To: Jenny Mannering, Inquiry Secretary
Parliament House, HOBART 7000
rur@parliament.tas.gov.au

Dear Ms Mannering

Please accept my contribution to the Legislative Council Inquiry into Rural Health Services. I'd like to comment on five areas:

1. Tasmanian Department of Health – lack of rural health policy
2. Commonwealth-State funding situation concerning Tazreach
3. Aged Care in remote areas
4. There is no National Strategic Framework for Rural and Remote Health
5. Rural-proofing policy is needed

1. The Tasmanian Department of Health – lack of rural health policy

There is a colloquialism circulating that, from a statistical perspective, Tasmanian's are older, sicker, fatter, dumber and poorer. This is not meant to be offensive, but to starkly state the comparative reality of a chronically impoverished rural State. The health disparities between rural communities across Australia and their urban counterparts are well-known, publicised relentlessly, and documented continuously without much effect, if any, in Tasmania.

I am concerned that the situation for people living in rural and remote Tasmania has significantly worsened over the past several years. In Tasmania, rural and remote health remains the poor cousin to urban-based acute health when it comes to getting attention and governmental decision-making. Money and power are concentrated in the acute health sector, and those interests continue to dominate the discourse on health expenditure and activity. There is currently, to my knowledge, no serious, documented policy commitment at State level in improving – or even understanding – the situation in Tasmania's rural and remote areas.

The Tasmanian Department of Health no longer has any dedicated staff with specific policy responsibility for rural and remote health, and consequently, has extremely limited expertise in the area. In effect, the Department of Health's policy commitment is confined to a part-time position that supports rural GPs. The effect of this is that it cannot and does not provide on-going policy support to the Tasmanian Health Service (THS) for its work in rural and remote Tasmania. It is worth noting, however, that the work being undertaken by THS staff in rural and remote areas continues to be committed, worthy and under-valued.

Rural health is not specifically addressed in the annual Service Plan for the THS, and, consequently, performance by the THS in rural health is not reported to Departmental Executive nor addressed in any systematic way. This is a truly sad situation for Tasmania, especially those living and working outside the Hobart CBD; the further from the Hobart CBD, the sadder the situation.

2. Commonwealth-State funding situation concerning Tazreach

The uninterested attitude of State government toward the health and interests of people living in rural and remote Tasmania is further evident in its approach to a Commonwealth funding commitment to Tazreach. During the last federal election, the Liberal government made a very

public commitment of $14.7m to Tazreach, which was re-iterated in publications from the Australian government Department of Health and more recently by Bridget Archer's office. I assume that the funding amount has been made available to the Tasmanian government, however, to date not a cent of that funding has been seen in action in Tasmania. Over 2 years later, funds have still not been made available to Tazreach. Based on my experience of the Tasmanian government, I believe that decision-making about expenditure and management of that funding has probably been taken out of the hands of Tazreach so that it can be directed at problems in the hospital sector.

Tazreach is the team within the Tasmanian Department of Health that administers a number of Commonwealth-funded programs for visiting services to rural and remote Tasmania. The federal election funding pledge followed a promise from the Labor party of around $4m, which was itself a response to campaigning by members of the public in North West Tasmania. That campaign was driven by a funding cut to Tazreach of approximately $2.5m pa following the end of a five year Tasmanian Heath Assistance Package (THAP).

It is a genuinely appalling – and perhaps unprecedented – situation when the Tasmanian government itself deprives its citizens of funding and services.

3. Aged Care in remote areas

In 2015 The Tasmanian Department of Health made a submission to the Australian government Aged Care Financing Authority (ACFA) on government operated aged care facilities in Tasmania. In that submission it was noted that, due to the well-known problem of market-failure, the Tasmanian government is the provider of last resort in remote areas of Tasmania, and that current funding levels from the Commonwealth were inadequate. Small rural and remote residential aged care facilities have quite distinctive sets of circumstances that make them very different to large or city-based facilities. In Tasmania, some of the circumstances that have a detrimental impact upon access to, and the cost of residential aged care services include:

- Small population centres
- More rapidly ageing populations
- Poorer quality housing
- Lower property values
- Geographical isolation
- Distance from service hubs
- Fewer transport options

In 2021 little has changed. Currently in Tasmania, people in residential aged care in remote areas live in a mixed facility rural hospital where their care is provided by nurses who are also rostered on to provide sub-acute care. Not only is this inappropriate to a residential setting, the Tasmanian government's financial contribution to supporting aged care is constraining its ability to support sub-acute care to those populations. This is exacerbating a cycle of worse access to services and worse health outcomes for everybody, and is further contributing to known health status disparities between people living in rural/remote and people living in urban areas.

4. There is no National Strategic Framework for Rural and Remote Health

The last National Strategic Framework for Rural and Remote Health was produced in 2012 by the Rural Health Standing Committee (RHSC) of the Standing Council on Health (SCoH). The RHSC commissioned staff from Tasmania to develop a draft reporting framework for the national policy in 2013. However, the RHSC, which was comprised of representatives of State and Territory governments and the Commonwealth, has been in abeyance for a number of years following its inability to effect change at State and Commonwealth level, and (to my knowledge) there has been no effort to implement the reporting framework or produce another policy Framework for rural and remote health.

This simply confirms my view that there is no policy commitment to rural and remote health in Tasmania. Without policy and performance reporting frameworks, Tasmania will not have the kind of information necessary for informed and prudent decision-making, and so the health disparities can only continue.

5. Rural-proofing policy is needed

The RHSC – without success – attempted to promulgate a "rural-proofing" policy approach. This had been developed in the United Kingdom and implemented in some areas at the time. On this approach, any policy under development would be "rural-proofed" by examining it through the "lens" of rurality. This would identify specific barriers to policy implementation and success, for example, where there is inadequate infrastructure or where costs would be higher than otherwise expected. Rural-proofing is not a complex or "all or nothing" exercise. It is not difficult to develop a tool for this purpose, and templates and guidelines were produced by the UK government. Furthermore, in implementing such an approach, any government Department could decide the scope and manner of its application.

Until policies are rural-proofed, many of the underlying fundamentals of rural and remote health outcomes will remain unchanged. Until then, inadequate decision-making will be perpetuated by decision-makers located in urban areas who are captive to policy discourse that is dominated by interests of the acute sector, and who will continue to be indifferent or ignorant of problems outside their narrow and ill-informed purview.

Thank you,

Dr Kim Atkins

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