Report to Legislative Council sub-committee inquiry into rural health services in Tasmania

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I would like to thank the sub-committee and its chair for their forbearance in allowing me to address them on this inquiry. I have been a passionate believer in the rights of rural, remote and Indigenous Australians to have access and equity to safe, appropriate, high quality health services within their communities.

I have worked in many rural and remote communities for over 47 years and had many roles within these communities, Rural Generalist and proceduralist, University academic and educator, Director and Executive Director of Medical Services of a number of Rural Hospitals, member of a Ministerial Rural Health Advisory Council and Chair of the Medical Sub-Committee of that body to a number of State Ministers of Health and as such I have gained a face to face and strategic policy knowledge of issues facing the third of Australians living outside of our metropolitan communities. I am a recent immigrant into Tasmania of some 9 years and the reason that I am living and working here is I feel passionately about this place that I have chosen to reside and probably my place of demise. I wish to see it and its people served well by a safe and equitable health system of high quality.

In Tasmania, since 2013, I have in my role as Tasmanian Medical Coordinator for Ochre Health, and prior to that, as a rural locum tenens, worked in most rural and remote Tasmanian communities, though predominantly in Queenstown, however my comments apply to the majority of the rural and remote facilities.

The issues within rural and remote health services in Tasmania can be divided roughly and simplistically into three principal areas, Facilities, Workforce and Governance Structure. I will address these in order.

1. **Facilities**.
When first entering rural facilities in Tasmania, one often notices relatively new buildings, well cared for and maintained. This is however deceptive in that the level of equipment is lower than required and unsuited to the provision of timely and quality services to address the acute and longer-term needs of the communities which they serve.

When I first arrived in Queenstown, to use this as an example with which I am most familiar, I commenced a Visiting Medical Officer role and noted there was no ventilator, no Radiology or Ultrasound access, much of the resuscitation equipment was old and disorganised. The access to appropriate pharmaceutical products was parlous with frequent shortages being exposed of basic medications e.g. IV and oral penicillins. Critical life-saving medications were rare and often withdrawn by the regional pharmacists due to a lack of rotational policy for expensive medications e.g. Tenecteplase for Acute Myocardial Infarcts.

Much of this has been addressed, particularly in the past 12 to 18 months however there is still no ultrasound and as such, radiology is dependent upon the presence of the two permanent part-time medical officers who will depart by the middle of 2022. There are frequent service gaps when neither these doctors are on call or are absent from the

community. A drive-in radiographer attends for elective radiology only on Wed and Thursdays of each week, not including public holidays.

There was an absence of telehealth support for clinical services. Such telehealth as existed was in meeting rooms, the Director of Nursing's office and a UTas funded education room which also acted as an adjunct meeting room for staff meetings. Since that time a "Telehealth" consultation room has been set up near to the GP Clinic but access is limited by the lack of specialists willing to provide public telehealth consultations. Private telehealth has been served better since the Covid 19 epidemic and better Medicare fee access.

What is missing is the critical network of Emergency telehealth services which exists in most mainland States and Health Services. These are basic to the support and retention of health staff by providing them with on site, timely clinical oversight in times of critical medical emergencies. This requires the Emergency Dept to have Telehealth cameras and screens linked to the Resuscitation Bay and equipment linked to a major DEM and their Emergency specialists in a tertiary facility. This happens in rural, remote and Indigenous Western Australia, Queensland, NSW, Victoria, South Australia and Northern Territory and have low opportunity costs in dollars but substantial health benefit in outcomes to patients and clinicians in rural and remote communities. There are many available exemplars, and these are not novel services as they have been widely operating since the mid-1990s. Tasmania has the poorest telehealth infrastructure in Australia. It is grossly inadequate to meet the needs of its communities and health providers. It will save substantial costs in reduction of unnecessary transfers, appropriate triage and delegation of patients to retrieval, to the right tertiary facilities, and most importantly to better outcomes and staff retention due to on-site clinical support.

2. **Workforce.**

The rural health workforce is characterised by significant numerical and skills deficit across Australia and across disciplines. Increased graduate numbers, especially in medicine, in the early 2000s has not translated to a level of rural and remote health providers sufficient to service the needs of our non-metro communities. Recent compounders include the commencement of the NDIS which has recruited many allied health workers from public health systems in search of better remuneration, acknowledgement and appreciation for their services. Yet another perverse outcome of good intentions.

There are many other reasons for this emigration which I will not go into fully as there are many documents, both in grey literature and published in public forums that deal with this more fully. Research into recruitment and retention, areas of research and publication from many of the University Departments of Rural Health, are major contributions to the body of knowledge around sustainable workforce. I can forward a number of these articles and papers if required. I would also reference many papers developed by Health Workforce Australia on workforce and workforce innovation. Much intellectual capital has been expended through this organisation on a number of potential solutions for rural and remote workforce.

The Tasmanian rural health workforce is characterised by the use of locum tenens in medicine and agency staff in nursing. This is to make up for the lack of local recruits who

see better remuneration with less obligation and commitment to a system they often find underwhelming in resources, support, capacity and overwhelming in work and stress.

Recruitment of professionals for permanent positions is inhibited by systems-based inadequacies. This includes poorer remuneration, lack of packaged employment structures, use of contracts which are non-competitive with other states and territories, and lack of career progression and experience for rural health professionals. Absolving responsibility to the Commonwealth sector and to private contractors without recent and regular review of industrial agreements has enhanced the exodus. Failure to acknowledge the Rural Doctors Associations of Australia and Tasmania as Registered Industrial bodies representing rural doctors has enabled the AMA to control the agenda which it neither understands not represents. It is essentially a specialist driven craft group. Its place is in tertiary hospitals and in metropolitan cities and not in the bush. This has resulted in a failure to re-negotiate the VMO Agreement between the AMA and government and has contributed to the reduction in rural practice and facility viability. This has been an outstanding unresolved agenda item since my time with RDAT in Tasmania.

Education and training of health professionals occupies a critical place in the creation of a sustainable rural and remote health workforce. Such activities as rural student placements, scholarships for rural intended students, active encouragement and recruitment of rural and remote students, rural Intern placements, new grad nursing student placements have been found to be successful tools in many States and Countries. Community engagement in the recruitment and support for their rural students has been widely used to considerable success. Publications on these “pipeline models” for the development of a rural, remote and Indigenous health workforce have been in the literature and in the field since the 1970s. In Australia these models have been slower to take up in Tasmania than elsewhere. The Rural Clinical School and the Burnie health education hub will hopefully correct this over the next 6 to 10 years. The role of the UTas University Dept of Rural Health in Launceston has a similar role in Nursing and Allied Health that needs to be expanded.

The recruitment/retention cycle for health professionals in rural and remote communities takes between 6 and 15 years to impact properly, more than our short political cycle and corporate memories can sustain. A tripartisan approach in Parliament is needed to attain a successful and sustainable policy agenda. Tasmania is rising from a pretty low base.

Innovations in rural workforce are necessary, available, difficult to commence and establish. It is endlessly frustrating and tiring. Successful modelling and trialling does not necessarily lead to successful implementation. As Peter Forster commented on his Queensland Health Systems Revue in 2005, “QH had great policies, it’s just that it’s an implementation-free zone”. Thankfully this did change substantially following his revue when better policies and systems were put in place. Professor Ruth Ballweg from the University of Washington State in Seattle once told me that for an innovation to succeed it firstly needed a “receptive environment” to establish and progress. To date Australia has a history of blocking even well proven established and trusted workforce models, which may be perceived as novel or innovative. That is with the exception of the Rural Generalist model in rural medicine which is a home grown model whose time has come and has broad tripartisan Federal and State jurisdiction support.

The development of the Rural Generalist Model is based upon the vision of "the right doctors, in the right places, with the right skills, providing rural and remote people with excellent health care". This has translated in Qld, its birthplace, to an additional 8 birthing centres with full obstetric and anaesthetic services opening in the past 15 years as well as an expansion in access to health services to rural and remote communities not previously experienced. It has enthused and inspired a generation of rurally focused graduates from the Rural Medical School and various Rural Clinical Schools and University Departments of Rural and Remote Health. Accessibility and safety is the key. The initial success of the model was contingent upon setting up the "receptive environment" to make it flourish. This was provided by Qld Health working with ACRRM initially, to create the legislative and industrial framework around the model which included an integrated education and training program, financial enhancement and professional status within the system. There are now over 22 Rural Generalist serviced hospitals in rural Qld serving over one third of the widely dispersed rural and remote communities.

In Tasmania a different model has been adapted by the THS. It has not achieved the intended objectives of the program but has taken a more conservative pathway which enhances the status quo. It has sought to create a more office based general practice broad based skills set and misses the opportunity to create RG hospitals outside of the "big two" tertiary centres. These larger rural hospitals interstate and overseas have been proven to be much more cost effective, provide a broader range of services, have a higher retention rate of medical staff. They operate successfully in communities of between 20,000 to 50,000 population. The concern within the current Tasmanian model is that is a "half-pregnant" model, not meeting its potential, and that it will continue to see the graduates of this program trained in anaesthetics, obstetrics, surgery and emergency medicine depart to grateful mainland States or into the specialist pathways where status and remuneration are better rewarded. A perverse benefit has come out of the Covid epidemic, a number of Emergency Medicine Physicians have chosen to use their EM Fellowship (FACEM) to convert to a Rural Fellowship and transition with their skills into Rural Medicine which they see as a better lifestyle and professional choice. Retention of this cohort may be contingent upon having a favourable endpoint to their and other RGs training. This does not exist in Tasmania currently with perhaps the beginnings of this in the Mersey Hospital which has had its scope of services degraded in the past 5 years.

The ongoing development of "mid-level" health professionals has continued to be impeded in Australia, and pretty much non-existent in Tasmania. Many countries, including the UK, Ireland, Holland, Israel, South Africa, India have adopted this as a way to provide services in an affordable and safe manner. Initially starting to surge in the US following the Vietnam war, there are now over 90,000 Physician Assistants and a similar number of Nurse Practitioners providing care in many rural, remote and underserved communities.

The US PAs are supported by the American Medical Association, Federal and State governments. The US President has his own personal PA in close attendance continuously. They share a mixed background and emanate from a range of State based education and training programs. They convert from Military medics, Paramedics, Nurse Practitioners, Allied Health Professionals, Medical and Biological Technologists and Scientists via a 24 to

28 month Bachelor or Master's course, into the Clinical roles of Physicians Assistants. Tasmania has a number of PA graduates from Australian courses with Paramedic backgrounds. They have formed an offshoot, the Australian College of Paramedic Practitioners. One such has been working in Ouse assisting Dr Meg McKeown in the practice there. They are seeking AHPRA recognition and require Medicare recognition to become an effective part of the workforce.

In nursing, the use and recognition of rural and remote trained nurses, the Remote Area Nurses, (RANs) trained via the CRANA and RIPERN pathways interstate are not recognised in Tasmania. This is a group of well-trained health professionals ideally suited to areas such as remote Tasmania. Whilst there are a few NPs currently in the State, they are not working to the full scope of practice of which they are capable. Many mature RANs are attracted to the Tasmanian rural lifestyle and would embrace the transition if there was professional and industrial recognition. Absence of a local training pathway has inhibited to development of this model in Tasmania but could be commenced by the UTas University Department of Rural Health negotiating to deliver the course locally at its campus in Launceston in concert with another State UDRH program. As with the RG model in Medicine, the RAN pathways are contingent upon Industrial and legislative recognition of their skills, scope of practice and place within the system.

3. Governance structure.
Tasmanian rural health sits within Community Health and Nursing. There is little voice in the governance for medical practitioners outside of those at an executive role in the regions. The loss of experienced rural doctor voices on the governance models has contributed to a shift in emphasis on services to the detriment of the range of services and equipment available to rural communities and their health providers. Other States have Clinical Senates which are multidisciplinary and have specific sub-committees for developing and adapting models of care across the State. Many have rural and remote strategic health services committees which "ruralises" policies and guidelines for the smaller facilities, (Usually but not limited to populations less than 50,000). It acts as a gate keeper to protect rural facilities from the impact of policies which ultimately degrade the services in these facilities. I would urge the implementation of such a senate and its sub-committees. There are many models available that can be readily adapted to Tasmania.

I will leave this paper there and invite questions if time permits. I have access to substantial literature if the Committee wishes me to forward it, both from the Australian and International perspective.

Thank you or your forbearance

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Professor Dennis Pashen, MBBS, MPHTM, HonDMD JCU, FACRRM, FRACGP, has been a Procedural GP for 20 years in rural North Queensland, an educator and academic for a number of Universities, the University of Queensland, James Cook University, Griffith University, and University of Tasmania. He was the founding Director of the Mt Isa Centre for Rural and Remote Health for 13 years, now the JCU Murtupuni Centre for Rural and Remote Health, the second UDRH established in Australia. He has been the Censor, Vice President and President of the Australian College of Rural and Remote Medicine, and until recently the Chair of the Quality and Safety Council of ACRRM. He has many publications on the topics of rural workforce and workforce innovation.

He has been a Board member of the Rural Doctors Associations of Queensland, Australia and Tasmania and President of both latter bodies. He was a Board Member of the Northern Regional Health Authority and the Rural Health Advisory Council to the Queensland Health Ministers as well as Chair of the Medical Sub-Committee of that Council for a time. He has worked as a Director of Medical Services for the South Burnett and then as Deputy Executive Medical Director of Rural for the Darling Downs Hospital and Health Service overseeing 18 rural hospitals. He has worked as a locum in remote Western Australia and Queensland since his move to Tasmania in 2013 and prior to taking up his role in Queenstown and with Ochre Health.

A full CV with listed publications is available on request.