Rural Doctors Association of Tasmania

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**RDAT Submission to the Legislative Council Government Administration Committee 'A' Inquiry into Rural Health Services in Tasmania**

Inquiry into Rural Health Services in Tasmania

Legislative Council

Parliament House

HOBART TAS 7000

Sent via email rur@parliament.tas.gov.au

12th March 2021

Dear Hon Ruth Forrest,

Thank you for the opportunity to provide a submission to the Legislative Council Government Administration Committee 'A' Inquiry into Rural Health Services in Tasmania. The Rural Doctors Association of Tasmania (RDAT) is the peak rural body for doctors working in rural and remote Tasmania and represents the views and aspirations of rural doctors. We aim to promote career pathways in rural practice, and support services provided by rural doctors in Tasmania. We support rural communities through advocacy and sustaining health services in rural Tasmania.

Please find enclosed our submission that aims to provide RDAT's ideas, concerns and future expectations of our Rural Health Services in Tasmania.

Any enquiries can be sent to office@rdaa.com.au.

Yours sincerely,

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**Terms of Reference point 2a.**
**Availability and timeliness of health services including Ambulance Services**

Successive governments have decreased the availability of ambulance services to rural areas. For example, in the North East Region, there is one ambulance based in Scottsdale that is staffed by a salaried paramedic and a volunteer if one is available. If that ambulance is on a call out or being used to transfer a patient to the base hospital (LGH) then it leaves the whole North East of Tasmania without emergency pre-hospital care. In the last 20 years this service has been downgraded from three ambulances to one. In a recent ambulance call out (March 2021) an elderly lady who had fallen in the local supermarket had to wait 60 minutes for an ambulance to arrive.

An increase in rural trauma from tourist-based adventure activities has the potential to increase demand for rural emergency services. The THS need to ensure that these facilities are capable of adequately assessing and managing patients. Pre-hospital care and a plan for retrieval are needed at rural sites to provide support. RDAT will continue to advocate for preventative measures in relation to these activities for example protective equipment, engineering standards, equipment standards and participant training.

**Terms of Reference point 2b.**
**Availability and timeliness of health services including Primary care, allied health and general practice services**

RDAT will continue to advocate for increasing funding in primary health care to prevent development of chronic disease and preventing acute exacerbations of chronic disease. General Practitioners are well placed to continue to deliver this healthcare with support from the State Government. There is a lack of 'bulk billing' general practices in Tasmania, primarily because the MBS rebates available to patients are woefully inadequate for GPs to assign as the full benefit of a consultation. Many other specialities are also in similar positions, including podiatry, physiotherapy and psychology. Even when patients have access to appropriate care plans that enables MBS rebates for these services, many providers are choosing not to bulk bill due to the cost of running a healthcare business.

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In order to provide the right care in the right place you need the right doctor with the right skills. In rural areas Rural Generalists are able to provide this with their extended scope of practice suited to the community in which they work.

RDAT believes the State Government needs to invest in the Tasmanian Rural Generalist Training Pathway in order to train the future Rural Generalists needed to staff Tasmanian District Hospitals and provide the excellent standard of care rural communities deserve both in primary care and in the hospital setting.

RDAT also understand the need for team care in rural areas. This is best completed through multipurpose facilities that can house GPs, physiotherapists, speech therapists, podiatrist and visiting medical specialists. This of course requires infrastructure spend by the State Government in rural areas.

Preventative Care is the key. Primary Care needs a team-based approach to keep Tasmanians in their homes. This means adequate allied health professionals and care packages. Currently programs needing a multidisciplinary approach such as weight reduction and pain management are incredibly difficult to access, particularly for poorer socioeconomic rural areas where the services are so badly needed. Preventing future problems such as diabetes, heart disease and kidney disease is key to keeping people out of hospital, and requires investment in training allied health professionals, dieticians, exercise physiologists and psychologists to manage these complex issues in conjunction with the patient's General Practitioner.

Adequate training and remuneration of Rural Generalists will provide a workforce to the areas of highest need in Tasmania to provide comprehensive Primary Care and undertake preventative healthcare.

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**Terms of Reference point 2d.**
**Availability and timeliness of health services including Hospital services**

District hospitals need to be adequately resourced and staffed to ensure maximum utilisation. The District hospitals not only provide step-down care, but they can also be the primary site of care for selected medical conditions within the scope of practice for the practitioner and the site.
Rural district hospitals have seen an increase in inpatient activity and complexity of patients. As pressure builds in Tasmania's major hospitals, there is a push for increased utilisation of rural inpatient beds. RDAT supports utilising rural hospitals and rural generalists to their full capacity, however, adequate staffing and resourcing is needed for this to occur. For example, as the number of emergency department presentations to rural hospitals increases, District hospitals will require dedicated staff for emergency presentations; currently the staff attending to emergency presentations in District hospitals are taken away from the care of inpatients. Also, the district hospitals are not funded for increased numbers of emergency presentations, drawing resources from existing block funding for the facility.

Rural Generalists with an extended scope of practice and special skills in a variety of areas staffing the hospitals would mean more complex patients may be able to be managed. Support from non-GP Specialist services, via telehealth or outreach services would assist. Adequate allied health particularly physiotherapy and occupational therapy, as well as nursing staff with generalist skills are also essential. This supports robust emergency care, inpatient care and rehabilitation.

RDAT would suggest further discussions between our organisation, the Australian College of Rural and Remote Medicine and the state Department of Health to further develop the role of the District Hospitals in the Tasmanian Health Service as they are currently underutilised, under-resourced and underfunded. The number of rural beds combined in the state is equivalent to a regional base hospital and these could be used more efficiently to deliver the right care, to the right patients, by the right healthcare team, closer to home.

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**Terms of Reference point 2m.**
**Availability and timeliness of health care services including 'other'**
**Aged Care**

Continuing to enhance communication with primary care providers will improve aged care outcomes. When RACF patients are admitted to hospital they come with unique challenges and extensive comorbidities. Their GP is likely to be the best source of information and well-placed to be actively involved with the care delivered in hospital. Communication between the admitting consultant and the primary GP would be beneficial to clarify health status, goals of care, and any advanced care directives, and would help plan transition back to the community. Whilst admitted, comprehensive geriatric review and input from specialist clinical nurse consultants would be a beneficial service for the Tasmanian Health Service to offer appropriate patients. On discharge, a medication summary, separation summary and verbal clinical handover to the GP and RACF will help avoid adverse clinical events by ensuring continuity of care.

**Terms of Reference point 3b.**
**Barriers to access Primary care, allied health and general practice services**

Increased access to primary healthcare can be facilitated by adequate remuneration of rural doctors as well as supporting the increase in other members of the primary care team with support to extend premises to provide more consulting space and support the payment of services provided by others such as practice nurses, and allied health care providers. Also needed is collaborative support of efforts to increase those willing to work in rural areas starting from intake to training in medicine, nursing and allied health. The Rural Generalist Program is a key facilitator of increasing FTE GP services in rural areas, and hence the increased access to primary healthcare in these areas.

Rural Generalist doctors need to be supported by emergency medicine and retrieval experts who can provide timely advice. Investment in a comprehensive emergency telehealth network (i.e., bringing the emergency specialist to the bedside) would assist with peer support, collegiality, clinical guidance and support care in local communities; keeping patients connected to their supports.

The consistent message from community general practice is that the MBS rebates for patients are set below the cost of the running a general practice. Therefore, it is of no surprise that Tasmania as some

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of the lowest bulk billing rates in the country. The State Government needs to continue to advocate to the Commonwealth to increase the MBS rebates or provide an alternative means of funding general practice to incentivise better chronic disease management as an alternative to '6-minute-churn' medicine.

**Terms of Reference point 3e.**
**Barriers to access Maternity, maternal and child health services**

Rural maternity services are the lifeblood of many rural health services in Australia. Tasmania is now limited to only three birthing units in the state. In the recent past many rural hospitals safety birth 50-100 babies per year with the skill mix of rural generalists and local midwives.
The position of the Rural Doctors Association of Australia is:

- Quality and safety must underpin the provision of maternity services in rural and remote areas.
- Rural women have a right to safe, high-quality maternity services as close as possible to where they live.
- The continuing trend toward downgrading or closure of rural maternity services must be halted and reversed.
- A highly skilled workforce is necessary to provide sexual, reproductive and maternal health care for rural women, and manage obstetric emergencies when they arise.
- Models of care for rural maternity services must be fit-for-purpose for their communities.
- A continuing decline in rural health infrastructure, including for maternity services, has negative consequences for the health and safety of rural people and, more broadly, on rural communities.

Access to safe, high-quality women's health services that deliver contraceptive, safe termination of pregnancy services, preconception, antenatal, perinatal and postnatal care provided by a well-trained and supported workforce diminishes the health risks for rural women and their babies.

We note that, in Queensland, rural maternity services have been *re-established* in a number of rural towns where the removal of those services had not demonstrated improved outcomes (as had been the justification for this action) but had in fact been to the detriment of local women and their families.

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Workforce training, recruitment, retention and development strategies are necessary to ensure the ongoing provision, maintenance and sustainability of rural maternity services.

**Terms of reference point 3f.**

**Barriers to access to Pain management services**

Chronic pain is a common condition experienced by may Australians. Tasmania has a distinct lack of chronic pain services that are accessible to rural Tasmanians. Patients experience extended weight times (up to two years), travel to Hobart and disruptions in their care due to changing providers within the service. RDAT would welcome a review into chronic pain services in Tasmania that meet the needs of rural Tasmanians.

**Terms of reference point 3g.**

**Barriers to access to Palliative Care services**

Tasmanians deserve appropriate, timely and quality Palliative Care at the end of life. The majority of Palliative Care delivered by medical practitioners is by GPs. It is well known that most Australians want to receive Palliative Care in the home, but unfortunately a significant number die in hospital, and for rural patients, away from their local communities. The opportunity to maintain skills through the PEPA program is an excellent initiative for GPs, as well as Palliative Care Nurse Educators who can provide advice and a sounding board for GPs. The Specialist Palliative Care Service in Tasmania is high quality, however, is under resourced to respond to Tasmania's ageing population and increased chronic disease burden. For example, in the North-West there is an under-resourcing of 1.0 FTE Staff Specialist in Palliative Care. This affects the health service's ability to provide high quality inpatient and community care.

In terms of recruitment and retention, the North-West region has trained over 10 GPs in 6-12 month training terms to upskill in Palliative Care, with some obtaining an Advanced Skill in Palliative Care and working as a Rural Generalist in this area. RDAT advocates for continued investment in Palliative Care and end of life care at home and in the hospital. This is especially important with the initiative of Palliative Care beds at the Mersey Community Hospital.

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Specifically, in the district hospitals, spending has been undertaken to improve Palliative Care spaces and the Department of Health should be congratulated for this. Continued education and training for district hospital staff will be required for long term success of Palliative Care in rural communities.

**Terms of reference point 3k.**
**Barriers to access to 'After hours' health care**

Adequate remuneration for on call and adequate numbers of doctors to share in the on call is essential. Doctors need to feel supported after-hours by having a critical number of practitioners on the roster to prevent burn-out. Utilisation of GP Assist type services as primary on call and then having a local doctor as secondary on call may be useful for areas that need to have regular rostering of on call doctors.

The Urgent Care Centre Feasibility Report 2019 identified UCCs as a feasible service model for Tasmania. There are barriers and opportunities for implementing a model of urgent care in Tasmania. Doctors with the skills to manage emergencies will be needed. Rural Generalists are well placed to manages such centres. There needs to be adequate numbers to share the workload, and adequate remuneration for after-hours work. Collaboration with the local THS facility will be required to ensure that patients who have presented to a healthcare facility for their ailment will be able to be transferred and managed in the most appropriate location in a timely manner. For example, a patient presenting to the emergency department that can be more appropriately cared for by an urgent care centre. Similarly, a patient attending the urgent care centre who is having a heart attack will need transfer to the nearest larger facility that can attend to that type of ailment.

**Terms of reference point 3m.**
**Barriers to access to 'other'**
**Health Literacy**

Health literacy starts with basic literacy. In rural areas there is a lack of basic literacy, making self-management, and some preventative care approaches difficult for many patients whose reading and writing skills are poor. Basic education for adults, with increased literacy classes, group sessions on health issues and information given in a simple easy to understand way would be helpful.

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Community health hubs to assist families in basic shopping/cooking/budgeting skills would help prevent many health issues. Efforts to extend year 11 and 12 education to rural students is applauded. Support of regional education initiatives delivered by tertiary education providers is called noting access has improved a great deal with on-line delivery ramped up due to COVID-19.

Support for community-based approaches such as those trialled in the anticipatory care project is to be encouraged e.g., Neighbourhood houses, Aboriginal Health Centres, Local Government Council initiatives, general practices. Many useful ideas came from this project but funding then disappeared.

Support for within-primary school efforts such as expanding the HealthLit4Kids initiative.
Heightened support of the work of 26TEN is advised.

Improving health literacy overall will help members of community understand any attempt by the government to educate them on the various health pathways. A key strategy for the government will be communicating to the public what services general practice can deliver and how they can prevent presenting to the emergency department with conditions that can be managed in general practice. Another key strategy will be helping the public understand the preventative health measures that are applied to the individual over a life course e.g., lipid management, blood pressure management and disease prevention (ischaemic heart disease, diabetes, chronic kidney disease and chronic obstructive pulmonary disease).

**Terms of Reference point 5.**
**Staffing of community health and hospital services**

Ensuring medical, nursing, and allied health staff are trained to provide care in rural settings. The Rural Generalist Training Pathway needs to be adequately invested in to ensure Tasmania is producing rural generalists for the future care of Tasmanian Rural Communities. Investment in Rural Generalist Allied Health Professionals to ensure allied health provision of care to rural communities should also be carried out in Tasmania.

The University of Tasmania Rural Clinical School has been graduating new doctors since 2007. Very few have returned to continue a career in the north west (or indeed in rural Tasmania generally).

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RDAT would welcome a review of the University of Tasmania's medical student intake policies and consider other strategies that may make the University of Tasmania more "fit for purpose" in addressing the medical workforce needs of rural Tasmania.

Ensuring the Mersey Community Hospital successfully transitions to a Rural Generalist model will be critical in ensuring staffing and continuity of care in the North West. This requires a well-resourced Tasmanian Rural Generalist Training Pathway, using the Mersey Community Hospital as a training hub. This would then supply Rural Generalists to other District Hospitals around the state. For adequate RG training and sustainable RG practice, this would require the Mersey Community Hospital to work towards providing a range of medical services including RG/midwife maternity services, RG anaesthetic services, RG surgical/endoscopy services, RG adult internal medicine services, RG led palliative care services, RG paediatric services, RG rehabilitation services, RG mental health services and RG led emergency medicine services. The training required should be developed not in isolation, but in conjunction with the NWRH and LGH.

To undertake Rural Generalist Training in Tasmania there needs to be specifically designated jobs for doctors in certain prevocational rotations (emergency, paediatrics, obstetrics & gynaecology and anaesthetics). There then needs to be adequate training places for Advanced Skills Training; this can be in many areas including emergency, anaesthetics, obstetrics & gynaecology, palliative care, mental health, adult internal medicine and retrieval medicine. Once a Rural Generalist has qualified there still needs to be the ability to maintain skills by rotating back through bigger centres for intensive periods of upskilling.

Maintaining continued connections with specialists at the North West Regional Hospital would ensure excellent standard of care, good support for the model of care at the Mersey and ensure consultants at the North West are working at the top of their scope of care. This should assist in staffing both facilities as well as assisting in staffing of district hospitals in the state.

The work to achieve this also require a good industrial agreement in which these staff are employed with adequate incentive to work in Tasmania.

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**Terms of Reference point 8.**
**Availability, functionality and use of telehealth services**

Telehealth services can be grouped in 2 areas. Primary care carrying our telehealth to patients to avoid the need to present at the medical centre. This is funded federally currently, and state government should campaign to continue the adequately remunerated Medicare item numbers, with caveats ensuring patients are seen by their regular doctor or practice.

Telehealth also applies to non-GP specialist clinics from the major hospital. This has been a significant success for rural patients to avoid the long stressful travel to the major hospital for outpatient clinics. RDAT would like to see this continue for rural patients and expand to allow video links which are better for both clinician and patient. The savings in travel costs and time for patients is key and means for some patients who struggle with the travel, and may cancel appointment, there is less likely to be a problem. In some practices support for a dedicated room to undertake videoconferencing would be helpful for those patients who do not have access to this type of technology. The room plus equipment that provides fast connection speeds would be useful.

**Terms of Reference point 9**
**Any other matters - integration**

RDAT recommends an improvement in integration across all parts of our health system and its key interfaces (e.g., primary health, mental health, disability services, aged care and acute care). A key priority should be integration of mental health and alcohol & drug services. Unfortunately, substance use and mental health are two key comorbidities that interplay and require extensive outpatient (and sometimes inpatient) support and care. RDAT does not believe these two services are best delivered independent of each other.

**Terms of Reference point 9**
**Any other matters – digitisation**

All specialist letters, emergency department presentations, investigations, discharge summaries, procedures and correspondence should be made available to primary care. A 'one-stop-shop' electronic medical record should be prioritised. This would allow for a seamless entrance to the

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Tasmanian Health System through the emergency department, specialist outpatients or day surgery; continue through an inpatient admission including ordering and signing investigations and providing a clinical handover back to primary care with written communication. We need to replace the 10+ ICT systems that clinicians and ancillary staff need to navigate on a daily basis to provide patient care. Overwhelming feedback from primary health clinicians is that My Health Record is not very user friendly. It is currently limited to shared health summaries, THS discharge summaries (albeit in limited form with poor formatting and difficult navigation) and MBS data. The THS could improve the formatting of electronic discharge summaries in their presentation on MyHR, include specialist letters/correspondence and all hospital investigations (including imaging).

Giving GPs access to hospital digital records would help to make information available for ongoing care. The information currently available in the DMR is presented in a more user-friendly way than MyHR. Other states, such as Queensland have an online portal that allows access to the hospital clinical records. Reports from primary health care providers in that state indicate that portal is limited in what clinicians can access. RDAT would recommend that if a similar model was adapted then Tasmanian GPs have available all of the DMR in the form of a web browser portal. Current remote interfaces with Citrix logins and remote desktop connections would not be acceptable. Timely communication and access to correspondence is the most important part of primary care's interaction with the Tasmanian Health Service and is often poor or non-existent. The THS needs to invest heavily in e-Referral technology with the ability to easily find the services for the applicable medical conditions, minimum referral standards, e-acceptance of referral, indication of wait time or physical appointment time and then communication back to the General Practitioner electronically.

With the increased number of presentations to district hospitals, especially with introduction of new mountain biking courses in rural areas; a continued investment in x-ray and ultrasound technology by the THS is needed to appropriately assess and manage patients in these rural emergency departments.

The Royal Children's Hospital in Melbourne has developed a web portal and phone app that helps patients (and their parents) keep up to date with their healthcare interactions with the hospital. It provides reminders for appointments, recent test results/investigations, enables electronic communication with hospital-based specialists and provides advice for common medical conditions.

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The THS could invest in producing a similar application for the Tasmanian context, in parallel with a health professionals' web portal.

Currently once a referral is written, it is printed and signed and then faxed to one of many numbers at the referral hospital. The Fax numbers change often and need to be checked on the Tas health directory before the fax is sent. The referrals are not acknowledged until a letter arrives in the post or the patient is informed, they have an appointment. Often correspondence is not received in a timely fashion about the outpatient appointment. Some consultation notes arrive to the GP practice by fax and then need to be scanned to the patient file.

**Terms of Reference point 9**
**Any other matters – Teaching opportunities**

As a product of increased medical student and junior doctor interest in rural medicine, many of our rural general practices are now limited in the space that they can provide teaching opportunities. The Rural Doctors Association of Australia has provided a budget submission to the Commonwealth Department of Health to increase the number of Rural Junior Doctor Training Innovation Fund places from the initial 50, to 400 Australia wide. Rural general practices are going to need to have access to infrastructure grants to improve facilities. The reason that this is so important is early prevocational exposure to rural general practice is a strong predictor of long-term training and retention in the rural workforce.

The Rural Junior Doctor Training Innovation Fund (RJDTIF) that enables early years doctors to continue a teaching and learning "immersion" in rural general practice needs to be adequately funded to ensure that practices are not further financially penalised for supporting this very beneficial project. We note that this project receives no support from the State Government.

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**Summary**

RDAT recommends:

- accessible primary care for all rurally located Tasmanians
- access to primary health care as the key to improving the health outcomes for rural populations
- more funding for pre-hospital care to reduce the delay to ambulances called to rural patients
- investment in the Tasmanian Rural Generalist Pathway, improved remuneration for doctors and investment in the infrastructure required to enable the right care in the right place by the right doctors with the right skills
- investment in Rural Generalist Allied Health Professionals
- the Rural Generalist model to be applied to District Hospitals
- district hospitals to be adequately resourced and staffed to ensure maximum utilisation
- access to safe, high-quality women's health services that deliver
- increasing the number of Rural Junior Doctor Training Innovation Fund (RJDTIF) places available for training opportunities for rural generalism
- a review of the University of Tasmania's medical student intake policies
- ongoing provision of Telehealth services to continue to support the rural patients and overcome barriers to access to services
- improvements in communication between primary care, hospital care, specialist care, mental health care, drug and alcohol services and prison health care with a single portal for all communication
- the Legislative Council Government Administration Committee 'A' to become familiar with the concept of a Rural Generalist Doctor and invite the committee to meet Tasmanian Rural Generalist Doctors as part of this inquiry