AMA TASMANIA
ABN 11 009 484 931

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The Inquiry Secretary
Legislative Council Government Administration Committee' A'
Inquiry into Rural Health Services in Tasmania
Legislative Council
Parliament House
HOBART TAS 7000
Tel: 03 6212 2249

Email: rur@parliament.tas.gov.au

Dear Ms Forrest,

RE: Legislative Council Sub-Committee Inquiry into Rural Health Services in Tasmania

Thank you for the opportunity to make a submission to the Parliamentary Inquiry into Rural Health Services in Tasmania.

AMA Tasmania represents doctors in Tasmania across the spectrum of primary and acute care. Our doctors are very concerned about the impact on their patients of having poor access to health services in rural areas, as well as in urban areas, where shortages in specialists, for example, can lead to unacceptably long waitlists and adverse outcomes for patients.

Please note our submission addresses the issues that pertain to the Terms of Reference, focusing more on the primary sector. We could easily double the submission length if we were to include issues within the acute hospital system, which impact all Tasmanians, regardless of where they live. But that will have to be left to another day.

General Comments:

> *"I moved from metropolitan Queensland just over two years ago. I did not realise I was moving so rural. However, I now realise the health care availability to my patients is very rural-like and very different to the mainland." (GP Northern)*

The State of Public Health Tasmania 2018 report found that while there was improvement, people living in rural areas of Tasmania have a lower life expectancy than those in more urban settings. The data for health outcomes by Local Government Area (LGA) in the Mortality Over Regions and Times (MORT) tables proves significant inequality of outcomes in rural Tasmania, for example, unemployment is higher in rural areas (especially youth unemployment) and income lower, leading to lower socioeconomic status, which is linked to higher smoking, obesity, and alcohol misuse.

As a consequence of their lower socioeconomic status, rural populations are less likely to have private health, so they are more reliant on the overstretched public hospital system and therefore suffer from significant delays in diagnosis. One doctor reported that he has two Gastro-Intestinal (GI) cancer cases, which he suspects will have significantly different outcomes due to delay in diagnosis because of the waitlists at the RHH. Rural populations also have limited access to allied health services in either the public or, in the even more limited, private sector. Added to this is the financial inequality of accessing care.

https://www.dhhs.tas.gov.au/__data/assets/pdf_file/0004/375025/The_State_of_Public_Health_Tasmania_2018_v10.pdf

https://www.aihw.gov.au/getmedia/fc0ef20e-7c18-4de4-a5c9-a350a0a90410/Mortality-Over-Regions-and-Time-MORT-books.pdf.aspx?inline=true

Terms of Reference:

To inquire into and report on health outcomes and access to community health and hospital services for Tasmanians living in rural and remote Tasmania, with particular regard to:

1. Health outcomes, including comparative health outcomes.

Tasmania is faced with an ageing population with an increasing prevalence of age-related chronic conditions, such as cancer, organ failure, and dementia, which may require palliative care (ABS, 2009). It is estimated that one in four of the Tasmanian population will be over 65 years old in the coming decades. In addition, the rurality of the population leads to people having shorter lives and higher levels of illness and disease risk factors than those in major cities.

The population in the North West health district is 111,954 (ABS, 2018). This rural and remote district has an older, poorer population with poor health literacy and has high levels of chronic disease and cancer with poor health outcomes, including mortality due to cancers and heart disease. 20% of the North West population are aged over 65 years (ABS, 2015).

The primary determinants of health remain poor.

https://www.primaryhealthtas.com.au/resources/community-health-profiles/

2. AND 3. Combined (1) Availability and timeliness of and (2) barriers to access to health services, including:

a. Ambulance services.

Access to timely Ambulance services in rural areas is difficult. One of our GPs reported that her surgery frequently waits an hour for an ambulance when called to the surgery.

b. Primary care, allied health, and general practice services.

There are three main types of rural practices in Tasmania:

1. Large centres with five-plus doctors - usually managed by large corporates who have a goal of making a profit. Some are owned privately and operate as a cooperative of doctors.
2. Smaller one to two Doctor practices with Rural Health Beds
3. Smaller one to two Doctor practices without Rural Beds

All GP Practices, regardless of size, have issues with varying degrees around:

i) Funding - from the State Government-funded Rural Health Beds, Federal Medicare Funding and Local Council and community support.
ii) Attracting Doctors
iii) Succession Planning

Funding

In recent years, the Government has changed its funding model to the Modified Monash Model (MMM). Some areas of Tasmania have been reclassified and are no longer considered rural. For example, Lilydale in the North East is now considered the same as Launceston and therefore is no longer eligible for some Commonwealth incentive funding. AMA Tasmania believes that the MMM has been detrimental to General Practice in Tasmania and would like to see it reviewed. So far, our calls have fallen on deaf ears nationally.

> *"MMM status is, I believe, part of the problem and leads to a compounding of the factors by negatively impacting on GP availability in rural Tasmania and funding for federal programs. There is a significant shortage of access to primary care on the outskirts of the MMM2 area surrounding Hobart and a complete misunderstanding of the local communities in these areas. There are rural towns without any public transport, which are considered equivalent to central Hobart under the current status. Burnie and Devonport are considered MM3, which appears appropriate this is not about reclassifying areas to a lower MMM rather push for some areas to be upgraded. It is my understanding when MMM was introduced, it was acknowledged that some areas would be disadvantaged by the new system and southern Tasmania would appear to be a prime example of this. There was talk with the election of the new AMA president/VP of taking this forward for challenge, but other priorities have taken over and this appears to have been dropped." (GP Southern)*

Uncertainty of funding for programs catering for rural communities' needs or narrowing the programs' scope also creates unease and a lack of confidence for GPs.

> *"Of the current programs supporting rural areas there is uncertainty around the future of program I find most helpful for my patients (Corumbene Rural Health) but others which appear well funded, but I don't see any meaningful patient engagement or improvement in outcomes e.g., Brighton Care collective. Others again appear well funded e.g., RFDS rural teen health program but will only accept patients from Central Highlands, at the last time of asking they had a case load of three patients, yet I have several patients in Southern Midlands who would benefit support but don't live in the right LGA." (GP Southern)*

Local Council funding and support for General Practice varies greatly. As per an independent report in 2013, Glamorgan Spring Bay Council was levying ratepayers $200,000 per year and contributing much the same in support for Triabunna, Swansea, and Bicheno. This money is used for practice buildings, cars, accommodation, locum subsidies and many other aspects of general practice. The Tasman Peninsula provide a house for the local doctors to use, and the Huon Valley Council provide general practice services in Geeveston. Other communities receive little to any Local Government support.

Variable funding is difficult to manage. With income or benefits from local councils and communities and variable state government funding, and reducing federal funding through Medicare, this is a management nightmare. Consistency would be most welcome for our state's GP management teams.

Attracting Doctors

Simply put, we do not have enough doctors both available and with appropriate skill sets to fill the demand for rural areas. The reality is that doctors with young families and working partners are more likely to be tied to city environments.

> *"We cannot find a doctor to come to our surgery to work. The owner and HR have been looking for more than a year. The workload is here. Please some!" (GP West Tamar)*

AMA Tasmania is aware that there is, for example, a need for one FTE doctor at the Tasman Medical Centre. Swansea urgently needs locum support and one FTE - this is especially so with a new aged care facility to be built over the next few years. Bicheno has just lost one FTE doctor and is desperately in need to recruit another. Triabunna has just had a resignation, so also needs one FTE doctor. Overall, there are four FTEs needed from Bicheno to the Tasman. This region is not alone. Much of the state is struggling to attract General Practitioners into their communities, and the shortage of GPs is not just in rural areas. For example, the two bigger population centres in the North West of Tasmania, Devonport (postcode 7310) and Burnie (postcode 7320), have experienced GP shortages for the past few years, making it difficult for patients to access a GP for routine care. Most GP clinics around the state have "closed books", and patients must travel to find a GP.

A key issue for attracting doctors to a rural area is that of income for GPs. Income in rural areas is no higher and, at times, less for rural practitioners. Only with Government and local council support are incomes more competitive. Reliance on Medicare payments only, even with some government locum support for the rural beds, most practices in Tasmania run at a considerable loss when established GPs take holidays, or professional development study leave.

> *".. I came (to Tasmania sic) for my own reasons, knowing that I could find a job when I got here. I would have liked to have cloned myself into three doctors within the first three months of my being here. There is a huge mainland immigration (myself included): where are the doctors in that immigration? Hobart and Launceston, not rural.*
>
> *Why aren't doctors coming: (why would you move to only earn 60-65% of billings in frustrating circumstances when you can earn 70% on the mainland with a good referral base? Why move from a private billing practice, where you might privately bill 30-40% of patients, to a practice where I privately bill about 5% of patients? Why move from a good education for your children within a short bus ride to an area where a "Good education" is at least 60 mins on the bus each way or more to a better school.)*
>
> *I do not have the answers to the questions. I do know that I am currently happy that I made the move, but that educational factors for my children are a huge concern. I receive so much positivity from my patients, thanks, appreciation, AND the professional satisfaction of trying to do the right thing by them. However, it is not easy, and I am often frustrated and in fear for my patients for the future." (GP Northern)*

Succession Planning

Without increased incentives to attract GPs into rural communities and proper succession planning being put in place within practices, access to general practice in rural areas will only worsen. A GP in the West Tamar region, a case in point, said that there are two GP Practices covering that region: one with one full-time GP, who is approaching retirement, and the other, which is only open four days a week. Appointment spaces are always full, with a two to three-week wait for an appointment. Added to this is that it is not uncommon for GPs not to accept new patients, therefore where do they go for medical attention? They either have to travel or not receive expert medical attention.

Allied Health

Similarly, there is a shortage of THS allied health and community services too. For instance, a recent referral to a private and public occupational therapy service for a palliative care client in Ulverstone led to the referrer being advised of a three-month wait. Another of our doctors lamented the apparent lack of psychologists, among other allied health services, to support rural practice.

c. Non-GP specialist medical services.

> *"Accessing private specialists in room is a lengthy delay. Cardiology waiting time is unacceptable. Accessing LGH outpatients is unacceptable. Orthopaedics is laughable." (GP Northern)*

Specialist and Emergency Department services are centred in and around major population centres. For people living in rural communities, it means having to travel some distance to access these services. Without appropriate and affordable transport, it can be difficult to get to specialist appointments. The more specialised the service, the further a person will have to travel. For some, this can be a disincentive to seek treatment or receive appropriate diagnoses. For example, the North West Health Service District has no respiratory physician, leading to delays in diagnosing lung disease, including lung cancer.

Recruitment of medical practitioners

Despite multifaceted efforts over many years (preferential entry for rural students, rural training rotations, financial incentives etc.), we remain dependent on overseas-trained GPs and Specialists in the North West of Tasmania. Poor recruitment mechanics, changes in specific place-based allowances and a habitual reliance on locums do not help. As recruitment for Mersey Emergency Specialists has shown, it can be done if the THS puts in a significant effort.

d. Hospital services.

With Emergency Department's across the major hospitals under severe pressure forcing people to wait long periods before they can be seen by a doctor and the threat of being discharged in the early hours of the morning to find your own way back home, there are people in rural areas who choose not to go to an ED, thereby delaying critical care.

Similarly, outpatient's services are also notoriously difficult to access. One GP stated there are "people having to wait greater than a year for a consultation and greater than three years for a knee replacement! Its atrocious. People needing a colonoscopy after positive FOBT (faecal occult blood test sic) wait greater than six months. Their cancer is growing!"

e. Maternity, maternal and child health services.

While there are some issues with maternity services in the North West, generally, the area of maternity, maternal and child health services from a General Practice perspective seem to be working relatively well.

f. Pain management services.

The Tasmanian Health Pathways has completed a review of its pain management pathways, including focus on medication in pain management, particularly opioid medications, and multidisciplinary approaches to complex pain. In rural areas, pain management is by GPs and allied health services locally. There is one Chronic Pain Service in Hobart.

Pain Management Pathways review completed

The following pathways were reviewed:

- Chronic Non-cancer Pain Pathway
- Complex Regional Pain Syndrome (CRPS) Pathway
- Analgesia in Adults with Acute Pain Pathway
- Medications in Chronic Pain Pathway
- Opioid Use in Chronic Pain Pathway
- Specialist Pain Management Requests Pathway.

The review acknowledged the difficulty accessing pain management services with long delays being the norm with limited resources for the entire state.

Although the THS and Primary Health have helped network GP's, Allied Health, Telehealth, etc., for patients with chronic pain in the North West, no funding has been allocated to improve coordination and maintain the nascent networks. Ideally, a multidisciplinary pain management team should be funded in the North and North West.

g. Palliative care services.

> *"I have three patients under palliative care at present and only one has had any Doctor review due to the impact of travelling time when already limited Palliative Care Clinician time. I will do my best with phone advice, but these patients are receiving an inferior service." (GP Southern)*
>
> *"Palliative care services seem to be adequate, although communication with GPs could be better." (GP northern)*

A health outcome for patients living in rural Tasmania includes that of a "good death" or "safe death". This could consist of a death in the home, a district hospital or remote hospital, a palliative care bed in a regional hospital or a regional private hospital.

Rainsford S, Phillips CB, Glasgow NJ, MacLeod RD, Wiles RB. *The 'safe death': An ethnographic study exploring the perspectives of rural palliative care patients and family caregivers.* Palliative Medicine 2018; 32(10):1575-1583. DOI: 10.1177/0269216318800613.

Dying in one's preferred place of death has been used as a quality marker. Rural and remote people indicate that their home is their preferred place of death; this may not be achievable for those living in Tullah or Roseberry where there is no community nurse service on weekends and little in the way of out of hours care on call by palliative care services. These people rely on the small rural hospitals for a place of death close to or within their community.

The district hospitals at Smithton, Queenstown and Currie have traditionally been seen as a safe place of death for palliative patients. This attitude is changing with the change to a locum workforce in Smithton and Queenstown with less trust by patients in the capacity of these doctors to care for palliative patients (anecdotal evidence). It is not known what palliative qualifications if any, the locum workforce has in these centres. Previously the established GPs had decades of experience in aged care and palliative care as well as a longitudinal relationship with their patients.

Education about palliative care: The palliative care nurse educator has provided education to nurses via the PEPA program, mentoring and tutorials. The GP population has changed every year, and the Specialist Palliative Care education provided to GPs has not been able to keep up with each GP rotating to the district.

Comparative table: Resourcing of Specialist Palliative Care Services in the three health districts in Tasmania- North West (mostly rural), North and South

North West
- has a population of 111,954 - no hospice (community visits much more time consuming than a hospice round) -low SEC and poor social determinants of health with high prevalence of complex comorbidities. - 1 - no hospital consultation CNCs

North - has a population of 146,000 - has hospice - has 2 FTE consultants - has 1 hospice registrar - has 1 FTE hospital consultation CNC
South - has a population of 276,000 - 1 FTE hospice consultant - 2x 0.6 FTE community only consultants - 2x 0.6 FTE hospital consultants - 1x oncologist working for pall care in community on sabbatical - 2x FTE registrars - 1x FTE hospice RMO - 1.8 FTE hospital consult CNCs Hospital patients in the South are seen every workday for treatment optimization and assistance with streamlining of D/C planning.

GPs in the North West have traditionally offered "cradle to the grave" medical care. This has changed in recent years with the advent of the locum workforce in Smithton and Queenstown and the scarcity of GPs in Burnie and Devonport. GPs will not travel out of town to visit palliative patients and rely on the palliative care nurses and doctors, and community nursing service to provide visits to palliative patients.

There are some positive outcomes through the Specialist Palliative Care Service (SPCS) NW, which has been training GP Registrars with a six or twelve-month attachment to the Specialist Palliative Care team. The GP Registrars study towards the Diploma in Palliative Medicine with the RACP and can achieve Advanced Skills in palliative medicine in General Practice with both Rural GP colleges. These GP registrars mostly stay in the state, and some remain in the NW offering palliative care to their GP patients (e.g., Dr Beddows in Burnie and Dr Andrewartha in Wynyard, who also both trained at the Rural Clinical School in Burnie). One registrar is now an emergency department specialist in the North West. Another is a Rural Generalist based in the MCH Emergency department. Building a dedicated palliative care skill base in the local Rural Generalists has taken eight years, but the confidence and skills of the Rural Generalist workforce enable palliative patients to be in safe hands in the community.

However, traditionally palliative care in the community in rural Tasmania is provided by general practitioners and community nurses. Specialist palliative care services support GPs in providing palliative care but do not have the workforce to take over care of the majority of patients. Indeed, patients prefer to have their own GP provide palliative care at home. Barriers to GPs providing palliative care include the Medicare remuneration, which does not cover the time for consultations, writing prescriptions, taking phone calls and distances to be travelled to visit patients at home. Some GPs will visit patients within five kilometres of the GP clinic, but beyond that, rely on the Specialist Palliative Care service and Community Nursing Service to provide updates.

Specialist Palliative Care Services in Rural and Remote Tasmania

The North West Tasmania SPCS medical staffing is well below the national benchmark of Palliative Care Australia. Palliative Care Australia recommends two FTEs Palliative Medical Specialist and one FTE Registrar per 100,000 population. The Australian and New Zealand Society of Palliative Medicine offers a note of caution in applying this recommendation in rural areas. It is noted that this modelling is based on traditional referral patterns, with 80-90% of referrals coming from Cancer Services. The SPCS regularly

receives referrals to patients with non-malignant conditions, including Huntington's disease, MND and end-stage organ failure (Dementia, renal failure, heart failure, COPD).

Reference: https://palliativecare.org.au/wp-content/uploads/dlm_uploads/2018/02/PalliativeCare-Background-to-Service-Delivery-2018_web.pdf accessed 05/02/2021.

Palliative Care Australia (2018) recognise that there are no formal benchmarks for palliative care staffing profiles. Palliative care services are expected to have access to the full complement of Allied Health practitioners and support of other staff, including music/art therapists, pastoral care, and bereavement counsellors. In the rural regions, including the North West, palliative patients have limited access to Allied Health practitioners. There is one Social worker with the SPCS NW, so there is limited counselling or bereavement support in the remote areas.

The essential roles of Allied Health practitioners in meeting the needs of people living with a life-limiting illness, their family and carer include:

- Providing support to manage physical symptoms, including medication, nutrition, communication, and mobility.
- Assisting people to maintain function and independence.
- Providing a wide range of psychological and social support, pastoral care, and bereavement support
- Providing therapies that focus on improving the quality of life of support people, families and carers and providing/sharing education with people with life-limiting illness, their families, and carers.

h. Pharmacy services.

> *"Adequate. Discharge summaries and patient discharge lists are usually clear and detailed." (GP Northern)*

From a palliative care perspective, community pharmacies have an important role in caring for palliative patients in the NW Tasmania communities. The Specialist Palliative Care Service Nurse Educator has contacted each community pharmacy in the North West in early 2020. This contact and education have encouraged the majority of the pharmacies to stock the essential medications for palliative patients at the end of life. The hospital pharmacy at Latrobe has commenced home deliveries to palliative care clients in need of this service.

Nursing homes also keep a small, locked cupboard of emergency medications. The palliative care nurse educator also contacted each nursing home and rural hospital in NW Tasmania to ensure that they stocked the essential medications for palliative care at the end of life. All but one nursing home have these in stock, and the one, which does not have any stock, is close to a large pharmacy in Devonport.

i. Dental services.

No feedback received.

j. Patient transport services.

> *"Non-existent! Terrible that a patient taken to LGH as an emergency may be sent home in the night to find their own way home e.g., taxi for 50+ kms." (GP Northern)*

With distance and transport being a barrier to receiving care for low-income Tasmanians, and with a high prevalence of low-income Tasmanians living in rural communities, it is not hard to discern the need to

support these people with improved access to patient transport services. The easier it is for a person to access care, the more likely they are to go to a doctor or hospital when needed.

k. 'After hours' health care.

Palliative Care Afterhours

The SPCS South, based in Hobart, provides an after-hours service for Hospital doctors and GPs in the South and North West. The SPCS NW has one FTE Staff Specialist, so it cannot sustain an after-hours service safely. The SPCS North provides this service in that district.

There is a "GP Assist" after-hours service for palliative care patients across the state; this is staffed by a nurse and GP who take calls from 6 pm to 7 am and on weekends and public holidays. This is phone support only.

The district nurses have dedicated funding for overnight nurses/ carers for palliative patients in the last days of life. This service relies on the phone support of Specialist services and GP assist for unplanned symptom issues after hours.

After-hours care consists of GP Assist via phone or going to the nearest ED. There is no out of hours pharmacy in the area.

l. Indigenous and culturally and linguistically diverse (CALD) communities.

The Aboriginal population is higher in rural and remote areas. The cultural needs of Aboriginal patients and their families need to be considered by those providing palliative care and bereavement services. These considerations include providing care at home, involving Aboriginal Liaison Officers and Aboriginal Health Services.

m. Other.

Not all GP practices in rural areas have applied to be COVID vaccination clinics; therefore, it will be imperative for the state government to fill the gaps and provide services to these vulnerable rural communities.

4. Planning systems, projections and outcomes measures used to determine the provision of community health and hospital services.

Tasmania is overall an ageing population, and health services need to be prepared to deal with increasing demand on their services as more people present with chronic health conditions. However, the younger generations mustn't be ignored. Tasmania is experiencing a property-boom and increased mainland migration. Our state is great for families, many who are having babies raising with it the need for more services.

> *One GP said, "I've got five new mums so far this year. But not enough GP services available to service them."*

5. Staffing of community health and hospital services.

> "Our local Community/ District Hospital is falling apart in the nursing/ staffing section. Nurse/ carer morale is low and injury rate high. Staffing is difficult and staff not happy." (GP Northern)

An example of staffing difficulties is seen within Community Palliative Care, where nurse recruitment is hampered by a cumbersome THS HR process, with each vacant post needing to be checked off by five levels of THS HR. This means that a nurse giving four weeks' notice cannot have any chance of working for a week with the replacement nurse for handover, as the recruitment process would not have started by the time they leave. This leaves the remaining nurses working to cover that nurse's work until a replacement is found.

Community/district hospitals attract Rural Health Bed income which helps to pay for a GP to service the beds. However, the way the Rural Health Practitioners (RMP) Agreement is structured means that GPs are not adequately recompensed for the work they are required to do to admit patients, provide care for patients and discharge patients. A minor improvement was achieved in the facility hours provisions in the last RMP, but not sufficient to cover real costs to the GP. This serves as a disincentive for rural GPs to work within district hospitals. Compounding this issue is the fact the RMP is complicated and difficult to use. It is highly likely that many practices do not bill for all aspects of the agreement. Certainly, there are a number of complicated pay structures that apply to these facilities, such that at times small practices struggle to have the management resources to bill appropriately for what they do.

While working within district hospitals provides some income to practices, it also does increase the pressure on the doctor with after-hours availability and additional skills required to service sub-acute beds. Finding full-time doctors and locum relief for holidays is more difficult.

6. Capital and recurrent health expenditure.

Health budgets are never enough – demand on services and cost of services is increasing faster than any government can afford to increase budgets. Hence there will always be competing interests and demand for the limited health dollar. This is where investment in prevention measures is critical, and investment in primary care services vital to try to keep people healthy for longer as well as in their home rather than in an expensive hospital bed. Programs like the Hospital in the Home are very welcome.

There are many areas of health that are underfunded and in need of additional doctors, nurses, and allied health professionals. One example is the nurse educator role in palliative care, which is vital for up-skilling generalist nurses in the district hospitals and nursing homes in remote areas. This role is not funded with recurrent funding.

Unfortunately, capital investment is also lagging. Equipment can cost into the millions, and replacement is often delayed; as a result, leaving ageing and less efficient infrastructure in place. A proper capital equipment investment plan is required from the State Government.

Long term planning is also required for building infrastructure. The RHH has a thirty-year master plan in place (arguably too long), the LGH is undergoing some level of master planning, but it is doubtful it will be sufficient, and the NW is being left to continue to patch up ageing infrastructure that failed to meet the needs of the community during the COVID-19 pandemic. AMA Tasmania believes it is time for the Government to commence discussions with the community about a single hospital for the North West Coast. A single hospital would allow for consolidation of existing services with more staff available for rosters, on-call, and general collegial support. It would also create the critical mass to support new services safely and sustainably.

7. Referral to tertiary care, including:

a. Adequacy of referral pathways.

There are some parts of the system that are working well. For example, the Tasmania Health Pathways has links to palliative care services and is a repository of information for clinicians.

Palliative Care - Community HealthPathways Tasmania

The Tasmanian Health Service website has referral pathways for clinicians and patients.
Welcome to Palliative Care | Palliative Care (dhhs.tas.gov.au)

The Tasmanian Health Service Formulary has helpful information about palliative medications.
Palliative Care - Tasmanian Medicines Formulary (health.local)

However, referring to Outpatients Clinic is not timely, with patients been left for months and sometimes years for appointments.

Pathways for more urgent care that doesn't need Emergency Departments needs to be clearer and accessible. One doctor put it this way, a patient "might not need ED now, but can't wait six months either – where do I turn?"

b. Out-of-pocket expenses.

Palliative patients living in the North and North West can access a PET scan as part of their oncology tests at either Launceston (out of pocket expense $700) or Hobart (no out of pocket expense for the test, but travel and accommodation costs are covered only in a limited way and a family member must accompany them).

Cardiology is severely under-resourced and overpriced. One GP's experience is that nothing is done at LGH with everything seemingly been referred to The Charles Clinic. Yet, they, too, are overworked and understaffed. Tests are very expensive. LGH needs more cardiology services - aged pensioners can't afford the Charles Clinic. We need to understand why cardiologists don't want to live in Launceston.

Federal Medicare Funding

The Medicare Benefits Scheme remains very challenging for General Practice with multiple billing modes and, in real terms, a falling Medicare rebate. As a result of cost cuts, the Medicare rebate for a standard consultation is now $30 to $40 in real terms, less than what it was when Medicare first started some 30 years ago.

Other blended funding helps with Practice Grants and Care Plans, for example, but again without a strong management structure, practices may be under billing for these. While good medicine is occurring in so many of these areas, if a practice has inefficient or inexperienced management, their Medicare Billing's maybe 10 to 20% less than they should be. Challenges with Medicare can result in significant reductions in income. A less complicated and inflexible Medicare system would help.

As rural areas are likely to be of lower socioeconomic groups, the reliance on bulk billing further reduces income.

c. Wait-times.

AMA Tasmania does not have access to wait times data. However, what is on the public record through the Report on Government Services and the Health Department's Dashboard (https://healthstats.dhhs.tas.gov.au/healthsystem) shows that there is a problem that needs addressing.

We believe the Private Cardiology Service is servicing the North and North West of Tasmania has a six-month wait for a new patient to be seen by a specialist.

Orthopaedic, ENT, Neurology, Cardiology, endoscopy, and colonoscopy all have unacceptable wait times and are certainly very poor compared to access and wait times on the mainland. See Report on Government Services 2021 and https://outpatients.tas.gov.au/clinicians/wait_times for data.

d. Health outcome impact of delays accessing care.

> *"FOBT positive – I refer – plus six months later still not done. I get letters from the National Screening program asking why they haven't had their colonoscopy? Yes, why?"*

Elderly patients wait years with pain for their hips and knees, and meanwhile, their mobility suffers and their health declines.

In NW Tasmania, palliative patients present late due to lack of access to medical imaging, GPs, and respiratory and other specialists. This delay is exacerbated by poor health literacy and overall poor health due to multi-morbidity. The outcomes are poorer for such patients in our community.

8. Availability, functionality and use of telehealth services.

> *"Telehealth has helped. I do a lot by phone now. Patients don't mind follow up with clinic or LGH specialists by phone once they are known. (It saves them a trip to Launceston, 100 km round trip and transport problems.) But we could do more if we had more doctors. I still only have the same number of hours in the day."*

AMA is working hard with the Australian Government nationally to ensure that some form of telehealth remains post-COVID. While telehealth cannot and should not replace a physical examination or face-to-face consultation, it does have a role to play with some patient care and has been welcomed by many patients and practitioners alike.

The THS has provided telehealth infrastructure and training for the Specialist Palliative Care teams for some time now. Palliative patients on the West Coast, King Island, can access telehealth consultations. GPs and primary health nurses in these areas can phone the palliative care team to discuss clients via telephone or videoconference calls.

9. Any other matters incidental thereto.

Mental Health

AMA Tasmania believes mental health should have been specifically included in the TOR as it is so important, especially within regions growing in population (for example, Kingston, Brighton, Sorell).
As for other craft groups, some sort of additional incentive, e.g., a specific rural allowance, would encourage specialists to move into rural areas to provide services. As it is, the great majority of psychiatrists are concentrated around the cities, making it harder for regional Tasmanians to access services.

In public community, mental health, simple things like access to office space can be a major barrier to providing a service. More infrastructure in rural areas is needed. Of course, more can be done with telehealth bringing services to the people, but there must also be the ability to conduct face to face consultations, which can be especially important in mental health.

Conclusion

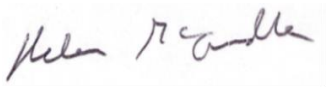
Time does not allow for us to go into more detail about the issues with rural health, other than to say that General Practice is under severe pressure and close to crisis mode; fewer doctors in training are choosing a career in general practice, Medicare funding is in real-time decline impacting on doctors' income and

shifting the burden of healthcare cost across to the patient. Yet, the role of the GP is growing in importance: there are new demands on doctors emerging through Voluntary Assisted Dying legislation, recommendations from the Royal Commission into Aged Care to be implemented and an increased focus on the provision of health care in the home and community.

There are many more challenges ahead. But we hope that this submission gives you some idea as to the strengths and weaknesses of the system as it currently stands. Some of the solutions lie with the State Government and within the purview of the Legislative Council. Unfortunately, others lie with the Australian Government, and we seek your support to advocate for change.

Thank you once again for the opportunity to put in a submission on this important issue.

Yours sincerely,



Dr Helen McArdle
President