely under attack with cuts to health funding, in contrast to the investment from the previous federal government. Obviously, there is a significant change coming down the line. The establishment of the Medicare Local, which we discussed a little earlier, came from the four different regional groups—you fused them together. Could you give me an idea over what period of time you undertook that transition.

**Mr Edmondson:** The transition was all but complete from day one of the Medicare Local's establishment, which in Tasmania occurred in November 2011. Effectively, that process commenced when the announcement of the Medicare locals' formation was first made. We worked together collaboratively in the development of a submission. However, the challenging part has come after. It is easy to put in a submission. The challenging part is around the cultural amalgamation of multiple organisations, around work at community level to help people understand that a single, statewide organisation is not going to forget that communities exist, to ensure that providers feel part of the process and to ensure that membership is engaged in the process of development. That is all the difficult stuff that follows first establishment. I would say that—

**CHAIR:** For what period of time have you been doing that?

**Mr Edmondson:** I was about to venture that that is a good two-year process.

**CHAIR:** You had really just got to that point, and now we have the shift to PHNs and a different philosophy and, I suppose, a different mode of putting the community together—trying to connect to the community to health.

**Mr Edmondson:** It is our hope that this process does not see a loss of those sorts of relationships, does not see a loss of community confidence in relation to who they are going to work with and how they are going to work with them. We hope that some pragmatism comes to play in the transition from one to the other, whether it be with us or somebody else, and that a considerable amount of what might have been established and is seen to be valuable and important would be taken through into the new PHN environment.

**CHAIR:** That is a good hope, but the people of Tasmania needed to be pretty alert to this. You say transition of care—we use all these lovely words—what that means for somebody up in Smithton, for example, who might have a mental illness and currently has a provider with whom they have established a relationship, is that their whole care relationship and structure is potentially at risk, right now, as this government dissolves Medicare locals and seeks to establish primary health care networks in a different way. They are going to bring in different people and they are going for value for money. That is always an important consideration but perhaps not front of mind for a person in Smithton who wants to keep their current service provider because it is working for them. The people of Tasmania need to be very aware that there is an awful lot at risk right now, that this government is cutting funding and that this is a structural change that could lead to loss of services. Could I ask once more, how many people are employed in your Medicare local?

**Mr Edmondson:** We have 150 staff.

**CHAIR:** What is the cost of dissolving the Medicare Local?

**Mr Edmondson:** The cost that we have calculated is in excess of $3 million. Just to clarify that, the difficulty for us in relation to having $60 million worth of additional work through the Tas health package is that that is why our costs are going to be a little higher than other Medicare locals: we have that large amount of extra responsibility and resourcing through that package.

**CHAIR:** Just to be clear: prior to the establishment of Medicare locals people were finding it very difficult to get their care connected. Medicare Locals came in to create that connected care. Now they are being changed, and the cost of making that change, which puts people's care at risk, is going to be $3 million from the health sector, which we already know is under huge pressure. If I was voting in Tasmania I would not think that was a great idea, but that is what we have at the moment.

Turning to the future of the primary health network, we have had evidence to say that there is great confusion. There have been dates set by the government for having documents out. That has all been delayed. What formal communication have you had from the government and what timeline has been written and delivered to you? All we can get at the moment is rumour, innuendo and gossip. Is there anything more formal from the government?

**Mr Edmondson:** The only formality is in respect of the words that are on the website, and if you read that you will have everything that Medicare Locals have in terms of a defined time line and information.

**CHAIR:** What is the budget that you are going to be looking after? What is the budget of the work that you do?

**Mr Edmondson:** Currently?

**CHAIR:** Yes.

**Mr Edmondson:** Our budget is currently $48 million.

**CHAIR:** So for $48 million and a very short time frame for you to change to a completely different structure and do business in a different way, which is set to be as early as 1 July next year—without any tender documents having arrived, without any form of communication—you have a website that is telling you the same information as that person with mental health issues in the north-west of Tasmania?

**Mr Edmondson:** That is correct.

**CHAIR:** That does not look like a very good plan from this Abbott government, does it?

**Mr Edmondson:** It is certainly a challenge, and it will provide challenges for us.

**CHAIR:** It is more than a challenge—it is chaotic. It represents a chaotic government. One of the things that I am very conscious of in your evidence today, and I know it was a concern for us coming out of the Horvath report, is this intention to have the GP at the centre—as if they were not. Frankly, I think it is just some nonsense that we have got out of the Horvath report. But you talked about the GP as being a helicopter overseeing this whole area. The evidence we have received in Tasmania lets us know that the Royal Australian College of General Practitioners, who are the GPs at the centre of that pyramid that you spoke of, were not consulted by the government. There was no consultation with the GPs before the government decided that they would announce a policy to tax every person $7 when they go to see a doctor, when they go and get any X-rays or diagnostic imaging, when they have to go and get a blood count. There was no consultation with the GPs for a GP-centred model.

We also heard yesterday, and in other places, about the PGPPP program, which is really important for Tasmania. Let us talk in real talk: what does this mean for a person in Burnie, for example? They expect that there are going to be doctors that they can go to and take their children to. To make that happen you have to plan the workforce. To get the workforce in the right places you have to make sure that you help perhaps young training

doctors to go and have a placement in a rural area where they think they might not be able to work. The PGPPP did that. It was part of Health Workforce Australia's planning, which is now gone. Tony Abbott thinks we do not need it—that has gone. PGPPP put young training doctors in rural areas and successfully was able to get many of them to take up practice in those areas. Tony Abbott does not think that is very important either, because that has gone. So we have a GP tax with no consultation with the AMA or the GPs; we have a PGPPP program that put doctors in rural, regional and remote areas—gone; we have Health Workforce Australia—gone; and we have the National Preventive Health Agency gone. Where is the good news for the people in Tasmania?

**Mr Edmondson:** I am not sure I can answer that question. I am not sure there is a huge amount. Having said that, I still think there are ways in which the health system can be configured to make it work more efficiently than it currently does, and we would certainly see that as being the fundamental challenge that lies ahead for primary healthcare networks in whatever the future environment holds for it. And we would certainly see that as being a fundamental responsibility of that structure.

**CHAIR:** Mr Edmondson, your Medicare Local is tendering for a Primary Health Network, isn't it?

**Mr Edmondson:** At this particular stage, notwithstanding the fact that we have not seen tender documentation, we would consider that it is certainly highly likely.

**CHAIR:** I understand that puts you in a difficult position in terms of maintaining a relationship with a government that is cutting and slashing funding left, right and centre to the whole medical health workforce, prevention and GP access point. But clearly you care about it—otherwise you would not be in the role you are in.

**Mr Edmondson:** Absolutely. We very strongly believe that the mantra of the system has to be based around good system integration, good system planning, good workforce planning and GP centrality in primary health care. They would be the fundamental tenets that we believe have to remain in respect of the future of primary health care—

**CHAIR:** Half of them have gone and the funding has gone. I think that Senator McLucas is alert to the $17 million that you are hoping might still be here for Tasmania after July next year. That means, I think, that we have put some important things on the record here today.

**Mr Edmondson:** I have both fingers crossed.

**CHAIR:** I am sure that, when people go to the doctors, they hope that the system is relying on more than fingers crossed.

**Mr Edmondson:** I understand.

**CHAIR:** I expect that they want more investment in health in Tasmania, rather than cuts to investment in health in Tasmania. That is what we are seeing—certainly from the Abbott government and now, it would seem, from the state government as well.

**Senator POLLEY:** We have heard this morning, and it is a fact, that we have the oldest population in the country. We also have the highest level of chronic illness, we are experiencing an epidemic of ice and drugs in the state and we now have a real issue with obesity. As we know, the ageing of our population generally is going to peak in the next two to three decades. We know that dementia is a huge issue. You have talked about primary health care, which is the focus of ensuring that we can stave off, for as long as we can, dementia, heart attacks et cetera. If there is any further evidence that you can provide to the committee following today's hearing, we would really like to hear it, because I think that you are in a central position to give us a pathway forward.

**CHAIR:** Thank you, Mr Edmondson and Dr Watson, and good luck.

**Mr Edmondson:** Thank you very much for the opportunity to talk to you.

**ELLIS, Mrs Neroli, Branch Secretary, Australian Nursing and Midwifery Federation (Tasmanian Branch)**

[10:11]

**ACTING CHAIR (Senator McLucas):** I now welcome Mrs Neroli Ellis from the Australian Nursing and Midwifery Federation Tasmanian Branch. Would you like to give us an opening statement?

**Mrs Ellis:** The Australian Nursing and Midwifery Federation Tasmanian Branch is both the largest nursing union and professional body in Tasmania, representing a nursing team of around 7½ thousand members. We actively advocate on behalf of members to pursue safe, quality patient care, and we will continue to do that regardless of the attacks on our healthcare system. We appreciate the invitation to contribute to the Senate Select Committee on Health's inquiry into the Abbott government's budget cuts to health and their effects on the Tasmanian community. We note for the record that we support the ANMF federal office submission.

We say that the budget measures are a blunt instrument to implement ideological reforms inconsistent with the principle of the provision of health services as a public good where access to adequate health care is the right of every Australian. We are committed to publicly funded universal health care. Australia's health system is siloed and fragmented, leading to service gaps, duplication and waste of resources. This is very evident in the Tasmanian context.

This verbal submission will broadly outline the issues that are most relevant and of most concern to ANMF, particularly in the Tasmanian context. I would like to set the scene in regard to Tasmania and where we are. I seek your indulgence if you have already heard this information from other submissions, but the context of what is happening here in Tasmania is quite unique and has relevance to the whole country. In recent years, we have been subject to significant challenges in relation to governance, financing, accountability and service delivery. This has led to periods of instability for both the population and our Tasmanian workforce. You may be aware that the Tasmanian Liberal Hodgman government is currently slashing health budgets across the state—both the Tasmanian Health Organisations and the Department of Health and Human Services. This inevitably leads to further reduction of services and further challenges for our members.

Around 2011 we saw a round of budget cuts that led to around 100 acute beds closing. For each of the four major hospitals it equates to a whole major acute surgical ward closing in each of those services. We also saw the funding for our graduate Transition to Professional Practice program being reduced by 40 per cent, hence only around one-third of our graduates getting employment in Tasmania. Our nursing graduates are predominately either unemployed in nursing or have to seek opportunities on the mainland. This instability, combined with the potential Abbott government budget measures, has provoked significant alarm for our members in Tasmania.

The population is characterised by an ageing population, greater than other states, with 16 per cent of people over the age of 65. The treatment for chronic conditions continues to increase, fuelled by relatively poor risk factor profiles, and potentially avoidable mortality remains significantly higher than the national average. The average income and education levels of Tasmanians are below those of most other states, with 31 per cent of Tasmanian households relying on income support, including age, disability and sole parent support. The demographic factors impacting on our inpatient costs have also been recognised by the Grants Commission. These include the assessment models for Tasmania are 16.8 per cent of the population aged over 65, whereas the national average is 14.2 per cent; 32.4 per cent of low socioeconomic population, whereas the national average is 21.3 per cent of the population.

Overall Tasmania has marginally fewer hospital beds per capita than the Australian average, and the rate of public hospital access is lower than the national average. There are long waiting times and an alarming number of patients on elective surgery waiting lists. The number of patients overdue for surgery in Tasmania has remained near or above 50 per cent for at least six years, and the total overdue number of patients make up 15.1 per cent of the total number of overdue patients Australia wide. The proportion of overdue patients on Tasmanian waiting lists far exceeds that of any other state. A concern to us is that the rate of hospital initiated postponements in Tasmania for 2012-13 was 16.3 postponements per 100 scheduled admissions. In Victoria the rate is only 6.2 to 6.8 postponements per 100 scheduled emissions. There is no doubt this is a direct impact of the closure of those acute beds over the last three years due to the budget reductions. There is ongoing tension between elective surgery and acute admissions fighting for that limited bed capacity left in our acute public hospitals.

We have a very high rate of access block and GP type presentations in emergency departments compared with the national average. The number of potentially avoidable GP type presentations accounted for 41.9 per cent of our presentations in Tasmania—the highest of any state or territory. There is no bypass availability in our Tasmanian public health system and very few after-hours GP services accessible.

The Tasmanian Treasury has released the figures of the impact of the federal budget for Tasmania. We have only received these figures in the last few months. The total negative impact on Tasmania's total budget up to 2024-25 is estimated to be $2.1 billion. Unfortunately, health is a primary area impacted—

**Senator McLUCAS:** Excuse me, Mrs Ellis, can you just go back a bit? I think this is new information to the committee. So the Tasmanian Treasury has released?

**Mrs Ellis:** The impact of the federal budget.

**Senator McLUCAS:** We will be very interested in this material. Can you start again?

**Mrs Ellis:** Okay. So the negative impact to the Tasmanian budget over the next 10 years, to 2024-25, is estimated to be $2.1 billion. However, of concern to us is that health is the primary area being impacted, with the projected decline to revenue in the next 10 years to 2024-25, relative to recent growth in funding, of a $1.77 billion loss of Commonwealth government funding to Tasmania's health system.

**Senator McLUCAS:** Over what period?

**Mrs Ellis:** Ten years. That is in addition to projected state budget cuts that are coming forward over the next four years under the state's budget. It is in this context that the budget initiatives as proposed are going to be keenly felt by the Tasmanian community.

In relation to the national health partnership agreement and the National Health Reform Agreement, they go to the heart of our integrated health system across the country where there are federal, state and private sectors contributing to cohesive linked care. These changes clearly initiate the dismantling of this system, where the collective cohesion will be fragmented; particularly as it relates to hospital systems. This is a particular concern in Tasmania, where the performance of our hospitals is already under great pressure through under-resourcing. It is not sustainable and will lead to very poor outcomes for the Tasmanian community, in the forms of greater emergency department waiting times, less access, greater elective surgery waiting periods, and further cancellations for elective surgery. The federal government has retreated from existing agreements whilst demanding productivity and efficiency, which will lead to what we say will be the perfect storm. The use now of policy instruments as blunt tools to change the behaviour of individuals, communities and organisations is without merit. Change is far more effective if key stakeholders are involved, especially the health workforce.

The withdrawal of funding under the national health partnership agreement has seen an immediate reduction of services in Tasmania. I will give specific examples in regard to those immediate reductions. Immediately after the announcement was made around the federal budget cuts, we saw 10 subacute beds sourced to OneCare, a private aged-care provider—beds which were enabling patients from the Launceston General Hospital to have early discharge to an aged-care environment. Funding for those 10 beds has now ceased. Those elderly patients now have to stay in the LGH in acute beds for that additional period of recovery time and, obviously, the staff at OneCare also lost hours and positions as result of that immediate budget cut to the national partnership agreement funding.

Secondly, the funding for a newly-commissioned subacute centre, the 20-bed John L. Grove Centre here in Launceston, which was newly commissioned last year, has no guarantee now of financial funding going forward past 2015. That centre has been very successful in allowing patients to move from acute beds at the Launceston General Hospital over to the subacute centre, to recover and recuperate pre-discharge to home or to an aged-care facility. Those patients will now have to be reabsorbed back into acute medical or surgical wards which just do not have that capacity. So that is another 20 beds being lost next financial year from our Launceston community.

Another example where our national partnership agreement funding will be removed and not continued is a 10-bed psychogeriatric unit in Hobart called The Jasmine Unit, which has been, again, specially set up to take around 10 patients with psychogeriatric mental illness. Those patients have been in a purpose-built area which has been working really well and, again, has meant those patients are not in acute beds at The Royal Hobart Hospital. That funding will not be continuing past 2015.

All of those sorts of initiatives that were set up under the previous federal government were all positive initiatives, to improve access for those that required acute beds and to have appropriate levels of access for subacute patients in our Tasmanian community.

We say there has to be a more sustainable methodology, to ensure successful programs and services cannot be cut by political whim. The government will say the funding was not guaranteed; however, there was an expectation of ongoing funding for those services. They were successful. There had been a lot of workforce planning, modelling and recruitment and set-up costs to actually enable those new subacute units. We now see that there is no certainty of ongoing funding, and hence the potential closure of those units—to the detriment of the acute hospital beds and acute services.

The abolition of Health Workforce Australia is another concern to us. The benefit was the focus and modelling on the number and qualifications and scope of the health workforce in the future, as a discrete cohort. We now see that there is a very great risk that that modelling, those projections and that work is now going to be lost.

In relation to primary care, the policy direction proposed in these initiatives is a direct attack on the primary and preventative healthcare—and therefore the health—of all our communities. There is a substantial retrograde step in both policy and service direction, and it is distinctly at odds with international recommendations. We see the GP co-payment, the dissolution of the national preventative health agency, and the shifting of funding from downstream to upstream services, combine to further reduce access to primary health services for the most disadvantaged in our community, who in Tasmania are over-represented. The benefits of co-payments are realised by the federal government but the costs are incurred by the state. The primary care co-payments are a genuine disincentive for people to seek assistance in a timely and appropriate manner.

The rhetoric around the primary care co-payment is to describe this initiative as a price signal to stop unnecessary GP visits. There has been no modelling to demonstrate that and to describe it without evidence is disingenuous in the extreme.

The lack of access to primary health care will also increase the acuity of the patients and the complexity of the patients by the time the present to the hospital, with a resultant extended length of stay and hospital stay or more costly health interventions. This increase in avoidable hospital admissions would add a substantial burden on nursing staff, who are already under considerable pressure to fulfil their duty of care and responsibilities.

The introduction of the GP co-payment would not only see an increase in the number of people using the emergency departments but would increase the time for each visit. As demand grows it will turn into a dramatic spike. The National Health Reform Agreement and the National Partnership Agreement on Improving Public Hospital Services were developed to improve public access to EDs and elective surgery by improving capacity and efficiency in public hospitals. The National Emergency Access Target, the NEAT, was introduced with a view to seeing 90 per cent of all patients presenting to emergency departments admitted to hospital or discharged home within four hours of their presentation. Despite increasing number of presentations to all emergency departments in Tasmania, staff have worked incredibly hard to meet the NEAT targets. This figure has been improving.

**ACTING CHAIR:** Ms Ellis, could I interpose there. We are running a little behind. Did you have very much more in your opening statement? I wonder whether, rather than providing it as an opening statement, you could provide it as a document? There are millions of questions we have already got ready to ask you on what you have already given us, and we will just accept your opening statement as a document to the committee and then perhaps we could go to questions. Is that okay?

**Ms Ellis:** I am more than happy with that.

**ACTING CHAIR:** You have got a lot to tell us, and I really do appreciate that, but we may go to questions now, if that is okay with you.

**Senator CAMERON:** Thank you, Ms Ellis. At the last election the coalition argued that there would be no cuts to health. How do your members view what is happening in Tasmania against that promise of no cuts to health?

**Ms Ellis:** I will add to that that this Liberal state government also said there would be no cuts to health—in fact, it said there would be improved access to health. So it is a double whammy for Tasmanians with both governments giving those sorts of indications pre-election. It is incredibly disappointing. We are doing everything we possibly can at the front line to ensure that people who present and patients receive quality care. But it has just been pushed to the brink. When you see patients waiting for five, six days in the emergency department for a bed, and you see mental health clients sitting in there for up to six days waiting for an acute psychiatric bed, it is really disheartening. Morale is no doubt at the lowest ever, due to the fact that there is only so much you can do with declining budgets and positions and services being cut around you.

**Senator CAMERON:** The submissions we are getting are more than people saying it is disappointing. People are saying it is a betrayal of trust. Wouldn't that be how you would describe this, if you were being told there were absolutely no cuts and then the cuts are coming in to the extent that they are?

**Ms Ellis:** I would completely support that position; however, many of our members are just so busy, so dedicated to providing care at the front line, they continue to soldier on day in and day out, 24 hours a day. There is no doubt that it is not only disappointing; it is to the stage now where we do not know how we are going to be able to manage into the future with this double whammy of cuts.

**Senator CAMERON:** Do you agree with the proposition that the health budget is in crisis?

**Ms Ellis:** We say it is now in crisis and going to go further into crisis. We saw a lot of the initiatives under the national partnership agreements, et cetera, offering some really tangible solutions. Had they been continued in the long term, it really would have taken some of those pressures off those acute hospital beds. We now see the attacks coming into primary health care as well. We are very concerned about the fact now that we are going to see a one-stop shop at hospitals. The access to primary health care is so limited now and potentially decreasing further that everything points to the emergency department—including mental health presentations, which should not be going to the hospital. We should be keeping people out of hospitals.

**Senator CAMERON:** The submissions we have had in other states are predominantly that the argument about a health crisis is manufactured. I have to say that in Tasmania I get a different feel in terms of the arguments that there is a crisis in Tasmania more than elsewhere. Are you part of a national—

**Mrs Ellis:** Federation? Yes. There is no doubt that we have struggling since the first round of budget cuts that came in in 2010—starting to reduce acute beds and starting to reduce primary health care services, including those sorts of initiatives like Hospital in the Home that allowed for early discharge, with nurses who had the right skills going to people's homes. There are all of those impacts. We are battling day to day and mistakes are happening. We are seeing nurses working unsustainable numbers of double shifts, because of the lack of employment of permanent or permanent contracts. The last tally we had was 500 double shifts in one month across the state. That is 17 hours straight. Mistakes are being made and it is untenable.

**Senator CAMERON:** I assume then that if the pressure is on because of a lack of funding, and nurses are making mistakes, the same pressure would be on the doctors and the specialists in the health system here, as well. Is the logical next step to say that mistakes would be made by doctors and specialists, as well, because of these funding problems?

**Mrs Ellis:** Mistakes are being made throughout the whole system, because of the stresses on the system. There is no doubt about that. People are doing the best they possibly can. The workforce are trying their hardest. But with the levels of service cuts, the level of budget cuts and the disunity of services, it is all impacting on outcomes.

**Senator CAMERON:** Does it mean that if these mistakes are being made people's health and lives are at risk?

**Mrs Ellis:** We will be the first to admit that you can only do so much. When you are working 17 hours straight there are medication errors being made. There are errors being made, and it is not only by the nurses working in the hospitals in the system. It is very unfortunate that people are being put at risk with the cuts and the levels of services now.

**Senator CAMERON:** The Australasian College for Emergency Medicine has people working with people who come in in emergencies, obviously. Your members would work with them in the hospitals. They are totally opposed to the $7 GP co-payment. They are also opposed to any co-payment or tax if people come to the hospital. They are saying it is just not feasible for that to be collected at hospitals. They are arguing in their submission that pushing people out of GPs and into the hospital emergency system is a recipe for disaster. What is your view on that?

**Mrs Ellis:** Absolutely. We are totally opposed to the $7 co-payment. We are concerned that for the cohort in Tasmania, where we have a very high number of socioeconomically disadvantaged people, there will be people not going to GPs or to their EDs until they absolutely have to be there. That is where we are concerned health will suffer. They will come there as true emergencies rather than having primary health and their health being monitored and managed in the appropriate setting.

**Senator CAMERON:** In the submissions we have had, predominantly—I think almost unanimously—I have not heard any other argument. I may be wrong and not have picked something up. But I think almost unanimously the submissions are that with the cost of the GP tax any savings that are made will be offset by far greater costs in the hospital system because of lack of early treatment for some conditions. Is that—

**Mrs Ellis:** There is no doubt about that. Just the administrative cost of collecting the $7 co-payment will be another administrative burden that nurses will have to do after hours. We do not have the luxury of support et cetera. All of those services have already been cut. Predominantly, nurses are there 24 hours a day, and after hours we do the admin work. We do every other part of the functions to keep the hospitals running in Tasmania.

**Senator CAMERON:** How can you have a position where all of the experts we have talked to in Tasmania say that the system just cannot operate effectively, because of the pressure on the system. The system is at over capacity. So if you put a $7 GP tax in place and you push more people into the hospital system—

**Mrs Ellis:** A disaster. There is no doubt it will be a disaster. We are already at capacity. Many of our wards are now running at over 100 per cent capacity, so we have people who are admitted waiting for beds as the other

patients are being discharged or are awaiting discharge. Any hospital running at 105 to 100 per cent capacity is dangerous. The recommended capacity for a hospital is 80 per cent, yet in Tasmania we are consistently running at 100 per cent capacity or more. They are actually going to be closing further beds now. Their hospitals have to save another $28 million each. It costs $6 million to run a 30-bed ward, so that equates to a whole acute ward being closed at each of the hospitals now, going forward with the state budget. The impact with the federal government's removal of the NPA incentives for sub-acute additional funding is that everything is coming back into the hospital.

**Senator CAMERON:** What is happening in Tasmania to get the community's voice heard on this? The community voice I have heard here that the hospitals are just not up to the task and we do not have enough GPs. You have confirmed all of that. What is being done to try to deal with it in the face of these cuts? Is there a campaign to try to maintain a decent health system in Tasmania?

**Mrs Ellis:** We have run campaigns. Regardless of those campaigns we have seen governments, particularly the current Liberal state and federal governments, ploughing ahead unilaterally. So there is no consultation. With the current unilateral decision making there is no ability for us to effect appropriate community change for the better.

**Senator CAMERON:** Governments can make decisions and lock themselves into that position, but you have individual federal coalition MPs and senators here. What is their position on this? Are they just saying that it is all okay?

**Mrs Ellis:** No. I have met with a few of our Tasmanian senators. No, it is not okay. It could not be okay for any politician to stand by and watch this happening.

**Senator CAMERON:** So they understand the issues? You are saying that the coalition politicians and senators understand the problems?

**Mrs Ellis:** I met with every single coalition member when the budget was first announced. They appeared to be completely in denial of the real outcomes of the budget. They kept referring back to certain figures and they kept saying that Tasmania was going to get more funding in the federal budget, but every time we gave them examples of exactly what it really meant, the federal coalition politicians were not interested. They were absolutely not interested.

**Senator CAMERON:** So they are in denial and they are not interested.

**Mrs Ellis:** They could counter any position that was put forward, by referring back to the figures, which are skewed. What we are seeing in reality is what we said was going to happen, which is that with these incentives the money has run out or is running out in the next financial year and therefore those services—those initiatives and sub-acute beds et cetera—have been cut and are being cut.

**Senator CAMERON:** I have been in Tasmania for two days on this and all of the submissions have been consistent about there being is a crisis. You are saying that the Tasmanian federal senators and MPs do not care?

**Mrs Ellis:** We have raised it with them and nothing has changed. All we can do is continue to lobby to try to effect change and bring to their attention what the reality of the budget cuts is. However, unfortunately, we have not seen any change to improve Tasmania.

**Senator WHISH-WILSON:** In regard to the budget cuts of roughly $1.8 billion that have been calculated by Treasury, how will they impact your sector and your organisation? Do you have any idea, for front line versus other occupations, what sort of potential impacts we are looking at in terms of staffing?

**Mrs Ellis:** One of the serious concerns for us is in regard to recruitment and retention of our nursing workforce. We have already seen this now with the Tasmanian governments proposed wage pauses, or freezes, for years going out, and the capping of two per cent. We will become the lowest paid nurses and midwives across the country. We are already having trouble recruiting to Tasmania, hence the number of double shifts that are being worked, particularly in specialty areas. We are seeing more use of agency and locum, which is a completely uneconomical way to staff any hospital. Of course locums have far better conditions than the locals, and yet we are seeing a greater reliance on locums and agency just to staff. That is happening particularly in hospitals in rural and remote settings. I have just been to Smithton and I heard from the nurses there what was happening to our rural communities. It is very concerning. The first cut arising out of the Tasmanian budget cuts is the Director of Nursing from Georgetown. They are not replacing the Director of Nursing, and when you lose that community leadership and stewardship that does impact on community health outcomes.

**CHAIR:** Yesterday we heard evidence that indicated there was a 38 per cent increase in wages that had to be paid to provide GPs in areas where they have cut permanent placements. With putting in temporaries and locums, the budget blow-out was really significant. That is probably important just in the context of the question.

**Senator WHISH-WILSON:** And of course it is not providing any certainty to the local communities, having locums come and go. I was trying to ask about retention and attraction, because it is such a huge issue. My wife is a physiotherapist here and we have to do backflips to get people to come in from Canada and Africa—anywhere we can get them. It is a huge issue here. How do you think we can go about addressing that? Is it a certainty of funding issue or is it a lot more than that?

**Mrs Ellis:** People leave not only because of wages—they leave more frequently because of their disillusionment about being able to offer quality care. We found when the last budget cuts were going through, which would happen again right now, that lots of nurses and their families leave—they do not want to work in an environment where every day they are being pushed to the brink and cannot fulfil their duty of care.

**Senator WHISH-WILSON:** Because they are healthcare professionals and this is why they have signed up for this type of work?

**Mrs Ellis:** It is the reason we do everything—to provide quality care and be able to make sure our patients and their families are cared for. When you cannot do that, it is incredibly disheartening and people do leave. We are very transient as professionals—we can leave and go interstate and, on top of that now, significant wage cuts and wage pauses, leaving us the lowest paid in the country, will have massive implications.

**Senator WHISH-WILSON:** You mentioned earlier the potential for putting increased pressure on emergency departments in hospitals with the GP co-payment. Can you tell us what the situation is now in emergency? I have heard some anecdotal evidence that already GPs are saying it has had an impact on the demand for their services, having to phone and follow-up appointments now with people who are already saying it has had an impact. Has there been any evidence of that at all with increased numbers through emergency or is it too early to say that?

**Mrs Ellis:** The latest figure shows about 40 per cent of our emergency presentations are cat 5, so GP-type presentations, and that is significant to indicate that access to GPs is getting more difficult. We do fear that it will become more difficult but, more important, we are concerned that people will delay seeing any health professional until it is too late and they have to go into ED—and therefore it is more complex and there is a longer length of stay—and it is much more expensive. It is the worst case scenario for the patient.

**CHAIR:** You spoke about how important the national partnerships were and how, had they continued, you were hopeful they might have had very different outcomes. People hear this national partnerships language and it is all too hard. What were the national partnerships doing, and what do you fear will happen now that some have been cut?

**Mrs Ellis:** As I outlined, some of the tangible examples where the national partnership agreement funding has ceased include the removal of our subacute new services. Funding for the 10 beds outsourced to an aged care facility from Launceston General for elderly patients to recover in a respite-type situation has been cut, so those patients now have to stay in the acute medical wards at the LGH. In addition to that, some psychogeriatric beds have not got ongoing funding from 2015, 10 purpose-built units at the Jasmine units in Hobart are being cut from 2015, as is the 20-bed John L Grove unit going to be cut. They do not have ongoing funding due to the NPA not being continued, but there was every expectation that that money would continue, hence the workforce planning and the infrastructure set up to enable that. They were very successful. That will be the final nail; in 2015, that will cripple our hospital access. We will not be able to do elective surgery. We will not have any beds to do elective surgery and there will still be people waiting five or six days, if not more. Our bed capacity is just dire. To cut down the NPAs will make it worse.

In addition, it was really helpful to have the NEAT, the emergency department funding, the incentives for reaching those targets through elective surgery and emergency 24-hour turnaround. It was significant. For all of that now to, at a political whim, unilaterally be moved away will be very difficult for us to continue to function.

**CHAIR:** Do you think that when the Tasmanian people were voting at the last election they were voting for the scenario you have just described?

**Mrs Ellis:** I think you are quite correct to say that the average person does not understand how the NPA funding was assisting the coordination of services. If they did not understand it pre-election, they will start understanding it now. They will see the outcomes of what is going to happen and the next 18 months will be quite dire. Due to the fact that we will have nowhere for our subacute patients to be transferred, they will have to stay in acute beds, which are absolutely precious.

**CHAIR:** Subacute is particularly important when you are managing an aged demographic, is it not?

**Mrs Ellis:** Correct.

**CHAIR:** Because you have people moving in and out of hospital. That is the bridge between home and hospital, is it not?

**Mrs Ellis:** Yes. It was very successful. We opened up the John L Grove only last year. We have only just refurbished it, opened it up, staffed it et cetera for this very successful program and now there is no more funding from 2015.

**CHAIR:** And that positive story you were able to tell about growing something was a result of Labor dollars invested in Tasmania, is that correct?

**Mrs Ellis:** Correct, under the national partnership agreement.

**CHAIR:** Under the national partnership agreement with the Labor government. Now with the Liberal government we are seeing cuts and cuts. You have indicated a lack of awareness of this among Liberal candidates. I want to put on the record a comment from yesterday, an impression we received yesterday from many of the witnesses who have stated that there is no factual basis for the Abbott government's claim that health spending is unsustainable. This was according to the AMA and the Royal Australian College of General Practitioners. They know the system. The Royal Australian College of General Practitioners are reasonably deeply involved in the system, and the Australian medical association, like the nurses. You have a pretty good idea about what is going on. What you have told us is quite frightening. Given that when you do the evidence base and you look at the numbers they are stating that health spending is not unsustainable, that investing in GPs, investing in primary health is vital and that is a critical part of sustainability of our system, what is your view of the Abbott government at the moment?

**Mrs Ellis:** We do not think it is sustainable to be consistently unilaterally changing funding methodologies. It is incredibly difficult for health professionals to continue to cope when one day we have subacute beds available and 12 months later we will not have. It is the funding methodology that makes it really difficult to have sustainable health. We need a really clear strategic plan and the pathways and the national partnership agreements have been agreed by all states through COAG. We could see where we were going. We could see some light at the end of the tunnel. They were really positive initiatives and it is really disappointing now that we are in this situation. It will have dire implications for our health outcomes..

**CHAIR:** There were things in place when the Abbott government came to power—agreements, contracts signed. Most people would not expect that they would get ripped up when the government came in but that is exactly what you have just described.

**Mrs Ellis:** Yes. There was no mandate to rip up any of those agreements or to remove those services. In addition, if I could move to the Tasmanian Health Assistance Package where we saw also some initiatives removed unilaterally overnight. One of them, core to our hearts, is the removal of the scholarships that were available specifically for Tasmanian nurses, to encourage rural nurses as a retention recruitment issue. There were millions of dollars of Tasmanian scholarships and the Abbott government has unilaterally taken those away.

**CHAIR:** When you said earlier mistakes are being made, it is all impacting on outcomes, could you give an example of the kinds of mistakes and what outcomes would be?

**Mrs Ellis:** I think there is no doubt that every nurse absolutely tries their hardest to deliver the best care they possibly can, but, as I mentioned, when they are working 17 hours straight, research shows that that is equivalent to a blood alcohol reading of 0.07. So nurses are working at pushed capacity, on incredibly acute, complex wards now. The length of stay has shortened and they are all highly complex patients now, requiring levels of treatment that need people to be alert. Unfortunately, after 15 or 16 hours, mistakes can be made, and, as I explained, they are the sorts of mistakes around medication errors et cetera; they are the most common mistakes that are made that nurses admit to. But it is a system fault—it is not the nurses' fault; it is a system fault. They do have implications. We do have to, obviously, report those through a quality mechanism. But it is not just the medication errors. There are other errors, particularly in ED, and particularly in wards. Anecdotally, I will report that we have heard people say that people have died, and they should not be dying but they have died. So it is getting to that situation now that people are being pushed to the brink.

**Senator McLUCAS:** Can I just ask one question? How many acute beds are there in the Launceston General Hospital?

**Mrs Ellis:** I think it has been reduced down to around 140.

**Senator McLUCAS:** And you are about to lose 30 of those.

**Mrs Ellis:** Yes.

**Senator CAMERON:** Mrs Ellis, are you a Liberal candidate?

**Mrs Ellis:** I don't think so! That is a very strange question. No. We are not affiliated!

**Senator CAMERON:** It does not sound like it to me! Sorry about that. I will tell my informant that they are wrong!

**CHAIR:** You never know who is listening and watching! But thank you very much, Mrs Ellis, for your evidence this morning. We will continue with our program, so I will call forward our next witnesses.

**AUCKLAND, Mr Stuart, Lecturer and Program Manager, Centre for Rural Health, University of Tasmania**

**HARRIS, Dr Martin, Lecturer, Centre for Rural Health, University of Tasmania**

[10:52]

**CHAIR:** Welcome. Is there anything you would like to add about the capacity in which you appear today?

**Dr Harris:** I am representing Associate Professor Tony Barnett, who is on other business. Stuart and I work with the university's Centre for Rural Health, where I am a mental health academic.

**Mr Auckland:** Together with Dr Harris, I am representing the Centre for Rural Health, where I am a program coordinator for the community health development program area.

**CHAIR:** Would you like to provide us with an opening comment? Then I am sure that the senators will have questions for you.

**Mr Auckland:** I am not sure how familiar the panel is, but I will just go through a bit of the history of the organisation. It is the Centre for Rural Health. Many of you might be familiar with its previous name, the university department of rural health. There are a number of such institutions or organisations around Australia, and we are but one of them—there is a single one here in Tasmania. We are affiliated with the University of Tasmania. It is a federally funded program through the Department of Health. I believe it was established in 1995 and has been ongoing since then. It works according to a set of key performance indicators which cross a range of different areas of interest—namely, rural research, rural project activity, and teaching and learning. So they are the three key areas that the organisation works with. As I said, it has a very strong research component. It looks particularly at doing research on key priority areas within the state here in Tasmania, and it also has a very strong engagement component with communities within Tasmania.

It does not have an undergraduate teaching learning program per se; it does, however, have an e-health unit, and it also has a postgraduate program. So there are a number of postgraduate students that are affiliated with the organisation that undertake either masters or doctorate work with us at the Centre for Rural Health.

It is a relatively small organisation. I think it is probably around potentially 15 full-time equivalents. We work across different interest areas. It has two main locations. Its base is here at the university campus at Newnham. It has an office down in Hobart—there a number of staff in Hobart—and it has staff that work out of the Burnie campus.

As I mentioned a moment ago, it has a number of key performance indicators which cover a range of activities. Those indicators relate to rural student placements. For example, it has responsibility for establishing networks and relationships with the rural health sector—the Department of Health and so forth. It seeks to place students in those rural areas and that is one key performance area. It has a population health key performance indicator, where it predominantly looks at community health, population health. It has an Indigenous health key performance area, a mental health key performance area and a pharmacy key performance area. The other KPIs are particularly around our research area and our partnership area. It has that range of KPIs—that is what we respond to the federal government for in our work.

It also receives some funding through grants that staff at the centre receive. They can be small, locally based grants or they can be large academic grants that we work on as well. Those are the main two areas of funding—and of course through our postgraduate students as well. That is essentially a bit of background to the centre.

**CHAIR:** Thank you, very much. Dr Harris, do you want to add anything?

**Dr Harris:** The challenge for us is to work in the current climate. The challenge is to address those needs that we see as emerging, and those challenging forecasts that Ms Ellis was describing become I guess the environment into which we contribute. So, within the limits of our KPIs, as Stuart has described, we look for those opportunities to make a difference and to generate those things that are going to be efficacious in those rural and remote communities. Our remit is really for rural and remote health. And those challenges become quite striking when you look at the current climate.

**CHAIR:** Can I just ask a couple of clarifying questions and then I will go to Senator McLucas. You have mentioned, Dr Harris, 'emerging needs'. I know that you indicated in your opening statement that you have a particular focus on mental health. More broadly, including mental health if you can, what are the emerging needs that you see in rural and remote Tasmania?

**Dr Harris:** Access to services—

**CHAIR:** When you say that, what do you actually mean?

**Dr Harris:** When people present, in terms of crisis care there is a limited range of professionals available to rural and remote communities; most of them are on a fly-in fly-out basis or they will come on a particular day and offer services. Those services are not necessarily attuned to the needs of the community. And those professionals disappear as well. So, while it might be a way of dealing with those situations, it is not ideal.

**CHAIR:** Could you name some of these rural and remote regions? Roughly where are they? We have a map from Medicare Local. Give us a flavour of where you are talking about.

**Dr Harris:** Interestingly, Tasmania is very much a rural community, but these issues become more acute the further west and north that you travel. The metropolitan centres of Hobart and Launceston aside—when you start moving west to Burnie and Devonport, it is more acutely felt. And certainly when you get down to the west coast—the areas around Queenstown, Strahan, Rosebery, Zeehan—those areas are really struggling. The further removed you become from those urban centres of Launceston and Hobart, the more acutely felt are those absences of professionals or the availability of services in a timely way.

**CHAIR:** So people fly in, or drive in, and do some work?

**Dr Harris:** They drive in and drive out. The FIFO analogy was that they are not there; they might be there on a Wednesday afternoon; they might be there on a Thursday morning; but it is very much an as-needs basis. It also depends on the capacity of those individuals to service those areas. Very few of them are based there. There are a few hospital bases—Queenstown is one—but there are limitations to those services being available in a timely way.

**CHAIR:** You also referred to the challenge of those needs, which seem to be increasing.

**Dr Harris:** Yes.

**CHAIR:** Why are they increasing?

**Dr Harris:** I think generally the challenge, as Neroli alluded to, is that the social determinants of health are very acutely felt particularly in those areas where unemployment, travel and timely access to professional help are all challenges. So the opportunity for someone to access the appropriate healthcare services becomes limited by their ability to: (a) travel, (b) access an appropriate person at an appropriate time, and (c) to be able to afford to do that. All those things—the constellations of factors that might limit someone's ability to seek help in a timely way—might be seen to be mounting against them in terms of their capacity and their ability to do so.

**CHAIR:** So they need to have healthcare but—to create a visual image—it might be a case of: somebody is not well, but they have a layer of: 'I can't afford to put the petrol in the car', 'I can't be sure that I'm sick', 'I don't want to go to the doctor because I normally don't like it', 'Nobody in my family goes there'. We start putting these layers of things on top of people, and their access is limited. That is what you really mean about 'social determinants of health'—help-seeking behaviours.

**Dr Harris:** Yes. There is also the uncertainty involved. One of the issues around mental health is the fact that there is a high degree of uncertainty involved; that impacts quite heavily on someone's capacity to seek help.

**CHAIR:** So a GP would be critical in these communities?

**Dr Harris:** Yes.

**CHAIR:** Mr Harris, Mr Auckland, you have heard what we have been saying this morning about the evidence we have received from the AMA and the Royal Australian College of General Practitioners, who were not consulted before the government made this decision to create a $7 impost on going to the GP, getting treatment, getting a diagnosis through a pathology test or getting an X-ray or an MRI. What is your view of the impact of a $7 co-payment, GP tax, in the context that you have just described to us?

**Dr Harris:** The cumulative effect is that it is a disincentive. The opportunity for someone to access care in a timely way is going to be—there is a deterrent involved in that. Again, the uncertainty of how much this is going to cost is very much a player in that help-seeking process. So, while $7 does not sound like much, the cumulative effect of referrals and ongoing payments, and the fact that there is an unknown capacity, an unknown quantity, there, I think would weigh heavily on someone's decision to seek appropriate help in a timely way.

Also, in terms of allied health, a lot of people now are seeking that kind of assistance from pharmacies. And, while I am not across the pharmacy process, I know anecdotally that pharmacies are getting a lot more of those walk-in requests for assistance. So there is a shift there from what would cost to what is free, and pharmacists are one of the last bastions of free advice, so they are getting a lot of these people presenting.

**Mr Auckland:** I do a lot of work out in communities and I think there is a lack of understanding—people hear about these sorts of things in the media, and they just do not understand, and it is not explained to them. It creates a sense of confusion their minds about what it all means, and they take it very much as they hear it, as you would

expect. There are other issues around health literacy and, by health literacy I mean their understanding about not only the clinical aspects of delivering health services but also the administrative side. There is a fair bit of research being undertaken at the moment around health literacy, and it is becoming an increasingly significant problem, particularly in some of those lower socioeconomic communities around the state. Whilst there are the issues around access that we talked about, there is also a lack of understanding about what this all means and, in particular, what it means for them as individuals, their families—or their communities.

**Senator McLUCAS:** Thanks very much for coming along. We actually met about a month ago up in northern New South Wales—Lismore. Our understanding of the role of RN is good. Can you tell me how many staff you have—you said it was a small unit?

**Mr Auckland:** I think it is approximately 15 full-time equivalents. A number of us are part time—just a handful are full time at the moment—but that staff fluctuates, because we have a fair bit of casual work. So we might have someone on board for about six months or so and then they might be associated with a particular activity, project or some research. In terms of a standard line, around 15.

**Senator McLUCAS:** Your funding is from the old DOHA—that is base funding, is it?

**Mr Auckland:** It is base funding that we receive and it covers mainly salaries and some operational work that we do. As I said, an amount of that is supplemented by our research grants that come in.

**Senator McLUCAS:** So that base funding from the Department of Health federally is how much?

**Mr Auckland:** I believe it is about $1.7 million at the moment.

**Senator McLUCAS:** Annually?

**Mr Auckland:** Yes.

**Senator McLUCAS:** Is that a contract?

**Mr Auckland:** Yes. It was previously over three years but they have been reduced to 12-month contracts.

**Senator McLUCAS:** When did that start being annual?

**Mr Auckland:** Last year.

**Dr Harris:** There has been a change in the contracts in the interim and the date on this extension—

**Mr Auckland:** It currently expires on 30 June 2015.

**Dr Harris:** There is no assurance of continuing funding, but we are hopeful.

**Senator McLUCAS:** That was my next question, Dr Harris—thank you. I want to go to primary health services: did you have any role in the Tasmanian Medicare Local?

**Mr Auckland:** Yes, I do a lot of work with Medicare Local. I sit on one of their committees—their community consultative committee. I have also undertaken research work for them; they contracted my agency to do work with them on a couple of projects. One was looking at social determinants of health, and I have currently got a fairly significant project with them around food security.

**Senator McLUCAS:** I am asking you now for a judgement: how effective has the Tasmanian Medicare Local been in your view in being able to manage that coordination and linking up of a fairly disparate health system? You are not special there: Australia has got a disparate health system. The purpose of the Medicare Local was to pull it together to make the patient pathway a little more navigable. How did that go here?

**Mr Auckland:** I think in the time that Tasmanian Medicare Local has been active—in its third year now—they have done remarkably well. I am very familiar with the different structures within the organisation. I think they work very well together. One of their key strengths as an organisation is their community connectivity. They do particularly well in that area. Around the issues of primary health, they are also quite effective.

My experience working with TML is that with the resources that they have that they do a good job. They are very good on partnerships. They are very good at bringing in key people when needed to work on programs and structures. I have a very positive view of that organisation and, in particular, the work that it has done in the time that it has been operating here in Tasmania.

**Senator McLUCAS:** You are aware, I am sure, that the replacement entity, the Primary Health Network, will be found through an open tender system—or a selective tender, actually. If the current organisation, Tasmania Medicare Local Ltd, is not successful in receiving that tender, what will that mean in a transition to a new organisation?

**Mr Auckland:** Without knowing what that transition would look like, what I can say—

**Senator McLUCAS:** It is a bit hypothetical. If you do not want to answer it, please say so.

**Mr Auckland:** What I can say is that some of the best brains and minds in health generally and in rural health in particular currently reside within Tasmania Medicare Local. I would say that, if they were not in a position to be providing their services in the future, there is a risk of losing some of those very key people, who have a lot of experience in that area. That would be a primary concern of mine. In communities like Tasmania, where your contacts, connections and work experience are really paramount, I think that would be a real risk. If you lose that, whoever or whatever organisation comes in to place has a fair bit of work to do to build up those relationships that have been developed over the three years that TML has been there. That is my primary concern, aside from potentially losing some of the programs that it is currently offering.

**Senator WHISH-WILSON:** Dr Harris, I am interested in the specific work you have done on suicide prevention. Are there any particular areas of the state you have been focusing on or is your work fairly broad?

**Dr Harris:** My work in this area has been going on for about 14 years and it has been broadly spread across the state in terms of my opportunities to contribute. A lot of that has been about research. It began with youth suicide and finished with suicide in the elder populations. Certainly, my concern for rural and remote areas has continued through that time, and increasingly I move towards an early intervention strategy. I think that waiting for the crises to occur so you can identify suicidality is a real risk. My work has been much more about developing those strategies that allow for some sort of early intervention and identification of those constellations of factors that might contribute to someone choosing suicide as a solution to their problems. Early in the piece, there are far more opportunities for effective intervention. I have worked in urban and metro areas and I have also worked on the far west coast. The problems multiply—the more remote you become, the more difficult they are. I have probably drifted from the question.

**Senator WHISH-WILSON:** No, I was just interested in whether there were any particular areas around the state that you see being as more acute. I know you study dislocation.

**Dr Harris:** Dislocation is certainly a major factor. When you see the suicide statistics for Tasmania, we figure high—second to the Northern Territory on a population basis for suicide completion rate.

**Senator WHISH-WILSON:** Amongst any particular demographic profiles like age groups?

**Dr Harris:** In the Territory there is a large contingent of Indigenous people, which probably is the reason for those communities outranking us. We rank second but clear of the mainland for suicide completions. In numbers, we range between 75 and 100 completed suicides per year. Clearly, there is an ongoing problem, and those statistics have not changed much over time.

**Senator WHISH-WILSON:** Is it amongst mainly younger people or is it mixed?

**Dr Harris:** We thought we had a handle on the youth suicide, but the statistics are suggesting that the youth suicide problem is again not being effectively addressed. The numbers of youth suicides are increasing. Some of the more recent information from Queensland would suggest that youth suicide—the factors that we have been addressing with some passion have not been effective.

**Senator WHISH-WILSON:** Has your research discovered a strong link to mental illness or are there other factors at play? For example, we hear about the rural community, farmers, being under a lot of stress and a lot of pressure, plus industry shutting down and people being retrenched and these kinds of things.

**Dr Harris:** All of the above. The issues around mental health and the strong links with depression—not all depressed people are suicidal and not all suicidal people are depressed. There is this desire for us to find a checklist which will give us those opportunities to intervene, but they are very crisis based. For every positive outcome on a checklist, you will miss somebody. There are constellations of factors, and that contextual and personal nature of suicidal contemplation begs the question about whether we can reduce it down to sets of risk factors and sets of circumstances. It is very complex. If it were not complex, we would have the answers. I do not think we have the answers yet, but we know a lot more about what we can do and how we can address those issues. It comes back to some of my earlier statements about the social determinants of health. You have addressed some of them: the downturn in the economy, the access to services in a timely way, the ability to unpack some of the problems that might actually lead someone to contemplate suicide as a solution—a very permanent solution to, possibly, a temporary problem. Those things require understanding of the trajectories and those constellations, but they also require access to an appropriate health professional in a timely way and not necessarily as a crisis response.

**Senator WHISH-WILSON:** That was going to be my next question. If you strip out the high Indigenous suicide rate in the Northern Territory, that would put Tasmania clearly on top of the table—and that is not something to be proud of. Would that be because we are a large rural electorate?

**Dr Harris:** That is a contributing factor. Certainly the rural and remote communities, the farm based, have a higher incidence of suicide completion. Coming with that are some of the staunch attitudes that are pervasive within those communities, which kind of—

**Senator WHISH-WILSON:** My state colleague Cassy O'Connor, as a minister in the previous Labor-Green government, spent a lot of time working on these health issues. She made the statement:

We also need to recognize that some of our unhealthiest citizens are also our loneliest.

She seemed to think that that dislocation was a huge factor.

**Dr Harris:** I think it is the major factor. That is my opinion. I think social connectivity is really part of that solution. Being able to develop the capacity for communities to be able to be ready for those kinds of initiatives is very much the state's suicide prevention strategy. The state suicide prevention strategy, I believe, is heading in the right direction. Certainly their capacity to make a difference—there is potential there, given the right funding, the right encouragement. I think the state committee is heading in the right direction, and I think the strategy is as well.

**Senator WHISH-WILSON:** So the idea of targeting more expenditure at a local level, which was obviously behind the Medicare Local issues we have been discussing here this morning—does it concern you that the changeover to the new health system is going to significantly reduce the numbers? I will get you the exact numbers if you want to see them. It was 62 down to 26, I think.

**CHAIR:** Sixty-one down to 30.

**Senator WHISH-WILSON:** That is essentially halving the number of access points. Can you see that as being an issue?

**Dr Harris:** That would concern me, yes.

**Senator WHISH-WILSON:** Are there any other collaborative approaches you could recommend to the committee in terms of these issues we are facing—disadvantage, poverty, education, secure and affordable housing? Is there any other approach you could suggest from your research? Do you think we need to revolutionise further, or were we on the right track with something like Medicare local?

**Dr Harris:** It is a complex question. I think in some ways it allows for that kind of community readiness that I alluded to. Facilitating that would be important. As I mentioned earlier, I am a strong believer in early intervention as opposed to crisis management. From an economic point of view it is better investing in that early intervention than it is in crisis management. You get more bang for your buck.

In terms of suicidality, it very hard to identify that. It is much easier to identify it at the crisis point and say, 'That person is potentially at risk,' or 'They're suicidal.'

**Senator WHISH-WILSON:** Have you found the volunteer network here useful, or is there more scope for resourcing in terms of training up people to work as—

**Dr Harris:** I think each community is different. Generalising is a little bit difficult. There are a lot of well-meaning individuals but the coordination remains a challenge.

**Senator WHISH-WILSON:** Okay. Who currently funds the volunteer watch program?

**Dr Harris:** There are a number of organisations that provide training. You would be aware of some of them. Rural Alive and Well is one you would be familiar with, and the CORES program. These are very well-meaning individuals who have a trickle of funding. They are losing that funding, consistently. The funding is drying up and their capacity to apply for more funding is limited.

**Senator CAMERON:** I only have a couple of minutes. I appreciate your being here and giving us the benefit of your experience. It just seems to me that, from what we hear across the country, there is concern about the budget cuts and the implications for health. When you come to Tasmania, that concern is amplified because of the existing problems in the Tasmanian health system. Could you summarise for me the key issues arising from the budget that are negative for health in Tasmania.

**Mr Auckland:** The main concern I would have is around primary health. One of the things that is so vitally important to make a difference here is to invest in primary health. If there are any changes to the amount of work and effort that has gone into that particular area, it would concern me greatly.

There is also a lot of scope to improve our understanding about the impacts of the social determinants on people's health and wellbeing, and making that link between the social determinants and an individual's or a community's health and wellbeing. If there are cuts in the work that is done in that area it would be of primary concern to me, as well.

I think there are real issues around recruitment and retention, particularly of health professionals in the area—particularly in the areas that we work in: the rural areas. That has been canvassed quite significantly I think in the few minutes that I have been here. That is a real concern. I think there needs to be ongoing continued investments in supporting health professionals that go into those sorts of areas. It would be of concern if the cuts impinged on that.

**Senator CAMERON:** We have had a couple of different views put to the inquiry. Everyone agrees that primary health is extremely important, and that it could reduce the costs of the hospital system dramatically if we could get primary health done correctly. The argument that has been put forward is that primary health has to be delivered through the GP as the key area. But we have other submissions from ancillary health professionals saying that focusing on the GP is not the best approach to get care into communities where there are no GPs or where the GPs are too expensive to access. I have given examples of the nurse practitioner. How important are nurse practitioners in rural and regional Australia?

**Mr Auckland:** I am in the school that thinks that primary health care is not necessarily best delivered through the GP sector—for a whole range of reasons. Other models, such as the nurse practitioner model, particularly in rural areas, are exciting. I think there is a huge potential to look at that sort of care model. I think those sorts of ancillary care models probably—at least potentially—offer the most opportunity, particularly in rural and remote areas.

**Senator CAMERON:** I am trying to deal with the argument that comes from the GPs and the AMA and the like—that the nurse practitioner and other ancillary models could leave people in a position where some of the more complex diagnostics cannot be undertaken. How do you deal with that?

**Mr Auckland:** I do not believe it has to be one or the other. I think there is midpoint somewhere where you talk about those sorts of circumstances—those more complex presentations and so forth where it would obviously be imperative to have the GP's input. If we talk about primary health care and health promotion in general, I believe that first line of attack is best delivered through primary healthcare professionals. I think that is the work that needs to be done at the coalface. I do not think it is one or the other; I believe it is a case of both.

**Senator CAMERON:** Mr Harris?

**Dr Harris:** I agree with my colleague, but I also think that some of the professional boundaries need to be explored. I think there are good reasons for some of that core work to be contained within a profession, but when we get to the edges of those boundaries that blur into other professions, there is a professional resistance to letting go, to letting others into the territory. I think that is worthy of challenge and I think there might be more creative solutions at the boundaries rather than at core.

**Senator CAMERON:** Other submissions we have had basically say that all this is too hard and that you cannot really break the hold of the AMA on these issues—that we should look at more practical outcomes. Should we just give up?

**Dr Harris:** To give up allows the status quo to continue. The status quo is not exactly working terribly well. I think that if we explore in a more rigorous way—and perhaps a more creative way where we reward a collaborative approach—it is more likely that opportunities will emerge. I would like to think that departments like ours, the Department of Rural Health—of which there are many scattered around the country—could look at those issues and explore them, particularly from the perspective of the impact for rural and remote health. They could look at where the opportunities lie and perhaps be more creative in the solutions they provide. I would like to think that we could do that.

**Senator CAMERON:** We had evidence this morning to the effect that doctors are really small businesses. They have to make a profit to make a living. I do not argue with that. But then, if there is no bulk-billing, that is a huge failure in the market for provision of access to clinical health services. Has there been any work done in your university about how you would deal with these issues in the rural and regional areas? You cannot get enough doctors there and, when you do get them there, they say, 'We are a small business and we have to make a profit, therefore we are not bulk-billing'—which puts primary GP health care out of the reach of many residents. How do you deal with that?

**Mr Auckland:** We have not looked at the economic modelling, and I think there is a huge potential to do that. But certainly we have looked at some of the social enablers, if you like, some of the other factors that potentially play in the role of whether a GP can retain his or her services in a community. Looking at that economic model is something we have not done. From my recollection, it is something we have certainly touched on but not significantly delved into over the years.

**Dr Harris:** My hesitance is a lack of information on that. I would like to think that those committed doctors in rural and remote communities are more inclined to bulk-bill because they are there for that reason, but certainly recruitment is problematic and keeping the GP there is problematic. Part of that problem would be the economic realities of their practice. I would like to have more information before I answered it definitively.

**Senator CAMERON:** The example I have been using is Tamworth, in New South Wales. I am from New South Wales. I have had advice that there are no bulk-billing doctors in Tamworth. In fact, in some of the outer suburbs of Tamworth it is the nurse practitioner supported by the University of New England medical students who provide the only affordable health care. Are there any examples of that in rural and regional Tasmania?

**Mr Auckland:** Not that I am familiar with; no.

**Senator CAMERON:** Would it be a model that could work?

**Mr Auckland:** It is not a yes or no answer, is it, really?

**Dr Harris:** It is food for thought. I would like more time to explore that.

**Senator CAMERON:** In Tamworth, we have the university sitting just up the road; so that is a demographic issue.

**CHAIR:** Thank you very much, Dr Harris and Mr Auckland, for your evidence this morning and for your work in the community as well.

**FITZGERALD, Dr Paul David, Treasurer, Rural Doctors Association of Tasmania**

[11:50]

*Evidence was taken via teleconference—*

**CHAIR:** I welcome Dr Paul Fitzgerald, from the Rural Doctors Association of Tasmania. Would you like to make an opening statement, Dr Fitzgerald?

**Dr Fitzgerald:** Yes, thank you. We have a forwarded a document signed by the president of the association, Professor Dr Dennis Pashen, who unfortunately cannot address the committee today. He is currently doing the remote rural locum in Karratha. He is three hours behind and has some obstetric procedures booked for this morning. So he asked me to address the committee in his stead. I would also notify you of a typo in the letter that he has presented. The sentence that begins with No. 4 should read 'withdrawal of funding of services', not 'withdrawal and funding of services'.

**CHAIR:** We have noted that.

**Dr Fitzgerald:** Thank you very much. The Rural Doctors Association of Tasmania is comprised of rural and remote general practitioners and other specialists in the state, and its focus is clearly on health rural and remote communities. One of the interesting things about the Rural Doctors Association generally and the state branches is that it is generally possible to link population health concerns with health service delivery in rural and remote communities.

Both Professor Pashen and I are population health specialists as well as general practice specialists. I am also employed two days a week by the Tasmanian Department of Health and Human Services as the director of the Tasmanian Rural Medical Generalist Pathway. So for two days a week I am technically a state employee. I also work for General Practice Training Tasmania. I was previously the director of training and now I am a medical educator.

In addressing the committee, we are very keen to make it clear that there are remote communities in Tasmania that have significant disadvantage with access to health services, even though it is a small state, and the population density is very low and one would assume that even people in remote areas would have reasonable access to services that are city based. The reality is that the west coast, the east coast and the islands really have very rudimentary health services compared to similar communities on the mainland. They have restricted access to imaging, investigation, emergency and in-patient services and they have little or no access to obstetrics, paediatrics and other specialised services. Many people have to travel up to four hours—often on very dangerous roads in poor conditions, particularly in the winter—or across water to access what we would regard as basic levels of care.

Although the new state government and the department of health services recognise the value of the rural generalist model—that is, developing general practitioners for these areas who have additional acute skills and specialised skills—there has really been a long history of deterioration of services in remote areas because of the agenda of centralised specialised care in the state. They have now deteriorated to the level where the posts in these areas are not attractive to people who are trained as rural medical generalists—so we are losing them interstate.

**CHAIR:** Thank you very much, Dr Fitzgerald. I note that the issues you have raised in your opening remarks are the ones that you have raised in your letter—which, as you indicated, is an addendum to the RDAA submission. We will now go to questions.

**Senator McLUCAS:** Thank you, Dr Fitzgerald, and I thank Professor Pashen, who is my former doctor—please say hello to him for me—for the submission. For the record, could you explain in a couple of sentences what a rural generalist is?

**Dr Fitzgerald:** There has been a move to train general practitioners with additional acute skills—that is, emergency department skills—and also an additional specialised skill that they can take to a rural and remote community. In some states that would anaesthetics or obstetrics or even surgery. In other areas it could be additional emergency department skills, paediatrics, palliative care, psychiatry—a range of skills. The idea is that we have people who not only are skilled to provide a high level of acute services in rural and remote communities but also can take an additional skill to that community so that members of the community do not have to travel long distances to access that skill.

**Senator McLUCAS:** I think it is good to have that on the record, so that potentially we can quote that as a definition in our report when we are reporting. So, by and large, a rural medical generalist will be employed by a state government? Is that right?

**Dr Fitzgerald:** In some states. In Tasmania, that is not really the case. The model that applies in Tasmania is that all of the rural and remote services provided by doctors are provided within a general practice model, and the services that are provided for the state facility are paid for under a specific agreement with the state. So the doctor would not be regarded as a state employee per se but as perhaps a contractor for specific services, such as emergency department services or other procedural services.

**Senator McLUCAS:** Is the work that you have been doing with the state government to try to build a pathway to employment of rural medical generalists? What is the work that you are doing with the Tasmanian government?

**Dr Fitzgerald:** This year we commenced a rural medical generalist training pathway, which identifies doctors who are already in general practice training who are interested in training for the additional acute skills and specialised skills they require to go to rural and remote areas. The program was promoted by Health Workforce Australia—which closed in July this year—and the initial funding came from Health Workforce Australia as part of a project to establish rural medical generalist training pathways in all states. We are in the early stages of the pathway, but we had 10 entrants to the pathway this year and we have had a significant amount of activity in terms of doctors training in those additional skills to go to remote areas.

**Senator McLUCAS:** How much did the state government receive from Health Workforce Australia to set up the training pathway process?

**Dr Fitzgerald:** It is a bit of a sore point. I do not actually have a budget. The initial funding was left over from some consultancy money that was given by Health Workforce Australia to the state government to look at ways in which Tasmania could implement a rural medical generalist pathway. They money was not all spent, so I was able to use that for the first nine months of the position. There is now funding identified for my role for two days a week for two years, but it is not specifically dedicated to this project. There is no other funding available.

**Senator McLUCAS:** But you would need money to be able to facilitate those training places.

**Dr Fitzgerald:** At the moment, the whole structure has been developed through networking and cooperation. We are using people in existing positions and identifying existing positions that might be funded through state governments in state hospitals and so on. We are using doctors who are already in general practice training positions that are funded through the local regional training program, General Practice Tasmania. It has really been a project in networking existing services that are funded from other areas.

**Senator McLUCAS:** I understand that. That is great. Thanks for that. Your submission does not go to alternative methods. You speak strongly about the rural medical generalists, and I appreciate that. But let's think about innovation, telehealth and other models of being able to provide health in quite remote areas. Has the Rural Doctors Association spent any time thinking about that? Do you have any comments about methods other than person-to-person health service delivery that you think should be promoted and progressed?

**Dr Fitzgerald:** The Rural Doctors Association has a close alliance with the College of Remote and Rural Medicine, which is a national and perhaps international leader in the provision of rural and remote teleconferencing and other services. Fortuitously, the person who set this up has also recently relocated to Tasmania, so we have access to those resources. Certainly through general practice training we are looking at that. It is something we are very keen to pursue. But at the end of the day we still need people on the ground as well. There is a limit to what you can do with teleconferencing and other remote services. I should also say that we are very fortunate in that we have the Antarctic base in Tasmania. We have access to all of their expertise on telehealth as well. That is outstanding at an international level. We do not have any shortage of competence, models and resources in this state.

**Senator McLUCAS:** That is good advice. Thanks for that. Just finally, I have a question on training places and training pathways for GPs. Do you have any comments on what the loss of the PGPPP program will mean?

**Dr Fitzgerald:** It is a serious concern, as you are probably aware, to the Rural Doctors Association. We understand that Senator Nash made a statement on the weekend that implied the government might be reviewing the availability of some sort of prevocational training positions for rural and remote training. We would certainly welcome that. Certainly the advice from places such as Queensland, the Northern Territory and Western Australia is that it is important to identify people who want to train rurally very early in their professional careers. An early exposure at a clinical level to rural and remote practice is very important in helping them to define their goals and targets for rural and remote training, more so than for doctors who are considering a city based practice.

The other issue—and this is more a global statement—is that without the PGPPP we are really asking doctors to select for a career in general practice without ever having had any exposure to it. For people entering general

practice training through the Australian general practice training model, the only real exposure most of them have had to general practice at all is through their PGPPP term.

**Senator McLUCAS:** Thank you. That is, once again, very good evidence.

**Senator WHISH-WILSON:** Dr Fitzgerald, I was interested in whether you have any metrics or are aware of any data that the committee could look at about the ratio of GPs to patients in rural areas and in urban areas as well and whether that was available for Tasmania.

**Dr Fitzgerald:** I could find that data and make it available to the committee, if you are happy for me to take that on notice.

**Senator WHISH-WILSON:** Yes.

**Dr Fitzgerald:** I should say that it is not just a question of numbers; it is a question of competencies as well. We have had quite a long history of servicing the west coast on a fly-in fly-out model. I have had the good fortune of doing a couple of rural and remote locums in that area. The quality and standards of the care that people in that community are getting are far below what I would regard as an acceptable level. It is not just numbers issue; it is also a skills and competence issue.

**Senator WHISH-WILSON:** You did mention in your earlier statement—I cannot remember the exact words—that we in Tasmania were at a disadvantage compared to similar communities on the mainland. You mean similar communities as in essentially rural and isolated communities?

**Dr Fitzgerald:** Yes. That was really brought home when Doctor Pashen moved from Queensland to Tasmania. That was what was behind his wanting to make a submission to this committee. He was probably one of the most experienced doctors in this area in the country and he was quite alarmed by the contrast between the services that were available in, say, Queenstown or Rosebery and the services he would expect to be available in Queensland in communities of the same size and remoteness.

**Senator WHISH-WILSON:** Would we be able to get copies of that—the more specific details of those contrasts? If we could look at a case study of some sort or another, it would be very useful.

**Dr Fitzgerald:** The issue of regional and remote services is poorly quantified. It has been a project of mine to try to get someone interested in doing it for a while, but I will certainly see what information we can get for the committee on that.

**Senator WHISH-WILSON:** Have you spoken to the University of Tasmania or any other research institutions about getting help with that project—or with Treasury or other government departments?

**Dr Fitzgerald:** I have run it past several university departments and they agreed it was a good idea; but I do not think anyone has the funding or the resources to do it.

**Senator WHISH-WILSON:** Have you asked for assistance at all from the state government to get some quantitative work done in this area?

**Dr Fitzgerald:** No, and I would not regard it as my brief to do that—

**Senator WHISH-WILSON:** No. I accept that.

**Dr Fitzgerald:** It would be a very interesting study and we would strongly support some funding to allow us to quantify what is actually happening on the West Coast, because it is an excellent example of what happens when continuing-care models disintegrate.

**Senator WHISH-WILSON:** If I could just get that on the record for *Hansard*: you would recommend to the committee that one of the outcomes we might consider is to get a proper quantitative study of the level and quality of healthcare services et cetera, and the potential disadvantage Tasmanian rural areas are at versus other national or regional areas, done.

**Dr Fitzgerald:** In particular, on the West Coast.

**Senator WHISH-WILSON:** Interestingly, on the same—or a similar—subject, Neroli Ellis mentioned earlier that in her area of nursing the fly in, fly out models and the short-term allocation of locums to fill these gaps is actually frightfully expensive; it is kind of counterintuitive in the sense that it blows out budgets. I presume it would be similar for general practitioners and other healthcare professionals. Do you agree with that in your area?

**Dr Fitzgerald:** The previous provider on the West Coast actually did not re-tender because of the cost of providing the service using that model. There is a new provider for that service now who is using a different model and it would appear to be making significant improvements in terms of the availability of experienced doctors in the area. The model that seems to be working better is what I would call a tag team model. That is, you may have several experienced doctors who rotate week about, or something like that, looking after these

communities. But they are always going back to the same communities and so there is much better continuity and much better handover. At some stage it would be wonderful if we could get to the point where we actually had doctors who wanted to live long term in those communities but at the moment that does not seem to be a prospect, given the very poor level of infrastructure and support in those areas. I could train someone who has the skills to be a rural and remote generalist but when they go to that area they will not be able to use those skills because the public health services and public hospital service have deteriorated to the point where it is not available. For example, if I could speak on behalf of Dr Pashen: he recently did a locum in Queenstown in winter. He was unable to admit a sick child to the hospital because of nursing competence issues. The only option he was presented with was transferring this child along an icy winter road to Hobart for observation. He did not do that; he found another way around it. But that is the level to which some of the services have deteriorated.

**Senator WHISH-WILSON:** How many people live in Queenstown?

**Dr Fitzgerald:** About 3,000. There are 5,000 on the West Coast in total, and I think a little over half of those live in Queenstown.

**Senator McLUCAS:** And there is no resident GP in Queenstown?

**Dr Fitzgerald:** No, there has not been for some time. Queenstown has been serviced by a fly-in fly-out model, as has Rosebery and Zeehan. There is a GP there now who is working about one week in two, and I understand there are other experienced GPs who are being taught to provide a full-time service there. As I say, the process is improving but even so to locate someone there with the sorts of skills we are talking about—rural medical generalist—would require a serious upgrade of the infrastructure and support services.

**Senator WHISH-WILSON:** Is there a disparity in average income for GPs in Tasmania versus other states? You might also let me know where we are getting most GPs from in Tasmania.

**Dr Fitzgerald:** I am not aware of a disparity in income. The fly-in fly-out model was paying Queensland and Western Australia and the Northern Territory locum rates, which would be a significant increase in remuneration. I am not aware of what the current contract arrangements are for these areas but I suspect that the payment structures are still paying more for people to go to remote areas than they would earn in their own practice in an urban setting. During the fly-in fly-out model quite a lot of the doctors were overseas-trained doctors engaged to address areas of workforce need. Under the new model that the current provider is putting in, we are seeing experienced rural doctors being relocated to this area. That is certainly a positive.

**Senator WHISH-WILSON:** Are university interns doing their final years in this area?

**Dr Fitzgerald:** Yes, some university interns do go to Queenstown.

**Senator CAMERON:** What are the implications of budget cuts on rural and regional health care?

**Dr Fitzgerald:** We have talked about the PGPPP. I presume we are talking about the federal budget here, rather than state. I am sure the Rural Doctors Association has already made a submission about the co-payment issue. It is fair to say it is a particularly big problem for Tasmania because in over 40 per cent of households in Tasmania the primary source of income is a Commonwealth benefit of some sort. We tend to see more of that in some rural and remote communities. Even though in some communities people are employed in mining and so on, the opportunities for employment have diminished significantly and so we are now seeing a lot more people in those communities who either could not move out when the mines closed or have moved in because of housing costs. In a town like Zeehan, which has had no significant employment for some time, there will be large numbers of people on disability pensions and other pensions. The actual morbidity base is quite complex, and their financial resources are quite limited.

There are two specific issues that concern me about the changes, which may not have been addressed with the committee before and I thought I might raise them. The first one is their potential effect on available training positions for general practitioners. You would appreciate that training practice positions for general practice training across Australia are at saturation point. Under the Australian General Practice Training model, general practice training is really an apprenticeship program and it depends largely on the goodwill and support of practice supervisors who host registrars in their practices for their period of general practice training. I would also say that the government wants to have an additional 300 positions, which is about 25 per cent, available by the end of next year. My concern is, if the co-payment does cause a drop in patient numbers, that the training positions will really be the first to go and that we may find significant problems placing registrars for general practice training in practices, as they attempt to maintain their core structure. I do not know that that has been addressed before the committee.

**Senator CAMERON:** We have certainly heard that specific point. What we have heard predominantly, and almost overwhelmingly, is that the co-payment is bad policy. I am not sure if you agree with that.

**Dr Fitzgerald:** If I take my RDAA hat off, I could to talk to that. I do not know that the Rural Doctors Association has a formal policy on that, and I understand that it has already made submissions. I have some background in government and in health service planning and, as part of that, have published on issues about determining how, if you like, economic markets apply to general practice. This may be a bit esoteric for the committee, and I am not actually arguing for co-payments in any way—but as I understand it the co-payment is a mechanism to manage activity in the general practice market. That is a fairly broad statement, but I have not seen any evidence to suggest that that is not the case from the government's point of view. I do not think the designers understood how the market operates.

My point hinges around the concept of the informed consumer—that is, the consumer who can make an informed choice based on price, availability and suitability of services. Whilst there is a small component of general practice which is episodic care—or what I would call fast medicine—where the patient may be considered to be the informed consumer, in the vast majority of chronic or complex care, or slow medicine presentations, the informed consumer is really the patient and their general practitioner working together as a team so that the general practitioner is acting as a broker in the health system for the individual patient tailoring their individual health needs to their resources and to whatever resources are available in the community. It is much the same as, say, a solicitor would help to negotiate the legal system or an accountant would help to negotiate the financial system. The co-payment actually puts the price signal in the middle of that relationship; it puts the price signal between the patient and the general practitioner. If it were to actually apply in any free-market way, it should really come after the general practitioner and not before the general practitioner, particular for patients with chronic or complex care needs. And so, as such, I do not think the market will operate as a free market and I understand that there is a lot of community concern and disquiet about this co-payment—and I think a lot of people instinctively see it is counterproductive—my take on that is that whoever designed it did not understand how the market works.

**Senator CAMERON:** That is helpful and that is consistent with the other submissions we have had from the AMA and other organisations. When you talk about the informed consumer accessing services on the basis of cost, my experience in New South Wales is that—I am not sure of the position in Tasmania—in rural and regional Australia, in towns like Tamworth, which are fairly big regional cities, people cannot get any bulk-billing. There is no access to bulk-billing and so that is really a market failure in terms of access and that is being taken up by most practitioners, assisted by medical students from the University of New England. How do you deal with a situation where, apart from the doctor shortage issue, we do have low-income people cannot access services even before the co-payment because of the lack of bulk-billing?

Apart from the doctor shortage issue, how do you deal with the situation where people cannot access doctors, even before the co-payment, because of the lack of bulk-billing?

**Dr Fitzgerald:** There are a number of questions in that statement. On the nurse practitioner issue, I do not necessarily agree that nurse practitioners are interchangeable with experienced, competent general practitioners. I would say that nurse practitioners have their specific competencies and general practitioners have their specific competencies. Part of the process that I am involved in is, if you like, upskilling general practice so that we are really looking at a situation where nurse practitioners and doctors would and could work as teams. I think the benefit for the community of that sort of situation is much better than an either/or approach, and that has certainly been my experience from working in teams with nurse practitioners in the past. I think they add an enormous amount of value to what doctors can do. And I should say, off the record, that no-one manages doctors more effectively than nurses—certainly much more effectively than doctors do. So I would see the relationship between nurses and doctors as being part of a team and I would see us trying to get everyone in that team working to their higher level of competency or to their highest level of skill, rather than saying, 'It's one or the other.'

However, I accept the issue about access to services and I accept the issue about payment for services. I am not aware that similar situations exist in Tasmania, and it would be rather difficult to maintain a practice, given the high rate of dependency on Commonwealth benefits in this state.

I am also advised that bulk-billing is available in Tamworth and I would be happy to forward some emails to you. This issue was raised yesterday and I did some research. I think where you would find that there is an issue is that there are not practices that universally bulk-bill. It certainly has been my experience, even in a billing practice, that you would bulk-bill at least 50 per cent of your patients because they are the chronic care patients, the people who are seeing you regularly, who are on pensions or health care cards and so on. On the advice about Tamworth, from a consumer perspective it may look as though there is no bulk-billing available, but I think, from the perspective of the doctors, it is available but it is not readily available.

**Senator CAMERON:** You may be right about that, but the correspondence that I have is from Tamworth residents who are age pensioners and they simply say that there is none now. They may not know where there is one, but that is different proposition, I think.

**Dr Fitzgerald:** I did contact the President of the Rural Doctors Association of Australia, who happens to be in practice in Tamworth. It may appear that way from the consumer point of view, but I do not think that is the case from the medical point of view.

**Senator CAMERON:** I suppose if it appears that way to the consumer—

**Dr Fitzgerald:** That is all that matters, yes.

**Senator CAMERON:** then it is still a problem.

**Dr Fitzgerald:** Yes, absolutely. I completely concur with that.

**Senator CAMERON:** That is good. Hospitals in Tasmania have been a fundamental problem. We have concentrated in our discussions here with you, Dr Fitzgerald, on primary health care, but people also do need that hospital care. Given that in Tasmania there has been $38 million removed from hospital budgets this year, I think, how does that affect rural and regional health care?

**Dr Fitzgerald:** Keep in mind that, for two days a week, I am employed by the state department of health; so I am a bit reluctant to comment specifically on issues to do with the delivery of health care. The practical issue from the general practice perspective is that, as I said, if you are acting as your patient's broker, then you and the patient still have the problem; you have to find a way to sort it out. What you will find in a situation where perhaps you have very long waiting times for elective procedures is that, effectively, there is no point referring someone to the public sector for an elective procedure, and so your only options are to manage the situation in a palliative sense or to discuss self-insurance with the patient. I have certainly had friends who have chosen self-insurance rather than wait for treatment of very significant health problems that were not going to be treated in a reasonable period of time in a public hospital in this state.

I understand that, in terms of the Australian economy, self-insurance is about 17 per cent of health expenditure. It is the fastest growing segment of the market. The problem with public hospitals always ends up being the problem of the general practitioner and the patient. What you will tend to find is that general practitioners will try to find backdoor ways or other ways of doing things. They tend to, if you like, almost cover over some of the gaps in the system rather than make them obvious. Certainly, from the Tasmanian point of view, I think it would be fair to say that access to elective procedures in public hospitals is extremely limited.

**Senator CAMERON:** This is a very serious issue that you raise. Can I just clarify: you are saying that if a patient comes to you and that patient requires hospitalisation and there are no public beds in the public hospital, you would then recommend palliative care or self-insurance?

**Dr Fitzgerald:** Sorry, palliative care is not what I mean. To palliate means to treat the problem symptomatically rather than resolve the issue.

**Senator CAMERON:** Not palliative care—

**Dr Fitzgerald:** No. I am sorry; that was a poor choice of words. I should clarify this by saying that I am only doing remote rural locums and educational visits in the clinical sense in Tasmania. I have been a doctor for 40 years, and I am sort of slowly winding down. In my last practice in North Sydney it was a similar situation—and that is getting on to five years ago now—there was no point referring someone to a public hospital for an elective procedure. It has been a longstanding issue. As the state hospitals generally try to maintain budgets, the elective procedures are displaced by acute and emergency, and that seems to take most of the hospital's resources. My point is that the deterioration of the state health system is, to some extent, hidden by the fact that GPs are trying to do the best for their patients and are finding other ways to get these problems resolved.

**Senator CAMERON:** In the context of rural and regional medical care, is there anything in the budget that provides more resources to rural and regional care and, if so, does that balance up the broader cuts in the budget?

**Dr Fitzgerald:** Leaving aside Senator Nash's statements on the weekend, which implied that there may be some improvements, for example, for doctors in remote areas in terms of subsidies and so on, it is not clear that there have been any issues put in this year's May budget that would make a big difference to rural and remote communities.

**Senator CAMERON:** Senator Nash is making more promises. There were a lot of promises made before the election that there would be no cuts to health care. Isn't that correct?

**Dr Fitzgerald:** I am not too sure whether I can comment on that.

**Senator CAMERON:** It is a fact, isn't it?

**Dr Fitzgerald:** If you say so, yes.

**Senator CAMERON:** Yes, it is a fact. Good luck with any more promises is all I can say.

**Dr Fitzgerald:** I understand that, and that is why I have qualified my statement.

**Senator CAMERON:** Thank you, Dr Fitzgerald.

**CHAIR:** Dr Fitzgerald, could you respond to a couple of comments that I am going to make arising out of the RACGP submission where they state, in response to the budget, that the government will reduce the funding for public hospitals by an estimated $1.8 billion over four years through the cessation of funding guarantees under the National Health Reform Agreement and through the revision of public hospital funding arrangements from 1 July 2017. Given the evidence that you have provided us so far this morning, what do you estimate would be the impact of that $1.8 billion cut in funding in the rural and regional areas?

**Dr Fitzgerald:** Probably the major problem for me is that we are looking for investment in remote and rural facilities when the state is already performing poorly in terms of overall health service delivery, and the state's budget is deteriorating. So we are not overly optimistic that there will be any resources available for investment in rural and remote facilities, at all.

**CHAIR:** In the evidence you gave us this morning, you spoke about the degrading of hospitals in rural and remote situations and the removal of resource capacity in terms of staffing to a point that you say means they simply cannot be used for the purposes they were originally designed for, and what the community might still think they are able to be used for. Do you have any further comment on the state of facilities in rural and regional Tasmania, in particular?

**Dr Fitzgerald:** A good example of what you are raising is obstetric services at Smithton. We had an experienced rural medical generalist providing obstetric services to the people in Smithton up until about two years ago, when the state government withdrew obstetric services. The argument was that there were not enough cases there to maintain the competence of the midwives. Effectively, it meant that the government could pull out all the funding for 24/7 nurse coverage for obstetrics.

That doctor has since left the area. He went to Burke, and I think he is now in the Northern Territory doing rural obstetrics. That is a fairly clear example of the sorts of issues that have been going on over a very long time in Tasmania. We currently only have one practice in Tasmania now doing rural obstetrics, and its future is also under a cloud.

There are no other rural and remote hospitals doing procedures, as such. Access to radiology is seriously limited across the state. You may have 1½ days of radiology for the west coast or the east coast. And it is only available in-hours. You can imagine what that means in terms of trying to run an emergency service. We are really doing pre-hospital care in our emergency services. We are not actually able to sort people out to the point where we do not have to move them out if they have anything other than a very simple problem.

All of the hospitals that we would regard as rural and remote hospitals are really struggling even to be called multipurpose centres. They may have a few acute beds but effectively they are operating at just a little bit above a nursing home level.

**CHAIR:** Could I ask you about the combined impact of the removal of $115.4 million over four years to the two programs. We have spoken about the PGPPP, but there is also GPET. Basically, this is training for doctors on site and as part of their ongoing training, plus the placement of new graduates. There has been $115 million removed from that funding line. What are impacts likely to be?

**Dr Fitzgerald:** The issues to do with general practice training are really quite complex. As I understand it, the regional training providers—17 nationally—will have to go to tender in the middle of this year. So it is very difficult to the talk about what the likely outcome is going to be until you see the tender documents. It is also difficult to talk about the quantum of funding that is going to be available for training until you see the tender documents.

I have already raised the issue of the co-payment's potential impact on training positions. With my rural generalist hat on I think that this tender process is actually an opportunity to improve training for rural and remote doctors. It may be possible to put some criteria in the tender process to select for more rural and remote training, or it may be possible to establish a dedicated national rural and remote training organisation and take the role from the existing regional training providers. So it is a very complex area. There are obviously coordination issues, which have been taken over by the Department of Health. I do not know how much the Department of Health's increased costs are going to eat up part of that $115 million.

**CHAIR:** Yes. There has been considerable concern expressed.

**Dr Fitzgerald:** It is a very complex area, and I guess I probably know too much about it to make a specific comment.

**CHAIR:** You sound like you know a reasonable amount, and I think you are complementing comments we have heard elsewhere. Could I ask you about the Medicare Locals change to Primary Health Networks. We know it is going to cost $3 million here in Tasmania for a name change and the removal of the capacity to respond to communities except where there is something proven called 'market failure', which is as yet to be defined. Do you have a comment about that transition?

**Dr Fitzgerald:** The Medicare Locals are interesting, because, if you could link the Medicare Locals more closely to the provision of state services, you would have really found a way to cross the Commonwealth-state divide in healthcare provision. I must declare an interest. I am actually on the general practice consultative committee that the Tasmanian Medicare Local has established, representing the Rural Doctors Association of Tasmania. I think in a general sense there is an opportunity to create something a little more positive, but I am not in a position to talk about the impact of funding or the impact of restrictions of what they can do. I think there is a real opportunity with Medicare Locals to address a whole lot of the issues of cost-shifting, duplication of services and so on that go on, certainly in primary care, because of the Commonwealth-state divide. No-one seems to be seizing that as an opportunity.

**CHAIR:** We heard from the Royal Australian College of GPs yesterday, who indicated that the introduction of the $7 co-payment, the GP tax, not only removes access to health care; it would shift the costs to states and individuals rather than actually save any money. We have also received from them and the AMA detailed evidence based submissions that assert there is no funding crisis, there is no emergency crisis of funding of the health sector. Indeed, they claim that, at 9.3 per cent of GDP, we have a very healthy, very effective, efficient system—the American system costing twice as much. Does it concern you that this language of fear and alarm around funding has created a climate in which cuts are now being advocated in a system that looks like it can ill afford cuts?

**Dr Fitzgerald:** This is a personal comment, of course. You will recall, when I talked about the problems with the design of the co-payment, my initial statement was that I regard it as a mechanism to manage activity in the general practice market; I do not regard it as necessarily a funding emergency issue. As I say, I have had some experience in government at a state level. There is a problem with Medicare from the federal point of view in that it is an open-ended commitment to fund whatever activity occurs in that segment of the market. I think probably successive governments have been trying to find a way to manage that activity, and I would regard this as an attempt by this government to put something in place so that, over the longer term, they can titrate, if you like, the level of the co-payment and so attempt to manage what is going on and give themselves some more budget surety.

**CHAIR:** Dr Fitzgerald, we are going to have to close up very, very quickly. Could I just ask you, for the record: was your organisation, the Rural Doctors Association of Tasmania, consulted before these massive changes to the health budget and health structures were announced by the Abbott government?

**Dr Fitzgerald:** I am not aware. I was not in this position at the time, but I was not aware that RDAT was consulted.

**CHAIR:** The AMA can declare they were not consulted. The Royal Australian College of GPs were not consulted. It looks like there might be a bit of a pattern there.

**Dr Fitzgerald:** I am not able to speak on behalf of Rural Doctors Association of Australia, but, from the point of view of the Rural Doctors Association of Tasmania, I am not aware they were consulted.

**CHAIR:** If you could find out for us, on notice, that would be very helpful.

**Senator CAMERON:** Dr Fitzgerald, the secretariat have a copy of the correspondence from the University of Sydney, which includes the Tamworth residents' claims about the problems of accessing health care in Tamworth. We will get a copy of that to you. On notice, I would be very happy if you could respond to the issues raised in that correspondence.

**Dr Fitzgerald:** I would be happy to respond—I have some emails from the doctors in Tamworth—but would it be more appropriate for me to ask the doctors in Tamworth to respond?

**Senator CAMERON:** I think that would be fine. They could respond directly to the secretariat and we will provide details of that. I would be happy to talk directly to the doctors in Tamworth as well, and they can contact me pretty easily, I think.

**Dr Fitzgerald:** Sure. The outgoing President of the Rural Doctors Association of Australia, Ian Kamerman, is in Tamworth. I could refer this to him; I had an email from him this morning.

**Senator CAMERON:** Yes, I would really like to clarify this—that would be great. Thank you.

**CHAIR:** Dr Fitzgerald, you might be aware, too, of the changes mooted to the higher education system. I wonder if the rural doctors might like to correspond with us about what they think an increase in the cost of a degree for medical science students would mean to their determination to choose rural practice or plastic surgery or some similar specialty. Thanks again for your evidence. If you would respond to those questions on notice, we would greatly appreciate it.

**Dr Fitzgerald:** Fine. Is it possible for me to be forwarded the questions specifically?

**CHAIR:** Yes, we will be forwarding them. The secretariat will be in touch with you.

**Dr Fitzgerald:** Thank you.

**BARWICK, Justine Ms, Operations Manager, Family Based Care Association North West Inc.**

[12:44]

*Evidence was taken via teleconference—*

**CHAIR:** Welcome. We have taken more time with some of our witnesses than we had anticipated, so I appreciate your patience in waiting to speak with us. Would you like to make an opening statement?

**Ms Barwick:** Family Based Care Association North West is the largest non-government provider of community services in the north-west of Tasmania. We see our role, as a community services provider of services such as respite personal care, domestic assistance and social support, to be integral in the wellness of our community. If we do our job well we see that we have a role to increase the health of the community and reduce presentations at hospitals.

**CHAIR:** Can I just put on the record what community based care is. You have listed the services you provide. This is something that is really deep in our community. You provide personal care for people who need help with showering and toileting. You also provide domestic assistance, so for people who might not be able to clean their home any more you provide cleaning services to ensure they are able to live in a safe, healthy and pleasant environment. You provide respite care for carers who are doing this care 24/7, so that they can just get a bit of a break. You also provide social support and also chronic disease management, working to help people improve their health. We are hearing about chronic disease a lot in this inquiry. You provide home care for veterans. You provide home maintenance, such as looking after the mowing, cleaning and a bit of window cleaning and the like every now and then.

**Ms Barwick:** Absolutely, and some advice around home maintenance issues.

**CHAIR:** You also provide disability support.

**Ms Barwick:** Yes, we do. We are an NDIS provider.

**CHAIR:** And you do spring cleaning once a year. But you have private and brokered services and tailored services to suit individuals. Could you give us an idea of what that is?

**Ms Barwick:** We accept inwards brokerage from other services, perhaps if Family Based Care are in a position to provide a more individualised, tailored support to another agency's client. We do accept inwards brokerage, as well. That is really looking at a holistic response to the care for the client. I think it is really important to note that all our services are provided to the client where they live, or within their community.

**CHAIR:** So we have people with a disability, people who are ageing, or the frail aged, and we have carers. These are the people you are constantly interacting with?

**Ms Barwick:** Yes.

**CHAIR:** We hear in the evidence that people in Tasmania are sicker, poorer and older on average than Australians in other states.

**Ms Barwick:** That is right.

**CHAIR:** So that gives you a degree of expertise in this particular area. Have you formed a view about the impact of the federal budget cuts to health, in terms of hospitals, hospital access, sub-acute beds, or the $7 co-payment?

**Ms Barwick:** I think we are quite uniquely positioned, especially in the north-west of the state—it is going to be here where the effect of policy rollout that affects our target group is going to be felt. As you said, we do have an ageing population in Tasmania. I think that is particularly so in the north-west. There is a bit of a retirement hub in our region. Lots of people move here because of the property values. They can buy a bit more with their dollars. But then when services are required, because we have people living remotely it is quite often problematic. I think all of the policies you mentioned have a big impact on our client group, particularly for people living regionally, as we all do in the north-west.

**CHAIR:** We have heard evidence today that the state cuts to the budget will particularly impact on hospitals in the rural and remote areas and what that means to some doctors. We have just heard from one doctor who said he would just not put anybody on an elective surgery list. He would palliate them and try and give them the treatment he could to manage their concerns or he would encourage them to get private health insurance. How do you think that method would work with the client base that you look after?

**Ms Barwick:** Certainly, we have numerous clients who are on elective surgery wait lists with conditions that have profound impacts on their lives. Being on a list has a huge impact on the amount of service that they need to remain living at home. Sometimes those needs are such that they are actually really very difficult to service

because of the inability to access the appropriate surgery in a timely manner. It really is very difficult for us to provide the service that they need while they are waiting for that intervention.

**CHAIR:** Elective surgery waiting lists are already very challenging in Tasmania. We are hearing that, if the $7 GP tax goes through the federal parliament, people will stop seeing their local GPs and they will delay seeking help until they reach a point where they do actually have to go to the emergency department because that is the only place that they will be able to get help. That will impact further on the elective waiting surgery lists, won't it?

**Ms Barwick:** Yes, it will, and that will have a flow-on effect to the services that we provide, because we are going to have more people waiting longer and not looking after their health, which flies in the face of the models of wellness and enablement that we are trying to roll out in our communities.

**CHAIR:** To get a sense of what it is like, can you take me through an example of somebody that you look after in the north-west—without identifying them personally—who needs elective surgery, and what it means in how you have to change and provide additional services to help them manage while they are waiting?

**Ms Barwick:** We would have a number of clients who would be waiting for knee or hip replacements. The support that we have to provide to them while they wait could be personal care up to three times a week, so you are looking at three hours a week there. Some of them are unable to access the community without appropriate support, so we are looking at providing some social support—possibly anywhere between two and four hours a week to allow them to get the basic necessities into the house by way of groceries, to go and pay a couple of bills and maybe to go to the post office. Of course, there are the carers who we need to provide some respite to, as well. We are looking at anywhere up to 12 hours a week that we can be providing to somebody who, with the appropriate intervention, may well need no support after a good recovery.

**CHAIR:** Because, while you are waiting for a hip or knees, if you become increasingly immobile you cannot work, if you are still of working age, or find employment. But you also cannot move around as freely, and it just gets more and more difficult.

**Ms Barwick:** Absolutely. Our families are concerned about falls during this time as well. If somebody has a pre-existing condition and then has a fall and suffers a fracture, it complicates the treatment plan and, therefore, the person is dependent on services for even longer. That is why they are keen to have assistance to access the community safely and to get those necessary errands run.

**CHAIR:** You are situated in Burnie. We have been hearing about the challenges of access to GPs already. We also know that the government, despite promising there would be no cuts to health, has decided to bring in a changed funding model for pathology services and diagnostic imaging—so X-rays, MRIs, CT scans and all of those sorts of things. In Burnie, could you confirm the level of access to those sorts of services that currently exists? We are hearing that it is quite difficult.

**Ms Barwick:** It certainly is quite difficult. I keep saying it: living regionally, we just do not have access to services. The client group that we support has largely been, during their working career, blue collar-type workers, given the area that we live in and the industrial pursuits that were in Burnie when our client group was working. So the resources available to them to access services are finite. If they needed to contribute to the cost of their own care, they would have difficulty doing that. It is definitely problematic, and any changes that would see an increased contribution from the cohort in this region would have a huge impact.

**Senator WHISH-WILSON:** You say you are a community based organisation. Does that mean you are privately funded or you have a funding source?

**Ms Barwick:** No, we have multiple funding sources. We operate multiple programs. The majority of our funding comes from the Department of Social Services to service our over-65 client group. We also get funding from the Department of Health and Human Services at a state level to provide support to the under-65 client group. We are a provider for the NDIS—the National Disability Insurance Scheme—we have some funding to assist carers and we have funding to assist those with chronic illness. So our funding sources are multiple, but of course that leaves us with issues where we have to acquit those funds to each agency and report on that; there is some compliance for each of those programs that we need to do. In round figures from all our funding sources, it is about $6 million that we deliver.

**Senator WHISH-WILSON:** We have heard from other witnesses today about issues with attraction and retention of suitably qualified staff to Tasmania, and to your area in the north-west. Has that been an issue for you?

**Ms Barwick:** Yes.

**Senator WHISH-WILSON:** How big an issue is it?

**Ms Barwick:** Huge—a huge issue. The problem that we have is that people are moving out of the north-west; they are not moving into it. To keep our business viable, with any tenders that we put in, to be able to put in an appropriate unit cost we obviously need to keep the cost of delivering our service down, but we need to be an employer of choice so that we are getting good employees in. It is a real problem, and also it is not a glamorous profession, by any stretch. For my money, it goes back quite a long way—certainly attracting nurses into aged care has been problematic for a long time. Even looking into high schools, it is quite acceptable for somebody in high school to say that they would like a career in supporting children—working in the childcare sector—but it is not really encouraged to be working in the aged or disability sector. So I think that, as a community, we need to do something about increasing our own stocks of our own sector.

**Senator WHISH-WILSON:** Generally, where would suitably qualified people train? Is that training available in Tasmania—apart from experience in the field?

**Ms Barwick:** Absolutely. We certainly do have RTOs that provide and offer appropriate qualifications. Appropriate qualifications for our sector are vocational qualifications, and we have good relationships with the local RTOs.

**Senator WHISH-WILSON:** Just another point of clarity—when you talk about disability, is it primarily physical disability or does that include mental health issues?

**Ms Barwick:** Yes, it is across the board. We have funding from the state to deliver a mental health program to the clients; we have funding from DSS to support carers of people with mental health issues; we support people through the NDIA; and our state under-65 funding to support people with a broad range of disabilities. So it is intellectual disability, it is physical disability, it is mental health issues and it is autism as well—we are quite a hub for autism here. We are also seeing a lot of clients in our area with Huntington's disease—we are quite a cluster for Huntington's disease—and clients with Huntington's disease have very complex care needs.

**Senator WHISH-WILSON:** Do you work with any treatment areas across the bigger field of addiction—alcohol and ice?

**Ms Barwick:** Yes, we certainly have good links with service providers and often there is co-morbidity, particularly with mental health. For issues of addiction, whether they be prescription or non-prescription, we do have good interactions with services to support the client to ensure a holistic approach.

**CHAIR:** Given the nature of the community care that you provide, I am wondering if you can give us a bit of an outline of the aged-care sector and the challenges that you face.

**Ms Barwick:** In relation to the support that we provide to our over-65 clients, our organisation is being greatly affected by the aged-care reforms that we have been experiencing for the last few years and will continue to experience. The move from block funding to individualised funding will be a challenge for our organisation and it will be particularly challenging for those organisations who are perhaps smaller than us and who may have fewer resources available to them than us. To articulate that a little further, you receive block funding in advance—so you receive your funding, you deliver the support and off you go. With individualised funding you to deliver the service and then you get the funding.

To be able to compete with big, for-profit providers—who can keep their unit costs down and therefore make quite large sweeping claims and applications for funding for services across big areas of Australia—is very problematic for us. Our community in the north-west is really quite regional, and a lot of our clients are very remote. We are concerned that if a big, mainland for-profit enterprise were to secure funding right across our region, they would not really appreciate the complexity of delivering support in such a region. That is really quite problematic. If the health of the region is not good, and we have already discussed that, it puts more pressure on the services that we provide.

**CHAIR:** Do think that carers and the people they are caring for will be dissuaded from seeking health care if they have to pay an additional $7 to go to the doctor?

**Ms Barwick:** Yes, I do. Our clients do not have a lot of money to support themselves. Most of our clients would not have anything tucked away for a rainy day and quite often they prioritise their own wellbeing down at any rate. If there is a cost involved, they would definitely not seek help until things were quite desperate.

**CHAIR:** When they hit that point of desperation, they have the options of going to Smithton Hospital or the Mersey in Burnie. What other options are there?

**Ms Barwick:** That is about it. There is a private hospital in Burnie, but lots of our clients do not have private health insurance. Several times a week staff go for a scheduled visit to clients and find them unwell. They are really disinclined to even call an ambulance because they are scared that they are going to be taken to hospital,

there will not be a bed and they will end up being in A&E until a bed becomes available. One of our young clients with profound disability spent two days in the Mersey A&E before there was a bed for him. So they are disinclined to ring an ambulance and disinclined to seek that intervention because they are worried that they are going to be on a trolley for a couple of days.

**CHAIR:** We heard from the nurses union a little earlier. I don't know if you heard the evidence. They reported that, sadly, there are mental health patients being held in A&E for six days. The people you are caring for are on a trolley in A&E for six days because the hospital is already operating at 100 to 105 per cent capacity, we have heard.

**Ms Barwick:** Yes. In the example that I just gave, this young gentleman who spent 48 hours in A&E is a quadriplegic. His care needs are very complex and it was quite distressing for him and for his family, a very articulate family who very much advocate for him and other people with disability. It concerns me what is going on out there for other clients who perhaps are not so articulate. It makes me understand their disinclination to go and seek help.

**CHAIR:** It sounds like you have an amazing task currently. With the cuts to health—we are talking about $50 billion out of the federal budget—I can only imagine that the task is going to get a lot harder. My last question is: do you have any interactions with Medicare Local?

**Ms Barwick:** Yes, we do.

**CHAIR:** What do you do?

**Ms Barwick:** We have funding from Tas Medicare Local to deliver our chronic disease and aged care program. It is not a big program. It is only a fairly small source of funding for us in the scheme of things. What we do with that funding is we employ a specialist coordinator to work with our clients with chronic illnesses, to walk alongside them for a time, to increase their connections to health services and other services within the community that can assist them to live in more of a well way. It is a model that encourages real buy-in from the client. They are in the drivers seat on this and we are seeing some good results from this program.

**CHAIR:** Are you aware that the Medicare Local is shutting down and is going to be replaced by a Primary Health Network? The cost of the dissolution of the Medicare Local in Tasmania, we heard today, is $3 million. What could you do with $3 million in the north-west of Tasmania?

**Ms Barwick:** We could do some great stuff for the communities of the north-west with that. My mind is swimming with that figure because, as I said, in round figures we had $6 million coming through Family Based Care to deliver services, so we could help half as many people again with that. It bends my mind a little bit.

**CHAIR:** It is very interesting. It certainly was not one of the things that the people of the north-west of Tasmania knew about before they cast their votes at the last election. Thank you very much for your evidence this morning and for your patience in waiting for us to come to you. We thank you for the care that your organisation is providing to the community.

**Ms Barwick:** Thank you.

**CHAIR:** I thank all the witnesses for appearing before the committee today. Thank you also to Hansard, Broadcasting and the secretariat. That concludes today's public hearing.

**Committee adjourned at 13:08**