RACGP
Royal Australian College of General Practitioners

RACGP Response to the Inquiry into Rural Health Services Tasmania

The RACGP welcomes the opportunity to respond to the inquiry into Rural Health Services in Tasmania. Much of Tasmania is considered rural and we have some regions that are extremely remote – Flinders and King Islands, Queenstown region as well as the far south coast.

1. Health Outcomes – Tasmania has some of the worst health outcomes in Australia. We are known as the poorest, sickest, most obese, and lowest health literacy of any cohort in Australia. Our rates of smoking are comparatively high and some areas such as Bridgewater have very high rates of smoking. There is significant inequality of outcomes for people living in rural and remote areas as against people living in Hobart or Launceston.

	Availability and timeliness of health services :	**Barriers to access:**
Ambulance Services	• Rural towns tend to have a branch ambulance services, which are dependent on volunteers. • Not enough availability of ambulances – eg in the Huon Valley, if the ambulance has taken a patient to the RHH then the Huon region can be left without ambulance cover. • Distances covered are very high and time from calling an ambulance to arrival can be too long – negatively impacting time critical illnesses such as heart attack and stroke. • Tourism expansions – such as the bike trails in Derby, need to take the availability of ambulances to assist with accidents into consideration prior to development.	• Inadequate ambulances • Lack of trained staff • Large distances to be covered • Ramping of ambulances at the major hospitals stops these ambulances from being able to participate where needed in their rural locations.
Primary care, allied health and general practice services	• Too much reliance on the use of locums to fill in gaps where recruitment of doctors is very difficult. • Too few locally trained GPs and a reliance on International Medical Graduates (IMGs).	• Too few locally trained GPs • Remuneration in rural General Practice is poor – most areas are lower socio-economic regions and so the need to bulk bill these patients is

	• Although Australia produces enough medical graduates, these numbers do not translate into adequate Australian GPs in areas of need or workforce shortage • Allied Health services are extremely difficult to find in many rural areas. There may be one day per week of a physiotherapist visiting a town, but this is not enough for managing the patients and creates difficulties for ongoing care. Some attendance of podiatrists, speech pathologists etc but waiting lists are long. • Lack of psychology services in rural areas where the demand is very high. • Huge wait times for home Occupational Therapists, domiciliary Physiotherapy visits, psychology appointments.	greater. This results in a much reduced income for the GPs compared to their non-GP specialist colleagues. This makes it very difficult to attract junior doctors to General Practice as a speciality. • Ageing population of GPs in Tasmania with inadequate junior doctors coming through to replace them. • Minimal training of allied health staff in Tasmania currently (this is due to change shortly). Currently physiotherapists, occupational therapists etc have to go the Melbourne or Sydney for their training. • Nurses and allied health staff are employed in the hospitals on a short-term contract basis which provides job insecurity to these vital health workers – this results in staff turn over and discontent. We would suggest that this needs to be reviewed and changed.
Non-GP specialist medical services	• Inadequate number of non-GP specialists in rural areas. Eg in the North-West there are no cardiologists, one respiratory specialist, no psycho-geriatricians, no neurologists, no access to cardio-thoracic services and a dearth of public psychiatrists	• COVID proved to be a barrier here with many of the non-GP specialists flying in from Melbourne etc and not able to do so during COVID. Some international specialists flew back to the UK etc during this time as well.

	• Reliance on locum specialists which does not provide continuity of care for the patients.	
Hospital services	• Most local community hospitals are almost always full. • There are concerns about ED standards of care • Absence of discharge planning commonly seen. • Poor communication between hospital medical teams and GPs (in larger hospitals) • Limited breadth of clinical specialities in NWRH, LGH and RHH • Local community hospitals often rely on GPs working as VMOs (Visiting Medical Officers) to cover the patients – doing on-call, daily ward rounds and seeing patients who are unwell during the day. The GPs have limited time as they are also working in the GP clinic at the same time.	• Difficulty in retaining doctors at NWRH and the Mersey – due to their family issues, schools, the hospital culture etc. IMGs tend to stay long enough to get their credentials and then move on.
Maternity, maternal and child health services	• Virtually no maternity services in the more rural towns. Patients need to travel to Launceston, Burnie or Hobart for delivery of their babies. • Community Hospitals do not do deliveries – other than unexpected deliveries which the local GPs manage. • Ante-natal care can be done by the GP in a shared-care arrangement but obstetric reviews and deliveries need to go to the 3 major hospitals.	• Inadequate number of Obstetrician-Gynaecologists in Tasmania – huge burden for a rural Ob-Gyn as they would be on-call constantly. • Distances that patients are required to travel.

	• Premature or difficult births may require a mother to be far away from her home and family for extended periods of time.	
Pain management services	• Almost a total lack of pain management services in rural areas. Pain services in Hobart are over –stretched and even private services are very difficult to access due to high demand. • No multi-disciplinary pain management teams in rural areas, so doctors tend to use higher amounts of opioids. • Huge demand for these services in rural Tasmania and services are just not available.	• Only pain services currently are in Hobart – patients who are able to get an appointment in one of these (which is very difficult and long waiting times), have to travel there and back which means a 10-12 hour return road journey from some rural areas of Tasmania. • Not enough pain specialists • Not enough multi-disciplinary pain teams made up of physiotherapist, psychologist and pain doctor.
Palliative Care Services	• Palliative care locally offers a very good service but has too few medical, nursing and allied health staff for a large case load. • No 24 hour access to palliative care services. • After hours care tends to fall onto GPs and the patient's families. • No palliative care services specifically for children.	• not enough staff • large distances required to travel to see Palliative care clinicians not always possible for patients – telehealth advice can help but not the ideal service model for these patients.
Pharmacy services	• Most towns have good pharmacy services. • Flinders Island does not have a community pharmacy in Whitemark but the GP practice has a GP-run pharmacy to provide medications.	
Dental services	• Very low availability of public dentists	• Very high costs for attending private dentists

	• RFDS flies dentists in to rural areas but need is great and availability is low. • Inadequate number of private dentists also – very difficult for patients to make an appointment to see a dentist.	• Even with private health insurance, costs are prohibitive • Poor nutrition in Tasmanians results in poor dental health – which then impacts general health.
Patient transport services	• Limited access depending on availability of drivers and vehicles. • Often has to be booked well in advance and that does not work if given an unexpected appointment	• Community transport will not go out to remote areas – requiring patients to rely on their family and friends.
'After hours' health care	• National after hours hotline and then GP Assist – good services and the after hours triage works well. • GP Assist will then phone the local GP or hospital or in a rural area with GP VMO services, the on-call doctor will be called to meet the patient at the community hospital. • Patient would normally need to travel to the hospital via ambulance or with family and long distances are often involved. • Limited GP coverage other than on weekends in some areas and GPs who are on-call.	• Few GPs want to work longer hours as they are so busy during the day • Difficulty in staffing a GP clinic during the day and no additional staff available to also work out of hours. • VMO – 'on call' work as in St Helens, Scottsdale, Flinders Island, King Island, and the west coast, is very tough on the doctors involved. Due to a shortage of doctors, the on-call rate is often one night in three or even one night in two in some areas and this can lead to burn out in doctors and result in doctors not staying on in areas where they are also required to work on-call.
Indigenous and culturally and linguistically diverse (CALD) communities	• Closing the gap has helped practices identify and support their Aboriginal communities. • Some Medical cover provided by local Aboriginal community centres.	

	• Cape Barren Island is covered by a weekly GP attendance with telehealth video consultations carried out between visits.	
Other	• No drug and alcohol services available in rural areas. • No eating disorder clinics available in rural areas. • No adolescent services • No diversionary services – so not able to help children who are getting into trouble due to drug and alcohol problems. • Family Planning and access to termination of pregnancy is very poor with patients still needing to travel to Melbourne to access these services. • Very limited access to Medical Termination of Pregnancy • Very limited psychiatry in rural Tasmania and there is a huge need.	• Financial viability of rural general practice which relies mainly on bulk billing is very difficult. Many practices make a loss – particularly if they need to rely on locums to run the practice. • Extremely high cost of locums – can be up to $2,000+ per day, which is not easily covered by bulk billed consultations. • Bulk billing rates must increase to allow General Practice to remain viable. • Rural populations are less likely to have private health insurance and so are reliant on the hospital system and this can result in long waiting periods and significant delays in diagnosis and treatment.

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

- GPs are not involved in the planning and this needs to change.
- My Aged Care is frustrating – community nurse referrals are centralised and not easy to organise.
- GPs have inadequate influence over an area which impacts their role and their rural patients and need to be more involved here.

5. Staffing of community health and hospital services

- There needs to be more staff invested in the rural communities which will result in less dependency on locums.
- Many nursing and allied health staff are employed on a contract basis – and often a short-term contract, which gives little job security and which is a huge part in the poor retention of staff.
- There is an inadequate number of RNs on duty in many instances due to funding issues. This is a limit to the quality of care provided to the patients as well as creating a burden for the GPs who may be on –call for that hospital facility.

6. Capital and recurrent health expenditure

- Some hospitals such as St Helens, have had a great deal of money spent on building an entirely new facility. This is a gorgeous facility but does not provide the community with any additional beds and it is still covered by the GP clinic in St Helens with their VMO GPs who are on-call.
- There is too much reliance on buildings rather than systems that are adequately staffed and resourced.

7. Referral to tertiary care including:

a. Adequacy of referral pathways – referrals are often rejected – eg LGH will not accept referrals from the north-west and so there is a reliance on private specialists with huge associated costs. Waiting lists are also very high in Launceston – a Category 1 neurosurgery patient referral has taken 12 months to see a neurosurgeon.

b. Out-of-pocket expenses – these can be extremely high and prohibitive. Patients are often forced to see private specialists as there are inadequate public services. Long distances are required to be travelled to see these doctors so there are high associated travel and accommodation costs and issues around reimbursement for these expenses.

c. Wait times – wait times are too large. 12 months for a CAT 1 neurosurgery referral, 3 years for a CAT 3 ear, nose and throat referral – and still waiting. Inappropriate follow up is blocking new patients getting in to see specialists.

d. Health outcome impact of delays accessing care – Likelihood of exacerbation of conditions and even death due to delays in accessing care. A patient is more likely to die of cancer in a rural setting than in a major city.

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8. Availability, functionality and use of telehealth services

- Telehealth has improved services for patients hugely and COVID has had a very positive impact on this.
- During the height of COVID, all general practice consultations were done via telehealth.
- Very remote and rural areas where patients are not easily able to attend their GP – due to long distances, lack of transport or just when the patients are really unwell, benefit highly from the use of telehealth as it provides access to medical care for many more people than the traditional model.
- Telehealth has allowed the residents of Cape Barren Island to have much improved access to health care – using video the resident nurse is able to contact the GPs and have the patient seen when they are unwell – reducing the number of patients who need to be transported off the island to seek medical care.
- It would be strongly requested that Telehealth services be continued.

9. Any other matters incidental thereto.

- Tasmania has the second highest rate of smoking per capita in Australia and regions such as Brighton have the highest rate of smoking per capita in Australia. Smoking is very expensive and so addiction to smoking is having a negative financial effect on the residents of these areas and the results of this can be poorer nutrition for families, not seeking medical and dental care due to financial concerns, resulting in poorer health outcomes.
- Recruitment and retention of doctors in Tasmania. - It is very difficult to attract young doctors to general practice as a speciality when they see their non-GP specialist colleagues earning sometimes three times as much as they are able to earn after similar training and skill levels. GPs need more earning parity with other specialities. Remuneration of our GPs is vitally important and the MBS items need to be reviewed to allow GPs to bulk bill patients and still have a viable business. Sustainability of General Practice is dependent on this occurring.
- The districts of workforce shortage need to change. Wynyard in north-west Tasmania is not considered a distribution priority area for GPs and yet Burnie, Penguin etc are considered areas of workforce shortage for GPs, which seems very difficult to understand. This means that there are issues keeping doctors. Local graduates have to leave the areas as there are too many international medical graduates (IMGs).
- Encouraging junior doctors to become a rural GP is essential. We must ensure that their student placements in rural GP clinics are positive, enriching experiences so as to encourage them to consider going back as an intern and then as a Registrar.