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9 March 2021

RURAL HEALTH SERVICES INQUIRY, Tasmania

background
experience of personal care and domestic support pre- and post-sixty-five years of age;
experience of Commonwealth Home Support Programme and Home Care Package
in receipt of Home Care Package [HCP] – Level 4;
post-ACAT assessment, wait of 12+ months for Level 2; and then 12+ months for Level 4

circumstances
retired lecturer, researcher, writer, visual arts practitioner
currently live in a north east Tasmanian seasonal seaside town [resident pop. < 2000]
20 kms from a rural town of Scottsdale; 80+kms from city of Launceston

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As a resident of Bridport, North East Tasmania, considered rural and remote Tasmania, I read the scope of this Inquiry and recognised it is remarkably broad. It resembles a 'root & branch' commission of inquiry, and I fear ultimately the outcomes will barely touch the visible, many, and compounding issues concerning health access and outcomes in rural and remote Tasmania.

Having said that, I sincerely applaud this endeavour, and thank the Government Administration Committee 'A' for this opportunity to make a submission to it.

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1. POPULATION

a truth for communities, such as this one, is their 'fluid' population

1.1 the obvious element contributing to this is, as a seasonal location, the increase in population during holiday times; but also

1.2 the resident population presents as exceptionally fluid: both these cohorts impact on recognised health needs and access

1.3 people retire to these communities, usually in reasonable health; then 'life intervenes' and demands and dependency on health access grows; resulting in

1.4 some people gravitating back to greater conurbations to be, as they will tell you, 'nearer hospital[s], doctor[s], and allied health services; this often happens with

1.5 couples in retirement who move to small regional communities – one person gets health issues and even though the more able partner does not wish to relocate [again], they will; and/or

1.6 following a bereavement, the remaining person may move to be nearer family; plus

1.7 younger families with employment and educational needs will relocate to larger conurbations.

in summary
Population fluidity, as experienced in small communities, can impact provision of many different services, including all health and allied health services, banking, and other essential life/living services.

2. HEALTH OUTCOMES in North East Tasmania, [Dorset]

are challenging due to several factors, including

2.1 retirement of a sole trader GP of 40+years practice, had a huge impact on individuals and families whose care he managed; his practice had
2.2 walk-in facility in Scottsdale and Bridport; earlier, in Derby; now
2.3 GP services are solely provided by Ochre Health; who
2.4 have been overwhelmed by the 3000+/– patients who have been left without
2.5 an immediate alternative and reliable GP service
2.6 Ochre already had a poor reputation for high turnover of locum GPs; plus
2.7 long waiting times for appointments; all of which results in
2.8 absence of opportunity to establish <u>continuity of care</u>; additionally
2.9 lack of sufficient number of consultation rooms impacts on their service provision

Let it be noted*: when this practice secured land on the NESM Hospital campus, they knew of Dr P McGinity's eventual retirement and the impact this would have on their practice; but during building they substantially reduced the foot print of the new building, thus eliminating a number of consultation rooms which directly impacted on the provision of promised allied health services plus reducing allocated space for Launceston Pathology facility*.

in summary

Ochre Health may be good well-meaning people, but their business model – or lack thereof – applied in Dorset, leaves much to be desired. The use of locums manifests as a lack of continuity of GP[s] and this cannot and does not provide continuity of care.

<u>3. CONTINUITY OF CARE & NON-GP SPECIALIASTS –</u> *the view from rural & remote Tasmania*

3.1 It can be difficult for people who *do not* have confronting co-morbidities and complex health issues to understand the exhaustion encountered by those of us who do; and
3.2 having to cope with a lack of continuity of care; due to
3.3 seeing a different GP nearly every appointment is serious and detrimental;
3.4 it can consume available energy for that day and perhaps the next or even the one after if a 'flare' is evident [for those of us with inflammatory conditions]

➔ *Many health matters require specialists; a single and vital example is rheumatology*

3.5 there is ONE rheumatologist practicing in North and North West Tasmania: in the private sector, across five sites
3.6 in Greater Hobart, there are many rheumatology practitioners; and
3.7 the Royal Hobart Hospital hosts dedicated out-patient clinics; but in
3.8 in North and North West Tasmania, people in need for such specialists, are assessed by – as the Tasmanian Health Service website describes – "General Medicine"

➔ Let it be noted: in this example, *General Medicine, aka General Physicians, cannot prescribe all medications that may be best suited to a person with an autoimmune inflammatory disease. These are medications for which the specialist applies direct to the PBS and, if approved, the prescription is sent direct to the patient*.

3.9 therefore a significant portion of the population of Tasmania [see below] are being denied access to the best treatment[s]/medication[s] for their condition[s]:

➔ <u>*As of the 30th June 2019*</u>

The Estimated Resident Population of the Northern Tasmania Region was 146,258

- North West Tasmania 112,765; • Southern Tasmania 275,434

➔ *Tasmania 2015*

- an estimated 119,000 people were reported to be living with arthritis; this is expected to increase by 20.5% by 2030
- Healthcare costs associated with arthritis and related musculoskeletal conditions 2015: $162.4 million, expected to increase by 2030: $197.7 million

Source: Arthritis Australia, 2016, *Counting the Cost:* part 1 Healthcare Costs.

4. NORTH EAST SOLDIERS MEMORIAL HOSPITAL, SCOTTSDALE [NESMH]

4.1 this facility seems to be constantly under threat of closure which is a short-sighted notion
4.2 it is the only staffed medical facility for this region; and
4.3 the needs for service have increased not decreased; due to
4.4 building of bike and walking trails, installation of better boating facilities; in addition
4.5 to meeting the needs of both resident and visiting population
4.6 both these categories can sustain any of the following which should be dealt with at a local facility and not automatically sent to LGH: fish hooks through fingers and other body parts; acute medical situations which can be triaged at local level; sporting related accidents; illness related to 'unnatural' living conditions – camping 'cheek-by-jowl' with less good hygiene; injuries sustained on farms, in industry and on roads**.

** North East Tasmania is an area devoid of passing lanes but which hosts log, milk, vegetable, sand, gravel, stock, containers, and many more heavy vehicles on it's roads. It is also flush with roads typically constructed post-World War 1, which are exemplified by their circuitous routes aka 'passes'.

& also ambulances

4.7 Dorset has a single ambulance; and
4.8 when this vehicle is in use, often transporting to LGH, there is none other available
4.9 if another is required in the area, it will be despatched from another station

in summary & suggestions

5 BIG PICTURE THINKING needed in, and demanded by, Dorset

Suggestion ONE

5.1 at NESMH there is an X-ray unit; but
5.2 it is only available Monday–Friday, 9a.m.–4p.m. [if staffed]
5.3 there is NO after-hours service
5.4 frequently *The* Ambulance takes people to LGH for X-ray [only]; this is
5.5 especially at weekends and during holidays when incidents are most likely to occur on any of the many bike and walking trails and during other sporting activities; additionally
5.6 the Dorset resident demographic covers many 'at risk' sectors:
5.7 aging: think falls/fractures, pneumonia, complex health needs, &c.; and add
5.8 visiting, and mountain bike fraternity: think falls/fractures, concussion, &c.
5.9 therefore – it remains common practice to transport people to LGH in private vehicles, often as a first option and frequently as the *only* option; however,
5.10 some of these trips may be avoided if X-ray available in Scottsdale.

Suggestion TWO

It would be a considerable breakthrough in the chronic need for rural beds for mental health constituents if the former high dependency James Scott Wing of NESMH could be thus instituted.

6. TRANSPORT

6.1 if your community hosts a Red Cross car, and you can afford the fare, you are fortunate; this service will take you from home to medical appointments in the city and return
6.2 the Community Transport service is another option, but if you are using a wheel chair, or on crutches, and they are using a mini-bus this is prohibitive
6.3 having been transported several times from LGH to NESM Hospital, Scottsdale, by Non-Urgent Patient Transport, this service is very good and must be maintained.

7. TRANSISTIONING FROM LGH TO NESMH

7.1 it is not necessarily automatic to transition to home via NESMH
7.2 in my experience, it is essential to make this preference known as frequently as possible while still an in-patient at LGH
7.3 using NESMH, or any other local hospital, as a transition option, frees bed[s] at LGH; and
7.4 provides an opportunity for recovery with professional assistance when/if required; it is
7.5. understood that, for example, if NESMH does not appear to have a physiotherapist on staff LGH may not approve this transfer; and yet
7.6 THS physiotherapists travel to NESMH during the week; although
7.7 it can be *ad hoc* – tomorrow, no, the next day, no, the day after that …; as was my most recent experience, [September 2020]
7.8 sometimes transfer is denied – not due to shortage of beds, but shortage of staff

8. POST-OPERATIVE ACCESS TO PHYSIOTHERAPY

8.1 it is noted that: people in receipt of a Home Care Package [HCP] Level 3 or above, are not eligible to access THS physiotherapists; and
8.2 therefore attend, for example, rehabilitation classes run by THS physiotherapists for people recovering from total joint replacement[s]; it is expected that
8.2 private physiotherapy must be sought and paid for through the package; this may be
8.3 a false economy as first, it assumes there are funds in the package; and two
8.4 it assumes that finding a private physiotherapist to, probably, attend in-home when residing at distance from a city or large town equals nigh impossible

in summary

Let it be noted: that loss of balance and loss of mobility is often what contributes to transition to residential aged care

9. ACCESS TO AFTER HOURS SERVICE

9.1 for non-urgent medical emergencies, transport may/can be provided by friends in the community – the 20 kms. to NESMH, Scottsdale; or c. 80kms to Launceston
9.2 at other times use Health Direct; in this community among friends we have successfully engaged with this service, and it proved very helpful on each occasion

10. COMMUNITY NURSES

10.1 this is a valuable service, which when operating well, can be very good; however,
10.2 there have been some challenging situations – wanting to change a dressing which was to stay intact until follow-up at out-patients clinic; and
10.3 accepting referral[s] from *My Aged Care* and then not following up on them

in summary

In the same way that it is necessary to stay alert at all times when dealing with the health service – either as out- or in-patient, it is necessary to self-manage your own care as much as possible.

11. LGH – Patient Travel Assistance Scheme [PTAS]

11.1 in September 2020, I was asked by PTAS to 'show just cause' as to why I travel to Hobart to see a rheumatologist when she is not the "nearest one";

11.2 recent changes to LGH–PTAS now dictate that support will only be provided if you travel to see a rheumatologist in the public sector in Hobart as there is none in the North and North West

11.3 if you travel to Hobart to see a rheumatologist in their rooms, no PTAS help is provided …

in summary

I attach my response to LGH–PTAS request.

final summary

➔ 'Battered-from-pillar-to-post' is how I have felt attempting to negotiate and secure health support. I do all my own research and manage to be reasonably informed. However, I am very aware that this is *not* the case for everyone.

With such high numbers of Tasmanians identified as 'functionally illiterate', I fear these people will struggle with this THS pitted with systemic failures. And further, things will not necessarily improve because too few are able, or fear, to speak up; so, the *status quo* will trundle along believing all is OK because of insufficient evidence to the contrary.

➔ NEVER, even if it is true, do you open a conversation with "I don't have much time …". I have experienced this both in out-patient clinic and with a Doctor from the same clinic over the phone. If the consultation has important information to impart, with these opening words, it will not be heard by the patient.

It sometimes appears that the seemingly small, maybe unimportant things which can have the greatest impact. For example, insufficient emphasis on communication during training. I highly recommend Dr Ranjana Srivastava's book *Dying For A Chat: The Communication Breakdown Between Doctors and Patients*.

➔ Finding health professionals to support your needs does not 'just' occur. It demands much work on the patient's behalf but usually by the patient.

➔ I was briefly supported by the Royal Flying Doctors Service [RFDS]; with excellent mental health and physical support. These disappeared when RFDS changed their remit to cardiac related cases only. There was no warning – and I was left … The RFDS seemed to have acquired funding to support people in rural and remote areas but then became 'choosy' about who they would support. I suspect, when they lose their funding, the cardio-patients will also be left stranded, too.

➔ Sometimes it is the small things. Following my last stay as an in-patient, my feedback to the LGH included these two items:

- as my hands become more afflicted with arthritis, the cutlery provided is too heavy and large and getting very difficult to handle
- similarly, the cup handle aperture is small and arthritic hands assist in spilling most of the contents; at NESMH mugs with a large[r] aperture are an option.