Health and Community Services Union

Submission to the Legislative Council Committee Inquiry into Rural Health Services in Tasmania

March 2021

HACSU

The Health and Community Services Union (HACSU) is the largest union in Tasmania, representing over 8,500 members across a range of sectors.

Approximately 2,000 of our members are employed in public health outside of the metropolitan areas of Hobart and Launceston, primarily for the Tasmanian Health Service and Ambulance Tasmania. We have approximately another 2,500 members in the regional areas of Tasmania employed in aged care, disability and community services, diagnostic services and private health.

The issues laid out in this submission are either known or have been reported to HACSU by members working in the relevant areas of the health service, or are known to us through our ongoing involvement in representing health workers and liaising with health administrators for over 100 years.

We are a strong and rapidly growing union that remains committed to working with stakeholders to ensure the best health outcomes and that the health system is properly supported to meet the health needs of the Tasmanian community, now and into the future.

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Preamble

Tasmania's health system has never developed a plan to deal with health services in rural and remote areas. In fact, we have significantly reduced these services to the determent of our entire health service.

Tasmanians living in rural and remote areas deserve decent health care and the government needs to work with stakeholders and the communities in these areas to develop and implement a comprehensive plan to address this.

We need to look at the system as a single system, rather than two separate and competitive systems – the population centres and the rural and regional areas.

1. Health outcomes for Tasmanians

It is an undisputed fact that Tasmanians are generally less healthy than other jurisdictions in Australia.

Tasmania experiences chronic disease at higher rates than other states. Similarly, Tasmania is poor in relation to rates of health risk factors comparatively and this has been well known for longer than anyone can remember.

Our state's regional areas have low socio economic structures comparatively, higher rates of smoking, obesity, poor nutrition and low physical activity levels and this is borne out in our overall health outcomes.

Whilst it is acknowledged that planning is in existence and strategic work has been done on these issues, the fact remains that significant investment into primary and preventative health measures is required and would result in measurable ongoing savings to the health budget. More will be made of the need for investment in primary and preventative health elsewhere in the submission.

Tasmania has a real opportunity to significantly reduce lifestyle related disease and illness and by doing so our community would be healthier. This has a wide range of benefits including less reliance on health services, higher rates of workforce participation and more productivity both at work and generally in the community.

2. Access, availability and timeliness of health services

2.1 Ambulance services

HACSU submits that Ambulance services are provided only by Ambulance Tasmania, a government agency falling within the Department of Health.

There are 54 locations around the state where Ambulance Tasmania resources are available to respond. Of the 54 locations, only 38 have paid staff.

Ambulance Tasmania, as of December 2020, employees 409 paramedics who are deployed in essentially three different methods. The vast majority are urban paramedics. Those who are stationed in country stations, called branch stations, work in different ways, either as a single branch station or a double branch station. Country paramedics work alone and rely on a volunteer to support them, which is often not available.

Single branch model

The paramedic works alone, nominally with a duty period from 0800-1925 (11 hours and 25 minutes) each day, with an on-call response for the remaining 24 hours of the day (12 hours and 35 minutes). These paramedics work a continuous 4-day work period followed by 4 days off, so they are on continuous duty for 96 hours straight (of which 46 hours is paid time and the remainder of which is in the on-call period), sleeping sporadically during the on-call periods.

Single branch station officers report significant concerns with fatigue and they drive a lot to take patients to urban hospitals. There appears to be no 'review' criteria to determine if the model is sufficient or should be upgraded, and it appears the decision to upgrade would be a funding-based Treasury or political decision, not based on clinical or statistical analysis.

Double branch model

This is very similar to the single branch model, but paramedics work alone. They do not normally work an on-call period and work a 2 day shifts and 2 night shifts every 4 days (48 hours) then have 4 days off.

A map and information about where the stations are located is available here:
https://www.dhhs.tas.gov.au/ambulance/volunteers/locations

Volunteer-only stations

Volunteer-only sites are nominally remote locations and service areas where populations are lower.

They are:

- Community Emergency Response Teams – Port Sorell, Poatina, Ellendale, South Arm
- Volunteer-only stations – Whitemark (Flinders Island), St Marys, Currie (King Island), Rosebery, Strahan, Tullah, Bothwell, Coles Bay, Dover, Dunalley, Maydena, Wayatinah

There are also 3 temporary single branch stations, established from COVID response funding, based at Alonnah (Bruny Island), Swansea and Miena. These have traditionally had a volunteer-only response, and most likely will return to that model if permanent funding is not provided.

Ambulance Tasmania also provides search and rescue/extraction/retrieval services from the Aeromedical section. Its helicopters (Hobart-based) and a fixed-wing aircraft (Launceston-based) and flight paramedics can also respond on-road if necessary due inclement weather.

The availability to access a paramedic response is at times severely limited.

Branch station paramedics often respond to jobs out of their nominal catchment area, particularly those close to the urban environment. In particular, Northern and Southern branch paramedics do a lot of urban work. We were advised in a consultation meeting with AT that Sorrell, New Norfolk and Huonville are in the urban environment (i.e. Hobart) for 70% of the time that they are deployed. Beaconsfield, Deloraine and George Town ambulances spend a lot of time in the Launceston urban environment.

Ramping at the RHH and the LGH contributes significantly to the urban engagement of Branch Station Officers. The Service, in our opinion, is grossly under-resourced and this has a significant impact on responses in the rural and semi-rural communities.

The Report on Government Services (https://www.pc.gov.au/research/ongoing/report-on-government-services/2020/health/ambulance-services) has Tasmania's statewide response times to high priority cases at 29.2 minutes at the 90th percentile in FY18/19, up from 22.8 minutes in FY 09/10. Tasmania's response times are clearly the worst in the nation.

Western Australia, for example, with vastly larger distances and significantly more remote locations, has by the same measure response times of 15.4 minutes at the 90th percentile. Using the same data at the 50th percentile for Tasmania sits at 12.9 minutes in FY18/19.

We understand it is much higher now, despite introducing 7 new locations with paid staff in recent years (Bicheno, Doges Ferry, Longford, St Helens, Miena, Alonnah, Swansea) and having much better access to helicopter resources. We genuinely believe this is because both urban and country resources are spending more times at hospitals waiting with patients.

To be clear, this means on average more than 50% of high priority cases exceed 12.9 minutes for a response. If a condition is serious, like a heart attack, the chance of survival reduces by 9% for every minute exceeding 9 minutes after the event – and that is when it is witnessed and there is effective on scene CPR. Effectively 50% of heart attacks won't be survived based on this response time statistic alone. The statistics are nominally worse for anyone more than 30 kilometres away from an Ambulance Tasmania resource (remembering the resource for a given community might be in the urban environment, much farther than 30 kilometres away).

We are aware, for example, of the Oatlands paramedic responding to Dover and New Norfolk being sent to White Beach, amongst other concerning combinations of locations.

2.2 Primary care and general practice services

As previously referenced, and of ongoing concern to HACSU, is the level of investment and appetite for the provision of proper and measurable primary and preventative health services in rural and regional Tasmania. Broadly, the underinvestment stretches further than regional areas and that in turn affects the availability of centralised services for people who live in rural and regional areas.

There remains a shortage of primary care and GP services, which then places great strain on hospitals and other larger GP clinics in the metropolitan area.

It is not uncommon for people who live in regional areas to have to wait a fortnight to get an appointment with a GP.

As previously referenced, this delay in (and in some cases, deferral of) seeking medical intervention or other primary care or advice leads to people becoming chronically unwell and in some cases suffering lengthy and costly complications that could have been avoided.

HACSU submits that investment in general practice and primary care services would over time lead to better health outcomes for Tasmanians and lessen the burden on the health budget and the hospital system.

Allied health professionals play a vital and key role in any proper primary health service.

2.3 Allied health

HACSU recently commissioned a report on allied health services in Tasmania in association with respected health policy analyst, Martyn Goddard.

The report centres on the demand for allied health services, the supply of available allied health professionals and the value that they provide to the health system.

We are very keen to explore the implementation of allied health generalist practitioners to be established and supported in rural and regional areas to support both generalist rural GPs and nurse practitioners who currently operate in Tasmania, albeit in a limited fashion.

Our submission is our report which can be read in full here:
http://bit.ly/demand-supply-value-a-report-on-allied-health-services-in-tasmania

2.4 Non-GP specialist medical services

The access to non-GP specialist medical services is limited. More investment in robust and sustainable telehealth and specialist outreach programs needs to be undertaken to ensure equitable levels of access to proper and directed care.

A model of care in regional areas, where the often-heralded rural generalist medical practitioners and other rural generalist health professionals are incorporated into the model with adequate scope, would create clearer and better access to specialist services for Tasmanians in regional areas.

2.5 Hospital services

HACSU has participated in a project within the THS called District HiTS (District Hospitals in Tasmania Staffing Model). This review commenced in 2018 and all but finished in 2020, after which there was a determination that rural nursing staffing overall was inadequate for the activity. Rather than immediately moving to fix the staffing levels, a business case had to be developed. All parties believed that this would be rudimentarily approved, however, these business cases were overall rejected by the budget and finance processes and the District hospitals in the majority remain under resourced.

District hospitals have reduced in size, and locations over a long period of time, once thriving local facilities have been closed or centralised or have become a shell of what they once were. As an example, New Norfolk Hospital no longer provides urgent or emergency care in any capacity.

Hospitals which once well served a rural community have either closed.

Most district hospitals have reduced services. Emergency departments are specifically designed to provide immediate trauma stabilisation services whilst waiting on patient transfer to a more suitable facility (nominally the 4 urban hospitals, MCH, LGH, RHH, NWRH).

It is extremely common for a patient who presents at a district hospital such as St Mary's or West Coast, to be taken ASAP to another facility, usually via an ambulance.

Staffing at these district hospitals is focused on their residential care role with less than half the hospital staffing provided for acute/inpatient care.

The 2-year average (July 2017–June 2019) was 57,030 days of patient care within all 13 district hospitals, of which 31,039 of these days were residential care.

There is little capacity to surge within the district hospitals. Staffing is often comprised of permanent part-time or permanent full-time staff only. Access to casual staff is a challenge and often when engaged these workers either a) don't live within the community or b) already are engaged at their preferred hours anyway. This leads to utilising overtime mechanisms to surge when needed, which is often not available.

The busiest district hospitals are Campbell Town, Midlands, Beaconsfield, and West Coast (Queenstown).

HACSU is very concerned about regional access to hospital services. Waiting lists for residential care are often extraordinary long, with regional residents often being required to go to a commercial facility for respite and long-term care (and often these are only available in urban areas).

Approximately 600 people a year present to emergency departments at district hospitals with a serious event at Category 1 or Category 2. Another 2500 present with Category 3 presentations. The vast majority of these cases will receive a transfer normally to the Big Four hospitals within 3 hours of presentation at the district hospital. Ambulance Tasmania paramedics would rarely take a patient to a district hospital, but volunteers may (despite the fact that volunteers are normally required to wait for a paramedic to transport patients). Most of these higher category presentations are "walk-ins" who are driven by a family member or another community member.

2.6 Maternity, maternal and child health services

Health services in regional areas in Tasmania, including district hospitals and multi-purpose centres, do not provide maternity services directly. Many used to provide antenatal and post-natal care for regional communities, but that ceased approximately a decade ago.

Many factors have led to this decline, including an unwillingness to accept that there is more to providing health services to people where they live than cost.

Shortages of appropriately trained and qualified health professionals, safety and quality considerations, cost considerations and duplication of services were all factors that led to the cessation of previously-provided services in rural and regional areas.

Whilst any investment must be prudent, mothers being closer to home and being more relaxed and comfortable during both pregnancies and birth will lead to better health outcomes for both the parent and the child. There is no doubt that more services could be provided regionally than is currently the case.

Child health services are provided both in clinic settings and in the community. The service is staffed by child health nurses. Child health nurses provide mothers with information, guidance and support on issues including breastfeeding, child health and development, infant and child nutrition, maternity health, and parenting skills.

2.7 Other matters

HACSU has, like many other member-driven organisations, raised ongoing and significant concerns about resourcing since the public health system was savagely cut by the Giddings government.

Significant unsophisticated administrative barriers remain in place and stymie any attempt by any health administrator to address these ongoing issues in the system.

We need to see the investments made by the government reaching service delivery areas. The focus must be on delivering services rather than designing or strategically planning. Too often do we witness plans with the best intentions that never make it to the implementation stage and all of the wasted investment that could have been redirected to service delivery areas.