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Monday, 16 February 2015

The Secretary
Joint Select Committee on Preventative Health Care
Legislative Council
Parliament House
HOBART 7000

To The Secretary,

The Royal Flying Doctor Service (RFDS) Tasmania would like to respond to the invitation to provide a submission to the Joint Select Committee on Preventative Health Care. The RFDS would also appreciate the opportunity to appear before the Committee to expand on this submission and to answer any questions that the Committee may have. The RFDS Federation is well known across Australia for providing high quality aeromedical and primary care services. For historical reasons, the RFDS presence in Tasmania has been restricted to aeromedical services, with some involvement in Primary Health Care in recent years in the support of Oral Health programs and research undertaken by the Menzies Research Institute.

The history of the RFDS is outlined in the attached brief overview. The ongoing focus has been the delivery of innovative services by radio, air or by establishing and staffing bush hospitals to service remote and rural Australia. The difference in morbidity and mortality rates for remote and rural Australians is an issue the RFDS is addressing. In Tasmania we are now building on past good work and our own investments in Primary Health Care to assist bridging this gap. Across Australia the inequities of health outcomes, between cities, regional and remote areas is challenging. For example men living in outer regional, rural, or remote areas will die 2.3 years earlier than men living in major cities and inner regional areas. 9.3% of all remote area babies are of low birth weight, compared to 4.6% in major cities. People living in remote Australia were 3.7 times more likely to have diabetes than city residents.

We have also attached an information paper, *Health Care Status and Access in Rural and Remote Tasmania*, that provides a more detailed analysis with specific referred to our remote areas. This work was commissioned in 2012, and we have recently commissioned Dr Kelly Shaw to update this work, also noting the changes in policy direction at the Commonwealth and State level since 2012/13. This updated report will be available in March 2015, and we would welcome the opportunity to share the findings and what solutions the RFDS will seek to address to improve the health inequities for remote Tasmania.

In particular, we would like to make the following comment on the first three terms of reference. The evidence is clear that there are considerable differences in health outcomes between remote Tasmania and those residing in areas where services are present and able to be accessed. Access to services is a critical contributor, with one of the social determinates of health being access to transport. The following case study, from work RFDS has undertaken in oral health is instructive,

Mary has five children, four of them under the age of 7. Mary's 10 year old daughter requires urgent dental attention having had a toothache on and off for three months. Mary calls the nearest public clinic for an appointment but is insistent on a particular time of day for the appointment. None are available and Mary's daughter cannot attend. When a worker at the Community Health Centre made enquiries some time later Mary explained that she needed an appointment at that particular time as she would have to take public transport with 4 children, including 3 pre-schoolers into the nearest town that had a clinic. Once there she would have a small window of opportunity to attend the appointment to enable her to catch the return bus otherwise she would have to remain in town until 5pm, a daunting and unnecessary burden for Mary. When an appointment was eventually made, Mary's 10 year old had 3 teeth extracted at the one sitting to alleviate the necessity of having to attend the clinic multiple times. Because of the issue of transport Mary's 10 year old had to undergo a level of procedure and intervention that normally wouldn't be deemed appropriate.

Through innovative partnerships, RFDS is now delivering oral health services in many remote areas of Australia, and will be expanding its service in Tasmania in partnership with the key providers.

In addition to the traditional aeromedical service, RFDS has always offered primary care services, for remote areas of Australia, in particular where the normal models of care are not sustainable. These have been supported by all three levels of Government, and local communities. RFDS has accessed fundraising from the major capital cities to support these remote services. Access to services is pivotal, both in supporting existing services, in developing services to a sustainable level and to support the referral and transport of patients and staff as is clinically appropriate. The development of an Integrated Primary Health Care Model that embraces all the exiting providers, by addressing the gaps in service provision is critical to improving health outcomes, and in addressing the social determinates of health. This is the main area the RFDS is focusing on. For example, we are in discussions with Active Tasmania to develop a partnership that will allow us to partner with them to assist in providing their successful, evidence based program to areas that currently do not have access. This will provide a strong focus on health prevention and promotion.

The challenges to providing an Integrated Primary Health Care Service to remote areas, is currently being addressed by the RFDS. We would be prepared to attend a Joint Select Committee meeting and explain our plans. We are not able to provide more detail at this stage as there are several tenders that are under active consideration by RFDS, and we are hesitant to provide specific details at this stage. We do however note that one tender is calling for scenarios that encourage innovative and alternative tenders. We are encouraged by this direction.

As indicated, RFDS Tasmania would welcome the opportunity to attend a hearing of the Joint Select Committee to answer questions and to elaborate further on this submission.

Yours sincerely,

A handwritten signature in black ink, consisting of a large, stylized loop followed by a horizontal stroke and a small upward tick.

John Kirwan
CEO
RFDS Tasmania

Attachment 1 A brief history of RFDS in Tasmania

Attachment 2 Health Care Status and Access in Rural and remote Tasmania, Information Paper 2013

General introduction

The Royal Flying Doctor Service (RFDS) is one of the largest and most comprehensive aeromedical organisations in the world. The Service began in 1928 as an emergency rescue service and today using the latest in aviation, medical and communications technology, delivers extensive primary healthcare and 24-hour emergency services to those who live, work and travel throughout Australia. The RFDS reaches 80% of Australia with no patient more than two hours away from help. Last year, the RFDS assisted 282,000 people through emergency rescues clinic services, inter-hospital patient transfers or telehealth services.

The RFDS is a Federation, with each of the six Sections operating within a Federation agreement, under the governance of the Federation board. The RFDS Tasmania Board is chaired by Mr Malcom White and all board members voluntarily contribute their time.

Our Mission:

To provide excellence in aeromedical and primary health care across Australia.

Funding

RFDS is funded through a combination of the Australian Government, State and Territory Governments, our own fundraising initiatives and the provision of other services. It varies between the different sections.

\$20 Note

The Australian \$20 note features the Rev John Flynn and story of the RFDS.

Quote

"Inside Australia we have long recognised that the Flying Doctor represents perhaps the single greatest contribution to the effective settlement of the far distant country that we have witnessed in our time."

*Sir Robert Menzies,
Prime Minister of Australia*

A Short History of the RFDS

Introduction

The RFDS began as the dream of the Rev John Flynn, a minister with the Presbyterian Church. He witnessed the daily struggle of pioneers living in remote areas where just two doctors provided the only medical care for an area of almost 2 million square kilometres.

Flynn's vision was to provide a 'mantle of safety' for these people and on 15 May 1928, his dream had become a reality with the opening of the Australian Inland Mission Aerial Medical Service (later renamed the Royal Flying Doctor Service) in Cloncurry, Queensland.

Timeline

The Very Rev John Flynn OBE (1880 -1951), 'Flynn of the Inland' lived in the Outback for most of his life, setting up hostels and bush hospitals for pastoralists, miners, road workers, railwaymen and other settlers.

In 1912, he established the Australian Inland Mission to minister to the spiritual, social and medical needs of people in the Outback.

In 1917, he received an inspirational letter from Lieutenant Clifford Peel, a Victorian medical student with an interest in aviation. The young airman and war hero suggested the use of aviation to bring medical help to the Outback. Shot down in France, he died at just 24 years of age and never knew that his letter became a blueprint for the creation of the Flying Doctor Service.

For the next ten years, Flynn campaigned for an aerial medical service. His vision was to provide a 'mantle of safety' for the people of the bush, and his vision became a reality when his long time supporter, H V McKay, left a large bequest for 'an aerial experiment' which enabled Flynn to get the Flying Doctor Service airborne.

At this time, Flynn also met Hudson Fysh, a founder of QANTAS. In 1927, QANTAS and the Aerial Medical Service signed an agreement to operate an aerial ambulance from Cloncurry, Queensland.

When our first pilot, Arthur Affleck, took off from Cloncurry on 17 May 1928, he was flying a single engine, timber and fabric bi-plane named 'Victory' (leased by QANTAS for two shillings per mile flown). He had with him the very first of our flying doctors, Dr Kenyon St Vincent Welch.

This DeHavilland could carry a pilot and four passengers at a cruising speed of eighty miles per hour for a range of 500 to 600 miles. In those days, not much territory was charted, and so our pilots were forced to navigate by river beds, fences, telegraph lines and other familiar landmarks. Despite these obstacles, in its inaugural year, the Aerial Medical Service flew 50 flights to 26 destinations and treated 225 patients. Flynn's dream had become a reality.

On 11 November 1928, a shy electrical engineer called Alfred Hermann Traeger invented a simple but ingenious device. His 'pedal wireless' was a major communication breakthrough, bolstering the fledgling Flying Doctor Service and transforming life in the outback. Before Traeger's 'miracle machine', radio communication between the Flying Doctor Base at Cloncurry and the stations did not exist. Telegrams and overseas cables could be sent and received from the nearest post office with a telegraph office but there was no widespread or reliable communication network for inlanders.

In 1934, the Presbyterian Church handed the Service over to a new organisation, the Australian Aerial Medical Service, and sections were established across Australia. A coordinating Federal Council was created in 1936 and bases sprang up around the country.

In 1942 the Service was renamed the Flying Doctor Service.

The School of the Air was established in Alice Springs in 1951. It enabled children on remote stations to communicate over the air with their teachers, and receive regular broadcasts, via the Service's radio network. Homework and written exams were collected by mail runs or the flying posties' network.

In 1955, the Flying Doctor Service added the prefix 'Royal' to its name. The honour was granted by Her Majesty Queen Elizabeth II in recognition of the Service's valued contribution to outback Australia.

Today, we own a fleet of 61 fully instrumented aircraft with the very latest in navigation technology. Our pilots annually fly the equivalent of 25 round trips to the moon and are responsible for the care of over 270,000 patients. We've come a long way from that first flight in 1928 that saw the Flying Doctor airborne.

RFDS Tasmania History

1960

The Royal Flying Doctor Service was formally established in Tasmania to provide a 24 hour emergency evacuation and inter-hospital aero-medical transfer service. Aircraft were chartered from Tasmanian Aero Clubs.

1993

The Tasmanian Section purchased an air ambulance.

1995

The state-run Tasmanian Medical Retrieval Service was established to provide emergency medical personnel to escort patients.

1996 – 2004

The State Government put the air ambulance service out to tender. The NSW Section, in-conjunction with the Tasmanian Section, was awarded the contract to operate in Tasmania. NSW provided the aircraft, pilots, engineer and administration. The Tasmanian Section provided the facilities and additional services to compliment the contract.

2004 – 2011

The NSW Section joined with the Victorian and Tasmanian Sections to become the South Eastern Section (SES) and was awarded the new aero-medical contract.

2012 & beyond

The RFDS SES welcomed the state government decision that it was awarded the new aero-medical contract for the next eight years (commencing in July 2012) with an option of a two year extension. The RFDS purchased a new King Air B200 aircraft that was delivered in May 2013. The service will remain based at Launceston Airport.

RFDS Tasmania

RFDS Tasmania works in co-operation with RFDS South Eastern Section to provide the facilities and additional services to compliment the Tasmanian state government contract. All money raised and donated in Tasmania stays in Tasmania to the benefit to all Tasmanians. The Board of volunteers governs the expenditure of donated monies and employs three part time staff to administer the donor management and marketing.

In 2012 the RFDS Tasmania Board, undertook a review of current services and the health needs of the remote and rural population in 2012/13. This review clearly indicated that there is a considerable need to improve health outcomes and services, and that the RFDS offers a tried and tested avenue for this to occur. RFDS offers both Aeromedical and Primary Health services. In the traditional RFDS areas this is a joint process that delivers considerable efficiencies and allows services to be delivered to areas that are not normally able to access services. This includes locally based services, visiting services, telehealth, medical chests and a range of other services, such as oral/dental and mental health.

RFDS Tasmania is now developing an approach to work with all the existing providers and funders to ascertain where we can assist in providing services within our areas of expertise. RFDS Tasmania

will be supported by the RFDS Federation and will build on successful models in other States and Territories.

Functions of RFDS Tasmania include:

Supporting the Air Ambulance service in a range of ways including:

1. Buying equipment above the Ambulance Tasmania Service (AT) air ambulance contract such as:
 - > Cots for well babies (\$26,000).
 - > Car booster seats, suited to transporting well babies and infants.
 - > Supporting patient transfers on intra-aortic balloon pump (IABP) by testing IABP-aircraft compatibility (in VH-MSM) and buying IABP lifters (\$25,000).
 - > Iridium satellite phone for Flight Paramedics to retain contact with Ambulance Tasmania Communications Centre (\$13,000).
2. Funding extra training for AT Flight Paramedics.
3. Supplying innovative drive-through shelter for patient transfers between road & air ambulance at Wynyard airport in 2010 (\$200,000).
4. Owning and maintaining the Launceston Airport RFDS hangar and offices (\$2 million).
5. Supplementing crew amenities for RFDS South Eastern Section and AT staff.

Tasmanian rural & remote practice

1. Supplying 25 GPS units for rural ambulances in Tasmania.
2. Funding the Menzies Institute for Medical Research Bio Bank research project.
3. The innovative pilot Dental Outreach service that has identified a significant area of unmet need, in particular with families and school age children.
4. Assisting the dental service on Flinders Island:
 - > Funding airfares of Launceston dental personnel and equipment, 6 times a year.
 - > Supplying a new dental chair and associated equipment in 2008 (\$55,000).
5. Offering annual scholarships, to enable medical, dental and nursing students to experience working in rural and remote Australia:
 - > Final year University of Tasmanian medical student has two-week placements in both Broken Hill (with the RFDS) and in Launceston (with Ambulance Tasmania).
 - > Final year Nursing student has a two-week placement with Central Operations at Port Augusta.
 - > Tasmanian dental assistant: has a two-week placement at Broken Hill working with the RFDS.

Promoting RFDS activity in Tasmania and nationally

1. Raising funds for the activities listed above and for future Tasmanian projects.
2. Informing government at all levels about RFDS activities, especially in Tasmania.
3. Informing school and community groups around Tasmania about RFDS local and national activities and history. Several presentations are given each month.
4. Providing a free educational resource about the RFDS to primary schools around Tasmania.

5. Contributing to the activities of RFDS Australia, via our Section's Director on the National Board.
6. Assisting the national aero-medical community (for example: in 2009 helped organise the annual scientific meeting in Hobart of the International Society of Aero-medical Services, Australasian Chapter).

Statistical Information

Royal Flying Doctor Service (South Eastern Section) – Tasmanian Operations 2013 - 2014

No of Aircraft & type	1 x Beechcraft Kingair B200
Number of Landings	2142
Kilometres Flown	440,754
Inter-Hospital Transfers	1025
Medical Chests	7
Rural Women's GP Clinics	65
Rural Women's GP Patients	748

Royal Flying Doctor Service – National Statistics 2013 – 2014

Service Area covered: 7,150,000 km²

For the year ended 30 June 2014	Daily Average	Year
Patient Contacts	773	282,000 (1)
Patient Transports	149	54,705 (2)
Health Care Clinics	44	16,096
Distance Flown (kms)	72,358	26,410,611
Number of Landings	206	75,314
Telehealth	398	82,305
Number of Aircraft		63 (3)
Royal Flying Doctor Service Bases		22 (4)
Staff Numbers (Headcount)		1,144
Staff FTE (Full-time Equivalent)		978

(1) Includes patients at clinics, patients transported, and telehealth
 (2) Includes primary evacuations, inter-hospital transfers, patients transported from a clinic, and repatriations
 (3) Does not include aircraft which will be decommissioned in 2013/14
 (4) A Royal Flying Doctor Service Base is a health facility that houses an aircraft and provides health services

Every day in many ways the Royal Flying Doctor Service
 takes the finest care to Australia's furthest corners
 so that anyone who lives, works or travels in remote and rural Australia
 can enjoy the best of health.



Royal Flying Doctor Service

TASMANIA

Health Care Status and Access in Rural and Remote Tasmania.

Information Paper
2013

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Citation:

Health Strategy Consulting, 2013. Health Care Status and Access in Rural and Remote Tasmania: Information Paper.

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Introduction

The Royal Flying Doctor Service, Tasmania is examining the feasibility of delivering primary health care services in Tasmania.

The RFDS was established to provide a 'Mantle of Safety' to those Australians who lived and worked in rural and remote areas. The initial service comprised a plane with a pilot and a doctor, travelling to a patient and transporting them back to a hospital for urgent care. Over time, flight nurses were included as an integral part of the crew.

All RFDS Sections now augment their emergency retrieval services with a range of primary care activities which are running across all states and territories. Now, in 2013, the RFDS Tasmania Board is examining ways that RFDS Tasmania can respond to Tasmania's rural and remote health needs, complementing the services already provided in Tasmania by RFDS South East section.

This work supports the mission of the RFDS: 'to provide excellence in Primary Health Care and aeromedical services in Australia'. This work is in line with the RFDS Tasmania Strategic Plan priority: 'further develop and execute the RFDS PHC model to meet the priority needs of rural and remote Australia'.

Health System Context

Defining Primary Care

The World Health Organization (WHO) defines primary care as the first point of contact with the health system. In Australia it is generally applied to a particular approach to care which is concerned with prevention, treatment and support with a focus on early detection and illness prevention. More recently, in the context of health care reform, primary care has come to mean care provided outside of hospitals and includes health promotion, illness prevention and treatment. For the purposes of this study, the latter definition will be used.

There is considerable agreement among national policy-makers in Australia and internationally that primary care should be the centre of an effective and efficient health care system¹ as primary care improves health and reduces illness (morbidity), death (mortality) and hospitalisation.

Primary care is provided by an array of people, including general practitioners, nurses, pharmacists, allied health professionals, dentists and many other providers across the local, state and federal government sectors, nongovernment organisations and the private sector.

In Australia, General Practitioners are the main primary health care workforce with approximately 90 per cent of Australians accessing GP services every year². GPs are funded by the federal government but work predominantly in the private sector on a fee for service basis. Community health centres and services are funded by the State.

The public hospital system, on the other hand, provides inpatient care. Hospital services account for the single greatest part (40 %) of the health budget. Hospitals are also required to provide free outpatient services and these are supplied on a per capita rate at

¹ World Health Organization (2008). Primary Health Care – Now More Than Ever. Geneva.

² Australian Institute of Health and Welfare (2012). Australian's Health 2012. Canberra.

six times as often as inpatient services ³ and so account for a considerable amount of hospital funding.

National Health Reforms

Health services are funded and organised by various levels of government and across departments. This situation has led to a long history of difficulties in the primary health care and hospital sectors working together to provide the best patient care possible and has produced inefficiencies through overlap, gaps and attempts at cost shifting. This is what is commonly referred to as 'the blame game'.

Australia is undergoing significant reform at a national and local level. The driver for reforms is first and foremost the unaffordability of the hospital system which will reach a critical stage within the next ten years. Indeed with the current growth of the health budget, state health budgets will require all of the states funds by as soon as 2020 (with no funds left for schools, policing etc). Clearly this is untenable.

Given the imminent crisis in health funding, a focus of the National Health Reforms is driving greater uniformity, regionalisation, transparency and accountability in health funding and health service delivery. A series of new players have been established including:

- ✔ Medicare Locals (to create a regional primary care infrastructure),
- ✔ Local Health Networks (to foster regional autonomy and innovation),
- ✔ National Health Performance Authority (to collect health information to highlight areas of inequity in health service delivery and health outcomes),
- ✔ Independent Hospital Pricing Authority (to set an efficient price for hospital services which will be how hospitals will be funded in the future, rather than the current block funding model. It should be noted that rural hospitals will continue to be block funded).

The National Health Reform Agreement between the Commonwealth and the States, signed in August 2011, sees the Commonwealth funding half of every dollar required to meet increases in the efficient cost of public hospital services from 2017-18, including growth in demand. In return for this funding, State Governments signed up to the introduction of activity based funding for public hospital services, greater transparency in

³ Duckett, S.J. (2002). Australian hospital services: An overview. Australian Health Review, 25 (1): p. 2-18.

the use of hospital budgets across Australia, and greater reporting of service provision, performance and funding.

The beginning of a period of transition for the health system in shifting the focus of care from hospitals to primary care (though probably a 20 year process) provides an opportunity for RFDS Tasmania to support new models of care and become a contributor to improved health outcomes in Tasmania.

National Health Reform - Tasmanian Situation

In Tasmania, the State Government has twice requested that the Federal Government take over funding of the health system due to the escalating costs of health in Tasmania, currently predicted to take over the entire Tasmanian budget by 2020.

The Federal Government declined to take over funding and management of the Tasmanian health system but committed a one-off extra \$325 million (over 4 years, commencing in 2012/13) under the Tasmanian Health Assistance Package, designed to ease immediate pressures across the system. A Tasmanian Commission on Delivery of Health Services in Tasmania has been established and is currently reviewing the efficiencies of the health system in Tasmania. The Commission will steer the use of the \$325 million rescue package. The Federal Government has been clear that no further extraordinary financial support will be available in the future.

The Commission released its preliminary report⁴ in February 2013 and from this it seems their work will focus on improving the efficiency of the hospital system rather than focussing on preventing hospital admissions through enhanced primary care.

In terms of the Tasmanian Government, it seems that the health system is becoming more decentralised with each of the Regions determining their own priorities within the state framework. This means that RFDS Tasmania would need to relate and engage with each of the Regional Offices around RFDS Tasmania's role within the region.

The Medicare Local, as a statewide organisation with a leadership role in primary health care, will be of primary interest to RFDS Tasmania. They are receiving substantial funding support, capacity development support, profile and branding through the Department of Health and Ageing. It is critical that RFDS Tasmania considers its role in relation to the Medicare Local including how it will work in partnership with the Medical Local.

⁴ The Commission on Delivery of Health Care in Tasmania (2013). Preliminary Report to the Australian Government and Tasmanian Government Health Ministers. Canberra.

Geography and Demography

Tasmania's Rural Areas

Currently the main method of classifying rurality (and therefore allocating funding) is the somewhat controversial Remoteness Areas Classification (RA)⁵. The RA classification organises areas into five categories; Major cities, Inner regional, Outer regional, Remote or Very remote. The map of Australia below gives an indication of the areas classified as rural and remote in Tasmania as compared to the rest of the country.

Accessibility Remoteness Index Australia 2006

ARIA+ and ARIA++ are indices of remoteness derived from measures of road distance between populated localities and service centres. These road distance measures are then used to generate a remoteness score for any location in Australia.

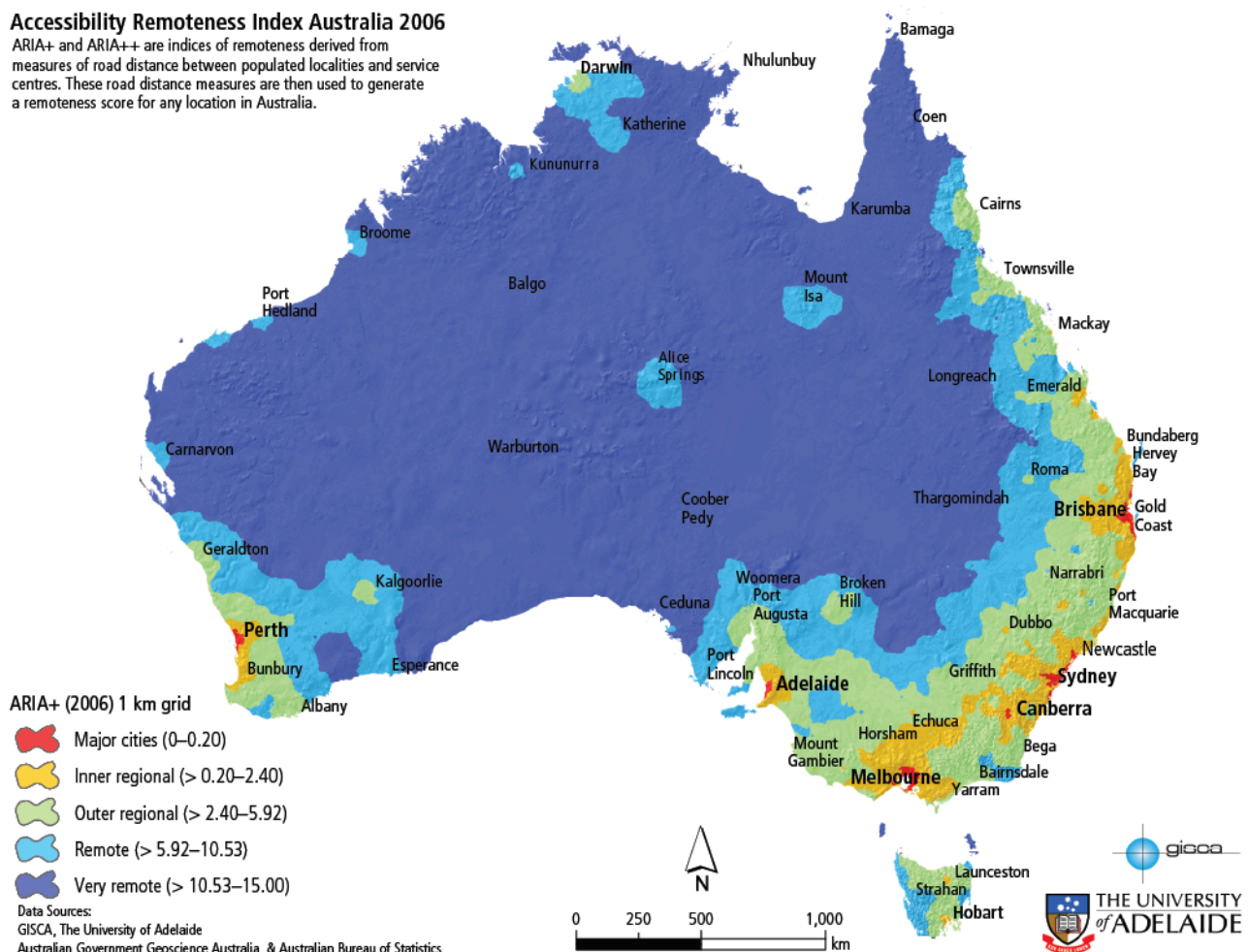


Figure 1. Map of Australia by Remoteness Area. Map from ⁶.

⁵ The Health Minister recently announced a new remoteness classification is to be developed but the RA classification will be used for at least the near future.

⁶ Australian Institute of Family Studies (2013). Families in Regional, Rural and Remote Australia. Canberra.

Figure 2A below shows a map of Tasmania classified by the Remoteness Area classification. As can be seen, all of Tasmania is classified as rural (RA 2 - 5) with significant areas of remoteness (yellow and blue), being the west coast, small sections of the east coast and the Bass Strait islands.

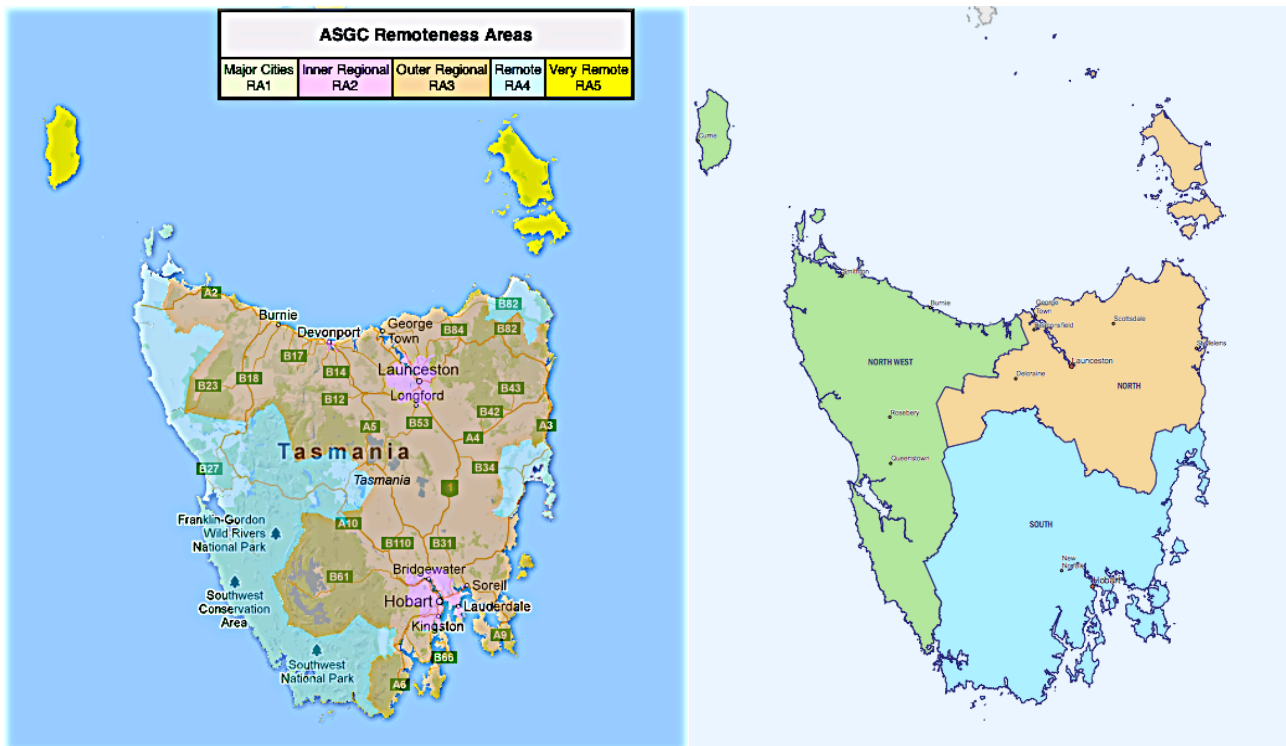


Figure 2A. Tasmania Map by Remoteness Area. Map from ⁷.

Figure 2B. Tasmania Map by Region. Map from ⁸

In contrast, Figure 2B shows the three regions of Tasmania used by almost all Tasmanian organisations. A real difficulty in interrogating statistics on rural and remote Tasmania is the historical tradition of considering the island state on this tri-regional basis. For most states in Australia it is straightforward to source demographic and health information comparing rural and urban areas. For Tasmania, health data is readily available for each of the three regions but each of the regions covers both remote populations together with an urban population. For example, Northern Tasmania (orange) includes not only Launceston (rural), but also Flinders Island (remote). This makes it a challenge to tease out rural and remote specific issues for Tasmania.

Table 1 below shows the rural and remote and the remote populations of each Australian state and territory. According to the RA classification, all of Tasmania is classified as rural. However, it is likely that the population of Tasmania and the members of the RFDS Board, consider Hobart and Launceston as urban centres. Therefore, the data has also been

⁷ www.doctorconnect.gov.au

⁸ www.yourhealth.gov.au.

presented with Hobart and Launceston omitted from the rural population count. Without Hobart and Launceston, the rural and remote population of Tasmania is 37 per cent or almost 200,000 people. Just over 10,000 people live in remote areas with 2,500 living on King and Flinders Islands. Interestingly, Tasmania has a much higher 'remote' population than Victoria.

	Rural & Remote (n)	% of Population	Remote (n)	% of Rural Population
NSW	1,883,773	26.0%	39,313	2.1%
Queensland	1,706,754	38.1%	137,895	8.1%
Victoria	1,320,057	23.8%	4,778	0.4%
WA	554,879	23.6%	163853	29.53%
SA	438,908	26.8%	60,237	13.7%
NT	231,331	100%	102,269	44.2%
Tasmania	511,195	100%	10,909	2.1%
Tas - HBA LST	191,793 <i>smallest</i>	37.5% <i>Third highest</i>	10,909 <i>Second smallest</i>	5.69% <i>middle</i>

Table 1. Population Breakdown by State and Remoteness Area, 2011. Data adapted from ⁹

Tasmania's Ageing Population

Australia's rapidly ageing population with the related higher rates of chronic disease are impacting significantly on the primary health care and acute care sectors as people with chronic diseases are the main users of health services. Chronically ill people frequently have comorbidities and socioeconomic problems that require close management and good primary care to improve their health status by preventing complications that require hospitalisation.

15 per cent of Tasmanians are aged over 65. This is higher than the Australian average of 13.5 per cent and is the highest of any State or Territory.

In terms of rural Tasmania, the population age spectrum is quite diverse and is shown in figure 3 below. The east coast of Tasmania has the typical rural population with proportionally more older people (as young people leave to seek education and work opportunities).

⁹ Australian Bureau of Statistics (2012), Regional Population Growth, Australia, 2011. Canberra.

However, the west of the state has the typical remote population where there are fewer older people, likely due to higher mortality rates and older people leaving remote communities due to lack of appropriate health services.

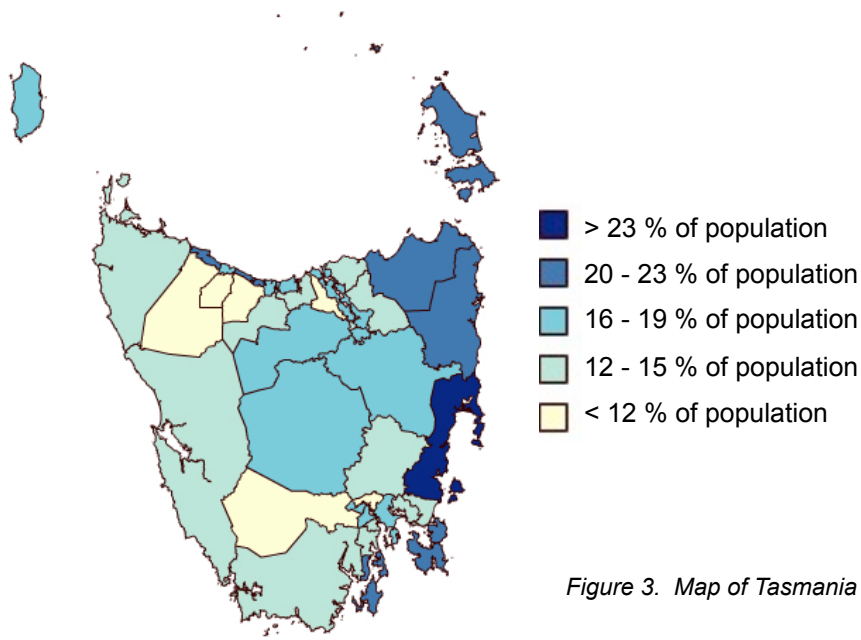


Figure 3. Map of Tasmania by 65 + population, 2011 Data. Map from ¹⁰.

Tasmania's Aboriginal Populations

As shown below in Table 2, Tasmania has a slightly higher proportion of Aboriginal or Torres Strait Islander people (3 %) when compared to the Australian average (2.3 %). This data and remaining data in this report includes Hobart and Launceston as rural as their data is unable to be extracted separately.

	ATSI Population in Rural and Remote	% of Total Rural and Remote Population	ATSI Population in Remote	% of Remote Population
NSW	84,051	4%	7,586	20%
Queensland	105,332	6%	32,514	24%
Victoria	15,546	1%	42	1%
WA	50,930	8%	32,980	22%
Tasmania	16,900	3%	605	6%
SA	13,325	3%	4,865	8%
NT	66,582	29%	52,780	52%

Table 2. ATSI Population Breakdown by State and Remoteness Area, 2006. Data from ¹¹.

¹⁰ Public Health Information Development Unit (2008). Social Health Atlas of Australia. Canberra.

¹¹ Australian Bureau of Statistics (2010). Population Characteristics, Aboriginal and Torres Strait Islander Australians, Tasmania, 2006. Canberra

The remote areas of Tasmania have a higher concentration of Aboriginal or Torres Strait Islander people which is highest on Flinders Island and the Circular Head regions as shown below in figure 4. While the proportion is high, the actual number of Aboriginal or Torres Strait Islander people living in remote Tasmania is just over 600.

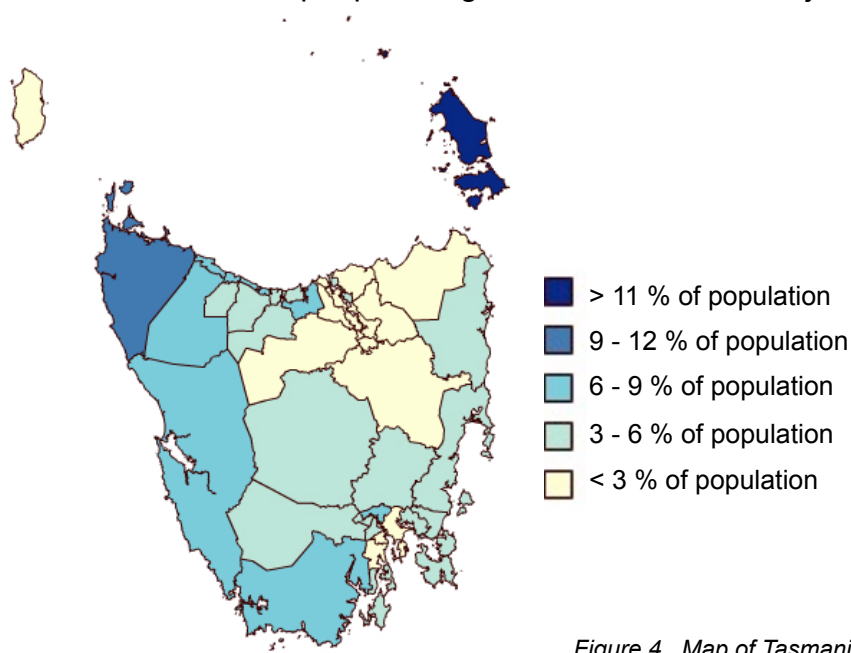


Figure 4. Map of Tasmania by Aboriginal population, 2011 data.
Map from ¹².

Tasmania's Socioeconomic Status

The socioeconomic status of the population is an important consideration in examining a community's health need. Several studies have found that groups who are socioeconomically disadvantaged have reduced life expectancy, poorer health and higher levels of risk factors for ill-health¹³. Tasmania has the highest proportion of people in the lowest quintile of socioeconomic disadvantage when compared to other states and territories as shown in figure 5 below. The greatest concentration of socioeconomically disadvantaged people is in the remote areas of the west coast and north east coast and Flinders Island (see figure 6).

¹² Public Health Information Development Unit (2008). Social Health Atlas of Australia, Tasmania.

¹³ AIHW (2012). Australian's Health 2012. Canberra.

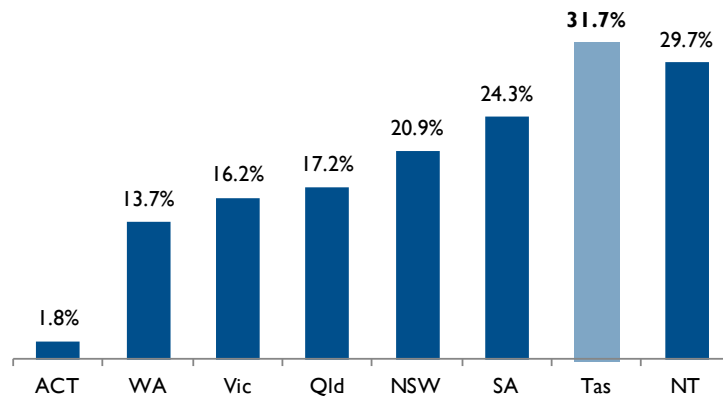


Figure 5. Proportion of the population in the lowest quintile of socioeconomic disadvantage. Graph from ¹⁴.

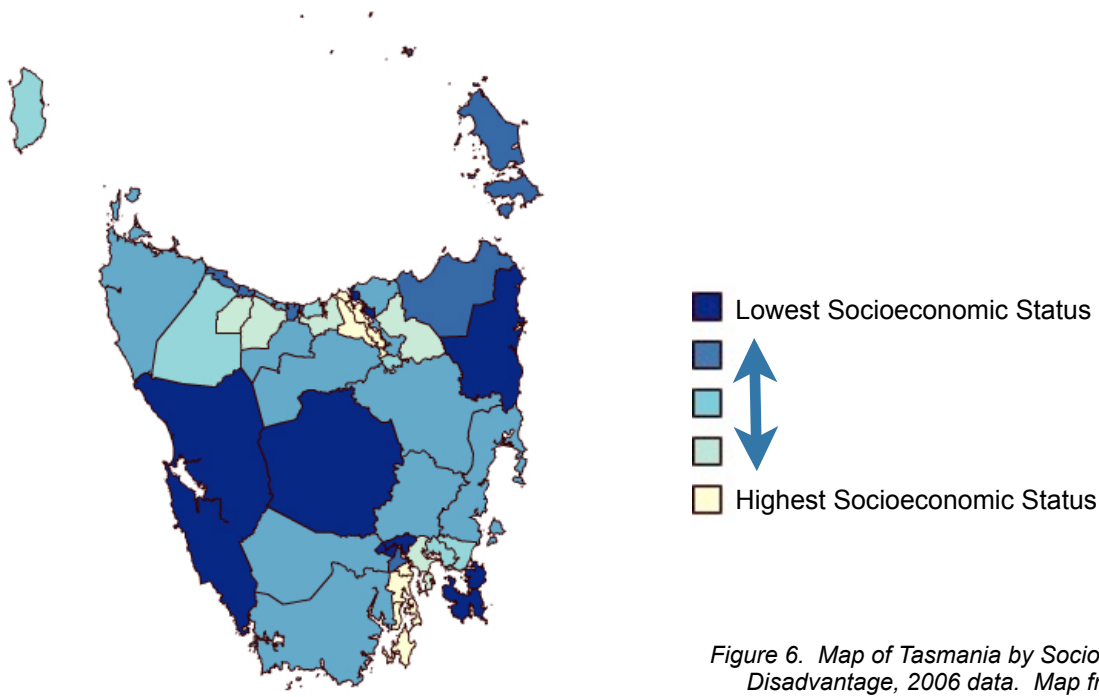


Figure 6. Map of Tasmania by Socioeconomic Disadvantage, 2006 data. Map from ¹⁵.

Conclusion

Tasmania is a state of regional centres, rural areas and more remote areas. Tasmania has an older population with approximately one third of Tasmania's population live outside of Hobart and Launceston. In terms of area, about one third of the state is classified as remote but with only about 2 % of the population living there. The remote areas of Tasmania are socioeconomically disadvantaged with a dispersed population.

¹⁴ Tasmania Medicare Local (2012). Primary Health Indicators Report. Hobart.

¹⁵ Public Health Information Development Unit (2008). Social Health Atlas of Australia, Tasmania.

Health Status

Australian Rural Health

Compared to their urban counterparts, rural Australians generally have poorer health and higher mortality rates (particularly due to falls, injury and burns) which results in a shorter lifespan¹⁶. In addition, people from rural and remote Australia tend to have a more advanced stage of disease when they eventually seek care from their primary health care provider compared to their urban counterparts¹⁷. In part this may be due to the difficulties in accessing primary care which mean people choose to delay consulting the General Practitioner for minor symptoms and wait until the symptoms become more severe.

Concomitantly, public hospital admission rates increase with remoteness¹⁸. Hospital admissions are even higher for people who live in remote areas. These high rates may also reflect the consequences of delays in seeking treatment such that it is too late to allow interventions which could prevent hospitalisation and premature death¹⁹.

Tasmanian Rural Health

While it is expected that the pattern of poorer health for rural Australians is repeated in Tasmania, there is a lack of data and analysis comparing Tasmania's urban and rural populations. As discussed previously, data is usually presented by region, with each region incorporating both remote areas and larger regional towns, which makes it difficult to examine rural and remote issues in particular.

Even the Commission on the Delivery of Health Services in Tasmania and the Tasmanian Medicare Local provides data at the tri-region level, and do not discriminate between the larger towns and rural and remote areas within a given region.

¹⁶ AIHW (1998). Health in Rural and Remote Australia. Canberra.

¹⁷ Commonwealth Department of Health and Aged Care (2001). Health services in the city and the bush: measures of access and use derived from linked administrative data. Canberra.

¹⁸ Australian Institute of Health and Welfare (2012). Australian hospital statistics 2010-11. Canberra.

¹⁹ Cancer Council NSW (2002). Remoteness and cancer incidence: mortality and survival in New South Wales 1992-1996. Sydney.

Death and Premature Death

While Tasmania's death rate is improving over time, Tasmania still has the second highest death rate in Australia, second only to the Northern Territory. The top causes are:

- 🌿 Cancer,
- 🌿 Ischaemic heart disease (heart attacks),
- 🌿 Other heart diseases (heart failure),
- 🌿 Cerebrovascular disease (strokes),
- 🌿 Chronic lower respiratory diseases (emphysema),
- 🌿 Injury and poisoning (violence and car accidents),
- 🌿 Diabetes mellitus.

This profile is very similar to the rest of Australia.

Premature death is when someone dies before the age 75 from a disease for which public health and medical interventions are available. Examples include lung and colorectal cancers, suicide, traffic accidents and ischaemic heart disease.

Figure 7 below maps avoidable mortality for all conditions for Tasmania. The remote Flinders Island and the west coast have the highest rates of avoidable mortality.

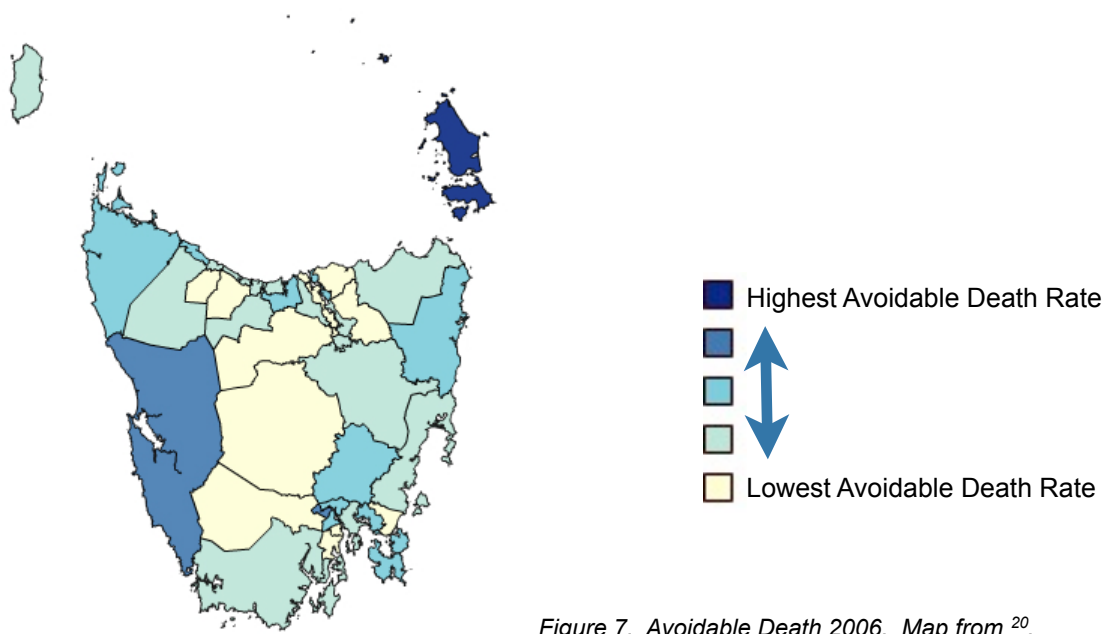


Figure 7. Avoidable Death 2006. Map from ²⁰.

²⁰ Public Health Information Development Unit (2008). Social Health Atlas of Australia, Tasmania.

Avoidable Hospitalisations

Avoidable hospitalisations represent a range of conditions for which interventions could have prevented the disease or condition from occurring.

Tasmania, as a whole, has mixed results in avoidable hospitalisations. For example, compared to the rest of Australia, Tasmania has fewer hospitalisations for diabetes but more hospitalisations for lung disease (likely linked to the high smoking rates seen in Tasmania) ²¹.

Unfortunately, avoidable hospitalisation data is not available for rural and remote Tasmania, but only at the tri-regional level, but is expected that avoidable hospitalisations would increase with remoteness as it does for rural and remote areas of Australia (see figure 8 below). Indeed, most avoidable hospitalisations are due to chronic conditions which are not being managed effectively to prevent complications.

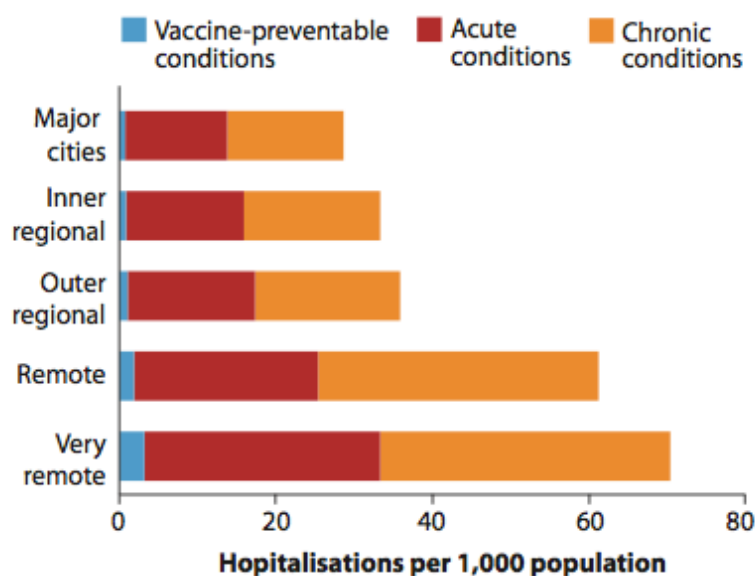


Figure 8. Avoidable Hospitalisations by Cause ²².

Health Indicators

The recent COAG report provides an excellent overview of Tasmania's health risk factors as compared to other jurisdictions (see Figure 9 below). What is immediately evident is that Tasmania has the highest smoking rates in the nation with almost a quarter of

²¹ Tasmania Medicare Local (2012). Primary Health Indicators Tasmania Report. Hobart.

²² AIHW (2012). Australia's Health 2012. Canberra.

Tasmanians smoking. This culminates in the high hospital admissions for Tasmanians due to Chronic Obstructive Pulmonary Disease ²³.

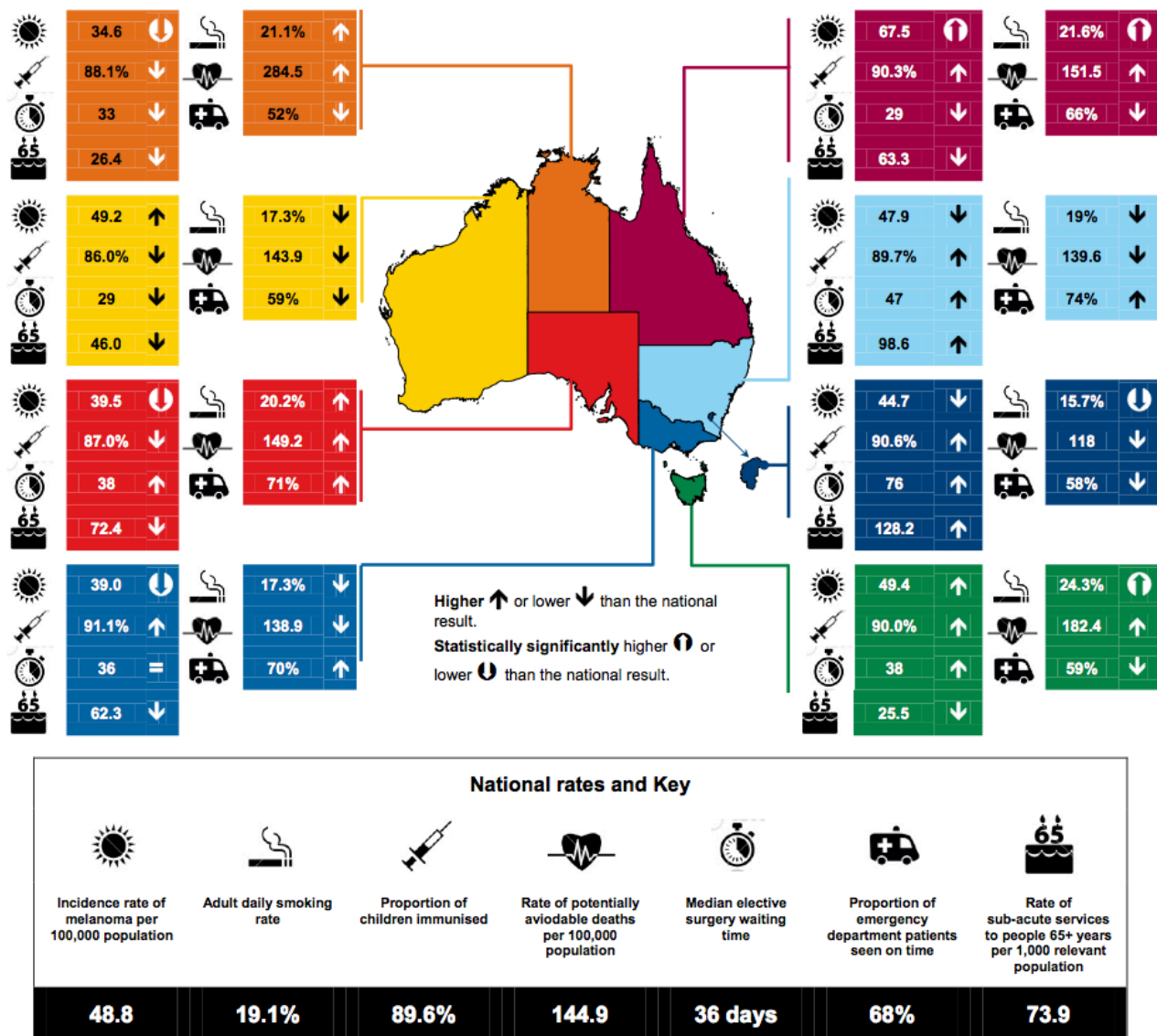


Figure 9. Schema showing each states relative health indicators ²⁴.

Figure 10 below shows the proportion of the population who have at least one risk factor (smoking, obesity, low physical exercise or poor nutrition). Almost all of Tasmania sits above the Australian average with the poorest health indicators seen on the west coast (unfortunately this data is not collected for the remote islands).

²³ Tasmania Medicare Local (2012). Primary Health Indicators Tasmania Report. Hobart.

²⁴ Council of Australian Governments (2012). Healthcare 2010–11: Comparing Performance Across Australia (Statistical Supplement). Canberra

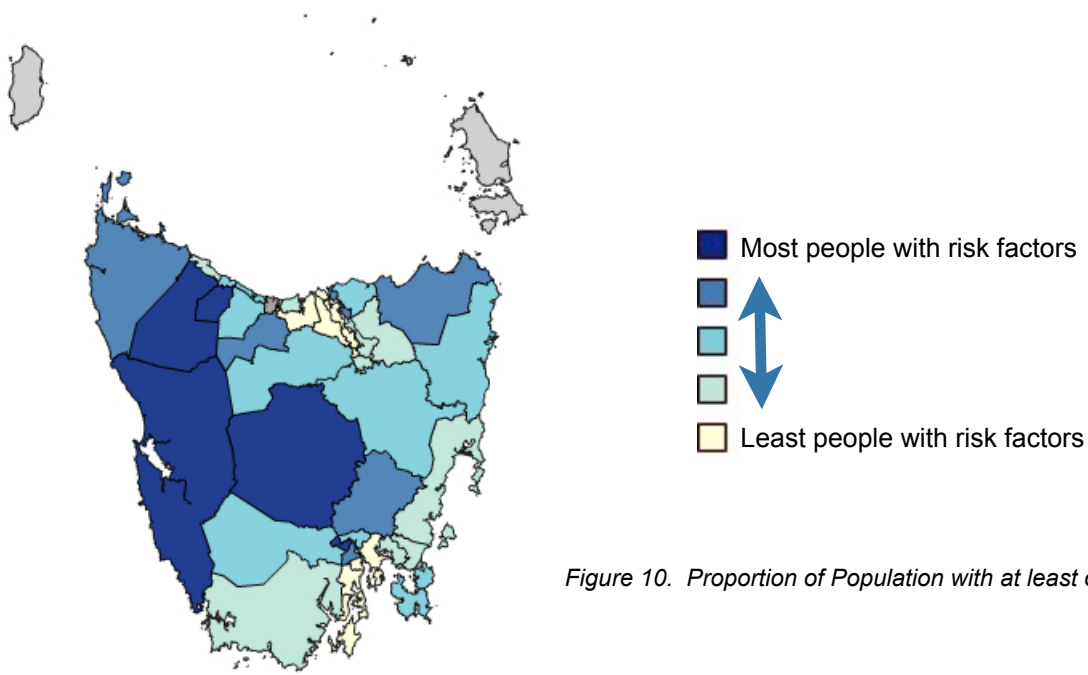


Figure 10. Proportion of Population with at least one risk factor ²⁵.

Dental Health

Dental health needs to be considered separately to other health issues because dental services were excluded when Medicare commenced and still remains somewhat outside of the mainstream public health system.

Tasmania has some of the worst dental health in Australia with the highest rate of complete tooth loss, the greatest number of dentures, the highest average number of missing teeth and the greatest number of people who haven't seen a dentist in the last five years ²⁶.

While we do not have data on the dental health of rural Tasmanians in particular, we do know that avoidable hospitalisations for dental diagnoses increases with remoteness ²⁷. We can therefore assume that the dental health of rural and remote Tasmanians will be some of the worst in Australia.

²⁵ Public Health Information Development Unit (2008). Social Health Atlas of Australia, Tasmania.

²⁶ AIHW (2007). Oral Health Status, In Australia's Dental Generations, The National Survey of Adult Oral Health 2004-06. Canberra.

²⁷ AIHW (2011). Oral health and dental care in Australia: key facts and figures 2011. Canberra.

Summary

Tasmanians experience poorer health across almost all indices when compared to other jurisdictions as do rural Australians. Rural and remote Tasmanians die earlier, have poorer health and have greater health risk factors (particularly smoking). The poorest health is seen on the remote west coast and Flinders Island.

Health Service Access

The previous section found that Tasmanians generally, and remote Tasmanians in particular, experience very poor health outcomes and have high risk factors for ill health. This section will examine the relative utilisation of health services by rural and remote Tasmanians.

Access to General Practitioners

This graph below shows that for Australia overall the number of GPs for a given population tends to increase as remoteness increases (see grey bar for Australian average). This is to be expected given the relatively sparse and small populations in remote Australia.

Tasmania (in green) generally does very well in the supply of GPs for the population. The only rural classification area which does not do so well is the 'Outer Regional' areas which are the small rural towns outside of the regional centres.

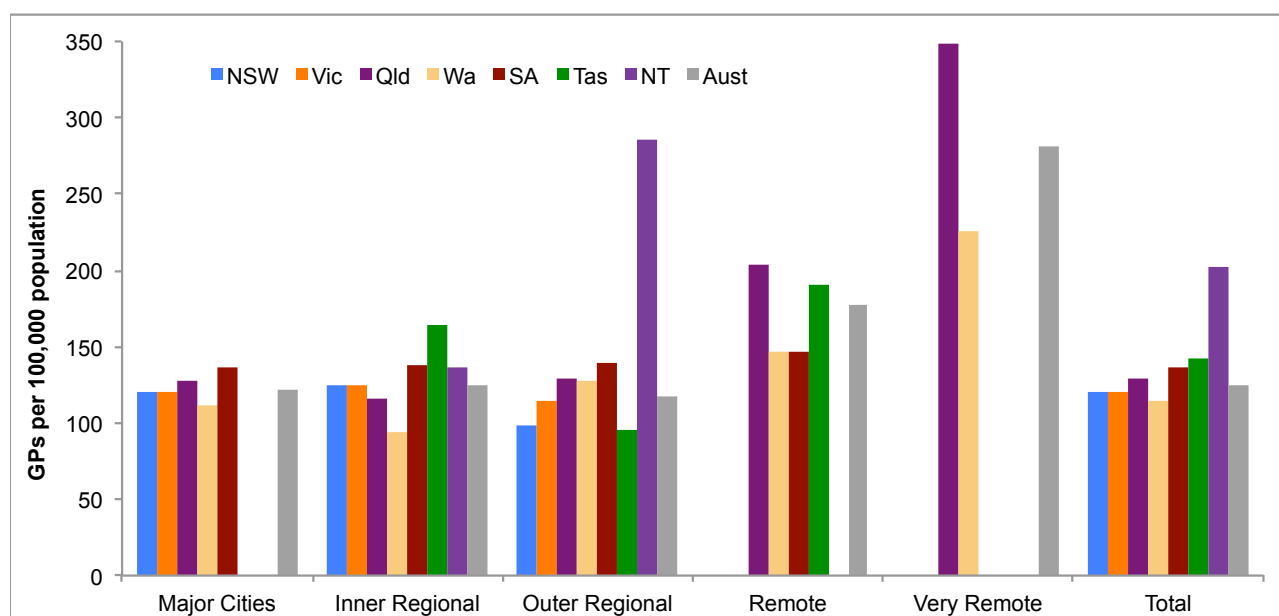


Figure 11. GPs per 100,000 population by state and remoteness area. Data from ²⁸.

Figure 12 below shows the average number of times a person receives a GP service which is a good proxy indicator of access. For Australia, the number of GP services per

²⁸ COAG Reform Council (2012). Healthcare 2010-11. Comparing Performance Across Australia. Canberra

person tends to decrease with remoteness (see grey bar) which is an indicator of the greater difficulties remote people have in accessing GPs.

However, while all of Tasmania visits the GP less than the Australian average, there is little difference amongst Tasmania's rural and remote areas which demonstrates surprising equity in access to GP services for rural Tasmanians.

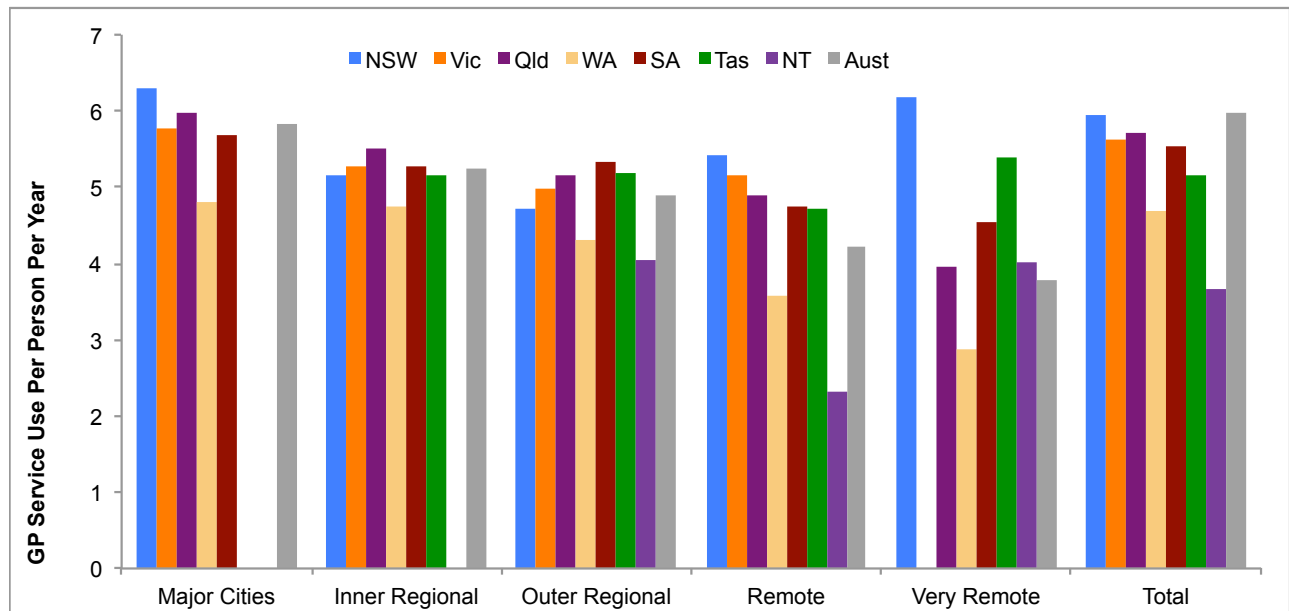


Figure 12. GP Service Use Per Person Per Year, 2010/11. Data From ²⁹

Access to Medical Specialists

Figure 13 below shows the average number of Specialist services received in each jurisdiction by remoteness. For Australia, the number of Specialist services accessed decreases with remoteness.

This trend is also seen in Tasmania (green bar) where Tasmania has consistently lower Specialist consultations in all remoteness classifications, with the exception of very remote areas. This exception may be due to the Medical Specialists Outreach Assistance Program providing outreach services to the islands and, indeed, RFDS services available to transport patients to Specialist care.

Unfortunately little is known about the nature of rural and remote Tasmanians accessing specialist care and, it is unknown whether the services were received locally or whether the patient had to travel to a regional centre or Hobart or indeed Melbourne to receive care.

²⁹ COAG Reform Council (2012). Healthcare 2010-11. Comparing Performance Across Australia. Canberra

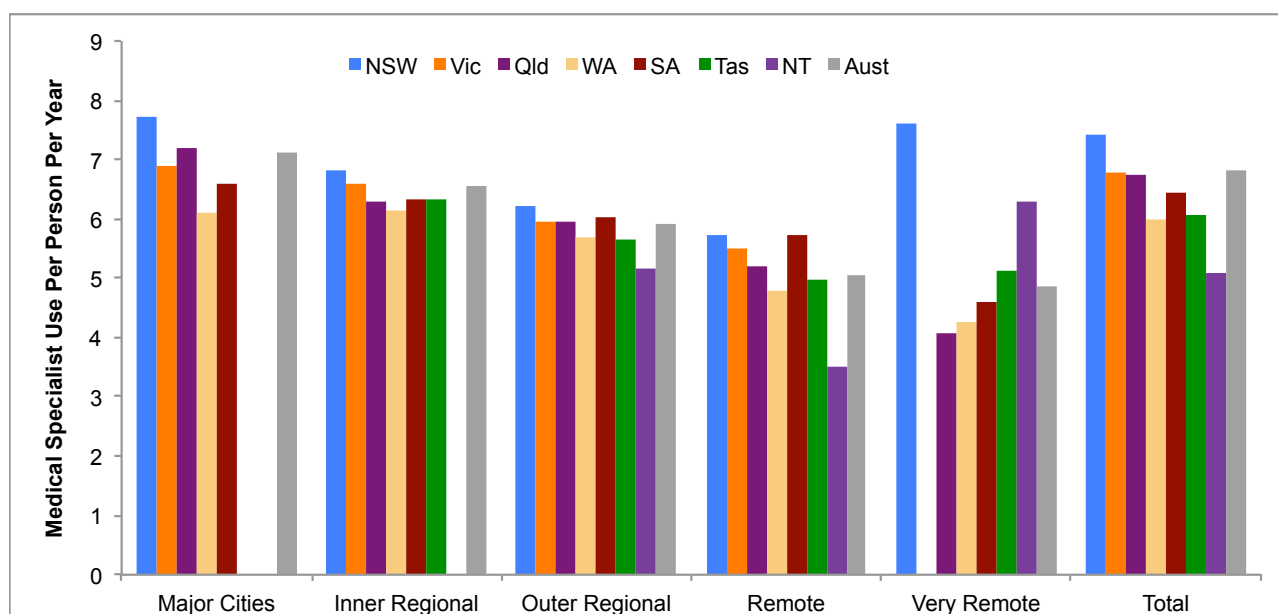


Figure 13. Specialist Service Use Per Person Per Year 2010/11. Data from ³⁰.

Access to Dentists

Tasmania has the lowest number of dentists per population (40 per 100,000 people) in Australia (national average is 63 per 100,000 people) ³¹ (see figure 14) and well under any other state for public dentists.

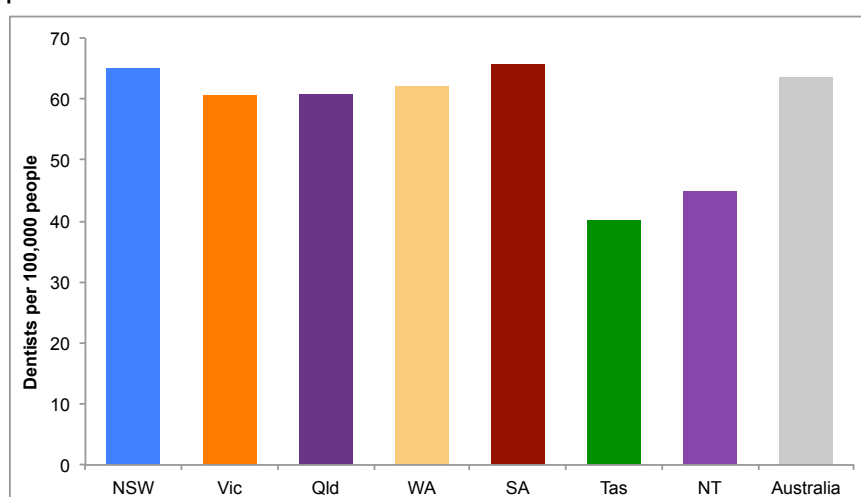


Figure 14. Dentists per 100,000 people, 2011. Data from ³².

³⁰ COAG Reform Council (2012). Healthcare 2010-11. Comparing Performance Across Australia. Canberra.

³¹ AIHW (2011). Oral health and dental care in Australia: key facts and figures 2011. Canberra.

³² AIHW (2013). Dental Workforce 2011. National health workforce series no. 4. Canberra.

Summary

While the previous section found significant health deficiencies amongst the Tasmanian population with the west coast and islands having the worst health, it seems that remote Tasmania has fairly good access to primary care services (GPs), mixed access to Medical Specialists but poor access to dental services.