2022 (No. 30)

PARLIAMENT OF TASMANIA

LEGISLATIVE COUNCIL
GOVERNMENT ADMINISTRATION COMMITTEE "A"

REPORT

ON

RURAL HEALTH SERVICES IN TASMANIA

Current Members of the Committee

Hon Ruth Forrest MLC (Chair)
Hon Nick Duigan MLC
Hon Luke Edmunds MLC
Hon Mike Gaffney MLC
Hon Dean Harriss MLC
Hon Sarah Lovell MLC (Deputy Chair)

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INTRODUCTION

1. Government Administration Committee A (the Committee) was established by resolution of the Legislative Council and its operation is governed by Sessional Orders agreed to by the Council.
2. The Committee met on 21 December 2020 and resolved to conduct an inquiry into rural health services in Tasmania in accordance with Sessional Order 5 (14).
3. On 21 January 2021 the Committee resolved to establish a Sub-Committee to inquire into and report upon health outcomes and access to community health and hospital services for Tasmanians living in rural and remote Tasmania, with particular regard to –

    1. *Health outcomes, including comparative health outcomes;*
    2. *Availability and timeliness of health services including:*

        a. *Ambulance services;*
        b. *Primary care, allied health and general practice services;*
        c. *Non-GP specialist medical services;*
        d. *Hospital services;*
        e. *Maternity, maternal and child health services;*
        f. *Pain management services;*
        g. *Palliative care services;*
        h. *Pharmacy services;*
        i. *Dental services;*
        j. *Patient transport services;*
        k. *'After hours' health care;*
        l. *Indigenous and culturally and linguistically diverse (CALD) communities; and*
        m. *Other.*

    3. *Barriers to access to:*
        a. *Ambulance services;*
        b. *Primary care, allied health and general practice services;*
        c. *Non-GP specialist medical services;*
        d. *Hospital services;*
        e. *Maternity, maternal and child health services;*
        f. *Pain management services;*
        g. *Palliative care services;*
        h. *Pharmacy services;*
        i. *Dental services;*
        j. *Patient transport services;*

   k. *'After hours' health care;*
   l. *Indigenous and culturally and linguistically diverse (CALD) communities; and*
   m. *Other*
4. *Planning systems, projections and outcomes measures used to determine provision of community health and hospital services;*
5. *Staffing of community health and hospital services;*
6. *Capital and recurrent health expenditure;*
7. *Referral to tertiary care including:*
   a. *Adequacy of referral pathways;*
   b. *Out-of-pocket expenses;*
   c. *Wait-times; and*
   d. *Health outcome impact of delays accessing care;*
8. *Availability, functionality and use of telehealth services; and*
9. *Any other matters incidental thereto.*

4. The Membership of the Sub-Committee was:
   - Hon Ruth Forrest MLC (Chair);
   - Hon Sarah Lovell MLC (Deputy Chair from January 2022);
   - Hon Nick Duigan MLC;
   - Hon Mike Gaffney MLC;
   - Hon Bastian Seidel MLC (until resignation from Parliament from January 2022); and
   - Hon Rob Valentine MLC (resigned from the Sub-Committee in March 2021).

5. The Committee notes:
   a. The Inquiry was advertised in Tasmania's three daily regional newspapers and circulated among the rural newsletters and newspapers. The Sub-Committee also directly contacted a number of organisations with specific knowledge or relevant expertise in this area inviting them to provide evidence to the Inquiry.
   b. On 26 March 2021, the inquiry was interrupted by the prorogation of Parliament for the State Election.
   c. On 24 June 2021, Government Administration Committee A resolved to re-appoint the Sub-Committee to continue its inquiry into rural health services in Tasmania, with a slightly expanded terms of reference to include mental health services in term of reference 2 (m) and 3 (m) which was made possible by the Cabinet reshuffle following the establishment of the new Government.

d. The Committee resolved that the Sub-Committee be authorised to receive all evidence and papers received on this subject in the previous Parliament. Those who had provided submissions to the previously established inquiry were invited to provide an updated submission, including on the terms of reference related to mental health. Stakeholders identified as having a particular interest in mental health were invited to provide a submission to the inquiry.

e. The Sub-Committee received 81 submissions.

f. Prior to the commencement of the formal hearings process, the Sub-Committee undertook a program of regional site visits during February and March 2021 to assist Committee Members' appreciation of services that are provided around the State.

g. The Sub-Committee conducted public hearings in Hobart on 20 August, 7 and 8 October 2021, 19, 26 and 30 November 2021, 17 February, 31 March, 1 April, 17 and 18 May, 20 June and 18 August 2022; in Launceston on 2 November 2021 and in Burnie on 3 November 2021.

h. The Sub-Committee Inquiry has established a dedicated webpage at https://www.parliament.tas.gov.au/ctee/Council/GovAdminA_RuralHealth.html. All submissions and transcripts (where evidence is made publicly available) are included on the Committee webpage.

i. On 7 January 2022 Hon Dr Bastian Seidel resigned from Parliament and thus from the Sub-Committee.

j. Before the Sub-Committee had finalised the Inquiry, Parliament was prorogued on 6 April 2022 following the resignation of Premier Gutwein. The Sub-Committee was re-established on 4 May 2022.

k. Hon Dean Harriss MLC was appointed to Government Administration Committee A in May 2022.

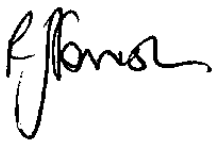
l. On 1 August 2022, the inquiry was again interrupted by the prorogation of Parliament following the resignation of Minister Petrusma. The Sub-Committee was re-appointed on 16 August 2022.

m. The work of the Sub-Committee was interrupted by the suspension of Parliamentary activity due to the passing of Her Majesty Queen Elizabeth II, following the consideration of the condolence motion in the Council on Tuesday 13 September 2022 and resuming after the National Day of Mourning on Thursday, 22 September 2022;

n. Hon Meg Webb MLC resigned from Government Administration Committee A on 28 September 2022.

o. Hon Luke Edmunds MLC was appointed to Government Administration Committee A on 28 September 2022.

6. The Committee intends that the Report be considered in its entirety as a Final Report of the Inquiry undertaken by the Sub-Committee.
7. The Committee acknowledges the work undertaken by Sub-Committee members and the Committee secretariat.
8. The Committee resolved that Appendix A – the Report of the Sub-Committee inquiring into Rural Health Services in Tasmania be received and incorporated into this Report for Tabling in Parliament.



Hon Ruth Forrest MLC
Committee Chair

25 October 2022

2022

APPENDIX A

PARLIAMENT OF TASMANIA

LEGISLATIVE COUNCIL

GOVERNMENT ADMINISTRATION COMMITTEE "A"

SUB-COMMITTEE REPORT

ON

RURAL HEALTH SERVICES IN TASMANIA

Members of the Sub-Committee Inquiry:

Hon Ruth Forrest MLC (Chair)

Hon Sarah Lovell MLC (Deputy Chair)

Hon Mike Gaffney MLC

Hon Nick Duigan MLC (from 29 June 2021)

Hon Bastian Seidel MLC (until 7 January 2022)

Hon Rob Valentine MLC (until 10 February 2021)

CONTENTS

ABBREVIATIONS

ABE	Affordable Budget Establishment
ABS	Australian Bureau of Statistics
ACCHOs	Aboriginal Community-Controlled Health Organisations
ADL	Activities of Daily Living
AHPRA	Australian Health Practitioner Regulation
AHS	Allied Health Services
AHP	Allied Health Professional
AIHW	Australian Institute of Health and Welfare
AIR	Australian Immunisation Register
AMA	Australian Medical Association
ANZSPM	Australian and New Zealand Society of Palliative Medicine
APS	Australian Pain Society
APC	Australian Pharmacy Council
AT	Ambulance Tasmania
AQF	Australian Qualifications Framework
CAMHS	Child and Adolescent Mental Health Services
CATT	Crisis Assessment and Triage Team
CERTs	Community and Emergency Response Teams
CHC	Community Health Centre
CHSP	Commonwealth Home Support Program
ComRRS	Community Rapid Response Service
COAG	Council of Australian Governments
CQHHS	Central Queensland Hospital and Health Service
CVD	Cardiovascular disease
DoH	Department of Health
DMR	Digital Medical Record

ECP	Extended Care Paramedic
EP	Exercise Physiologist
FOBT	Faecal occult blood test
FTE	Full Time Equivalent
GDM	Gestational Diabetes Mellitus
GP	General Practitioner
HACC	Home and Community Care Program
HACSU	Health and Community Services Union
HCT	Health Consumers Tasmania
HEMS	Helicopter Emergency Medical Services
HHS	Hospitals and Health Services
HSM	Health Service Manager
HSP	Health Service Provider
HTS	Health Transport Services
ICT	Information and Communications Technology
LGA	Local Government Areas
LGBTIQ+	Lesbian, gay, bisexual, transgender, intersex, queer and other sexually or gender diverse people
MBS	Medicare Benefits Schedule
MCH	Mersey Community Hospital
MMM	Modified Monash Model
MORT	Mortality over Regions and Times
NDIS	National Disability Insurance Scheme
NEPT	Non-Emergency Patient Transport
NIP	National Immunisation Program
NOF	Neck of femur [fracture]
NRGP	Rural Generalist Model of Practice
NWRH	North West Regional Hospital

NRHA	National Rural Health Alliance
OCNMO	Chief Nursing and Midwifery Office (Western Australia)
ORH	Organisational Research in Health
OTA	Occupational Therapy Australia
PAC	Public Accounts Committee
PACER	Police, Ambulance and Clinician Early Response
PBS	Pharmaceutical Benefits Scheme
PCT	Palliative Care Tasmania
PEPA	Program of Experience in the Palliative Approach
PESRAC	Premier's Economic and Social Recovery Advisory Council
PGOATas	Pharmacy Guild of Australia (Tasmanian Branch)
PHN	Primary Health Network
PHT	Primary Health Tasmania
PPEI	Promotion, Prevention and Early Intervention
PTAS	Patient Travel Assistance Scheme
RACS	Royal Australian College of Surgeons
RDAT	Rural Doctors Association of Tasmania
RFDS	Royal Flying Doctors Service
RG	Rural Generalist
RHH	Royal Hobart Hospital
RHOF	Rural Health Outreach Fund
RHMT	Rural Health Multidisciplinary Training
RIPERN	Rural and isolated practice nurse model
RJDTIF	Rural Junior Doctor Training Innovation Fund
RMP	Rural Medical Practitioner
RPA	Royal Prince Alfred Hospital
SET	Surgical Education and Training
SPCS	Specialist Palliative Care Services

STPI	Short term psychological intervention
SwIM	Strength with Immersion Model
TANA	Trauma Awareness Network Australia
TasCOSS	Tasmanian Council of Social Service
TPMN	Tasmanian Pain Management Network
TRDF	Tasmanian Role Delineation Framework
TSP	Transition Support Programs
UCC	Urgent Care Centre
VMO	Visiting Medical Officer
WIL	Work Integrated Learning

EXECUTIVE SUMMARY

This Inquiry is the first conducted by a Tasmanian Parliamentary Committee into rural and regional health services. There have been a number of previous inquiries into acute health services and into preventative health. This targeted inquiry has confirmed a number of concerning realities regarding access to health services and health outcomes for individuals and families living in rural and regional areas of Tasmania.

Tasmanians experience poorer health outcomes than those living in most other regions of Australia. Furthermore, when compared to Tasmanians living in urban areas, those living in rural and remote areas are older, sicker, poorer and experience more negative health outcomes related to the social determinants of health. This results in a greater need to access a range of health services, many of which are not available locally. Poorer health outcomes, particularly with regard to mental health, are further exacerbated for LGBTIQ+ Tasmanians.

The poorer health outcomes of those living in rural and regional Tasmania are linked to multi-faceted access barriers across a number of underlying factors. These factors include a higher percentage of residents living in low socio-economic circumstances and poverty; lower levels of literacy, including health and digital literacy; higher costs associated with access to health care and stigma experienced by marginalised Tasmanians.

As a result of the barriers experienced in accessing timely health care, Tasmanians living in rural and regional areas often delay seeking care and have more complex healthcare needs. Almost 50 per cent of rural or regionally based Tasmanian adults have three or more chronic health conditions.

Unless specific action is taken, health outcomes, including mental health, for Tasmanians living in rural and regional areas are likely to get worse.

The importance of ensuring a trauma informed approach to health care, particularly related to the provision of mental health care, is essential. Raising community awareness and encouraging the delivery of trauma informed services is integral to improving health outcomes

Availability of integrated and multidisciplinary health care services is an important part of overcoming access barriers and requires an approach that is informed by local community needs.

To address the inequity in health outcomes for Tasmanians living in rural and remote areas, the Committee found a holistic intergenerational wellbeing approach to the delivery of health services is essential.

Evidence received by the Committee described similar challenges and points of view related to the Terms of Reference. The matters raised have been considered and consolidated in the Report. For those interested in understanding more fully the extent of the challenge in ensuring all Tasmanians have equity of access to quality health care and

similar health outcomes, the Committee encourages further reading of submissions and transcripts of evidence available on the Committee website.

The Committee thanks all stakeholders who provided evidence. Their valuable insights into, and varied experience within health care in rural and regional Tasmania and beyond, has informed the Committee's work. As many of the matters raised crossed over a number of the Terms of Reference, the findings and recommendations of the Committee are consolidated and follow the Executive Summary.

The Committee heard significant evidence of barriers to access of timely care throughout rural and regional Tasmania. Overarching themes include workforce shortages and recruitment challenges, the inability of some health professionals to work across the full scope of practice for which they are qualified, the lack of integrated, community-centred multidisciplinary care and inflexible funding and employment arrangements. A 'one size fits all' approach will not meet the health needs of rural and regional communities, nor will it enhance recruitment and retention of health practitioners to rural and regional Tasmania.

High staff turnovers and a reliance on locums to deliver health services in rural and regional areas limits access to continuity of care and the positive health outcomes associated with continuity and timely access to care.

The findings in this Report clearly articulate the underlying challenges that contribute to poorer health outcomes, barriers to timely access of health care, workforce shortages and the lack of multidisciplinary and innovative models of care to address some of these challenges. One example of an innovative model of care is the Police, Ambulance, Clinician Emergency Response (PACER) service, which has been implemented in Southern Tasmania, to support people experiencing mental ill health with a community-based response and avoid acute care admission. Due to the success of PACER, it is to be expanded statewide. This success reinforces the need for innovation across a broad range of health care services.

There is growing recognition that the capacity for health professionals to work across the full scope of their practice is crucial to the effective delivery of health services, particularly in rural and regional areas.

This includes the expansion of pathways such as rural generalism with demonstrated benefits related to delivery of timely, accessible health care in rural and regional areas. The rural generalist program initiated at the Mersey Community Hospital is relatively new and an important aspect of improving the rural and regional medical workforce.

Other professions including nurse practitioners, paramedics, pharmacists and other allied health professionals have faced limitations to the full utilisation of their skills within the health workforce. This is particularly important in rural and regional areas.

The Committee urges the State Government to identify and remove barriers relating to legislative limitations, employment arrangements and education and training across identified areas of workforce shortage.

The policy recently announced by the Victorian Government to fund the Higher Education Contributions Scheme (HECS) costs of nursing and midwifery undergraduate students and provide scholarships for postgraduate studies in areas of need including intensive care, cancer care, paediatrics and nurse practitioner specialities, should be actively considered by the Tasmanian Government. Graduates educated in Tasmania are more likely to remain and work within the Tasmanian health system post-graduation. A similar approach to support the training and education of health professionals in areas of identified workforce shortage, including nurse practitioners and allied health professionals, should also be considered.

The Committee recommends the adoption of a long-term strategy specifically focusing on the poorer health outcomes experienced by Tasmanians living in rural and regional areas. This strategy should take a person-centred holistic approach, with a particular focus on preventative health and wellbeing that considers intergenerational factors.

The Committee further recommends the Tasmanian Government monitor, measure and report health outcomes progress against both the recommended long-term strategy and all existing Department of Health strategies.

The Committee notes the Australian Government is primarily responsible for funding General Practice (GP) services and primary health care. Despite this, the Committee received evidence that the Tasmanian Government and to a lesser degree, Local Government, have stepped in to provide some services in rural and regional Tasmania where services that should be funded by the Australian Government have not met health care needs of the community.

Many General Practices in rural and regional Tasmania no longer offer bulk-billing of GP care. The current Medicare Benefits Schedule (MBS) rebates are insufficient to provide financial sustainably for many rural and regional General Practices. This is compounded by the complexity of the patients' health status, lack of access to GPs in many areas thus longer waiting times to receive care and greater deterioration in the health of the patient.

The lack of access to Medicare Provider Numbers for general practice nurses, and thus the capacity to fund essential health care provided by them, has resulted in inadequate funding to cover administrative costs associated with operating many rural and regional general practices. This has contributed to the reduction of 'bulk-billing' of patients attending general practices in rural and regional Tasmania.

Without bulk-billing, the impact of the financial burden for these patients can and does further delay seeking care resulting in a more complex health condition when care is sought or the person may attend a local hospital to avoid the out-of-pocket expenses. These factors contribute to the inequity of access to timely health care, financial hardship, poorer health outcomes and avoidable increase in demand on acute health services.

As the Australian Government is responsible for funding of the majority of primary health care provided in rural and regional Tasmania, the challenges related to the inadequacy of the MBS and impact of the Modified Monash Model highlight the need for ongoing collaboration between the State and Australian Governments. A collaborative and innovative approach, that is community-informed, is needed to address poorer health

outcomes and access barriers, and to meet the specific needs of individuals living in rural and regional areas.

The Committee recommends the Tasmanian Government continue to seek adequate funding to meet the needs of rural and regional Tasmanians, including lobbying for a dedicated rural health fund. The MBS review, completed in 2020, should be examined to ensure the MBS rebates are fit for purpose to meet the unique and increasing needs of rural and regional Tasmanians. If funding gaps continue to persist, the Tasmanian Government should encourage further review of the MBS related barriers to equitable health care in rural and regional Tasmania.

The Committee acknowledges the significant impact of the COVID-19 pandemic on the delivery of health services, including the provision of timely health care in both the primary and acute health care settings. These challenges have been compounded by workforce shortages related to COVID-19 isolation requirements and the temporary suspension of non-urgent surgeries.

A number of health care innovations, expansion of digital health services and expansion of the scope of practice for some health professionals, in response to the COVID-19 pandemic, should be maintained to promote timely access to care and vaccinations.

This Report contains comprehensive evidence clearly describing the inequity related to the lack of access to care and the resultant poorer health outcomes faced by Tasmanians living in rural and regional areas. This Report should be read in conjunction with the submissions and transcripts of evidence, published on the Committee website. Appendix A contains definitions and a glossary related to health-related terminology and a description of the roles of health professionals referred to throughout the Report.

A number of actions taken by the Tasmanian Government in response to growing demand in health care, including in rural and regional areas are acknowledged. However, the evidence is clear – a dedicated focus on and direct action to address the lived experiences of Tasmanians living in rural and regional areas, who at times face insurmountable barriers to access timely and quality health care, must be a priority. Without specific, targeted and urgent action, the comparatively poorer health and mental health outcomes for those Tasmanians are likely to get worse.

Tasmanians living in rural and regional areas deserve better.

Hon Ruth Forrest MLC
Inquiry Chair
7 October 2022

1. FINDINGS

Tasmanian health outcomes

1. Tasmanian adults experience poorer health outcomes than those living in most other parts of Australia.

2. Compared to Tasmanians living in urban areas, Tasmanians living in rural and remote areas are older, sicker and poorer and have:
    a. lower socio-economic circumstances;
    b. higher rates of:
        i. smoking;
        ii. obesity;
        iii. poor nutrition;
        iv. low physical activity levels; and
        v. chronic disease;
    c. longer wait times and limited access to many health care services including allied health professionals;
    d. less access to multidisciplinary care;
    e. higher rates of disability; and
    f. poorer mental health outcomes.

3. Tasmania has the highest rate of any state or territory of adults with three or more chronic conditions (almost 50 per cent).

4. Unless specific action is taken, the health outcomes for Tasmanians living in rural and regional areas are likely to get worse.

5. A holistic intergenerational wellbeing approach to the delivery of health services to address the inequity in health outcomes for Tasmanians living in rural and remote areas is essential.

6. LGBTIQ+ Tasmanians have significantly higher rates of adverse mental health outcomes (including psychological distress, self-harm and suicide ideation), with those living in rural and regional areas experiencing some of the worst outcomes of any population group in the country.

Availability, Timeliness and Barriers to Accessing Care

7. Continuity of primary health carer is valued by Tasmanians living in rural and remote areas.

8. Barriers to access of health care in rural and regional Tasmania are multi-faceted and relates to a range of matters including:
    a. a higher percentage of residents living in low socio-economic circumstances and poverty;
    b. lower levels of literacy, including health and digital literacy;

c. higher cost of:
    i. health services;
    ii. transport to access services; and
    iii. digital, technology and access;
d. geographical distance to metropolitan health services;
e. lack of suitable housing for health professionals in rural and remote areas;
f. inadequate access to high speed internet and lack of access to modern digital infrastructure and associated technology in rural health facilities;
g. lack of community awareness of all available allied health services and programs;
h. stigma experienced by people, including sex workers, LGBTIQ+ Tasmanians, culturally and linguistically diverse Tasmanians and those with mental health conditions, intellectual disability and dementia;
i. a lack of dedicated and inclusive services to meet the specific needs of women, including sexual and reproductive health care and pregnancy termination services and the needs of LGBTIQ+ Tasmanians; and
j. inability to self-refer to mental health services.

9. The availability of ambulance services in rural and regional Tasmania relies heavily on a volunteer workforce. Increasing demand and inadequate resources in urban areas is requiring redistribution of volunteer resources which increases their workload and impacts on the availability of ambulance services in rural areas. This is further exacerbated by the loss of some volunteers due to the COVID-19 pandemic.

10. Increased demand and access block at emergency departments continues to contribute to a lack of timely access to ambulance services and longer response times.

11. Patient Travel Assistance Scheme (PTAS) is a necessary service however the current model does not meet the needs of all rural and regional communities.

12. The Government commissioned a review of PTAS seeking to address equity of access to health care, and has accepted all recommendations of the review.

13. The use of telehealth has expanded access to a range of health services and plays an important role in patient health care in rural and regional communities, however telehealth should be used as a complementary service to in-person health services rather than a replacement.

14. Compared with urban areas, Tasmanians living in rural and regional areas experience significantly longer wait times and poorer access to:
    a. General Practitioners;
    b. non-GP specialists including but not limited to:

i. pain specialists (there are none in rural and regional Tasmania);
ii. palliative care professionals;
iii. rheumatologists;
iv. neurologists; and
v. psychiatrists;

c. allied health professionals, including but not limited to:
i. occupational therapists;
ii. exercise physiologists;
iii. social workers; and
iv. psychologists and other mental health professionals;

d. Dentists and other oral health professionals; and
e. Pharmacists.

15. Some non-GP specialist services are not available at all in rural and regional areas of Tasmania.

16. Comparatively Tasmania has lower numbers of allied health professionals than other Australian jurisdictions, compounded by a disproportionate shortage in rural and regional areas.

17. The Government acknowledges there are a range of challenges in recruiting and retaining health professionals, including a lack of allied health career pathways and has been working with UTAS to address these challenges. UTAS is also developing its Allied Health Expansion Program.

Workforce Shortages

18. Workforce shortages are a challenge across the state. This is compounded in rural and regional Tasmania by a range of factors including a maldistribution across the state, the capacity to cover periods of leave, ill health and professional development. This relates particularly to the following professions and services:
a. palliative care;
b. pharmacists;
c. general practitioners;
d. psychologists;
e. mental health professionals;
f. social workers;
g. occupational therapists; and
h. many non-GP specialists, many of whom are unavailable in rural and regional areas or only available privately outside the urban centres including:
i. neurologists;
ii. rheumatologists; and
iii. pain specialists.

19. The Government's Health Workforce 2040 strategy seeks to address the statewide workforce challenges.

20. Taking a person centric approach to the recruitment and employment of medical professionals in rural areas can improve recruitment and retention through enabling greater professional support and sustainable workload support.

Models of Care for Rural and Regional Tasmania

21. Rural Generalism
    a. Rural generalist programs provide an incentive for GP's to work in rural and regional areas by broadening and recognising their scope of practice with appropriate remuneration;
    b. Rural Generalists enhance medical staffing and service delivery in rural and regional hospitals in a cost-effective way, compared with the cost of engaging locum medical practitioners; and
    c. Rural generalism is being utilised effectively in other jurisdictions.

22. To promote equity of access to health care in rural and regional Tasmania, a place-based approach to care is needed. A 'one size fits all' approach to service delivery is inappropriate to meet the diverse needs of rural and regional areas of Tasmania.

23. Community engagement to establish which services are actually needed in which locations will enable better utilisation of limited resources.

24. It is acknowledged that Local Government participates in the delivery of health and wellbeing services in rural and regional communities. However State and Federal Governments are responsible for the delivery of primary and acute health care and need to ensure these services are appropriately resourced and funded.

25. Innovations in health care adopted during the COVID-19 pandemic that enabled the expansion of services and greater utilisation of available health professionals have been beneficial in delivering timely care to Tasmanians living in rural and regional Tasmania.

26. The environment and method in which mental health care is provided is important to positive outcomes. An integrated mental health service is required to enhance timely access and overcome the barriers to appropriate care.

27. Models of collaborative and innovative multi-disciplinary care enhance timely access to services and have improved patient outcomes, including:
    a. the strategic partnership between the Royal Flying Doctor Service and the Tasmanian Government (including oral health);
    b. the *Rapid Access to Specialists in the Community* initiative;
    c. flexible use of pharmacists throughout hospitals/emergency departments;
    d. GPs who employ nurse practitioners and/or paramedic practitioners; and
    e. Police, Ambulance and Clinician Early Response (PACER).

28. Regional and rural hospitals have latent capacity and alternative, innovative and place-centred models of care could provide greater utilisation of the available workforce.

Scope of Practice

29. There is growing recognition that the capacity for health professionals to work across the full scope of their practice is crucial to the effective delivery of health services in rural and regional Tasmania.

30. A number of health professionals experience barriers that prevent them from working across their full scope, including:
    a. Legislative barriers;
    b. Limited numbers or absence of employment opportunities;
    c. Cost of and time required for training with no guarantee of employment; and
    d. Limited access to MBS rebates, with some care/services provided not eligible for a rebate, thus the service provider does not receive any remuneration.

31. The barriers in Finding 30(b) were particularly relevant to:
    a. pharmacists;
    b. paramedic practitioners; and
    c. nurse practitioners.

32. Nurse practitioner and paramedic practitioner workforces are not as broadly utilised in Tasmania as other jurisdictions.

33. Bipartisan support for the New Zealand Government's commitment to an enabling health workforce, including financial and legislative support, facilitated increased numbers of nurse practitioners to practice across their full scope, and resulted in improved access to healthcare in New Zealand.

34. The Committee notes UTAS's commitment to expand a range of health disciplines throughout Tasmania.

Medicare Benefits Schedule

35. The Commonwealth and State funding arrangements for the delivery of health services can impact availability and timely access to health care in rural and regional areas.

36. The Australian Government established the *Medicare Benefits Schedule Review Taskforce* in 2015, with the Final Report being released in December 2020.

37. The current Medicare Benefits Schedule (MBS) has shortcomings that can negatively impact on patient outcomes. For example, the MBS rebate does not

reflect the cost of running a General Practice, particularly in rural and regional practices.

38. In rural and regional communities, patients have to travel further, attend less frequently, and present with more complex health needs, exacerbating the financial pressures on a GP practice.

39. The reduction, and in some cases cessation, of bulk billing results in out-of-pocket expenses to patients, and thus a barrier to care.

40. The Modified Monash Model has had a detrimental impact on Tasmanian GPs, particularly in rural and regional practices. The reclassification of some rural and regional areas in Tasmania under the Modified Monash Model has led to a reduction of funding, restricting access to Commonwealth funding and incentives.

2. RECOMMENDATIONS

The Committee makes the following recommendations to the Tasmanian Government:

1. Adopt a long-term strategy to address the poorer health outcomes experienced by Tasmanians living in rural and regional areas, with a particular focus on:
    a. preventative health and wellbeing;
    b. a person-centred holistic approach;
    c. local community health needs;
    d. intergenerational factors;
    e. removing access barriers;
    f. the delivery of trauma informed care; and

    monitor, measure and report health outcomes and progress against the strategy.

2. Working with the Australian Government, establish collaborative and innovative funding models to meet the specific needs of individuals living in rural and regional areas particularly the:
    a. consideration of a dedicated rural health fund;
    b. active support of multi-disciplinary models of care; and
    c. avoidance of duplication of services and/or costs in areas where health services attract both Tasmanian and Australian Government funding.

3. Take an evidence-based approach to identify health care needs in rural and regional Tasmania and strongly advocate for additional Australian Government funding to:
    a. support the delivery of viable primary health services;
    b. deliver community-centred alternative models of health care;
    c. support the recruitment and retention of primary health care providers; and
    d. avoid shifting of costs and responsibility for these services to the Tasmanian Government.

4. Monitor, measure and report health outcomes for Tasmanians living in rural and regional areas against the Department of Health Strategic Priorities 2021-23.

5. Adopt a strategic approach to deliver integrated, multi-disciplinary models of care, including mental health services, that:
    a. are community-centred and specific;
    b. support health practitioners to work collaboratively;
    c. include the delivery of after-hours care; and
    d. do not rely on fee for service.

6. In collaboration with the Australian Government, address barriers preventing the full utilisation of the health workforce, including review of:
    a. relevant legislation;
    b. employment arrangements;
    c. funding arrangements; and
    d. scope of practice for all health professionals, with particular regard to:
        i. Nurse Practitioners;
        ii. Rural generalists;
        iii. Paramedics (including paramedic practitioners); and
        iv. Pharmacists.

7. Where appropriate, the Tasmanian Health Service adopt a single employer model that encompasses hospital, rural generalist and general practice services.

8. Advocate and seek support of the Australian Government to ensure the Medicare Benefits Schedule (MBS) supports the financial viability of rural and regional general practice services including the timely implementation of the relevant recommendations from the Australian Government's *Medicare Benefits Schedule Review Taskforce*, with particular regard to:
    a. increased rebates under the Medicare Benefits Schedule (MBS) related to primary care in rural and regional settings;
    b. access to MBS rebates that enable an expansion of and appropriate remuneration for health services delivered by non-GP health professionals, including nurse practitioners, paramedic practitioners and pharmacists; and
    c. collaborative models of care.

9. To address specific workforce shortages in rural and regional Tasmania, including:
    a. update its *Health Workforce 2040* strategy with a focus on workforce shortages in rural and regional Tasmania;
    b. develop flexible working arrangements to enhance worker retention, including guaranteed peer support, access to Continuous Professional Development (CPD) and adequate time away from active duty;
    c. consider alternate funding models and remuneration of health professionals in areas of high workforce shortage;
    d. address career pathway limitations; and
    e. work collaboratively with UTAS, TasTAFE and other registered training authorities to identify and address key areas of workforce shortage including, but not limited to:
        i. exercise physiologists
        ii. general practitioners;
        iii. neurologists;
        iv. nurses and nurse practitioners;
        v. occupational therapists;
        vi. pain specialists;
        vii. palliative care professionals;

viii. paramedics and paramedic practitioners;
ix. pharmacists;
x. psychologists;
xi. rheumatologists;
xii. rural generalists; and
xiii. social workers.

10. Actively consider funding the Higher Education Contributions Scheme (HECS) costs of nursing, midwifery and allied health undergraduate students and provide scholarships for postgraduate studies, including nurse practitioner specialities and allied health professionals, in areas of identified workforce shortage.

11. Work with the Federal Government to improve access to digital health care in rural and regional Tasmania through:
    a. ensuring rural communities have access to modern digital infrastructure and associated technology in rural health facilities; and
    b. a targeted, community centred approach to investment in digital literacy.

12. Ensure all communications related to the availability of health services in rural and regional areas of Tasmania, are clear, contemporary and accessible.

13. Consider the employment of a Health Systems Navigators, particularly in rural and regional Tasmania, to assist individuals and families to find and engage with appropriate health professionals and services.

3. ESTABLISHMENT AND CONDUCT OF THE INQUIRY

Government Administration Committee A (the Committee) was established by resolution of the Legislative Council and its operation is governed by Sessional Orders agreed to by the Council.

The Committee met on 21 December 2020 and resolved to conduct an inquiry into rural health services in Tasmania in accordance with Sessional Order 5 (14).

On 21 January 2021 the Committee resolved to establish a Sub-Committee to inquire into and report upon health outcomes and access to community health and hospital services for Tasmanians living in rural and remote Tasmania, with particular regard to –

1. *Health outcomes, including comparative health outcomes;*
2. *Availability and timeliness of health services including:*
    a. *Ambulance services;*
    b. *Primary care, allied health and general practice services;*
    c. *Non-GP specialist medical services;*
    d. *Hospital services;*
    e. *Maternity, maternal and child health services;*
    f. *Pain management services;*
    g. *Palliative care services;*
    h. *Pharmacy services;*
    i. *Dental services;*
    j. *Patient transport services;*
    k. *'After hours' health care;*
    l. *Indigenous and culturally and linguistically diverse (CALD) communities; and*
    m. *Other.*

3. *Barriers to access to:*
    a. *Ambulance services;*
    b. *Primary care, allied health and general practice services;*
    c. *Non-GP specialist medical services;*
    d. *Hospital services;*
    e. *Maternity, maternal and child health services;*
    f. *Pain management services;*
    g. *Palliative care services;*
    h. *Pharmacy services;*
    i. *Dental services;*
    j. *Patient transport services;*
    k. *'After hours' health care;*
    l. *Indigenous and culturally and linguistically diverse (CALD) communities; and*
    m. *Other.*

4. *Planning systems, projections and outcomes measures used to determine provision of community health and hospital services;*
5. *Staffing of community health and hospital services;*
6. *Capital and recurrent health expenditure;*
7. *Referral to tertiary care including:*
    a. *Adequacy of referral pathways;*
    b. *Out-of-pocket expenses;*
    c. *Wait-times; and*
    d. *Health outcome impact of delays accessing care;*
8. *Availability, functionality and use of telehealth services; and*
9. *Any other matters incidental thereto.*[1]

The membership of the Sub-Committee was:

- Hon Ruth Forrest MLC (Chair);
- Hon Sarah Lovell MLC (Deputy Chair from January 2022);
- Hon Nick Duigan MLC (from June 2021);
- Hon Mike Gaffney MLC;
- Hon Dr Bastian Seidel MLC (Deputy Chair until resigned from Parliament from January 2022); and
- Hon Rob Valentine MLC (resigned from the Sub-Committee on 26 March 2021).

The Inquiry was advertised in Tasmania's three daily regional newspapers and circulated among the rural newsletters and newspapers. The Sub-Committee also directly contacted a number of organisations with specific knowledge or relevant expertise in this area inviting them to provide evidence to the Inquiry.

Prior to the commencement of the formal hearings process, the Sub-Committee undertook a program of regional site visits during February and March 2021 to assist Committee Members' appreciation of services that are provided around the State.

Members of the Sub-Committee visited the following sites:

- Mersey Community Hospital;
- Smithton Medical Centre;
- Nubeena Medical Centre;
- Dunalley Medical Centre;
- Dover Medical Centre;
- Scottsdale Medical Centre;
- St Mary's Medical Centre;

[1] Regional centres: defined as Modified Monash Model 2 (i.e. outside greater Hobart and greater Launceston.

- Queenstown Hospital;
- Queenstown Medical Centre; and
- King Island Hospital (through an Electorate Tour).

On 26 March 2021, the inquiry was interrupted by the prorogation of Parliament for the State Election.

On 24 June 2021, Government Administration Committee A resolved to re-appoint the Sub-Committee to continue its inquiry into rural health services in Tasmania, with a slightly expanded terms of reference to include mental health services in term of reference 2 (m) and 3 (m) which was made possible by the Cabinet reshuffle following the establishment of the new Government.

The Committee resolved that the Sub-Committee be authorised to receive all evidence and papers received on this subject in the previous Parliament.

Those who had provided submissions to the previously established inquiry were invited to provide an updated submission, including on the terms of reference related to mental health. Stakeholders identified as having a particular interest in mental health were invited to provide a submission to the inquiry.

On 7 January 2022 Hon Dr Bastian Seidel resigned from Parliament and thus from the Sub-Committee.

Before the Sub-Committee had finalised the Inquiry, Parliament was prorogued on 6 April 2022 following the resignation of Premier Gutwein. The Sub-Committee was re-established on 4 May 2022.

On 1 August 2022, the inquiry was again interrupted by the prorogation of Parliament following the resignation of Minister Petrusma. The Sub-Committee was re-appointed on 16 August 2022.

The work of the Sub-Committee was interrupted by the postponement of Parliamentary business due to the passing of Her Majesty Queen Elizabeth II following the consideration of the condolence motion in the Council on Tuesday 13 September 2022, until the resumption of Committee activity following the National Day of Mourning on Thursday, 22 September 2022.

The Sub-Committee received 81 submissions. The Sub-Committee conducted public hearings in Hobart on 20 August, 7 and 8 October 2021, 19, 26 and 30 November 2021, 17 February, 31 March, 1 April, 17 and 18 May, 20 June and 18 August 2022; in Launceston on 2 November 2021 and in Burnie on 3 November 2021.

The Sub-Committee Inquiry has established a dedicated webpage at https://www.parliament.tas.gov.au/ctee/Council/GovAdminA_RuralHealth.html. All submissions and transcripts (where evidence is made publicly available) are included on the Committee webpage.

This Report should be considered in its entirety as the Final Report of the Inquiry.

4. EVIDENCE

TERM OF REFERENCE 1

HEALTH OUTCOMES, INCLUDING COMPARATIVE HEALTH OUTCOMES

Evidence received by the Committee clearly described the reality of poorer health outcomes, higher rates of chronic disease and a higher incidence of factors related to adverse health outcomes (social determinants of health) for individuals and families living in rural and remote Tasmania.

Rurality was identified as an independent risk factor for poor health with rural Tasmanians experiencing poorer health outcomes than non-rural Tasmanians. The negative impact on the health and wellbeing of those living in rural and regional areas of Tasmania (outside greater Hobart and greater Launceston) as a result of where they live creates inequity in health outcomes deemed unacceptable by many of those providing evidence to the Committee.

Dr Denis Lennox, retired Executive Director, Rural and Remote Medical Services, challenged this notion:

> *We have come to accept over decades that rural health services are failing and there has been a perverse resignation to that status. The serious question is why? Why is this so? I have come to see that the critical characteristic of rural services which makes them so prone to failure is their small size, small capacity. Now, this does not necessarily mean that a small service could not flourish, but you have to manage that risk and in any other circumstance if a corporation or a government body or whatever it might be recognises that there is an inherent risk in an operation that you are carrying out, then you put in place appropriate risk management strategies. We have rarely done this for rural health.*
>
> *I have concluded that we are plagued by a syndrome that affects every part of our society from executive government to rural communities themselves and I refer to it as the 'frontier syndrome,' this sense that because a small community is remote and distant from major centres then you simply cannot expect to have a good health service. In fact, that has been presented to me on numerous occasions. They'll name a particular location, 'Denis, this is … don't you realise...' and implied in that statement is 'we can't expect a good service'. I think this is a sad resignation to a reality that we have poorly risk-managed rural health services in Australia for a very long period of time and it has become accepted that that is the way it is.*
>
> *We have made many attempts at government level, particularly federal and state levels, to redress it, but most of those have simply been a band-aid to the problem and from the federal point of view there was a series of band-aids, particularly related to medical workforce, not least of which were the actions to recruit and make it possible for international graduates to practise in rural locations for periods of times. But none of those redressed the core problem, the core problem being small size.*
>
> *Now, if you think about small size of service it has critical flow-on effects for both the community and for management and recruitment of services. The very first thing is that if you have a small sized community - when I say small, I mean small in head count or professionals who are providing that service - then you risk accessibility issues. In other*

words, unless each of those small number of professionals - let's talk about doctors which is my particular area of expertise - unless those doctors have a full range of competence in practice then the community lacks access to service. For example, if a community has two doctors and both of those doctors are male, then a significant number of the elderly female patients in that community will probably not access services or gynaecological problems as they might otherwise do.

...

***Dr LENNOX** - ... Access becomes fraught and then capacity becomes fraught. If that community has an expectation, for example, that there is a 24/7 medical service at the hospital, then you have to consider the full time equivalent of doctors that are required to provide a 24/7 service, and not just a headcount. We traditionally considered that if we have a doctor in the town, that is adequate. In decades past, in an era of the veterans and even some of the baby boomers, being in a rural community and providing service on a 24/7 call has been the way that things are done. Many have done that with great grace and extraordinary capacity. Some have become rather crusty and cynical, and I know that syndrome quite well, having engaged many rural doctors in conversation. But I can say, the next generations will not do that. They will not contemplate working in that way, and neither should they.*

There is a critical issue then about capacity, and finally, there is a critical issue about financial viability, or business viability. You can imagine that if there is anything that fractures parts of the service in terms of the scope of practice, the availability of the workforce to perform all functions, and the integration of the service in a financial sense, all of those simply add to the greater fragility of the service. In fact, those are what contribute to the chronic failure of these services.

The traditional response to that is, firstly, the frontier syndrome that I mentioned. Why would we expect to be any different? This is just the nature of living in small rural communities. The second response has been, well, the service is not up to scratch. There is a risk to women in providing birthing services here, there are not enough women being birthed every year to sustain a service. Traditionally, the response by health service managers and health service executives has been to close service down. That has been the fear of rural communities for decades now - that someone will move in and close down the service.

The reality is, that scenario is not necessary. If we redress the reality that rural services are inherently fragile, that does not necessarily mean they can't close. With appropriate active management, not passive resignation to the circumstance, but active management at each of the elements at its core - we've seen here in Queensland that where a service was on the brink of failure, and the loss of the community was going to be enormous - that could be turned around.

Many colleagues have argued at different times that it is not justified to have the number of doctors that I have often advocated for in rural communities, but the work we have done has been very objective. We worked with data which demonstrates the number of doctors that you would expect in a community based not only upon the population, but upon the demographics; upon the relationship between demographics and demand for medical

services; the relationship between morbidity and mortality and the demand for medical services. In fact, in some instances, when you apply those measures, when you adjust the population with those characteristics, particularly in Indigenous communities, you will actually double the number of doctors warranted on that community beyond what might be in a larger, high socio-economic status centre.

When you track through that pathway and then develop the business model, it becomes evident in many circumstances that rural services can sustain a much larger health service. And once you begin to build capacity, the range of service options available to the community increases, there's greater access to services, there's greater satisfaction by the rural community, and the business model improves. It's crucial to that business model to ensure that the firewall between Commonwealth funded services - that is, general practice services - and state funded services - hospitals - is closed. That represents one of the greatest risks to the fragility of the rural medical service.[2]

The Premier, in his capacity as Minister for Health, in Budget Estimates hearings made the following comments in relation to commonwealth responsibility in health:

We recognise the challenges in primary care. I recognise the efficacy of all state premiers and health ministers, no doubt, to the Commonwealth, and of course to deliver better primary care to our communities we need to think differently about how this is done, and we're committed to exploring ways in which the Tasmanian government can work with the Australian government - GPs, stakeholders and the community - to deliver something truly innovative.

General practice and primary care services in the hard-to-staff areas of Tasmania are run by the State in fact are fully integrated with Tasmania's single public health and hospital system. We will work with the Australian government to explore ways in which a trial can be sustainable, effective and patient- and community-focused.

We expect this primary care reform also to be bold. In Tasmania we want to lead the country in implementing Australia's primary healthcare 10-year plan, and aligning this with our Department of Health Strategic Priorities 2021-2023, which includes reforming the delivery of care in our community.

Tasmania's primary care reform will encourage collaboration, integration of services within the State Health Service and reduction of silos between sectors of health. It will bring multiple clear benefits for patients and our community and giving better access to bulk-billing GPs, better integration between general practitioners, and other medical specialists, streamlined sharing of information and greater benefit from our record investment in digital health.

The model will focus on people, most importantly, ensuring patient outcomes are at the centre of all decisions, and that we care for our healthcare workers and enable them to work at the top of their scope.

This primary care reform, I know, will be ambitious, and we recognise the challenges in primary care, which is a product of what is a fragmented health system, frankly, with the

[2] Dr Denis Lennox, *Transcript of Evidence*, 31 March 2022, pp. 14-16.

responsibilities and funding across the health system split between the Tasmanian and Australian governments.

Our communities don't necessarily see this, and nor should they. They see a system that, despite the best efforts of our dedicated and hardworking GPs, is characterised by falling bulk-billing rates, and increasing difficulty accessing GP appointments. It's no surprise patients feel that the emergency department becomes their only option. That's why we're committed to exploring ways the Tasmanian government can work with the Australian government, and we're willing to lead the charge in that reform area.[3]

The Premier made the following comments in relation to Commonwealth responsibility for urgent care centres:

***Mr ROCKLIFF** - .... The Newstead Medical Group commenced the GP-led after-hour urgent care services on 31 July last year. Between August 2021 and February 2022, there were 1791 attendances at the Newstead Medical urgent care centre. Of these attendances, only 8.1 per cent subsequently presented to the Launceston General Hospital ED, and 4.2 per cent went on to be admitted to hospital. The early results provide an early indication of the success of the Newstead Medical urgent care centre in diverting less urgent patients away from the LGH ED. There are also some federal government commitments in that area as well.*

***CHAIR** - In terms of other expansions?*

***Mr ROCKLIFF** - Or urgent care centres. Looking more broadly at the GP After Hours Support Initiative, there were nine successful applicants in grant round one. Six were pharmacies, and three were GP practices, with a total of $644 719 allocated. Of the six successful applicants in grant round two, four were GP practices, one X-ray facility, and one the Pharmaceutical Society. The total funds allocated for the six applications was $1 408 023. One GP practice was successful in round one and two. ... There's also a hospital avoidance co-investment fund. One application was received for that co-investment fund, and one GP practice was successfully granted $153 750.*

***CHAIR** - Is that all federal money, minister, or all state?*

***Mr ROCKLIFF** - All state. A state initiative. Increasingly, as a state, we're stepping into where, frankly, the Commonwealth should be. And I have said that publicly, even before a change of government.*[4]

The Tasmanian Government submission stated:

*As the Australian Institute of Health and Welfare **(AIHW)** has recognised, Australians living in rural and remote areas have, on average, shorter lives, higher levels of disease and injury and poorer access to and use of health services, compared with people living in metropolitan areas. The health outcomes experienced by people living in rural and remote areas may be impacted by factors including higher mortality rates and lower life expectancy; higher instances of chronic disease; higher rates of smoking and alcohol consumption; higher rates*

[3] Premier Rockliff, *Transcript of Evidence*, 7 June 2022, p. 97.
[4] Premier Rockliff (in his capacity as Minister for Health), *Transcript of Evidence*, 7 June 2022, p. 80.

of road injury and fatality; and increased physical and occupational risk (e.g. mining and agriculture).

In Tasmania, we have a number of unique geographic and demographic characteristics compared to other Australian states and territories. These include an older and more rapidly ageing population, the lowest average annual income level, a higher rate of dependency on social welfare and the highest rates of multimorbidity.

Additionally, Tasmania's population is small and more regionally dispersed than other states and territories, with more than 50 per cent of our population living outside of the capital city. While most Australians (71 per cent) live in major cities, Tasmania has no areas classified as a major city. Around two-thirds of Tasmanians live in inner-regional locations (including Hobart, Launceston and Devonport) and around one-third live in outer-regional locations (most regional towns). A small proportion lives in locations classified as remote or very remote, such as the West Coast and the Bass Strait Islands.

These factors have widespread implications for the health status of Tasmania's population and the people and systems that support Tasmanians' health and wellbeing.

Available data indicates Tasmanians living in rural and remote areas are more likely to experience risk factors contributing to poorer health outcomes. For example, based on data published in the Report on the Tasmanian Population Health Survey 2019, of the 14 Local Government Areas (LGAs) with a proportion of current smokers above the state average, 12 are rural or remote LGAs, while the two lowest rates of current smokers were recorded in the Greater Hobart area. Of the 19 LGAs with proportions of people with a body mass index in the overweight and obese categories above the· state average, 16 are in rural and remote areas. Additionally, of the 15 LGAs with the highest rates of self-reported health status being in the fair to poor category, 13 are in rural and remote areas.

In 2017-18, the age-standardised prevalence of self-reporting of some important chronic conditions in Tasmania was significantly greater than for Australia overall. These included mental health and behavioural conditions; arthritis; hypertension; and heart disease, stroke, and vascular disease. Almost 50 per cent of Tasmanian adults have three or more chronic conditions, which is the highest of any state or territory.

Many rural and remote areas of the state are experiencing changing population patterns which are different to those being experienced by Tasmania as a whole. Recent population growth in Tasmania has largely been led by net migration from interstate and overseas, with a large proportion of this growth being experienced in Greater Hobart and other major population centres in Tasmania. Conversely, many rural LGAs are experiencing low or negative population growth, often driven by internal migration to other areas of Tasmania and low rates of natural increase (the difference between births and deaths). Additionally, many rural and remote areas of the state are more impacted by seasonal population variations, such as tourist numbers and seasonal workers. These changing population patterns in rural and remote areas are factors which influence local health service delivery, viability, and subsequent sustainability.[5]

The submission from Primary Health Tasmania (PHT) noted:

[5] Tasmanian Government, 2021, *Submission #72*, pp. 7-8.

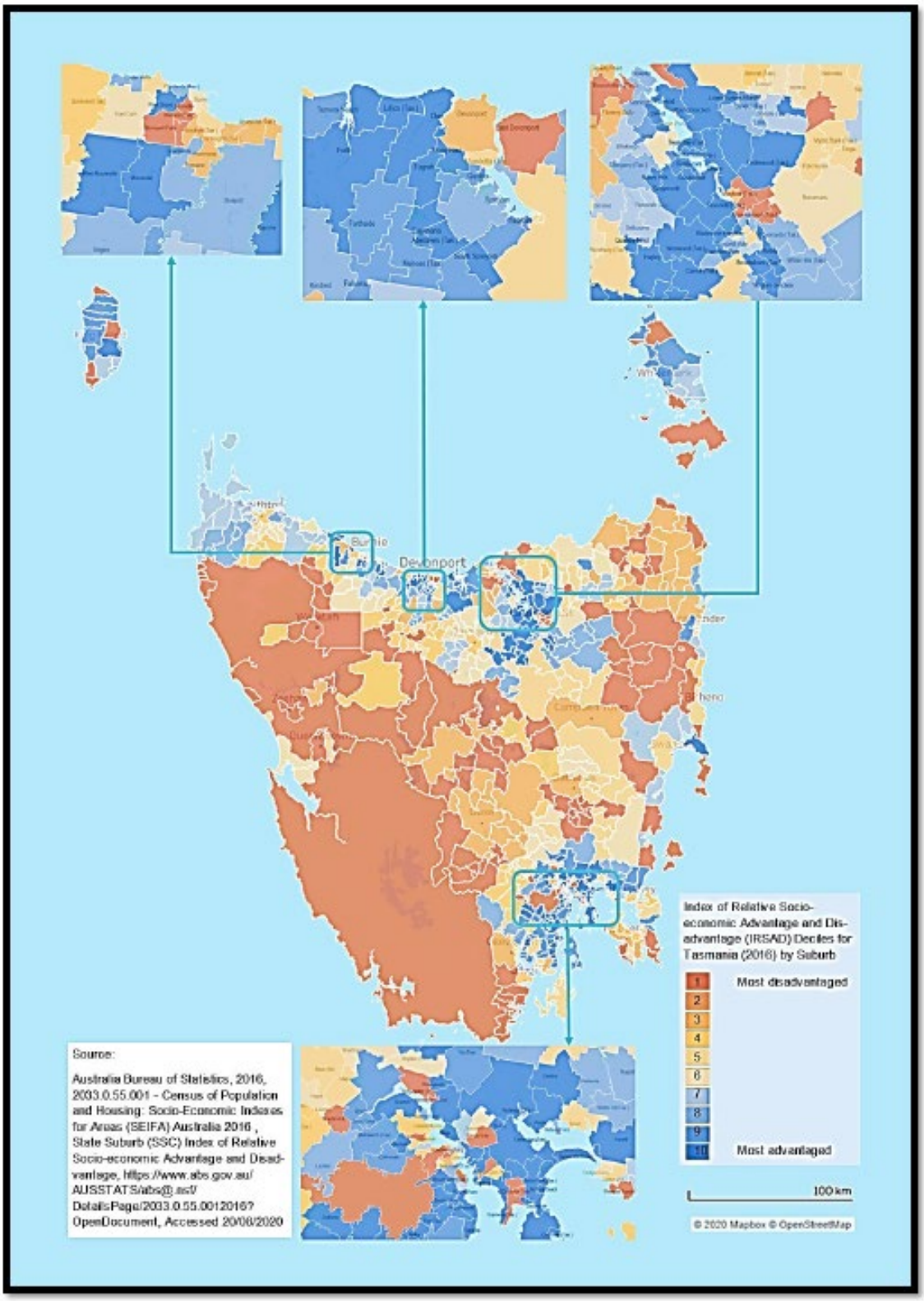
> *People in rural areas are more socioeconomically disadvantaged - our education, occupation, and income affect our health status. Socio-economic disadvantage is strongly associated with poorer health outcomes. Figure 1 depicts the areas of socio-economic disadvantage (coloured red and orange) within our community. Although there are pockets of disadvantage throughout Tasmania's main population centres, these are mostly rural and remote areas.*[6]

According to the Health and Community Services Union (HACSU) submission, Tasmanians are generally less healthy than other jurisdictions in Australia:

> *Tasmania experiences chronic disease at higher rates than other states. Similarly, Tasmania is poor in relation to rates of health risk factors comparatively and this has been well known for longer than anyone can remember. Our state's regional areas have low socio-economic structures comparatively, higher rates of smoking, obesity, poor nutrition and low physical activity levels and this is borne out in our overall health outcomes. Whilst it is acknowledged that planning is in existence and strategic work has been done on these issues, the fact remains that significant investment into primary and preventative health measures is required and would result in measurable ongoing savings to the health budget. … Tasmania has a real opportunity to significantly reduce lifestyle related disease and illness and by doing so our community would be healthier. This has a wide range of benefits including less reliance on health services, higher rates of workforce participation and more productivity both at work and generally in the community.*[7]

[6] Primary Health Tasmania, 2021, *Submission # 64*, p. 5.
[7] Health and Community Services Union, 2021, *Submission #45*, p. 4.

Figure 1. Index of Relative Socio-economic Advantage and Disadvantage (IRSAD) distribution in Tasmania by suburb



The Australian Medical Association (AMA) Tasmania's submission noted:

> *The State of Public Health Tasmania 2018 report found that while there was improvement, people living in rural areas of Tasmania have a lower life expectancy than those in more urban settings. The data for health outcomes by Local Government Area (LGA) in the Mortality Over Regions and Times (MORT) tables proves significant inequality of outcomes in rural Tasmania, for example, unemployment is higher in rural areas (especially youth unemployment) and income lower, leading to lower socioeconomic status, which is linked to higher smoking, obesity, and alcohol misuse.*
>
> *As a consequence of their lower socioeconomic status, rural populations are less likely to have private health, so they are more reliant on the overstretched public hospital system and therefore suffer from significant delays in diagnosis.*
>
> …
>
> *The population in the North West health district is 111,954 (ABS, 2018). This rural and remote district has an older, poorer population with poor health literacy and has high levels of chronic disease and cancer with poor health outcomes, including mortality due to cancers and heart disease. 20% of the North West population are aged over 65 years (ABS, 2015). The primary determinants of health remain poor.*[8]

The Tasmanian Council of Social Service (TasCOSS), in its submission to the Our Healthcare Future reform process, noted that Tasmanians living in rural and remote communities face compounding inequities in access to healthcare services, which in turn have an impact on rural health outcomes:

> *Tasmanians who live in rural areas have worse health than Tasmanians living in urban areas. Rurality is an independent risk factor for poor health and rural Tasmanians experience poorer health outcomes than non-rural Tasmanians.*
>
> *For example, in 2018-19, the rate of potentially preventable hospitalisations for chronic conditions among people living in outer regional Tasmania was 13.3 per 1000, compared to 12.9 for inner regional Tasmania. In 2019, compared to 21.7% of Tasmanians, the proportion of residents in rural LGAs reporting fair/poor health was:*
>
> - *West Coast: 44.4%*
> - *Derwent Valley: 38.2%*
> - *Glamorgan/Spring Bay: 32%*
> - *George Town: 31%*
> - *Sorell: 30.5%.*
>
> *As a consequence, Tasmanians living in rural regions have a higher relative risk of mortality than Tasmanians living in the greater Hobart and Launceston areas.*
>
> *Poor outcomes in preventable health conditions among Tasmanians living rurally can be correlated with a range of socially mediated risk factors that are themselves correlated with*

[8] Australian Medical Association Tasmania, 2021, *Submission #52*, pp. 1-2.

rurality. Tasmania's rural regions generally report higher rates than the greater Hobart and Launceston regions of:

- *Daily smoking*
- *Obesity*
- *Inadequate fruit and vegetable consumption*
- *Insufficient activity and muscle strengthening*
- *Alcohol consumption causing lifetime harm*
- *Use of wood as main heating source (a risk factor for asthma).*

But inequities in health outcomes for rural Tasmanians also stem from inequities in healthcare access. As has been documented and discussed in numerous studies … access can be difficult for all Tasmanians. However, Tasmanians living in rural and remote communities can face particular struggles to access healthcare. Rural areas have fewer services. Tasmania's rural areas have the nation's second-lowest rate of GPs per 100,000 residents (90.8 in 2019, compared to 112.2 for the state's urban areas and 100.6 for Australian rural areas as a whole).

As of 2019, for instance, there was/were:

- *One general practice each in the Circular Head, Derwent Valley, Flinders, George Town, King Island, Southern Midlands and Tasman LGAs;*
- *Two general practices each in the Break O'Day, Central Highlands, Kentish and Latrobe LGAs*
- *Three general practices each in the Meander Valley, Sorell and Waratah-Wynyard LGAs.*

Low levels of GPs are often correlated with higher-than-average rates of fair/poor health among LGA residents. Compared to Tasmania as a whole, where 21.7% of people reported fair/poor health in 2019, the rate of fair/poor health among Tasmanians living in predominantly rural LGAs with low GP levels was:

One general practice:

- *Circular Head: 28.6%*
- *Derwent Valley: 38.2% (second highest in state)*
- *George Town: 31%*
- *King Island: 27.9%*

Two general practices:

- *Break O'Day: 22.6%*
- *Kentish: 26.6%*
- *Latrobe: 28.7%*

Three general practices:

- *Meander Valley: 17.9%*
- *Sorell: 30.5%*
- *Waratah/Wynyard: 21.4%*

Meanwhile, ambulance response time for areas outside Hobart are often significantly longer than those in town (32.8 minutes at the 90th percentile, compared to 25.6 minutes for Hobart, which equates to one of the longest waits in the country).

Mental health, and access to mental health services are a particular concern for Tasmanians living rurally. In 2017-18, Tasmanians living in outer regional and remote areas had higher rates of high/very high psychological distress than those living in inner regional areas (14.6%, compared to 13.5%),13 and in 2019 the suicide rate was 20 per 100,000 people living outside of Hobart, compared to 17.8 for Hobart dwellers. Nevertheless, the proportion of remote/very remote Tasmanians receiving state-funded clinical mental health services in 2018-19 was 1.6%, compared to 2.2% for Tasmanians residing in Hobart and Launceston. For MBS/DVA-subsidised services, the proportion in very remote areas (7.9%) was only 70% that of people in Hobart and Launceston (11.3%), and for young people (aged 25 years or less), the proportion was only 57% (6%, compared to 10.6%). All of these issues are compounded for Tasmanians on low incomes and facing compound inequities…

In this regard, it is worth noting that at the last census the median weekly household income of Tasmania's outer regional areas is 82% of that of the state's inner regional areas; in the case of remote areas, this proportion drops to 76%. It is also worth noting the proportion of households with incomes below $650/week across Tasmania's remoteness regions and in the state's highest and lowest-income LGAs are as follows:

- *Tasmania: 26.3%*
- *Inner regional: 24.6%*
- *Not in any significant urban area: 28.6%*
- *Outer regional: 29.7%*
- *Remote: 34.1%*
- *Hobart: 21%*
- *Break O'Day: 40.7%*

From a workforce development perspective, what is also of concern is that the Tasmanian outer regional/remote health workforce is older than the state average and younger people are not taking up these positions at the same rate as they are statewide.

In 2019, the proportion of Tasmanian medical practitioners aged 60+ was 18.8% in outer regional areas and 37.8% in remote/very remote areas, compared to 16.5% for the state as a whole.

By the same token, the proportion of outer regional medical practitioners aged 30-39 under 30 was 22.5% and of remote/very remote was 12.9%, compared to 25% statewide.

Similarly, the proportion of the Tasmanian nursing and midwife workforce aged 60+ was 17.8% in outer regional areas and 27.3% in remote areas, compared to 14.2% for the state as a whole.

By the same token, the proportion of remote/very remote nurses and midwives aged under 30 was 8.3%, compared to 16.5% statewide.[9]

[9] TasCOSS, 2021, *Submission #33*, pp. 4-7.

The Health Consumers Tasmania (HCT) submission similarly outlined a range of factors which contribute to Tasmania's health profile, which includes changing demographics, the growing burden of chronic disease and comorbidities and changing consumer health care needs:

> *Tasmania has one of the most rural and remotely dispersed populations of any state or territory with just ten percent (10%) living outside major population centres of Hobart, Launceston, Burnie and Devonport. Our rural and remote communities are older, sicker and poorer than the rest of Tasmanians, and in many instances, other rural and remote communities throughout Australia.*
>
> - *Australia's spending on prevention and public health is lower than many other Western countries, at 1.7% of total health expenditure ($2.23 billion in 2011–12) compared to 7% in New Zealand and 5.9% in Canada.*
> - *Rurality is considered an independent risk factor for poor health outcomes. Rural and remote Tasmanians experience poorer health outcomes than those living in our four largest population centres.*
> - *Rural and remote health and community services generally depend more on generalist service providers, including general practitioners (GPs) and registered nurses. There is limited availability of allied health professionals in most rural and remote areas. Some specialist services may be available locally, whereas others are provided for by 'visiting' health professionals.*
> - *The role of GPs is increasingly important as the population ages and the burden of chronic disease increases, resulting in greater needs for care of complex conditions and negotiation of a complex healthcare system.*
> - *In 2016, Tasmania had the highest proportion, (33 per cent) of people, living in the most disadvantaged areas compared to other states and territories. In the 2016 ABS Census, the rural local government areas (LGAs) with highest levels of disadvantage were George Town, West Coast, Central Highlands and Tasman.*
> - *In Tasmania, 17.7% of our population are over the age of 65, compared to the national average of 14.6%. The result is that Tasmania has an older population with greater susceptibility to chronic disease and comorbidity. For example, the Glamorgan-Spring Bay LGA has Australia's oldest population with one of the highest rates of chronic diseases, including mental health.*
> - *Population aging is exacerbated by migratory patterns.*
> - *Population aging and chronic health conditions often go hand in hand creating an increased burden on our rural and remote health care systems.*
> - *Key chronic conditions for rural and remote Tasmanians include mental health issues, arthritis, back pain and other pain management, asthma, diabetes and CVD* [cardiovascular disease]. *Chronic disease contributed to 90% of all deaths in Australia in 2011, and exhausted 36% (or AU$27 billion) of the allocated health expenditure in 2009.*
> - *Tasmanian rural and remote communities have a higher rate of disability than the rest of Tasmania and other states and territories. People with disability have higher medical expenses than the general population.*
> - *Tasmanians reported feeling more stressed and less healthy than in previous years with significantly more Tasmanians reporting financial hardship and food insecurity.*

In 2018, a Royal Flying Doctors Report identified key priority areas:

- *A need to increase GP and medical services based on population size and need in the municipalities of the Central highlands and West Coast in particular.*
- *Significant workforce deficits on the West Coast, North West Coast, Central Highlands and Midlands areas. Centralising more services in Hobart, Launceston and Devonport-Ulverstone will not give rural populations better access to health care on it's own as there are other barriers to access*
- *Transport time and costs to regional centres to visit health care professionals can be difficult and problematic. Transport issues within rural communities can also limit services located within the same community in rural and remote areas.*

Specifically, the RDFS (sic) reported:

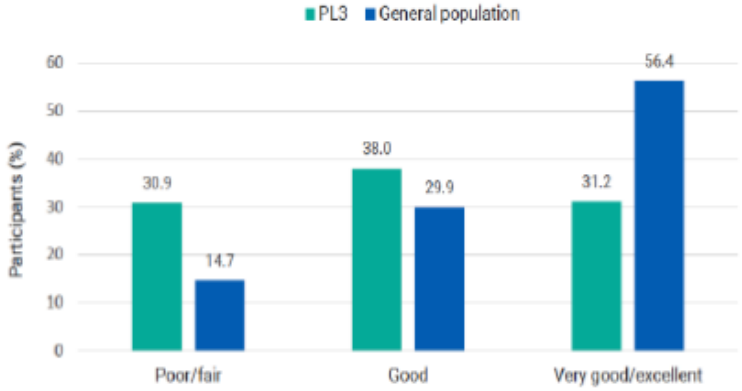
- *GP service provision and access are lowest in the southern and central municipalities. The Central Highlands area for example was named as one of the 6th highest deficit rural locations in Australia for GPs. Shortages also exist in the municipalities of Huon, Derwent Valley, and Southern Midlands, West Coast and Glamorgan-Spring Bay*
- *Significant shortages of nursing staff across the state particularly in the remote areas of Flinders and King Islands*
- *That allied health provision is lowest and significantly low on the West Coast, Southern Midlands, Huon Valley, Derwent Valley, West Coast, Waratah Wynyard, Central Highlands, Glamorgan-Spring Bay and King Island. Lesser shortages exist on Flinders Island, Dorset, Break O'Day and Northern Midlands municipalities*
- *That optometry services are virtually non-existent outside of the three major populations centres*
- *That dentistry deficits are highest in the West Coast, Central Highlands, Southern Midlands and Glamorgan-Spring Bay areas, Tasman Peninsula and Flinders and King Islands. Other rural areas have excessively high rates of locums*
- *That there is a significant shortage of imaging services throughout rural Tasmania particularly in Huon Valley, Derwent Valley, Tasman, Central Highlands, Southern and Northern Midlands, Glamorgan-Spring Bay, Break O'Day, Dorset, Circular Head and Waratah-Wynyard*
- *Pathology services shortages are greatest in West Coast, Waratah Wynyard, Meander, Glamorgan Spring Bay, King Island, Tasman Peninsula and parts of the Huon Valley*
- *That there are less than half the number of pharmacists per 100 000 people in Tasmanian's rural and remote areas compared to Tasmania's four largest population centres.*[10]

According to the Working it Out submission, there are higher rates of adverse health outcomes for members of the LGBTII+ community:

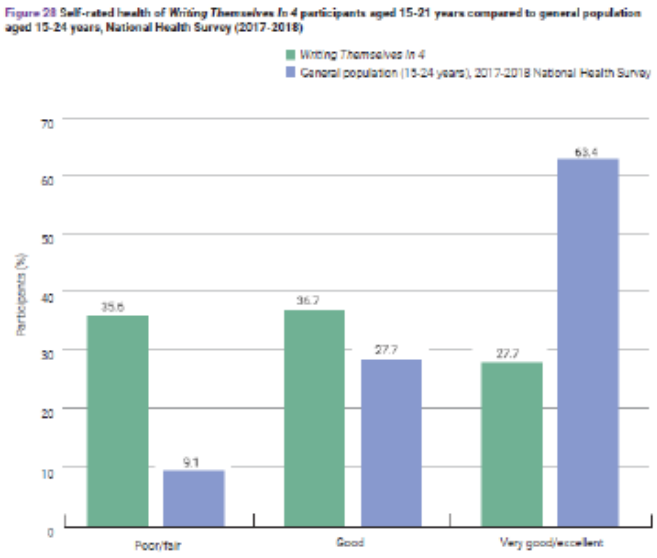
> *Two recent, large national studies - **Private Lives 3** (Hill et al., 2020) for over 18's and **Writing Themselves in 4** (Hill et al., 2021) 15-21 y.o – have found that LGBTIQ+ people experienced much poorer health outcomes than the general population.*

[10] Health Consumers Tasmania, 2021, *Submission #56*, p. 4.

Figure 8: General health (n = 6,792)



Writing Themselves in 4 WTI4 (Hill et al., 2021): : Self-rated assessment of overall health



Outcomes for people living in rural and remote locations, were poorer than the average, with as few as 24% of LGBTIQ+ adults in rural areas reporting very good or excellent health and 36.7% reporting poor or fair health (Hill et al., 2020).

Mental health (levels of psychological distress, self-harm and suicide ideation) outcomes are some of the worst of any population group in the country.

Tasmanian specific data from the above two studies … show that:

PL3 [Private Lives 3]

• 62.2% of LGBTIQ+ Tasmanian adults reported high or very high levels of psychological distress in the past 12 months, compared to 13% nationally.

• 79% had experienced suicide ideation at some time in their lives (13.3% nationally)

• 8% of people had attempted suicide in the past 12 months (0.4% nationally), 36.7% ever in their lives (13.3% nationally).

WTI4 [Writing Themselves in 4]

• 83% of LGBTIQ+ Tasmanian young people reported high or very high levels of psychological distress in the past 12 months, compared to 27% nationally.

• 89% had experienced suicide ideation at some time in their lives.

• 11.6% of people had attempted suicide in the past 12 months (3.8% nationally), 32.7% ever in their lives (5.3% nationally).

These outcomes are related to ongoing experiences of discrimination, abuse or harassment, with those impacted 1.6 times more likely to experience suicide ideation and psychological distress than those who had not experienced these abuses (Hill et al., 2020).[11]

The Royal Flying Doctors Service Tasmania (RFDS) submission noted:

In 2015 RFDS commissioned an update of the 2013 report called "Provision of Primary Health Care Services Strategic Study" …

This 2015 Report focused on the available epidemiological data at the LGA level. The key findings where the health of Tasmania's population is adversely affected by:

• high rates of lifestyle risk factors for chronic disease (smoking, nutrition, alcohol, physical inactivity, obesity, and mental health)

• high rates of chronic disease and multimorbidity (particularly cardiovascular disease, diabetes, cancer, musculoskeletal conditions, and injury).

It is clear that rural Tasmanians experience poorer health outcomes than non-rural Tasmanians. The highest premature mortality is observed on the remote West Coast and Flinders Island. Rural Tasmanians also have poorer access to local general practice services, with the majority of GPs per capita in Tasmania located in Hobart or Launceston.[12]

The Diabetes Tasmania submission stated that diabetes is a condition that exposes the challenges to Tasmania's health system:

Diabetes disproportionally affects rural/remote, socioeconomically disadvantaged and minority populations in Australia. Tasmania has a higher rate of diabetes than the national average, and when combined with an older and more rapidly ageing population, the future is not only one of increasing numbers but increasing complexity as well.

GPs and primary care services in the state, as well as aged and disability care providers, are not sufficiently resourced in their current models to effectively manage adults with diabetes in our communities to maintain health and reduce reliance on acute and emergency services. Specialised, multi-disciplinary teams are required to support GPs and other primary care services in the state.[13]

The Palliative Care Tasmania (PCT) submission noted the particular challenges of Tasmania's ageing population with respect to palliative care services, particularly in rural communities:

[11] Working it Out, 2022, *Submission #78*, pp. 3-4.
[12] Royal Flying Doctor Service Tasmania, 2021, *Submission #53*, pp. 5-6.
[13] Diabetes Tasmania, 2021, *Submission #21*, p. 3.

Regional and rural communities on Tasmania's East Coast have the highest proportion of older Tasmanians. Triabunna - Bicheno (29%), reflecting its popularity as a place to retire. This was followed by Forestier - Tasman (27%) and St Helens - Scamander (25%).

Not all Tasmanians who need palliative care have access to services when they need it and where they need it, particularly at home and in community settings. These gaps are most pronounced in under-served and vulnerable communities, including rural communities.[14]

[14] Palliative Care Tasmania, 2021, *Submission #17*, pp. 4-5.

TERM OF REFERENCE 2

AVAILABILITY AND TIMELINESS OF HEALTH SERVICES INCLUDING:

A) **AMBULANCE SERVICES;**
B) **PRIMARY CARE, ALLIED HEALTH AND GENERAL PRACTICE SERVICES;**
C) **NON-GP SPECIALIST MEDICAL SERVICES;**
D) **HOSPITAL SERVICES;**
E) **MATERNITY, MATERNAL AND CHILD HEALTH SERVICES;**
F) **PAIN MANAGEMENT SERVICES;**
G) **PALLIATIVE CARE SERVICES;**
H) **PHARMACY SERVICES;**
I) **DENTAL SERVICES;**
J) **PATIENT TRANSPORT SERVICES;**
K) **'AFTER HOURS' HEALTH CARE;**
L) **INDIGENOUS AND CULTURALLY AND LINGUISTICALLY DIVERSE (CALD) COMMUNITIES;**
M) **MENTAL HEALTH SERVICES; AND**
N) **OTHER**

Availability and timeliness of, and access to, primary health care in rural Tasmania is not equitable with the major urban centres and the focus on tertiary or acute health care has exacerbated this inequity.

The Primary Health Tasmania (PHT) submission noted:

> *Tasmania faces a complex mix of current and future health system challenges and many of these challenges are exacerbated by rurality. Our small population suffers significantly higher proportional disadvantage compared to other states and territories. Tasmania already has an older population compared with the national profile, and population growth projections to 2050 are in the 65+ age group. This is coupled with a growing burden of chronic disease, which, if not managed effectively in the community setting, escalates quickly to a hospital setting.*
>
> *…*
>
> *Our organisational positions are not necessarily different for Tasmanians living in rural and remote areas – there are some fundamental building blocks that if prioritised and done well will have far reaching implications for all Tasmanians but particularly people in rural and remote areas – and it starts with a government policy and funding shift to address the historic imbalance favouring hospital-centric care, in deference to more sustainable, affordable and accessible, community-based care. This will bring opportunities for different approaches to support people to preventatively and actively manage their health and wellbeing. It will also start to positively address the financial equation - and deliver more effective, accessible and efficient care that is less costly for Government, Tasmanians and their communities.*
>
> *…*
>
> - *Access to primary care services varies across Tasmania - managing chronic conditions in primary care requires proactive healthcare by multiple professionals who work as a team with the patient and focus on their outcomes. Primary care is the main pathway into the health system for most people with chronic disease and it is their first point of contact and often their main form of care. Primary care services include medical, nursing, pharmaceutical, diagnostic, allied health, mental health, and dental, and for many, home and community support services.*
>
> - *Primary care is critical and comprehensive, but organisations are challenged by fragmentation, poor coordination, and variable integration into the overall health system. People in rural and remote areas have less access to health professionals and to multidisciplinary teams than people who live in more urban areas.*[15]

Dr Ross Lamplugh, Co-Founder Ochre Health, noted delays in access to rural health care:

> *Medicare is trying to encourage doctors to spend six minutes with a patient, that is what it does. That is how you make the most money out of Medicare. I am really proud of my colleagues that we haven't fallen into that trap. Some people do, but most people don't.*

[15] Primary Health Tasmania, 2021, *Submission #64*, pp. 3-5.

The reality is that those quick patients who just pop in who just need a script, or need something quickly, you can make some pretty good money out of those patients because you see them quickly and you get paid the same as you would if you spend 20 minutes with them. You don't see as many of those patients in the bush. Patients wait for a long time to see their doctors. They need more care. They present with more problems and you don't see the quick consults.

You are then working in an area where you don't have the same capacity for people to pay privately. If I was seeing patients in Bondi, and maybe I am a bit arrogant, but I think I would have full books and I could charge whatever I liked to every patient I saw. I suspect I could at least double my income that I could earn in Bourke by doing exactly the same work in Bondi and just applying a high private fee to all of the consultations.[16]

A: AMBULANCE SERVICES

Tasmanian Ambulance Service provides services to the whole State through a variety of arrangements including double and single branch stations, volunteer only stations and Community Emergency Response Teams (CERTs). Volunteers are relied upon to support this service in many rural areas of the State.

According to the Tasmanian Government submission:

Tasmania provides emergency ambulance care and transport services and a non-emergency patient transport service across a network of 54 urban, rural and remote ambulance stations and Community Emergency Response Teams (CERTs) which are staffed by volunteers. Information on Ambulance Tasmania stations and staffing models is provided at https://www.ambulance.tas.gov.au/emergencyambulance/ambulancelocations.

In urban fringe and rural areas, Double Branch Stations are supported by paramedics, who are rostered on over 24 hours and are supported by volunteers. Single Branch Stations are staffed by a paramedic who over a four-day period is rostered on day shifts and is available on-call after hours. Volunteer only stations are staffed by volunteers from a base station, and CERTs are volunteer only response, which are deployed from residences rather than a station.

In the north west, both the NWRH and MCH have 24-hour, seven-day emergency departments for people in this region. As at December 2020, there were 69.2 FTE at the NWRH emergency department and 57.4 FTE at the MCH emergency department. Additionally, people may present with emergency conditions at district hospitals and some facilities will experience inpatient emergencies from time to time. District hospitals are equipped to undertake some emergency services as described in the TRDF, which differ depending on the nature of the facility and availability of appropriately trained staff. Where a patient presents on-site at a district hospital, a nurse trained in life-support completes the initial assessment. Locally, the nurse will also liaise with a tele triage service or an on-call RMP who may be requested to attend after-hours to perform further assessment or management of a patient. In a life-threatening emergency, Ambulance Tasmania will be called and in some cases the Aero-Medical Retrieval service will be required. These services can provide advice from a distance, stabilisation on arrival and retrieval of patients to a

[16] Dr Ross Lamplugh, *Transcript of Evidence*, 17 May 2022, p. 5.

place of definitive management. Ambulance Tasmania may also utilise the emergency facilities of larger district hospitals to stabilise seriously ill patients prior to retrieval.[17]

According to the HACSU submission:

Ambulance services are provided only by Ambulance Tasmania, a government agency falling within the Department of Health. There are 54 locations around the state where Ambulance Tasmania resources are available to respond. Of the 54 locations, only 38 have paid staff. Ambulance Tasmania, as of December 2020, employees 409 paramedics who are deployed in essentially three different methods. The vast majority are urban paramedics. Those who are stationed in country stations, called branch stations, work in different ways, either as a single branch station or a double branch station. Country paramedics work alone and rely on a volunteer to support them, which is often not available.

Single branch model

The paramedic works alone, nominally with a duty period from 0800-1925 (11 hours and 25 minutes) each day, with an on-call response for the remaining 24 hours of the day (12 hours and 35 minutes). These paramedics work a continuous 4-day work period followed by 4 days off, so they are on continuous duty for 96 hours straight (of which 46 hours is paid time and the remainder of which is in the on-call period), sleeping sporadically during the on-call periods. Single branch station officers report significant concerns with fatigue and they drive a lot to take patients to urban hospitals. There appears to be no 'review' criteria to determine if the model is sufficient or should be upgraded, and it appears the decision to upgrade would be a funding-based Treasury or political decision, not based on clinical or statistical analysis.

Double branch model

This is very similar to the single branch model, but paramedics work alone. They do not normally work an on-call period and work a 2 day shifts and 2 night shifts every 4 days (48 hours) then have 4 days off. …

Volunteer-only stations

Volunteer-only sites are nominally remote locations and service areas where populations are lower. They are:

- *Community Emergency Response Teams – Port Sorell, Poatina, Ellendale, South Arm*
- *Volunteer-only stations – Whitemark (Flinders Island), St Marys, Currie (King Island), Rosebery, Strahan, Tullah, Bothwell, Coles Bay, Dover, Dunalley, Maydena, Wayatinah.*

There are also 3 temporary single branch stations, established from COVID response funding, based at Alonnah (Bruny Island), Swansea and Miena. These have traditionally had a volunteer-only response, and most likely will return to that model if permanent funding is not provided.

Ambulance Tasmania also provides search and rescue/extraction/retrieval services from the Aeromedical section. Its helicopters (Hobart-based) and a fixed-wing aircraft

[17] Tasmanian Government, 2021, *Submission #72,* p. 36.

(Launceston-based) and flight paramedics can also respond on-road if necessary due inclement weather. The availability to access a paramedic response is at times severely limited.

Branch station paramedics often respond to jobs out of their nominal catchment area, particularly those close to the urban environment. In particular, Northern and Southern branch paramedics do a lot of urban work. We were advised in a consultation meeting with AT that Sorrell, New Norfolk and Huonville are in the urban environment (i.e. Hobart) for 70% of the time that they are deployed. Beaconsfield, Deloraine and George Town ambulances spend a lot of time in the Launceston urban environment. Ramping at the RHH and the LGH contributes significantly to the urban engagement of Branch Station Officers. The Service, in our opinion, is grossly under-resourced and this has a significant impact on responses in the rural and semi-rural communities.

The Report on Government Services (https://www.pc.gov.au/research/ongoing/report-ongovernment-services/2020/health/ambulance-services) has Tasmania's statewide response times to high priority cases at 29.2 minutes at the 90th percentile in FY18/19, up from 22.8 minutes in FY 09/10. Tasmania's response times are clearly the worst in the nation.[18]

The Joint Standing Committee of Public Accounts (PAC) conducted a follow-up review of the Auditor General's Report No. I of 2016-17, Ambulance Emergency Services to assess the actions taken by Ambulance Tasmania in response to the recommendations contained in that report. Recommendations include that:

- AT develop strategies to improve response times to those of other jurisdictions and undertake cost benefit analysis of those strategies before deciding on implementation; and
- AT investigate whether the additional resources in the North and North West regions were effective in reducing average response times.

The PAC found:

AT has implemented strategies to improve response times, including a commitment to 42 additional paramedics, but state the increase in demand has negated the benefits.[19]

According to the Rural Doctors Association of Tasmania (RDAT) submission:

Successive governments have decreased the availability of ambulance services to rural areas. For example, in the North East Region, there is one ambulance based in Scottsdale that is staffed by a salaried paramedic and a volunteer if one is available. If that ambulance is on a call out or being used to transfer a patient to the base hospital (LGH) then it leaves the whole North East of Tasmania without emergency pre-hospital care. In the last 20 years this service has been downgraded from three ambulances to one. In a recent ambulance call out (March 2021) an elderly lady who had fallen in the local supermarket had to wait 60 minutes for an ambulance to arrive. An increase in rural trauma from tourist-based adventure activities has the potential to increase demand for rural emergency services. The

[18] Health and Community Services Union, 2021, *Submission #45*, p. 5-6.
[19] Joint Standing Committee of Public Accounts, Report No 34, *Review of Auditor-General's Report No. I of 2016-17 Ambulance Emergency Services*, 2020, p. 15.

THS need to ensure that these facilities are capable of adequately assessing and managing patients. Pre-hospital care and a plan for retrieval are needed at rural sites to provide support. RDAT will continue to advocate for preventative measures in relation to these activities for example protective equipment, engineering standards, equipment standards and participant training.[20]

Adjunct Associate Professor Ray Bange, in his submission prepared with his colleague Registered Paramedic Matt Wilkinson-Stokes, noted the impact access block in tertiary hospitals has on ambulance availability and timeliness:

Access block and ambulance ramping at hospitals is a widely reported and highly visible indication of patients being delayed treatment and placed at risk. It is an interruption to patient flow at a key interface of care with an increased likelihood of adverse health outcomes.

Ambulance ramping provides a KPI of the prevalence of access block and ED overcrowding. When inpatient hospital services are unable to meet demand, patients remain in the ED, which reduces the capacity of the hospital to accept new patients. Ambulance ramping also means that paramedic teams are not available for other services which effectively decreases the available health resources within the wider community.[21]

Dr Elizabeth Grey, a rural GP working on the East Coast of Tasmania noted the benefits of placing permanent paramedics in rural communities:

…the decision and eventual provision by State Government of permanent paramedic services to Bicheno and Swansea has greatly eased emergency, acute and non-acute spontaneous presentations to respective General Practices. This has enabled GP's to adhere to time constraints and provide comprehensive patient care. It has ensured patients receive timely and appropriate care; especially out of hours.

The extended care paramedic (ECP) is able to provide necessary home-based assessment and care that enhances local health care. In addition, the working relationship between ECP and GP is one of mutual support and collaboration. Access to the ambulance service depends on whether the paramedic is already in attendance to a patient, and communication with the Ambulance Communications officer.[22]

According to Mr Shane Johnson, Franklin resident, the volunteer workforce is deployed outside of their area at times of need:

***Mr JOHNSON** - … Many of us wonder when we come over Vince's Saddle into the valley whether our health outcomes matter a bit less than others. Should the regional unpaid volunteers be used to underpin the Hobart service at the expense of their local communities? What should a reasonable call out time be for a person needing emergency care in Cygnet, in Judbury and Mountain River and Huonville? How long should we expect to wait? The situation is only likely to come under more pressure.*

[20] Rural Doctors Association of Tasmania, 2021, *Submission #30*, p. 2.
[21] Adjunct Assoc Prof Ray Bange OAM, 2021, *Submission #54*, p. 17.
[22] Dr Elizabeth Grey, 2021, *Submission #55,* p. 1.

A Huon Valley Council report shows that there is demand for 700 new homes in Cygnet and the council is very keen to meet that demand. Port Huon already has a residential zoning capacity for an additional 1500 homes. What should happen?

As a first thing I think we need to measure the callout times and we need to measure the outcomes of those callouts. I am sure the data is there. It would be easily retrieved. We can find out what the situation is and then let's set agreed standards that must be met. We don't expect to have an ambulance on every corner. We understand that if Huonville Ambulance is called away, then it is tough luck that you need an ambulance.

***CHAIR** - But if it is called away to sit in Kingston to do town work that's a different thing.*

***Mr JOHNSON** - That's exactly right.*

...

***Mr JOHNSON** - Let's resource the service so that the standards that we set are met. We don't expect them to be the same standards as the metro, and I don't know what they are, how long the ambulance service is required to get to a call out but we need to know what that standard is. As a first step the practice of sending the Huonville ambulance to Kingston on standby needs to stop. It's having a deleterious effect on the fatigue of the officers, both paramedics and volunteers. I am told they can be woken at 1.30 on a Sunday night, 'We need you to go to Kingston'. They may not get a call out from Kingston and then they just drive back to Huonville.*

The person I described who talks about getting smashed, he tells me that - and this is a fit young man, a footy coach at Huonville - it has taken him two days to recover from a shift.[23]

In relation to ambulance response times, the Department of Health dashboard includes data on the median time from when the phone number of the triple zero caller and the address of the incident are confirmed to when the first ambulance arrives at the emergency incident, which as of April 2022 is 14.6 minutes.[24]

According to Ms Sonya Williams, Brighton:

It is amazing. We've just had people get sick because - I know the ambulance is absolutely pushed and a lot of our people, I will tell you now, will use it as their service. Whereas it means other people are suffering. We've had a lady who waited four hours for an ambulance, ended up in ICU because of the wait.[25]

Ms Jennifer Hadaway, Dover:

I have spoken to Ambulance Tasmania for the simple reason that we were involved in a life-threatening situation in August. My husband had to be raced to hospital, and we waited four hours for an ambulance. They were wonderful. They phoned continually to ask whether his vital signs were ok and how we were coping. But, they couldn't get an ambulance to him for four hours.[26]

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[23] Shane Johnson, *Transcript of Evidence*, 8 October 2021, p. 50.
[24] https://healthstats.dhhs.tas.gov.au/healthsystem (accessed August 2022).
[25] Sonya Williams, *Transcript of Evidence*, 8 October 2021, p. 40.
[26] Jennifer Hadaway, *Transcript of Evidence*, 7 October 2021, p. 51.

Minister Rockliff and Joe Acker, Ambulance Tasmania provided the following comments

CHAIR *- I will go to ambulance services, minister, if I may. We heard from some of our rural smallest services where they have a high reliance on volunteers, that because of the nature of the demand in other areas, volunteers are being taken from the community they are volunteering to, and then required to go to a neighbouring municipality. They did not agree to volunteer there because that is not their community as such. Not that they are overly complaining about this, but they are sitting in a lay-by area waiting because the ambulance service from that area has gone to somewhere else.*

So, volunteers from the Huon are sitting at Kingston because the Kingston crews are over at New Norfolk, for example. .... I would like you to tell the committee more about how you determine what the service will look like where. From what we have heard, a lot of these ambulance volunteers are feeling disenfranchised by being required to fill all these gaps they feel should be covered by an increased number of paramedics, for example.

Mr ROCKLIFF *- ... I am* [told] *we currently we have some 420 volunteer ambulance officers assisting Ambulance Tasmania. Recruitment is ongoing and we have commenced work with the Volunteer Ambulance Officer's Association on a memorandum of understanding to work together on an attraction, retention and also importantly training and support for volunteer ambulance officers as well. That is about a $50 000 commitment. I commend all volunteer ambulance officers.*

...

Mr ROCKLIFF *- ... I met a couple of volunteer ambulance officers on the island recently at the opening of the upgraded King Island District Hospital. Support is required for our volunteer ambulance officers, particularly in those smaller communities, because they may well be called out to a very serious episode, a crash or whatever it might be and quite likely know the person. ...*

...

Mr ACKER *- I want to share the minister's respect for our volunteers. We couldn't do without them; they provide an invaluable service to our communities across the state. They also provide an opportunity to be fiscally responsible and financially responsible to the community. We have engaged ORH, which is called Organisational Research in Health, to do a five-year retrospective look at the calls that Ambulance Tasmania has responded to. That helps us identify the demand in each community. As communities have higher volumes of case load then we do know that it starts to significantly impact the volunteers' workloads. That's the stations that we identify for moving to career stations, as we recently have just done in New Norfolk. The New Norfolk station is now made a paramedic-only career station due to the high volume that we are seeing there.*

The data that we are looking for in the next 10 years will also be informed by ORH looking at evidence through the ambulance response data and that will identify where we are moving to future career paramedic station and moving volunteers to other lower volume stations. We make this decision based on evidence.

Going back to the minister's question, and again through the minister, the deployment model that we do use is a demand deployment model to ensure that we are responding

appropriately to high acuity patients. We would be wanting to have quick response times when patients are suffering severe medical and trauma emergencies and we move ambulances from low volume stations to higher volume areas where the next call is likely to be happening. As you suggest, Chair, that is impacting volunteers because they are moving from their communities to provide coverage. We monitor that and we are working closely with our volunteers to ensure we're meeting their expectations, as well as working every day to meet the performance of our system.

***CHAIR** - Minister, on the basis of the work that's been done, how many stations have been upgraded from a single-branch station to double-branch stations, and how many double-branch stations have gone to career stations in the last four or five years? …*

***Mr ACKER** - … We have been making changes currently with the 48 new paramedics and the new upgrades to Dodges Ferry and other places - Strahan, Ouse, New Norfolk, as I mentioned. We have made a number of changes from single branch to double branch over the last five years, but we can provide that.*

***CHAIR** - Of the 48 new paramedics promised, how many have been employed, …*

***Mr ACKER** - We have 42 appointments, so 42 of those 48 paramedics are dedicated to stations, and we are recruiting six more. I understand just today that we've identified two paramedics for Campbell Town, and we have one spot in Strahan and I believe this is filled. There are probably three vacancies that we will be doing another recruitment very quickly to fill.*

…

***Mr ROCKLIFF** - As part of that commitment, we are also doing a workforce scan for what we might need for future purposes.* [27]

The following update was provided in a Question on Notice response from the Premier, dated 7 September 2022:

The New Norfolk ambulance station was upgraded from a Double Branch Station to career station in January 2022. As part of the 2022-23 State Budget, the Tasmanian Government has also funded upgrades to the Sorell and Huonville stations which will see them operate as career only stations as well.

Single branch stations upgraded to double branch stations include Wynyard (20I8-19), Deloraine (2019-20), George Town (2019-20), Beaconsfield (2019-20), Sheffield (2021-22) and Dodges Ferry (2021-22). Other stations have been upgraded from volunteer-only to single branch stations, as well as the establishment of a new single branch station.

The Government has also committed to undertaking a review of ambulance service demand across the Tasmania. The outcomes of this review will help to inform future investments into the ambulance service to ensure these align with projected future demand and provide better care to Tasmanians. It is currently anticipated this work will be completed by the end of 2022.[28]

[27] Minister Rockliff and Joe Acker, *Transcript of Evidence*, 30 November 2021, pp. 31-3.
[28] Question on Notice response from the Premier, dated 7 September 2022, p. 5.

B: PRIMARY CARE, ALLIED HEALTH AND GENERAL PRACTICE SERVICES

The Tasmanian Government submission:

> *The Tasmanian Government continues to work with the Australian Government to improve community access to essential medical services for people living in rural and remote areas of Tasmania. This includes working with stakeholders to support progression of work under key Australian Government initiatives related to rural primary health, for example:*
>
> *Coordination Units for the development of the National Rural Generalist Pathway - in Tasmania, the Coordination Unit will continue the work of the Tasmanian Rural Generalist Pathway training junior doctors to become rural generalists. Rural Generalists are GPs working in rural areas with skills in emergency medicine, and an additional skillset of community need.*
>
> *Rural Junior Doctor Training Innovation Fund - the Australian Government has contracted Ochre Health to work collaboratively with DoH and other key stakeholders to deliver rural primary care rotations for interns and residents in locations such as King Island, Queenstown, Scottsdale and St Helens.*
>
> *As part of its COVID-19 response, the Tasmanian Government committed $5 million to assist primary care services across the state to adapt and continue to deliver care safely throughout the pandemic. This funding has been distributed to GPs and community pharmacies across the state, with approximately $1 million provided to PHT to support a program targeted at building GP readiness and participation in Tasmania's COVID-19 response. The PHT program has a focus on building capacity in Tasmania's rural and regional areas, by helping general practices with their ongoing outbreak preparedness and management.*
>
> *DoH continues to work to improve communication and collaboration with GPs. As demonstrated in some of the examples above (including ComRRS and SPCS) DoH has progressed… a range of projects and programs to provide alternatives to inpatient and hospital care.*
>
> *To further support primary care, as part of the First 100 Days implementation plan following the 2021 State Election. The Tasmanian Government has commenced good faith negotiations with the RFDS to develop a long-term strategic partnership to support health services in Tasmania. This partnership will ensure the important services the RFDS provides to rural and regional communities across the state can continue into the future, including aeromedical flight services, as well as primary health care in rural and regional areas, with a particular focus on dental and mental health.*
>
> *The Tasmanian Government also provides support through the Tasmanian Rural Generalist Pathway, which facilitates training for aspiring rural GPs to meet the current and future health care needs of rural and remote communities. The THS provides guaranteed internships for all University of Tasmania domestic graduates and offers rural primary care intern and resident medical officer placements (in locations such as King Island, Queenstown, Scottsdale, and St Helens) through the Rural Junior Doctor Training Innovation Fund. As noted above, the establishment of the new Rural Medical Workforce Centre at the MCH will drive the Rural Generalist Training Pathway within Tasmania, supporting training*

of Rural Medical Generalist Specialist doctors by managing advanced skills rotations and engagement with relevant medical colleges.[29]

In relation to allied health:

The Tasmanian Government, through the THS, delivers a range of allied health services at rural primary health sites across Tasmania. This includes services such as occupational therapy, physiotherapy, podiatry, speech pathology and social work services. Other allied health services such as audiology, dietetics, prosthetics and orthotics and psychology are generally provided as inpatient, outpatient, subacute and/or rehabilitation services at tertiary hospitals.

Provision of allied health services at THS rural primary health sites is commonly done through an outreach service model, with services operating out of a 'regional hub' based at one or more sites in greater Hobart, greater Launceston or Devonport. For example, community-based occupational therapy services provide outreach services into clients' homes, workplaces and into rural inpatient facilities. Other allied health professionals may be based at a rural primary health site and provide services at that site and/or within a geographical area. As with other health professionals, recruiting to site-based positions in regional areas is challenging which can impact service availability.

The Australian Government also funds and commissions a range of allied health services in primary health settings. For example, this includes services under Medicare Chronic Disease Management Plans, through PHNs such as PHT and through the TAZREACH program administered by DoH. Changes to services commissioned by the Australia Government can also change which allied health services are available in rural and regional Tasmania.

Allied health services generally require a health professional (GP, medical specialist, nurse or other allied health professional) referral for a client to access the service (with the exception of social work services which accepts self-referrals). Once received, referrals are triaged to determine acuity. Priority is given to highest acuity referrals to ensure patients with the greatest clinical need are prioritised for access to the relevant allied health service. If a high acuity referral is received by an allied health service and access to an appointment~ cannot be provided at the closest rural primary health site (for example, due to the interval between scheduled visits or availability of appointments), an appointment at an alternative site would generally be offered. For eligible clients, community transport could be arranged to support access to services at an alternative site. This approach supports patients to access allied health services when they need them and seeks to prevent deterioration in health status. [30]

The AMA Tasmania submission noted:

Rural populations also have limited access to allied health services in either the public or, in the even more limited, private sector. Added to this is the financial inequality of accessing care.[31]

[29] Tasmanian Government, 2021, *Submission #72*, pp. 26-27.
[30] Tasmanian Government, 2021, *Submission #72*, pp. 19-20.
[31] Australian Medical Association Tasmania, 2021, *Submission #52*, p. 1.

As already noted, HCT in their submission identified limited availability of allied health professionals and specialist services in rural and remote areas and a greater reliance on generalist service providers including visiting health professionals.[32]

The HCT submission stated:

- *there is a need for afterhours health care with consumers noting it was effectively non-existent in some rural areas and with urgent rural medical care generally being undertaken through ambulance callouts and emergency departments*
- *availability of and access to GP services does not take into account peak tourist and harvesting season needs. Wait times to access medical help can treble in key areas of the East Coast, West Coast, George Town, Dorset and Tasman District over summer*
- *excessively high levels and reliance on locum GPs and other medical staff may lead to delayed diagnosis impacting poor health outcomes in rural areas*
- *locum turnover does not meet best practice in person centred care because need is not matched with social or cultural needs*
- *consumers in rural and remote communities do not have regular access to home visits. There may be genuine need in specific cases for GP home visits*
- *less urgent medical matters required a substantial road trip to a major town centre and was reliant on being able to access private transport since no public transport was available.*[33]

The HACSU submission expressed concern at the level of investment in and appetite for the provision of proper and measurable primary and preventative health services in rural and regional Tasmania:

> *Broadly, the underinvestment stretches further than regional areas and that in turn affects the availability of centralised services for people who live in rural and regional areas. There remains a shortage of primary care and GP services, which then places great strain on hospitals and other larger GP clinics in the metropolitan area. It is not uncommon for people who live in regional areas to have to wait a fortnight to get an appointment with a GP.*
>
> *As previously referenced, this delay in (and in some cases, deferral of) seeking medical intervention or other primary care or advice leads to people becoming chronically unwell and, in some cases, suffering lengthy and costly complications that could have been avoided. HACSU submits that investment in general practice and primary care services would over time lead to better health outcomes for Tasmanians and lessen the burden on the health budget and the hospital system. Allied health professionals play a vital and key role in any proper primary health service.* [34]

The RDAT submission stated:

> *RDAT will continue to advocate for increasing funding in primary health care to prevent development of chronic disease and preventing acute exacerbations of chronic disease. General Practitioners are well placed to continue to deliver this healthcare with support*

[32] Health Consumers Tasmania, 2021, *Submission #56*, p. 3.
[33] Health Consumers Tasmania, 2021, *Submission #56*, p. 6.
[34] Health and Community Services Union, 2021, *Submission #45*, p. 7.

from the State Government. There is a lack of 'bulk billing' general practices in Tasmania, primarily because the MBS rebates available to patients are woefully inadequate for GPs to assign as the full benefit of a consultation. Many other specialities are also in similar positions, including podiatry, physiotherapy and psychology. Even when patients have access to appropriate care plans that enables MBS rebates for these services, many providers are choosing not to bulk bill due to the cost of running a healthcare business.

In order to provide the right care in the right place you need the right doctor with the right skills. In rural areas Rural Generalists are able to provide this with their extended scope of practice suited to the community in which they work. RDAT believes the State Government needs to invest in the Tasmanian Rural Generalist Training Pathway in order to train the future Rural Generalists needed to staff Tasmanian District Hospitals and provide the excellent standard of care rural communities deserve both in primary care and in the hospital setting. RDAT also understand the need for team care in rural areas. This is best completed through multipurpose facilities that can house GPs, physiotherapists, speech therapists, podiatrist and visiting medical specialists. This of course requires infrastructure spend by the State Government in rural areas. Preventative Care is the key. Primary Care needs a team-based approach to keep Tasmanians in their homes. This means adequate allied health professionals and care packages. Currently programs needing a multidisciplinary approach such as weight reduction and pain management are incredibly difficult to access, particularly for poorer socioeconomic rural areas where the services are so badly needed. Preventing future problems such as diabetes, heart disease and kidney disease is key to keeping people out of hospital, and requires investment in training allied health professionals, dieticians, exercise physiologists and psychologists to manage these complex issues in conjunction with the patient's General Practitioner. Adequate training and remuneration of Rural Generalists will provide a workforce to the areas of highest need in Tasmania to provide comprehensive Primary Care and undertake preventative healthcare.[35]

Dr Denis Lennox made the following comments in relation to the funding of rural generalists:

In that 2002 year, with other colleagues, I devised a form of medical practice which was a direct response to the needs of the community. That is, someone who was fully competent in primary care practice, including the broad elements of public healthcare as well because doctors in the rural community are often involved in public health issues, not only individual practice issues. They needed to have full competence in secondary level service, in other words, in hospitals. They needed to be able to cope with emergencies, in-patient care of patients in a hospital level.

They needed to have a capability at a specialist level and at least one discipline that we nominated at that stage, related particularly to a need in rural Queensland. So, obstetrics was high on our list, anaesthetics was high on our list. Since about the time that I retired, probably 2016-17, we were largely filling the quota of doctors with obstetrics and anaesthetic skills in rural Queensland. We had rebuilt birthing services in Queensland and at that stage we needed to temper the number who were wanting to do anaesthetics or obstetrics.

[35] Rural Doctors Association of Tasmania, 2021, *Submission #30*, p. 3.

That gave us an opportunity to push further in the other disciplines, which we had anticipated would surely be required in the future. That includes mental health, adult medicine, emergency medicine et cetera.

There is a full range of specialist level, practice capability that this doctor needs. It is the same capability that general practitioners had in the mid-20th century but have now lost. It is a process of restoring that. We gave to this doctor a new title the 'rural generalist' recognising the difference from the general concept of the general practitioner and the outcome of the training programs for general practitioners to say we needed to devise an entirely different category of doctor or discipline of medical practice and that was accepted in 2005 by the Government of Queensland.

The next thing we needed to do was to ensure that this recognised practice was valued for its true worth. So, in a landmark industrial case in 2005 we attained specialist equivalent salary status for rural generalists in Queensland. That made a huge impact. When I went first to recruit into the training pathway that I'll talk about in a moment, when I was able to tell medical students that there was a prescribed discipline, well-established, well-recognised and that it was going to be remunerated in our state at specialist status, the reaction wasn't so much about money, the reaction was about recognition and value. They said to me, over and over again, 'wow, this is a worthwhile pathway for us to travel in Queensland' and that has certainly proven to be the case.

So, they were two central planks; recognition of practice and value of practice. I'll just touch on this very briefly. The recognition of practice process became a very sophisticated complex task. Beyond the simple means of just recording and having formal recognition of that discipline in Queensland, we then needed to consider the status of all the doctors in rural Queensland who were practising in the field and whether they measured up to those new criteria or not. Obviously, it's not going to be acceptable to have a number of them simply not recognised because they haven't tracked the formal training pathway or haven't obtained the qualifications, and not reward them for the work they were doing that they had done their own way to that pathway.

So, we established a fairly sophisticated process of assessment of all rural doctors who were practising currently and then, with the College of Rural and Remote Medicine, developing pathways for them to attain the status within a period of five years and the government established a contract with those doctors that would remunerate them at the new specialist level providing they progressed their qualifications within the period of five years.

***CHAIR** - At the front end you're talking about?*

***DR LENNOX -** At the front end. So, if they were in service they were paid the new salary level up front, accepting a contract they would complete the necessary formal training pathway within a period of five years. We didn't grandfather anyone. We provided a formal tracked pathway and assisted and guided them.*

***CHAIR** - But you did pay them. So essentially, it's a form of grandfathering them with a commitment to that assessment.*

***DR LENNOX -** Yes.*

***CHAIR** - Oh, that's good. …*

DR LENNOX - *They were remunerated but they were required to obtain the qualifications. That was a huge task, but it was completed and only with a few difficulties in the end, but it was completed. This occurred over other disciplines as well, I won't go into detail on those at the time in Queensland. We were addressing addiction medicine and some other unrecognised disciplines in Queensland. I think there was a total of about 120-odd doctors who were in this circumstance, so it was a relatively large task.*

So, then we established a pathway of training and what became evident in this process was up until that point, a few Australian graduates who were tracking to rural practice found their own way there. They developed their own pathways, if you like, to obtain that outcome. We recognised that we needed to establish a pathway that made a very clear, supported, tracked, highway in effect, to practise as rural generalists in Queensland. Career navigation was crucial and we began that process at medical school, becoming enrolled with medical skills to develop the interest of medical students.

James Cook University probably rose to the occasion on this more than any of the universities in Queensland, but Griffith University picked it up subsequently as well, and it makes enormous sense that we are active in recruiting a potential rural generalist workforce at medical school level. So, the interest and passion are developed at that level and medical schools provide the opportunity for the students to begin experiencing exposure and training in those rural generalist contexts.

The career navigation process continued on. Rather than just allowing the medical students and graduates just to stumble along on their own way, we provided each of them who committed to this pathway with colleagues who would oversee and guide them up, it was a one-to-one engagement. We had a number of support medical staff, career advisers and mentors that each of the trainees from medical school was attached to, who followed them right through with the development of their career. Because, of course, these are the years in which they are navigating significant other challenges which might impede or help them towards the end goal of winding up in rural practice. Partnering, children, children with health issues which turned out to be a very common problem - we discovered that when we actively managed that situation, some people who were passionate about finding themselves in rural practice, who seemed to be encountering absolute opposite things to that pathway, we managed to get there anyway.

One classic example. I remember a young lady with enormous passion to do this whose husband was a policeman, found she was headed off at the pass because her husband contracted cancer. This required him for a period to be in a larger centre for accessing radiological and other cancer treatments. So, we modified the pathway for this lady, and we stayed with her on the course of her husband's treatment and recovery from cancer. The pathway was purposely designed for her around her family circumstances. In that period of time, I think three children arrived as well. So, there were delays to her progress. Eventually, she completed, he recovered, and she went on to a flourishing career in Kingaroy. In fact, she became a leader in rural generalist services in that context. Building general practice, et cetera. So, career navigation is crucial.

The second part of it is that we have promised to the graduates that they will get further, faster. We copped some criticism for this, that we had developed an elite pathway. Within the medical profession, within student ranks, there was concern that why should rural

generalists get favour over the others? We said, 'well, you might see it that way, but my perspective is that we are giving rural communities particular consideration, because they have long suffered due to the lack of doctors. They have long suffered by the medical pathway not delivering the workforce.' So, in my view, it is entirely justifiable to provide an elite pathway for rural generalists.

So, we established positions in hospitals that were dedicated in the early postgraduate years to rural generalists, in which hospitals are committed to give a range of terms to them in advance of others in the junior workforce. They were given privileged access to training opportunities in the pathway, and crucially, at the other end, I developed a pathway on the basis that if we received five years of valuable service at the peak of their career from each of our rural generalist graduates, I would be satisfied. In other words, we didn't expect that they would necessarily remain for the whole of their career in a rural location and that's become a crucial part of the whole concept.

If a young medical student thinks that we're drawing them down a pathway which has become a dead end and if they get themselves here they've got no options and they can go nowhere else, then that becomes a huge impediment to actually going there in the first instance. So we have a significant number of rural generalists now who have provided valuable service as rural generalists for five, six, seven or so years and at that point have chosen to move into specialist training in the discipline of their specialist training interest and are now practising as respiratory physicians, addiction physicians, emergency physicians, anaesthetists and obstetricians.

In other words, we have tracked them down a pathway where they've provided valuable service to us and then when their family circumstances mean they can no longer remain in a rural location, they have options. Their success in tracking into specialist training has been remarkable. That's been an important part of the offering so the development of that pathway has been absolutely crucial.

That's been formalised to some degree. I don't think the national rural generalist pathway is quite as sophisticated yet probably as the Queensland pathway but nevertheless, there is recognition of that at a national level, a national rural generalist pathway in place.

The National Rural Health Commissioner has responsibility for oversight of that and I think they are working with the College of Rural and Remote Medicine and the College of General Practitioners at the moment to progress the special-funded pathway to rural generalist practice through the Commonwealth.[36]

The Royal Australian College of Surgeons (RACS) submission highlights the difficulties in the retention of medical graduates:

Retaining local medical graduates to work in Tasmania after obtaining their primary medical education has been difficult. There are a significant number of local medical graduates in Tasmania relocating to [the] *mainland where future employment opportunity and remuneration are perceived to be greater. This has ongoing impact on Tasmanian hospitals, as recruiting surgeons and Trainees from other states is difficult. Based on anecdotal feedback from medical graduates to RACS there is a desire for local medical*

[36] Dr Denis Lennox, *Transcript of Evidence*, 31 March 2022, pp. 19-22.

graduates to stay and seek employment in Tasmania, but without appropriate funding the prospect of career progression for SET Trainees and FRACS is not as abundant as in other states. Additional training posts in Tasmania will allow Trainees who wish to train locally to do so and will lower the risk of specialist medical professionals relocating to mainland Australia.

Providing a sustainable training platform is necessary to encourage trainees to consider practice in a rural setting. Establishing prevocational junior medical officer and unaccredited registrar positions is necessary to provide a viable pipeline for aspiring SET Trainees to stay and train in regional, rural and remote areas. Early surgical experience in a rural setting is crucial in the retention of prospective trainees. Once they acquire the necessary skills for SET training, they often have family and other social connections tied to a particular geographical area which make relocating unlikely in any setting. Without opportunity for further employment in Tasmania after internship and residency, the likelihood of exiting to metropolitan hospitals in mainland Australia is high.[37]

The THS North submission commented on the availability and timeliness of allied health services (AHS) to people living rural and remote:

- *Very limited local availability of Social Work, Physiotherapy, Podiatry and Occupational Therapy; limited or no access to other allied health services in public e.g. Dietetics, speech pathology, psychology, audiology, orthotics, prosthetics.*
- *High number of rural inpatient sites and small bed numbers make it difficult to provide sustainable service; services are stretched in Launceston making outreach difficult; patients are triaged according to priority of needs, making a significant time loss in travel for AHS to visit rural sites for few patients.*
- *Very low base of established positions in rural areas or to service rural areas.*
- *Low base of established FTE in Launceston, unable to meet all local high priority needs.*
- *Rural and regional AHS sits under separate service division.*
- *Limited access to AHS services for children via St Giles.*[38]

The Arthritis and Osteoporosis Tasmania submission noted:

The provision of services for those with arthritis and related musculoskeletal conditions benefits greatly from a multi-disciplinary team approach (physiotherapy, occupational therapy, podiatry, psychology, and specialist rheumatology nurses). However, there are shortfalls in confidence and skills among allied health professionals in the management of arthritis – in particular, inflammatory arthritis. Early diagnosis and improved management of people with arthritis is needed at GP level, with evidence suggesting targeted information and education campaigns are required. Adults and children with symptoms indicative of inflammatory arthritis require urgent attention and referral to rheumatologists for advice, yet there is either no availability, or limited access for this to occur. People with arthritis who are struggling to remain in the workforce due to their condition, have few options in terms of advice and programs to assist them to remain in the workforce. There is limited

[37] Royal Australasian College of Surgeons, 2021, *Submission #66*, p. 2.
[38] THS North, 2021, *Submission #44*, p. 1.

access to specialised rheumatology physiotherapy services in the State, with the existing part-time position at RHH predominantly tied to the outpatient clinics. It is fair to say there has however been a noticeable and gradual decline in specialised rheumatology allied health services across Tasmania over the past two decades.[39]

According to the Women's Health Tasmania submission:

> *Access to bulk billing GPs is also extremely difficult across Tasmania, and it is a significant barrier to accessing services. In most of our consultations the inability to afford primary health care is named as the number one barrier to maintaining good health.*
>
> *For those attending GP appointments, many women reported not being able to get an appointment with a GP in less than 2-3 weeks – a significant issue in areas with no 24-hour medical services, and which are a long way from ambulance base services.*
>
> *Some rural areas rely heavily on locum GPs. In our consultations women talked at length about the importance of having the same person providing general practitioner services over time; building trust and an understanding of their health. Women felt there is a great need for local and consistent GP services in rural communities.*
>
> *In our consultations some women told us they had access to periodic mobile service delivery or diagnostic services, oral health services or outreach allied health services and spoke very highly of these. For example, The Bone Bus, mobile breast cancer services and the Vitamin D bus were all commended. However, some of these services only go to regional centres and women in more remote parts of the start must drive long distances to reach them.*
>
> *Women also raised the lack of access to allied health services, which play a key role in chronic disease management. Many allied health services in rural Tasmania are provided from clinics in regional centres to reduce travel time for the clinicians. However, transport is required for people to be able to access these clinics; this can be a significant barrier to access.*
>
> *Women also raised the lack of access to GPs who had a special interest* [in] *women's health or in other particular areas such as LGBTIQ+ health or specific serious illnesses, and a lack of access to sexual and reproductive health care, specifically termination services. Currently only 5 GP practices outside urban centres offer access to medical terminations to patients. These are in Devonport, Longford, New Norfolk, Richmond and Huonville. Combined with limited regional access to surgical termination services… this makes access to these services constrained and costly.*[40]

Professor Andrew Wilson made the following comments in relation to the Queensland model (number of GPs per population):

> *Queensland has this model which allows people in those sorts of settings to have a mix of payments. They get a salary from Government, but they also got a proportion of the earnings that they had through MBS billing, through private practice billing as part of that, and it also made it very attractive.*

[39] Arthritis and Osteoporosis Tas, 2021, *Submission #43*, p. 3.
[40] Women's Health Tasmania, 2021, *Submission #22*, p. 5.

There needs to be some creativity in the way we start to think about funding this. It has certainly moved a long way, from when I had similar sorts of responsibilities here in New South Wales in the late 1990s and early 2000s. There was a situation in far western New South Wales where there was a small number of doctors - I can't remember the exact number, but we are talking fewer than 20 doctors - who worked in that area. When you looked at the MBS billings and what they were getting, and special payment arrangements and what they were getting from the state government, a large amount of money was being paid into those areas. There is no doubt in my mind, that if we had been able to find a way to bring the Commonwealth and the states together to fund those positions - if we found some way to get that shared funding arrangement - that we could create very attractive remuneration for people to work in those rural areas. Not necessarily aiming for people to be there forever, but building packages which incentivise them to stay for periods like five or ten years. There could be a remuneration which may have a bonus, for example, at the end of that time. Not a $20 000 bonus but a $100 000 or $200 000 bonus - the sort of thing that will attract the sorts of graduates we see today, who may well be carrying substantial debt when they graduate from medical school.

***CHAIR** - Just on that model, that has been used in various forms to say well, a certain population should have a certain number of GPs. It is one GP to 1000 people, as a ballpark. We heard from Dr Lennox that does not work in a rural environment; it actually can have a perverse outcome. Would you like to talk more about that?*

***Prof WILSON** - I won't say those sorts of ratios are plucked from the air; but we compare health systems and we look at the number of doctors that people have in one place compared to another and it is a sort of community average of what might be expected. It doesn't necessarily bear any relationship to access to health care for people. If you don't have any bulk billing service within a rural community, then it doesn't really matter how many doctors you have there, there is a group of people who are going to be disadvantaged and unable to access that service because they can't pay the co-payments. You have to think about it in terms of access.*

The other thing is that we need to be flexible and we need to think more broadly about how we utilise the available health staff. At the moment, our system is built around doctor billing. If your system, if your town, is staffed by a private practitioner then basically most of his or her income has to come from billing arrangements. If you have other competent primary health care practitioners in that town, how do they get paid? Who is going to pay them? We need more flexible arrangements for remuneration which allow for other people to provide those services in conjunction with whatever medical staff are there.

***Mr DUIGAN** - Thank you, Andrew. My question is on that particular issue. State Governments tend to spend their health budgets in the big city hospitals but when a general practice falls over in a small rural or regional town, everybody looks to the state Government, what are you going to do about that? Are you going to stand that service up? Is there a direct correlation between the state spending some money in that space, whether it be in conjunction with its multipurpose centre in the town or whatever it is? Is there a direct, evidenced benefit to a pay off at the other end?*

***Prof WILSON** - Under our system, in essence, the states become the default provider when other systems fail. Inevitably, state governments end up having to staff different services*

and that's an ongoing problem here in New South Wales, in Queensland, whatever, where the state government has to step in.

If I am interpreting your question correctly though, I think what you're asking is - if you proactively invest before the system's failed, what's the return on that investment? I am not sure that there is a lot of evidence to go with this, but I think it would certainly fit in with the other comments that I make that if you don't build those other things around your medical services that are there, you're almost setting them up to fail. You have to have those other elements around it in this day and age to provide a proper service so, yes, I think there is a return on investment from some up-front expenditure. Whether that comes from state or commonwealth coffers, my view is that for most rural communities it should be a shared responsibility to make this happen.

Denis [Lennox] *probably spoke a bit about the Longreach arrangements where they have a third party which has become an administrator of those pool funding arrangements. That is a model which has been advocated also by a number of the rural health organisations in Australia, of having this regional or local consortia that become holders for funds from the different sources and provide and make that proactive investment which is broader than just the medical service.*

***Mr DUIGAN** - How difficult or otherwise is that to achieve in a policy or regulatory setting where we are at the moment? How much has to change in order for that happen easily?*

***Prof WILSON** - I don't think it's a regulatory issue. It's a policy issue that governments can address. Governments can agree that's the way they're going to do things. There already are exemptions, for example, that allow different billing arrangements for small communities within the Commonwealth legislation so there are ways that can be achieved if there's a will to do it. We have seen that in some of the smaller communities.*

There are challenges in this, particularly if there is a hospital involved. If there is a hospital involved and it is staffed by a state health authority, then there's a whole separate set of awards. There are industrial issues that become part of what's there so that becomes a trickier situation to negotiate as to where that boundary sits but remember, for many rural communities, it's their primary health care services and their emergency services which are the key thing that they're looking for security around.[41]

Mr Rodney Croome, Equality Tasmania informed the Committee:

Participants emphasised the need for more support services, especially inclusive health care providers in rural and regional areas of Tasmania.

I'll quote one personal story that was printed within the report:

> *My life in rural Tasmania is one of fear and sadness. I have had to give up on medically-transitioning because surgery is so inaccessible and with hormones alone.*
>
> *I would not pass. I would merely be making myself a target for even more violence by being visibly queer.*[42]

[41] Professor Andrew Wilson, *Transcript of Evidence*, 31 March 2022, p. 33.
[42] Rodney Croome, *Transcript of Evidence*, 18 May 2022, pp. 2-3.

Mr Rodney Croome, Equality Tasmania highlighted the lack of knowledge where inclusive medical services are available:

> *In the submission that Equality Tasmania made, there was reference to three national pieces of research that look at the health needs of LGBTIQ+ people in rural areas. One of them was Private Lives 3, which was conducted by La Trobe University in Melbourne. That was a survey of LGBTIQ+ people across the nation in general; Writing Themselves in 4, which is a research piece looking at the needs of young LGBTIQ+ people; and there was a trans mental health survey that was also national. The message from all three pieces of research was very clear. I should have mentioned, obviously in each case there was a Tasmanian cohort for each of those surveys, and I think Ruby's going to mention a bit about the Tasmanian cohort in the Private Lives 3 survey.*
>
> *The overall picture from those surveys when it comes to rural health is that LGBTIQ+ people who live in rural Australia tend to have greater mental distress because of an experience of greater discrimination, stigma, and prejudice and, at the same time, less access to inclusive health care, including inclusive mental health care. I won't go into each of the different metrics that the studies look at in terms of access to health care, and in terms of mental stress and feelings of lack of safety and not belonging, they're all there, they're fairly clear.*
>
> *Since these surveys have been released - those three were all last year - the Tasmanian Government has released its own survey of the LGBTIQ+ community, that was released just last week - two-weeks ago - last week.*
>
> ***CHAIR** - Recently.*
>
> ***Mr CROOME** - Recently. That survey was the largest of its kind ever done in Tasmania. As I said, it was an initiative of the Tasmanian Government and the work was undertaken by the University of Tasmania; Ruby was one of the researchers. That has a couple of pages devoted to rural issues - page 69 it is. Again, it reflects the findings in the national research that I mentioned. The survey found, I'll quote here:*
>
> *The issue raised most often by LGBTIQ+ in rural Tasmania was that healthcare and mental health support is hard to find in rural and regional areas, that access is difficult and often supports were felt to be unsuitable for LGBTIQ+ people to access.*
>
> *So for the people in rural Tasmania who responded to this survey, health care and access to health care and inclusive health care was the number one issue.* [43]

Jane Haybittel, North West Eye Surgeons and Devonport Eye Hospital expressed concern regarding the potential for the Commonwealth to withdraw funding, resulting in the loss of a public system on the north-west coast of Tasmania:

> *My request today is for the Tasmanian Government to recognise the major contribution North West Eye Surgeons provides to the people of the north-west coast and with continued support and collaboration the model we have created can be sustainable into the future. The model can be replicated across Australia as it treats accident and emergency and provides a specialised diagnostic process to determine the causes and urgency of surgical medical intervention or urgent referral to a neurosurgeon or neurologist or cardiologist and*

[43] Rodney Croome, *Transcript of Evidence*, 18 May 2022, pp. 2-3.

much more. These emergencies come from accident and emergency, doctors, optometrists and work sites.

Where we were a few years ago, the public waiting list for cataract surgery, glaucoma, ocular plastics, vitreoretinal, strabismus surgery in both adults and children, corneal graft surgery, was four years. Prior to Devonport Eye Hospital receiving the public contract for all ophthalmic public surgery on the north-west coast, the waiting list was down to 17 months. The waiting list since we received the contract in January 2021 is now down to six to eight months. The reason being that the Commonwealth Government has funded a final year fellow registrar who is able to perform surgery so the registrar, - be it a 'he' or 'she' - is fully trained and is able to operate on their own with one of our surgeons being in the building. So we brought the public waiting list down to six to eight months.

There is no limitation on how many surgeries we do and this is as instructed by the Commonwealth. Previously, with the public list we would be given x number of patients and the public system would release so many cataracts and so many of this and so many of that. Only category 1s were monitored. Now, we have a waiting list and we try to service this waiting list as effectively, as efficiently and as quickly as possible. The waiting list down from four years to 17 months and now down to six to eight months is a great achievement and affects the figures for the entire Tasmanian elective surgery waiting list numbers.

North West Eye Surgeons received Commonwealth funding as the first ever, as I understand, in Australia for public outpatient ophthalmology.

As I understand, the Commonwealth Government is able to look at Medicare statistics. The State Government - and this is how I understand or perceive the system to be - that the State Government and the Commonwealth Government do not marry as far as looking at the figures through Medicare. I am not sure how the State Government, where they get their figures. Some funding for public outpatients (inaudible). We didn't get this and for many years we have bulk billed public patients which is not sustainable in a private ophthalmology practice.

After the Commonwealth was alerted, the Commonwealth looked at the bulk billing rates. No ophthalmology practice private in Australia or anywhere in the world would be bulk billing patients because it's not sustainable. It's not profitable. In fact, it's not at all viable.

After servicing patients for 27 years, the option was to close our door because the money did not equate with the expenses and fortunately the Commonwealth looked at our bulk billing rates which were way above and not even equitable to any other specialist practice, especially ophthalmology which is very cost driven because of all the equipment that we have and the trainees operating this equipment. This was given to us last year. The bulk billing rate, for example, is $76.80 for a first patient consult and if this requires multiple tests, we can bulk bill for one or two other things but most of the bulk billing is that figure. The follow-up fee is $38.60 and as I said, this is not sustainable for all the diagnostic equipment required in an ophthalmic practice. North West Eye Surgeons have always bulk billed laser surgery and when I say laser surgery none of this is cosmetic laser surgery. We have five different lasers, and for these lasers the rebate from Medicare is approximately

$400 per laser. We have never ever billed a private or a public patient and we will continue to do that.

However, the Commonwealth has recognised that before you have any of these lasers - and we have five different lasers - the only laser that is not rebateable from Medicare is one laser that we have which is for floaters in the eye, where they vaporise the floater. It's called laser vitreolysis. It's regarded as cosmetic surgery.

...

The Commonwealth government is now providing funding for all patients and recognising that if one has a laser you need multiple diagnostic tests before the laser is performed. These lasers are invasive and they require a lot of diagnostic tests. So, the Commonwealth has funded us for a consult. The consult fee is approximately $260 and then they will also pay us a procedure fee for any of the lasers, which would equate to the Medicare rebate fee of $380. For a public patient we are now receiving approximately equitable with a private patient as long as we don't do more than one laser or even if we do a procedure in the rooms, which is very common, the Commonwealth will pay for the consult and the laser or procedure.

The north-west coast has been acknowledged by the Commonwealth as an ophthalmic area of need, which I have been trying to highlight for many years, not for financial benefit, but for continuity, and from the cases that we see on the north-west coast from newborn babies to patients over 100 is absolute essential service. The Commonwealth looked at the bulk billing numbers and have given us the recognition and asked us to present our case to the College of Ophthalmology, which we haven't had time to do because we've grown so much.

...

The reason for the urgency of this meeting is to ensure that the State and the Commonwealth Governments continue to provide funding for patients' consulting which saves many lives and enables patients to be treated as a matter of urgency in their own backyard. If the Commonwealth funding is withdrawn, the public service will cease to exist. I urge you to consider the effects this would have on the health and wellbeing of north-west coast patients - approximately 150 000 patients - ranging in age from neonates who are born prematurely in Hobart and then referred to us to follow up on the north-west coast so that they can come home, and neonates born in Burnie or Devonport with their eyelids still closed, with tumours, with cataracts, many sensational cases. If this consulting was not funded by the Commonwealth Government, no other private surgeon will do what we have done for the last 27 years.

I am not seeking funding. I am asking you all to make sure that this service that is available at the highest possible level for public and private patients is sustainable into the future. As I said, our patients range from newborn to over 100 years of age. We are fortunate to have received the public operating contract and this enabled one of the companies from New South Wales, Presmed, to partner with us and provide continuous care for patients into the future. Presmed has not previously bought or had any interest in Tasmania. However, they

have 100 ophthalmologists across all specialties and would be able to continue the very professional care we have provided in all specialties.[44]

C: NON-GP SPECIALIST MEDICAL SERVICES

To access non-GP specialist medical services, GP's are required to issue a referral. However, waiting times to access non-GP specialist medical services can be lengthy. Non-GP specialist medical services are not readily available in many parts of rural Tasmania.

According to the Tasmanian Government submission:

> *The Rapid Access to Specialists in the Community initiative includes the development and implementation of a service that provides GPs and other primary care health professionals with rapid access to staff specialists in the north and north west of the state. This initiative is targeted at supporting GPs to provide care in the community for people with chronic and complex healthcare needs, particularly during early acute exacerbations of chronic conditions.*
>
> *General medical specialists will provide the service at primary and secondary healthcare sites, such as GP practices, residential aged care facilities, district hospitals and CHCs. This will provide GPs and other health professionals with rapid access to THS specialists for advice and patient review. Additional staff specialists will be employed by the THS to provide this dedicated service.*
>
> *Providing rapid access to staff specialist support will enable provision of timely and appropriate care in the most appropriate setting. This initiative is expected to support improvement in health outcomes, patient experience of care, and rates of avoidable hospitalisation, due to earlier and appropriate interventions being progressed in the community, closer to the person's home.*[45]

The following table illustrates some demographic data relating to non-specialist GPs employed in Tasmania in 2019.

[44] Jane Haybittel, *Transcript of Evidence*, 31 March 2021, pp. 1-4.
[45] Tasmanian Government, 2021, *Submission #72*, p. 40.

Figure 2 Medical specialties with selected workforce indicators 2019

Profession	Over 60 years	Overseas trained	Specialty training in Tas	FTE per 100,000 population				Work-force size
				Tas	South	North	North West	
Addiction medicine specialists	75%	50%	Yes			0.8		4
Anaesthetists	12%	17%	Yes	22.1	26.3	22.8	11.2	115
Dermatologists	20%	20%	No	1.3	1.5	2.0	0.0	5
Emergency physicians	5%	11%	Yes	10.0	11.9	7.3	9.0	57
General practitioners	28%	10%	Yes	102.1	114.8	89.0	88.5	607
Intensive care specialists	0%	18%	Yes	3.0	3.6	2.1	2.7	11
Medical administrators	50%	0%	Yes	1.4	1.8	2.0	0.0	6
Obs. and gynaecologists	8%	18%	Yes	8.6	10.7	7.0	5.6	38
Occ. and enviro. specialists	75%	25%	Some	0.5	0.5	0.7	0.0	4
Ophthalmologists	22%	35%	Some	4.2	5.1	4.0	2.7	23
Paediatricians	16%	34%	Some	7.2	8.6	3.7	8.6	38
Pain medicine specialists	50%	33%	Yes	0.9	1.5	1.1		6
Palliative medicine specialists	33%	17%	Yes	1.1	1.3	0.0	0.0	6
Pathologists	27%	27%	Yes			6.1		33
Cardiologists	41%	36%	Some	4.9	5.1	4.6		22
Endocrinologists	18%	18%	Some	1.9	2.3	1.8	0.9	11
Gastroenterologists	23%	15%	Some	3.0	3.7	2.7	2.0	13
General physicians	19%	25%	Yes	6.4	4.3	9.7	7.1	32
Geriatricians	25%	25%	Some	2.7	4.2	1.1		12
Haematologists	0%	42%	Some	2.2	1.7	2.6		12
Immunology and allergy phy…	33%	0%	No			0.4		3 or less
Infectious disease physicians	17%	33%	Yes	1.2	1.6	0.8		6
Medical oncologists	7%	21%	Yes	2.6	3.1	2.1		14
Nephrologists	10%	20%	Yes	2.1	2.1	2.1		10
Neurologists	8%	17%	Yes	1.8	2.6	0.9		12
Nuclear medicine physicians	43%	29%	Some	1.1	1.7	0.6		7
Respiratory and sleep med…	31%	15%	Some	2.5	2.2	2.7		13
Rheumatologists	10%	10%	Some	2.0	3.1	0.8		10
Psychiatrists	35%	26%	Yes	13.2	17.6	9.3	7.5	77
Public health physicians	29%	14%	Yes			1.4		7
Radiation oncologists	25%	0%	Some	1.7	1.3	3.0	1.0	8
Radiologists	18%	36%	Yes	8.6	11.7	6.4	4.0	45
Rehabilitation physicians	17%	0%	Some	1.3	2.2	0.4		6
Sexual health physicians	0%	50%	Some	0.4	0.7	0.0		3 or less
Sport and exercise specialists	50%	0%	Some	0.3	0.6	0.0	0.0	3 or less
Cardiothoracic surgeons	25%	25%	Some			0.8		4
General surgeons	34%	24%	Some	6.4	6.8	7.7	3.5	29
Neurosurgeons	25%	50%	Some			1.1		4
Oral and maxillofacial surgeons	0%	0%	Some			0.4		3 or less
Orthopaedic surgeons	26%	19%	Yes	6.0	6.7	6.2	3.8	27
Otolaryngologists	60%	20%	Some	1.7	1.8	2.2	0.9	10
Paediatric surgeons	0%	50%	Some			0.5		3 or less
Plastic surgeons	23%	69%	Some	2.7	3.2	2.1		13
Urologists	30%	50%	Some	2.2	2.4	1.9		10
Vascular surgeons	25%	25%	Some			0.8		4

Key to shading

(Proportion of workforce) over 60 years	*0-10%*	*11-24%*	*25% plus*
Specialty training available in Tasmania	*Yes*		*No*
FTE of professionals per 100,000 population compared to Aus	*At or above*	*Below*	*Significantly below (by 25% or more)*
Overseas trained (proportion of workforce with first specialty from overseas)	*0-15%*	*16-29%*	*30% plus*
Workforce size (using headcount)	*More than 10*		*10 or fewer*

In a Question Without Notice from Hon Ruth Forrest MLC, dated 29 April 2022, the following information was clarified in relation to Rapid Access to Specialists:

> *The Rapid Access to Specialists in the Community Service commenced delivery on 1 April 2022. The Service covers population centres in northern Tasmania, currently extending west from Launceston through to Deloraine and surrounding areas. There will be further services delivered in the North West as the model continues to develop. To ensure continuity with the recent impacts of community transmission of COVID-19 on the Tasmanian Health Service (THS), the service has transitioned to telehealth for the present time.*
>
> - *The service has been integrated with existing health services by providing specialist support predominantly to general practitioners (GP) in primary care such as GP practices, District Hospitals and Community Health Centre, Hospital Aged Care Liaison Team and the Community Rapid Response Team with rapid access to THS specialist for advice and patient review.*
> - *There have been 104 patients referred to this service, with 228 episodes of care provided to date.*
> - *Patients are benefitting from the additional support provided to their GP's which is enabling more appropriate plans of care and better access to advice relating to issues such as comorbidities. Work is well underway to develop a process to quantitatively measure service effectiveness, patient outcomes and GP perceptions of the service and to provide an opportunity for feedback about potential improvements ahead of any further expansion. This mechanism will be implemented once "in person" services resume.*
> - *As the health system response to the ongoing situation with COVID-19 in Tasmania, update of the service by GP's and other community-based health professionals has affected service delivery. Despite the impacts of COVID-19 in 2022 presenting the in-reach service being delivered "in person", the medical specialists continue to provide telehealth support to participating GP's. The THS is currently planning for the recommencement of in-reach services.*[46]

The RACGP submission noted an inequality in health outcomes for people living in rural and remote areas.:

> - *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.*
> - Reliance on locum specialists which does not provide continuity of care for the patients.[47]

According to the Arthritis and Osteoporosis Tasmania submission:

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[46] Question without Notice, dated 29 April 2022, https://www.parliament.tas.gov.au/ctee/Council/Tabled%20Documents/RUR/220506%20-%20QON%20from%20Ruth%20Forrest%20MLC.pdf.
[47] RACGP, 2021, *Submission #65,* pp. 2-3.

Availability and timely access to specialist rheumatology services has long been an issue for Tasmanians, particularly for those living in rural and remote Tasmanian communities. Rheumatology specialist services in Tasmania are currently delivered in both the public and private systems (estimated total 4FTE) and are almost exclusively centred around Hobart. It is understood only 1.2 FTE of the 4FTE operate in the public health system (RHH). There are no public rheumatology specialist services in the north and north-west regions. Anyone seeking to access public rheumatology specialist services in Tasmania has no option but attempt to access specialist services through RHH rheumatology outpatient clinics.

However, a lack of capacity in the current service model means long waiting times for rheumatology outpatient clinic appointments in the south. The COVID-19 pandemic, prolonged staff sick leave and loss of staff have all impacted on rheumatology service provision at RHH this year.

The current waiting times for non-urgent cases is 769 days, and referrals are apparently no longer being accepted. For semi-urgent cases, the estimated wait time is 139 days, and for urgent cases (Category 1), the estimated wait is 175 days. Private rheumatologists in Hobart see patients from all areas of the State, including up to 30% or more coming from north/north west regions.

There is a vast number of people with arthritis in Tasmania who do not have the financial capacity to access private rheumatology services. Without prompt diagnosis and an appropriate management plan in place, these people inevitably end up on surgical waiting lists for joint replacement and/or other costly tertiary treatments. There is a private rheumatology specialist (0.7 FTE) based in Launceston who services specific locations across the north/north west, supported by funding from Rural Health Outreach Fund (RHOF) Services (TAZREACH). As of 1 July 2020, the locations reported as being funded for annual visits included: King Island (4 visits); Queenstown (6 visits); and Wynyard (10 visits).[48]

The Department of Health website provides further detail of TAZREACH services, including services delivered and frequency of visits to the regional and remote areas of the State including the Bass Strait Islands.[49]

D: HOSPITAL SERVICES

The Tasmanian Government submission provides detail:

… there are 13 district hospitals in rural and remote areas across Tasmania which provide inpatient care to subacute and stable acute patients. Access to district hospital beds not only allows people in rural areas to have care provided closer to home where possible, it is also an important component of helping to manage patient flow through the acute care system. When patients cannot go directly home, and the care required can be provided by local Rural

[48] Arthritis and Osteoporosis Tasmania, 2021, *Submission #43*, pp. 2-3
[49] https://www.health.tas.gov.au/professionals/tazreach-services-outreach/current-tazreach-funded-outreach-services - accessed 26 March 2022.

Medical Practitioners (RMPs), patients are transferred, where appropriate, from the major hospitals to district hospitals.

At the district hospitals, hospital care may be provided by a range of health professionals, including RMPs and nursing staff. In facilities with RMPs, these are usually general practitioners who provide inpatient services including admission, review and discharge of patients in district hospitals, including acceptance of patients transferred from other hospitals; and on-call services.

Each district hospital has between four and 20 inpatient beds that may be made up of various care types depending on the need of the local community as well as capacity and capability of staff at the time of the admission. The 2019-20 occupancy levels for the district hospitals is shown in Table 6 below.

Table 6: Total Occupancy Rates (%) of District Hospitals (subacute), 2019-20

Facility	Beds	2019-20
New Norfolk District Hospital	14	76%
Midlands Multi-Purpose Centre	4	57%
Beaconsfield	4	81%
Campbell Town	6	114%
Deloraine	20	56%
Flinders Island	5	35%
George Town	15	56%
NESM Hospital Scottsdale	18	41%
St Helens	9	27%
St Marys	8	37%
HealthWest, Queenstown	9	37%
*King Island HHC	*(6) 3	27%
Smithton District Hospital	12	56%

* King Island HHC has temporarily reduced available beds during its redevelopment stage from 6 to 3.

While district hospitals typically show moderate to low occupancy levels, this is not indicative of inefficiency as they also provide many other services, including first response emergency care, a range of outpatient clinics, residential aged care, and community health services. DoH is currently considering the service delivery and staffing models for the district hospital facilities to ensure they are best configured to support quality health outcomes for Tasmanians in rural and remote areas.

As noted above, Tasmania's district hospitals have an important role to play in assisting the four major hospitals, improving patient flow between Tasmania's acute facilities, and supporting better patient outcomes for those living in rural and regional communities. [50]

[50] Tasmanian Government, 2021, *Submission #72*, pp. 33-34.

The following updated data was obtained during the 2022/23 Budget Estimates process:

Statewide

Table 1: Total Occupancy Rates of District Hospitals and Contracted Sites (acute/sub-acute beds)

Facility	Beds	2018 - 19	2019 - 20	2020 - 21	2021 – 22 To April 2022
New Norfolk District Hospital	14	85%	76%	84%	78%
Midlands Multi Purpose Centre (Oatlands)	4	43%	52%	44%	41%
Beaconsfield	4	93%	80%	46%	50%
Campbell Town	6	93%	114%	75%	115%
Deloraine	20	61%	55%	56%	51%
Flinders Island	5	31%	29%	21%	61%
George Town	15	64%	56%	69%	60%
NESM Hospital Scottsdale	18	48%	40%	44%	43%
St Helens	9	32%	26%	30%	30%
St Marys	8	38%	35%	36%	41%
HealthWest, Queenstown	9	37%	37%	33%	32%
King Island HHC^	4	28%	27%	33%	36%
Smithton District Hospital	12	42%	56%	33%	36%
Huon Regional Care, Franklin	9 *	67%	59%	15%	25%
Esperance MPC, Dover	3	56%	44%	57%	48%
May Shaw Health Centre Inc., Swansea	3	66%	67%	57%	59%
Toosey (Longford)	2	66%	60%	70%	76%
Tasman MPS	4 **	97%	100%	61%	50%

* Huon Regional Care Franklin had all beds closed for 7 months (July 20 – Feb 21) and in

**Tasman MPS increased availability of acute/subacute beds from 2 to 4 beds at the end of 2020.

^2020 - KIHHC has reduced available beds during the redevelopment stage from 6 to 5 – now has two functioning resus bays.

Updated data on district hospital separations was provided in a Question on Notice response from the Premier dated 7 September 2022:

Table 2 – District Hospital Separations (including contracted sites)

Rural Inpatient Facility	2020-21
Midlands MPC	72
New Norfolk	303
Beaconsfield	65
Campbell Town	160
Deloraine	271
Flinders Island	185
George Town	564
Scottsdale (NESM)	706
St Marys	291
St Helens	401
HealthWest, Queenstown	239
King Island HHC	162
Smithton District Hospital	347
Huon Regional Care Franklin	19
May Shaw	117
Esperance MPC	34
Longford (Toosey)	24
Tasman MPS	35
Total	3995

Demand on hospital services, both regional and tertiary hospitals can be exacerbated through the avoidance of preventable admissions. The submission provided by Occupational Therapy Australia (OTA) provided evidence regarding the shortage of Occupational Therapists in Tasmania and noted, with regard to preventable hospital admissions:

> *Occupational therapists also prescribe assistive equipment and home modifications. These are interventions which can significantly reduce the risk of injurious falls. Between 2009 and 2010, one in every 10 days spent in hospital by a person aged 65 years or older was directly attributable to an injurious fall (AIHW, 2013).*
>
> *The average total length of stay per injurious fall incident was estimated to be 15.5 days (AIHW, 2013). According to one study, these hospitalisations typically incur costs of between $6,000 and $18,600 per incident (Watson et al., 2010).*
>
> *An injurious fall can also be life threatening. Neck of femur (NOF) fractures – the most common kind of hip fracture – are associated with particularly high rates of premature death (AIHW, 2018). According to an Australian study, the mortality rate for patients*

admitted to hospital with a NOF fracture is 8.1 percent after 30 days and 21.6 percent within one year (Chia et al., 2013).[51]

The late Mr Bill Dermody, retired nurse, made the following comments in relation to the use of rural hospitals in decanting patients from the major hospitals:

> *When we moved to New Norfolk, the New Norfolk Hospital had an emergency department, a maternity ward, a fully functional X-ray department five days a week, and physiotherapists five days a week, as examples…*
>
> *Therefore, people were able to present at the New Norfolk Hospital 24 hours a day, seven days a week, and all the beds were for people from the Derwent Valley community - not as it is now, with the majority of beds being for the overflow at the Royal Hobart Hospital, and people not being able to present at the New Norfolk Hospital due to the fact that the emergency department and the maternity ward at the hospital are closed.*
>
> *The X-ray department was reduced to only two days a week. The type of X-ray is being reduced as to what X-Rays are available. There is now only two days a week of physiotherapists.*
>
> *With my background, it is worth being involved in the Australian Nursing and Midwifery Federation (ANMF). The closure of regional health centres meant that it centralised the health system to the three major hospitals. This dramatically reduced health services in regional areas, dramatically increased pressure on the major hospital emergency departments. Waiting times at the emergency department and ambulance ramping dramatically increased. This all coincided with the dramatic reduction in services at regional hospitals and the closure of regional health centres. With the dramatic reduction in health services in New Norfolk, the population over this period increased from around 6500 to now, with a population of over 12 000 in the Derwent Valley.*
>
> …
>
> *Nearly five years ago I foresaw that the waiting time was only going to get worse, so I did some investigation into health practices in other states. I did this because I was aware, as an example, in Queensland in most regional hospitals and regional health centres, they introduced nurse practitioners 24 hours a day, seven days a week. So, people were able to present at regional hospitals and regional health centres which they cannot do in Tasmania.*
>
> *I spoke with the secretary of the Australian Nursing and Midwifery Association, Queensland branch, and investigated the implementation of nurse practitioners 24/7 in regional hospitals and most regional health centres in all other states. This is the only state where there are no nurse practitioners in regional hospitals, 24/7, and in regional health centres, and therefore people are unable to present. In other states it has reduced the need for people who are unable to see a GP to have to call an ambulance or attend a major hospital emergency department because they can be seen by a nurse practitioner.*
>
> *This is one of the major contributing factors as to why, compared to other states, Tasmania has the worst waiting times in the emergency departments and ambulance ramping. If nurse practitioners were introduced 24/7 at the New Norfolk Hospital this would mean*

[51] Occupational Therapy Australia, 2021, *Submission #57*, p. 2.

that when they are not able to see a GP, people can present at the New Norfolk Hospital and a nurse practitioner would be able to diagnose their health issue and then either liaise with the Derwent Valley or Central Highlands medical centres - whichever medical centre that they attend - or if necessary admit the person to the New Norfolk Hospital and intervene with the patient until they were able to liaise with the person's general practitioner or the general practitioner was able to attend to the patient at the hospital. Nurse practitioners through their training, in Tasmania, are able to do 99 per cent of what a GP can do.[52]

E: MATERNITY, MATERNAL AND CHILD HEALTH SERVICES

According to the Tasmanian Government submission:

> *Across the state, Tasmanian women can access or be referred to the maternity services of their choice, including the THS maternity services. This service in generally the nearest service to their place of residence and one that offers the patient's preferred model of care. Pregnant women are able to assess the model of care that best meets their needs. There are a range of midwifery-led models of care that are utilised within the THS that vary across the three regions of the state. These include the Midwifery Group Practice model, where a patient is cared for by a primary (and back up) midwife who they are able to get to know well for their pregnancy, labour, birth and postnatal needs, and the Know Your Midwife or Team Midwife model, where a patient is cared for by a team of midwives, in consultation with doctors, during their pregnancy.*
>
> *Across all three regions, Midwife Satellite Clinics are utilised that make these maternity services available to women within their local community*.[53]

The Women's Health Tasmania submission provided the following feedback in relation to maternity, maternal and child health services:

> *Women also told us that there is a lack of support for mothers with young children in some rural areas with consequences for the mental health of young mothers. The Child Health and Parenting Service and playgroups are valued, but women report that their access to local maternity services, childcare services, Child and Family Centres, respite services, family support services and child and adolescent mental health services is severely constrained.* [54]

According to the HACSU submission, maternity, maternal and child health services Health services in regional areas in Tasmania, including district hospitals and multi-purpose centres, do not provide maternity services directly:

> *Many used to provide antenatal and post-natal care for regional communities, but that ceased approximately a decade ago. Many factors have led to this decline, including an unwillingness to accept that there is more to providing health services to people where they live than cost. Shortages of appropriately trained and qualified health professionals, safety and quality considerations, cost considerations and duplication of services were all factors that led to the cessation of previously-provided services in rural and regional areas. Whilst*

[52] Bill Dermody, *Transcript of Evidence*, 19 November 2021, p. 4.
[53] Tasmanian Government, 2021, *Submission #72*, p. 36.
[54] Women's Health Tasmania, 2021, *Submission #23*, pp. 6-7.

any investment must be prudent, mothers being closer to home and being more relaxed and comfortable during both pregnancies and birth will lead to better health outcomes for both the parent and the child. There is no doubt that more services could be provided regionally than is currently the case. Child health services are provided both in clinic settings and in the community. The service is staffed by child health nurses. Child health nurses provide mothers with information, guidance and support on issues including breastfeeding, child health and development, infant and child nutrition, maternity health, and parenting skills.[55]

F: PAIN MANAGEMENT SERVICES

According to the Tasmanian Government submission:

> *The Tasmanian Government is committed to delivery of quality pain management services. The Tasmanian Pain Management Network (TPMN) is responsible for the strategic direction and delivery of pain management services across the continuum of care in the THS. The TPMN aims to provide high-level leadership, expertise and specialist clinical advice to the THS, clinicians and other stakeholders to promote optimal health outcomes in the area of pain management services in Tasmania, establishing links with GP, consumers and other relevant state and national bodies.*
>
> *DoH is also working in collaboration with PHT to develop a Tasmanian Pain Management Strategy that will provide the foundation and framework for the delivery of pain management service throughout the state and enable a collaborative, well connected network of organisations and stakeholders to progress evidence-based solutions for the Tasmanian community. Consultation has included consumers and public and private providers with an interest in pain management services. The Tasmanian Pain Management Strategy will provide an agreed framework in which pain management services are delivered equitably across Tasmania while optimising patient outcomes and experiences through providing value-based care.*
>
> *For patients in the north and north west of the state, the THS has partnered with the Royal Flying Doctors Service Victoria to provide access to telehealth appointments with a pain specialist. A number of GP clinics in north and north west Tasmania have also signed up to utilise the telehealth pain management service.*[56]

Bernadette Smith, Australian Pain Society:

> *If we are looking at the burden of the disease, it is consistently evident from a health economics perspective that back pain was the leading cause of pain disability in 2017. When we look at things from a rural perspective, we actually see that our rural clientele - rural people in rural communities outside the major cities - are about 23 per cent more likely to suffer the burden of the disease, and 30 per cent if you are aged between 50 and 64. So, from a rural perspective, it is already a huge burden and an economic cost. And when we look rurally, we already have an even bigger burden on top of that.*

[55] Health and Community Services Union, 2021, *Submission #45*, p. 9.
[56] Tasmanian Government, 2021, *Submission #72*, p. 28.

The other thing is that Tasmania has no paediatric pain service, yet we see that 25-35 per cent of children and adolescents experience chronic pain.

A second important problem with chronic pain - which is why it's so pleasing to see it was on this inquiry - is comorbidity, which is incredibly common among people with chronic pain. Approximately 75 per cent of people will understandably suffer other mental health conditions, and then what we see is that the comorbidity actually worsens the burden - so, for example, major depression in patients with chronic pain associated with reduced functioning, increased disability, more lost time from the workplace, and of course increased healthcare costs. Sadly, it is the leading cost of economic and social exclusions. So, we have this huge burden.

…

On the issue of access to appropriate services, approximately 0.2 per cent of patients with chronic pain will actually be seen by a tertiary pain service, and 80 per cent will not actually receive appropriate treatment. The tricky part here is that this Australia-wide problem is actually very similar in Tasmania. In Tasmania, our only tertiary pain service, the Persistent Pain Service, is in Hobart. I think they have 1.4 full-time equivalents of medical consultants, 1.4 full-time equivalents for physiotherapy, and 1.4 for psychology. They recently lost their accreditation by the Faculty of Pain Medicine as a training organisation. So, no doubt that means less funding for them as well.[57]

According to the RDAT submission:

Chronic pain is a common condition experienced by many Australians. Tasmania has a distinct lack of chronic pain services that are accessible to rural Tasmanians. Patients experience extended weight (sic) *times (up to two years), travel to Hobart and disruptions in their care due to changing providers within the service. RDAT would welcome a review into chronic pain services in Tasmania that meet the needs of rural Tasmanians.*[58]

According to the THS North submission:

Access to pain management services is low to almost non-existent across the whole region, not just rurally.[59]

The Health Consumers Tasmania submission noted feedback from consumers regarding the 'poor availability of pain management in rural and remote communities.'[60]

The Health Consumers Tasmania Submission identified the following pain related issues:

There is poor availability to pain management in rural and remote communities.

Barriers to attending medical appointments by our consumer members include lengthy wait times, cancelled and delayed appointments which potentially impacted on and adversely affected patient stress and mental health, pain management and outcomes. Timing of

[57] Bernadette Smith, Australian Pain Society, *Transcript of Evidence*, 3 November 2021, p. 28.
[58] Rural Doctors Associations of Tasmania, 2021, *Submission #30*, p. 7.
[59] THS North, 2021, *Submission #44*, pp. 1-2.
[60] Health Consumers Tasmania, 2021, *Submission #56*, p. 7.

appointments early and late in the day to assist in overcoming time and transport barriers may overcome some access barriers for rural workers.[61]

The Question on Notice response from the Premier, dated 7 September 2022, provided the following update on the Tasmanian Pain Strategy:

The Tasmanian Pain Strategy was created through a joint project between the Department of Health and Primary Health Tasmania and commenced in 2019. The development of the Tasmanian Pain Strategy was impacted by the COVID-19 pandemic

The Strategy has 4 priority areas:

- *Knowledgeable, empowered, and supported consumers.*
- *Health professionals are educated about, and are supported to deliver, best practice evidence-based care.*
- *People living with pain have timely access to interdisciplinary care and support that is evidence-based.*
- *Measure outcomes with an aim to improve performance of health services in managing pain and support continuous quality improvement strategies and innovation.*[62]

G: PALLIATIVE CARE SERVICES

According to Dr Rosemary Ramsay, appearing on behalf of ANZSPM:

The provision of palliative care in the rural areas of Tasmania is variable. In rural Tasmania palliative care is mostly provided by GPs, community and palliative care nurses and residential aged care staff. Specialist palliative care services support GPs in their provision of palliative care but do not have workforce sufficient to take over the care entirely. These various combinations of health professionals and services create disparities in access and quality of health services for rural and remote patients. It also means it is difficult to determine exactly who delivers palliative care in rural and remote Tasmania.

Some patients can be admitted to a specialist inpatient unit, others only have the choice of dying in their local hospital or aged care home if home is not an option.

There are many positive features of providing palliative care in our rural and remote settings. Local services and local practitioners offer a sense of familiarity, community and continuity and ANZSPM wishes to see equitable, consistent and high-quality provision of palliative care across our whole population. We believe that this inquiry represents an important opportunity to understand the exact needs of patients, families and communities in rural and remote Tasmania and understand the true state of palliative care in these areas.[63]

According to the Tasmanian Government submission:

[61] Health Consumers Tasmania, 2021, *Submission #56*, p. 7.
[62] Question on Notice Response from the Premier, dated 7 September 2022, p. 6.
[63] Dr Rosemary Glanger, *Transcript of Evidence*, 2 November 2021, p. 48.

Palliative care services are targeted at enhancing quality of life for people living with incurable conditions. Palliative care services provide a system of care which aims to enable people to live as actively and comfortably as possible and to support the person and their family. Having access to palliative care in rural and remote communities is important as it allows people in those communities to access care close to, or within, the home, improving the patient experience of care by limiting or removing the need for long and/or frequent travel to access services in larger centres.

Palliative care services are delivered across a range of settings in Tasmania. Services are delivered by a 'community of care' that includes primary care providers such as GPs, health and community services and volunteer organisations.

The Tasmanian Government funds specialist palliative care services across the state, including inpatients and community-based services. The THS has dedicated Specialist Palliative Care Services (SPCS) teams in the north, north west and southern regions (which cover their whole region, with the north west based team also servicing the west coast). These teams support palliative patients and their families across care settings.

The SPCS teams comprise medical, nursing and allied health professionals whose sole focus is palliative care. They work in partnership with health and community service organisations and groups (including volunteers and community members), that provide most of the palliative care in Tasmania.

Care provided by the SPCS teams includes symptom management, psychosocial support, bereavement support for staff and families, assistance with case conferencing, advanced care planning advice and education for staff on palliative approaches.

The SPCS teams receive referrals from GPs, consultants, other hospitals and residential aged care facilities for consultative advice on the management of patients. Upon referral to SPCS, patients receive a specialist nursing or medical assessment as required and advice is provided for complex symptom management. The SPCS provides advice and support to the patient, GP, and/or facility staff depending on the complexity of the care required (this may be via a single visit or through ongoing management). To facilitate timely assessments, particularly in rural areas, much SPCS advice is provided by phone.

As part of a 2018 Tasmanian State Election commitment, specialist palliative care clinical nurse educators have been recruited in each region of the state. These positions have proven valuable, providing essential training and upskilling across the health and aged care systems. Additional funding was allocated in the 2020-21 state budget to extend Clinical Nurse Educator positions in SPCS.

Building upon these initiatives, the Tasmanian Government has committed $4.25 million to Palliative Care Tasmania to continue their successful GP education and training programs. workforce development and community education and awareness. The Government has also committed $6.8 million towards better palliative care services in partnership with private hospitals and service providers, and $10.5 million to significantly strengthen in-home palliative care and after hours care services.

In the lead up to the August 2021 State Budget the Tasmanian Government will be working with the peak palliative care and health bodies and the community sector regarding the best

approach for expanding hospice at home services and state-wide after-hours palliative care support.[64]

According to the Palliative Care Tasmania submission:

> *Currently there is not an after-hours palliative care service model that meets the needs of the Tasmanian communities, including rural communities. Many rely on local experienced GPs. However, levels of experience vary considerably across communities. On call nurses are also stretched. Palliative care and care of the dying is a substantial part of current community nursing practice. Additional investment is required to facilitate out of hours palliative care support.*
>
> *There is a lower availability of grief, loss and bereavement support for rural Tasmanians. In an ideal situation, where best practice palliative care is provided, grief can be managed by existing social and community supports. However, for many rural Tasmanians their experience includes being separated from their loved ones and communities, resulting in complicated grief. This usually requires management from clinical providers. We need to recognise that our rural medical professionals are often providing palliative care for their friends, or people well known to them in their communities. This results in additional mental health impacts.*
>
> *Physical palliative care infrastructure is not consistent across regional and rural Tasmania. For example, in the North and North East there are palliative care suites in most of the regional hospitals, this is similar in Southern Tasmania (noting there are fewer regional hospitals). Unfortunately, there are no designated palliative care beds in North West Tasmania. The Tasmanian Government has announced that 4 beds at Mersey Hospital will be imminently opened. However, this is 2 below the national standard based on population. Mersey is not an optimal site for people living on the West Coast of Tasmania. PCT has consistently lobbied for beds at North West Regional Hospital to help meet community need.*
>
> *In order for these regional and rural palliative care beds to be effective, the workforce supporting them must be skilled and experienced delivering palliative care. Levels of expertise on palliative care can vary widely, resulting in inconsistency in care.*
>
> *Limited time and access to professional development and to best practice resources restricts health professionals' effectiveness in providing palliative care. There is also the challenge of providing professional development to an understaffed workforce, which is time poor. As a result, patients can "fall through the gaps", leading to development of significant health issues, psychological distress, and potential increased cost to the health system.*
>
> *Essential health professionals, clinicians and health services alone are insufficient to address the needs of people with life limiting conditions and their families. Communities of Care must be developed and supported as part of an effective community palliative care model.*
>
> *PCT believes this is a reason why rural Tasmanian women, in particular have reported that people with life-limiting conditions have been transferred out of small communities to larger centres, causing significant stress for them and their families. There is a shortfall in the supply of palliative care practitioners due to an ageing palliative care workforce. However, while feedback from PCT consultations affirmed that the workforce is older, it also indicated*

[64] Tasmanian Government, 2021, *Submission #72*, pp. 21-2.

that the typical entry point to palliative care work is at a later career stage. It was also indicated that there is a demand for more male workers in order to provide options for clients who would prefer services to be provided by a male.

Tasmania's rural areas do not have consistent coordination of care. We do not have palliative care clinical nurse coordinators or a consistent multi-disciplinary approach to care, which is critical to ensure that rural Tasmanians are supported to die well. We talk about "person centred care" but we try and make the person fit an unsustainable system, rather than mobilising the system around the person and family. As a result, we waste money by ensuring our system continues to force dying Tasmanians away from their communities and into hospital where unnecessary interventions are provided.

Fragmentation of care is a major issue, with families often left to navigate the complex system. Coordination of specialties and providers involved in end-of-life care, such as GP, Geriatrics, Palliative Care, Psychiatry, NGO support agencies, is required. However, for this to happen there needs to be consistency in the training and knowledge across the workforce to be able to deliver this effectively. Quality coordination, liaison and collaborative partnerships between palliative care specialist teams, aged care teams and general practitioners in an integrative model of care in the community are needed. High quality, person-centred palliative care also requires a more inclusive definition of 'workforce' which recognises and values the roles of both the paid workforce as well as the informal and community supports that make up our communities of care.[65]

The Palliative Care Tasmania submission concluded:

Tasmania's regional and rural palliative care workforce provides the absolute best support they can in challenging circumstances. They are faced with issues including:

- *Staff shortages;*
- *No consistent after-hours palliative care services;*
- *Transient workers within their workforce;*
- *Lack of coordination of care and multi-disciplinary approaches to care;*
- *Lack of key trained people in palliative care in their workforce;*
- *Difficulty accessing professional development;*
- *Increased trauma and mental health issues as a result of consistently caring for community "friends";*
- *Lack of physical infrastructure to offer respite, pain management and other symptom control methods.*

The impact on dying Tasmania's include;

- *Lack of choice of place of care and place of death;*

[65] Palliative Care Tasmania, 2021, *Submission #17*, pp. 5-8.

- *Accessing care in later stages of diseases, leading to increased complexity in management;*
- *Increased complexity resulting in removal from community to a larger "metro" hospital; and*
- *Families being separated resulting in exacerbated mental health and social impacts for the dying and their loved ones.*

In order to overcome these issues and plan effectively for larger increases in demand, it is critical that the Government investment in community palliative care that is consistent across Tasmania.[66]

H: PHARMACY SERVICES

According to the Tasmanian Government submission:

> *Community pharmacies in Tasmania are privately owned businesses that provide a range of services to their local communities. The Tasmanian Pharmacy Authority (the Authority) approves and registers pharmacy business premises and manages and regulates pharmacy ownership in Tasmania. There were 161 pharmacy business premises in Tasmania registered with the Authority at 30 June 2020. The Australian Government and community pharmacies hold responsibility for ensuring access to essential medicines and delivery of pharmacy services in rural and regional Australia under the 7th Community Pharmacy Agreement.*
>
> *In terms of state government pharmacy services, Statewide Hospital Pharmacy in the THS provides hospital pharmacy services to patients of Tasmania's acute public hospitals through on-site pharmacy departments, and a remote service to the district hospitals. Services include clinical and specialist pharmacy services, dispensing medications, on-site doses of chemotherapy, involvement in local national and international clinical trials and specialist support services including the telehealth-based Remote Clinical Pharmacy Service. As noted above, the Australian Government is responsible for the funding and policy management of the PBS.*
>
> *The Tasmanian Government has invested in and progressed a number of successful initiatives that support increased access to appropriate health care, within their own community, for people living in rural and remote areas of Tasmania.*
>
> *The Government acknowledges there is still a way to go in achieving equity of access to health services for all Tasmanians within their local community (wherever safe and possible). The Government is committed to continuing to work toward this by progressing initiatives targeted at increasing access and support for primary and community care and reducing the need for avoidable and/or unnecessary hospitalisation. Improving community care is a key feature of the next stage of the Government health reform program.*[67]

According to Ella van Tienan, Pharmaceutical Society of Australia:

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[66] Palliative Care Tasmania, 2021, *Submission #17,* p. 8.
[67] Tasmanian Government, 2021, *Submission #72*, p. 29.

… southern Tasmania is well serviced by pharmacists, but the majority of them were actually in the hospital and the metropolitan area. Fred down at Dover does not have anybody to support him, and so, he says, 'well it looks like I am in an area that is well serviced by pharmacists, but actually I am here by myself, and my mate in Geeveston is by himself'. There is no data as to what the distribution throughout the state is. If you just look at that report, it looks like -

***CHAIR** - By pharmacist, not pharmacy.*

***Ms van TIENAN -** Yes, it looks like there are enough pharmacies, and it looks like, in that data, we have enough pharmacists in the south, but actually the spread of them is not sufficient to cover the workload.*

***CHAIR** - Is locum use monitored? Obviously, if you are a single pharmacist and you get sick or want to take a break, is that monitored? Do we know how many locums are used?*

***Ms van TIENAN -** We don't know. Anecdotally, there are not enough at the moment, and COVID-19 has made that worse because we can't get them into the state. Anecdotally, there are shortages of pharmacists everywhere at the moment.*[68]

According to the Pharmacy Guild of Australia (Tas) submission:

Genuine health reform and significant cost savings can be delivered through the better utilisation of community pharmacists. International experience shows that there are both significant savings and improved health outcomes by following two key principles:

***1.** Removing regulatory restrictions which inhibit health practitioners from practising to the full extent of their capabilities;*

***2.** Allowing patients to choose who provides their primary health care, particularly in the case of chronic disease management.*

Community pharmacists provide a range of primary health care services beyond dispensing that are crucial to the health of Australians. These services help patients achieve positive health outcomes and cover, for example, advice to mothers regarding the use of medicines while breastfeeding; sexual health and contraception advice; assessing ailments such as minor wounds and sporting injuries and providing assistance to elderly and other people regarding the health system and their access to social welfare and other community services.

As a 2014 report by the Grattan Institute stated, pharmacists are among the most trusted of all professionals, are found in most communities throughout Australia and are accessible to patients without a long wait. Yet, compared to several other countries, pharmacists in Australia are still not able to practise to their full scope of practice.

The main gaps are in areas such as the administration of vaccines, therapeutic substitution, continued dispensing, prescribing and laboratory testing. Australia lags behind countries with equivalent economies and health systems including Canada, the UK, Ireland, the USA and New Zealand where there are examples of these practices being undertaken by pharmacists.

[68] Ella van Tienan, PSA, *Transcript of Evidence*, 30 November 2021, p. 6.

…

The National Competency Standards Framework for Pharmacists in Australia 2016 define scope of practice as "…a time sensitive, dynamic aspect of practice which indicates those professional activities that a pharmacist is educated, competent and authorised to perform, and for which they are accountable."

Figure 1 … illustrates the components of Scope of Practice and how these are achieved.

*Competency, that is, the required **knowledge**, skills and attributes to prescribe, dispense, administer and review medicines is initially achieved through completion of an accredited program of study that is approved by the Pharmacy Board of Australia.*

*These programs of study include university degree programs and intern training programs. Foundational core knowledge is achieved through a curriculum mapped to the National Competency Standards Framework for Pharmacists and the Australian Pharmacy Council (APC) Performance Outcomes Framework. Practical competency assessments and work integrated learning (WIL) components of degree programs, and the supervised practice requirements of provisional registration further develop knowledge and allow for demonstration of the required **skills.***

Fig 1. Understanding Pharmacist Scope of Practice, adapted from Poudel A, Lau ETL, Campbell C, Nissen LM[34]

*The Competency Standards give pharmacists the **accountability** to prescribe, dispense, administer, and review medicines as they form the basis of what is considered the acceptable standard of contemporary professional practice in Australia.*

*It is through state and territory legislation, that the **authority** is given for pharmacists to prescribe, dispense, administer, and review medicines. It is this legislative authority that also currently restricts pharmacists from practicing to their full scope. The scope of practice for the pharmacy profession as a whole is defined by the competencies described in the 2016 Competency Standards. As professional practice evolves and the profession matures to meet the needs of the health care system, and society in general, so do the competency standards due to their dynamic nature and regular review cycle. The capacity of the competency*

standards to support and enable professional practice and growth over time is invaluable to champion full scope of practice for pharmacists now, and in the future.[69]

I: DENTAL SERVICES

According to the Royal Flying Doctors' Service submission:

> *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 have not seen a dentist in the past five years.*
>
> *Tooth decay is Australia's most prevalent health problem even though it is largely preventable. In 2013-14 the average weighted cost per hospital separation across Tasmania's four public sector acute hospitals varied from $4,761 to $5,539, with dental admissions being one of the highest preventable admissions. Conversely an average preventative dental check-up, including x-rays and cleaning, can be carried out for approximately $180-$200.*
>
> *The Australian Dental Association (ADA) Tasmanian Branch submission to Our Health Care future states, In Tasmania, dental conditions were the biggest reason for preventable hospital admissions. That's over 12.5% of preventable hospitalisations. Most of these admissions were for children requiring dental treatment, most often dental extractions, under a general anaesthetic in the Day Theatres of Tasmanian's major hospitals. Children who have required dental treatment in a hospital are likely to need repeat general anaesthetic dental treatment in future years. The best predictor of future dental caries is the presence of dental caries now in a person's mouth.*
>
> *Rural Tasmanians experience poor oral health at significantly higher rates than people living in major centres. Across the nation there are almost three-and-a-half-times less dentists in rural and remote areas. High rates of diabetes, heart, stroke, and vascular disease would indicate poor oral health in remote Tasmania. Specifically, these conditions are strongly linked to poor periodontal/ oral health.*
>
> *For some country Tasmanians, particularly the most socio-economically disadvantaged, there are barriers to accessing existing services for reasons that are often complex and cumulative.*
>
> *To address these disparities, particularly of access, RFDS has developed innovative oral health programs that derive from its experience of running dental outreach programs around Australia and that build on its profile and high levels of trust in rural communities. These programs are underpinned by a number of principles:*
>
> **>** *Operate where other services don't;*
>
> *> Employ different service models depending on the needs of the community;*
>
> **>** *Ensure close co-operation with other service providers in the region;*

[69] Pharmacy Guild of Australia (Tas), 2021, *Submission #42*, pp. 6-8.

> Provide preventative, early intervention and treatment services;

> Orientate the services toward potential to prevent future disease and provide appropriate care to groups considered at higher risk of dental disease; and

***>** Structure visits to maximize outcomes and move beyond emergency and demand dental care.*

Using a partnership model, the RFDS Mobile Dental Care program focuses on remote and rural areas of Tasmania where there is the greatest unmet need.

Both the areas of service and the engagement model have been designed in consultation with:

> Oral Health Services Tasmania

> Commonwealth Department of Health

> Local Governments

> Community Groups

> Aboriginal Corporations

> Australian Dental Association Tasmania and private dentists

In the 2016 Federal election campaign, Senator Nash, on behalf of the Commonwealth Government, committed $11 million over two years (2016-17 and 2017-18) to enable the RFDS to continue providing its current suite of dental services and/or to expand service provision to enable access for more remote and rural Australians in underserved areas.

The RFDS provides a mobile service that works in multiple areas including: Circular Head/Smithton, East Coast/Swansea, North East/Scottsdale and King and Flinders Islands. We currently employ five dental staff, including dental therapists, dentists, and dental assistants. We are currently exploring ways to expand our dental offerings, to meet the needs in the community.

Our staff provide a fixed clinic model and a visiting service to the schools and aged care environments. The aged care visits are another RFDS Tas innovative service.

Eligibility is determined by residing in an eligible area and having the service delivered in this area. This has caused issues with some areas of service in the south. It also presents challenges for our prosthetic services, as it requires the Launceston-based prosthetist and his staff to travel to eligible areas to provide a service.

We are currently assessing how we can fit out the King Island dental clinic, to allow the Prosthetist to undertake this work on island.

A purpose-built dental truck was required to expand services to schools, aged care facilities and more remote communities. The truck enables delivery in areas where there are no – or sub-standard – built facilities, while maintaining accredited standards of work health and safety issues, infection, and sterilization controls.

RFDS staff can drive the dental truck to location, plug it into 3 phase power and water, and commence operations, negating the need for moving valuable equipment, including heavy infrastructure such as dental chairs, and allowing on-site sterilisation.

At the end of July 2020, we have seen 3,029 patients over 7,464 visits and delivered 41,297 dental treatments since we commenced our dental outreach program on 1 May 2017.[70]

According to the Tasmanian Government submission:

In Tasmania, public dental services are delivered through the Tasmanian Government's Oral Health Services Tasmania (OHST) at several clinic locations across the state. In addition to public services provided through OHST, the Royal Flying Doctor Service (RFDS) also provides adult and children's dental services at a range of locations across Tasmania (including on King and Flinders Islands using Tasmanian Government facilities).

OHST provides local access for children's public dental services, with OHST clinics in over 30 locations across the state. This includes a number of clinics in rural and remote areas including (but not limited to) Scottsdale, St Helens, Sheffield, Smithton, Wynyard, Deloraine, King Island and Campbell Town. There is no waiting list for children for public dental care in the community. OHST also operates a mobile preventive dental service which travels to public schools in rural and remote areas. Public dental services for children are funded by both the Tasmanian Government and the Australian Government through its Child Dental Benefits Schedule with no out of pocket expenses for these services.

OHST also provides public dental services for adults. These services are delivered in the four major centres of Hobart, Launceston, Burnie and Devonport. OHST also contracts local private providers to deliver publicly funded dental activity in other areas, including rural and remotes areas. For example. OHST currently has contracts in place with private providers in Queenstown and St Helens.

The Patient Travel Assistance Scheme ***(PTAS)*** *(discussed under Section 3 below) can be accessed to support travel for rural and remote areas for emergency dental services, or for routine dental care when a patient's medical condition necessitates specialist medical backup at the time of dental treatment. Demand for adult services is high, which means emergency care must be prioritised over general care. While there are waiting lists at each major centre for general care for adults (with COVID-19 services shut downs last year contributing to wait lists) appointments to people on waiting lists for general dental care are offered based on who is at the top (i.e. has waited the longest), with waiting lists for those living in rural and remotes areas no greater than those for people living in the main centres.*

In addition to the services outline above, the Tasmanian Government has committed a funding injection of $5 million to deliver an additional 20 000 dental appointments for public patients through outsourcing arrangements. The Government will work closely with key stakeholders to ensure this funding is targeted at providing care where it is most needed. Additionally, the Government signed a Memorandum of Understanding with the RFDS in April 2021, which included a commitment of $300 000 funding in 2021-22 to support the

[70] Royal Flying Doctor Service Tasmania, 2021, *Submission #53*, pp. 15-16.

provision of oral health services in regional Tasmania, with an initial focus on the West Coast, Huon Valley and Central Tasmania.[71]

In relation to the provision of adult dental services, Mr Webster, Mr Monty and Dr Ioan Jones provided the following comments:

The defined cohort is really children for oral health services and the universal service. So, obviously, giving people the best start is what we are focused on. But over the years as the federal government has funded adult services and the state government has provided funding, we have wandered into the adult service. That will continue as long as the National Partnership Agreement is rolled over but it is not the core service of oral health services; it is the children cohort. Unfortunately, to expand that beyond that is probably beyond the resources currently provided….

***CHAIR** - So any parent who rings to make an appointment will get one, how do you reach out to some of the quite disadvantaged families with children who really need the service but perhaps don't know they can access it? … Is there a proactive approach families with children?*

***Mr WEBSTER** - The first is using the network of child and family learning centres - I think that is what they are called these days - across the state, which is expanding. So, some of the services we visit; we have spots to visit those child and family centres, and promoting services through those. Obviously, the ongoing visits to schools across the state is part of that as well and also visibility in local areas.*

Having clinics like the new one, which will be at Legana, matches to where we are seeing population growth in our 0 to 17s. We are trying to have that visibility as well as running ongoing learning campaigns, advertising campaigns and things like that.

The main method is visibility and accessibility so it is important that we maintain our network of clinics, that we visit schools, that we visit child and family centres and things like that. It is important we have visibility and accessibility across the state.

Mr MONTY - *We also have a really good health promotion program, which perhaps Ioan Jones might like to comment on.*

Dr JONES - *To build on that, we have a health promotion manager who works very closely, as Dale has already said, with the child and family learning centres. She has developed amazingly good contacts through a strategic health promotion plan, working with child and parenting services, school nurses and so on, and working with other NGOs. She is trying to increase knowledge and understanding, the impact of poor rural health on general health, but also recognising that there are barriers in place. So, we are trying to increase the capacity of other people to help us in our mission. We can't be everywhere, so we're recognising there are other organisations out there that can help us. If we can embed rural health into curricula; if we can embed rural health into early childhood development, that is where we can prevent the disease.*[72]

[71] Tasmanian Government, 2021, Submission #72, pp. 20-21.
[72] Dale Webster, *Transcript of Evidence*, 17 February 2002, pp. 10-11.

According to Lee Jefferies, King Island resident:

> *No access to a dentist for 10 months. Due to travel restrictions and lack of availability of appointments for a dentist in Tassie, I was unable to get an annual check-up. The visiting private dentists all had to cancel their visits to King Island and so we were left with no options. The Royal flying doctors provide a public dental service but they are under such demand with serious dental work that it is not possible to get preventative care done with them.*[73]

According to the Huon Valley Council submission:

> *With no adult dental service in the Huon Valley, there are barriers to the community accessing treatment in Hobart due to the lack of public transport, long commute times and the cost of travelling from regional areas to New Town.*[74]

J: PATIENT TRANSPORT SERVICES

According to the Tasmanian Government submission:

> *Many Tasmanians living in rural and remote areas of the state are accustomed to traveling to access health care services, particularly for specialist medical and hospital services. A key guiding principle of the One Health System reforms was that clinical services would be delivered only where they can be provided safely and consistently, which means some patients may have to travel. For example, the One Health System reforms identified an alternative model was required in the north west in order to provide a stronger, higher quality birthing and maternity services. After extensive consultation with all stakeholders, a new service was established with public inpatient and birthing services delivered by the North West Private Hospital in Burnie and antenatal and postnatal care delivered by the THS at the MCH, the NWRH in Burnie and at a number of other rural sites via outreach services….*
>
> *Since 2014, the Government has introduced a range of measures to improve patient transport across the state, as well as investing in telehealth services to reduce the need to travel where possible. These initiatives are designed to support patients to access the most appropriate care in the most appropriate location. Some key initiatives include:*
>
> > *A new integrated retrieval and referral service has been created to provide access to timely, high quality care for critically ill and injured people.*
> >
> > *Construction of state-of-the-art helipads at the NWRH and MCH.*
> >
> > *Operation of a low-cost bus service between the NWRH and MCH.*
> >
> > *Enhancing Non-Emergency Patient Transport (NEPT) services across the state, with five private contractors now available to supplement Ambulance Tasmania services.*[75]

[73] Lee Jefferies, 2021, *Submission #18*, p. 1.
[74] Huon Valley Council, 2021, *Submission #19*. p. 5.
[75] Tasmanian Government, 2021, *Submission #72*, p. 31.

The submission provides further information about key patient transport services and initiatives:

Patient Travel Assistance Scheme

The Patient Travel Assistance Scheme (PTAS) supports equity of access for Tasmanians to specialist medical services by providing financial assistance with travel and/or accommodation costs where these services are not available locally.

PTAS is available to Tasmanian permanent residents who are being referred to the nearest dialysis/oncology treatment centre more than 50 kilometres (one-way) from their home, or a specialist medical service/lymphedema treatment more than 75 kilometres (one-way) from their home or not available in Tasmania.

…

***Non-emergency patient travel services* [NEPT]**

Ambulance Tasmania's Health Transport Services (HTS) are situated in each geographical region and provide NEPT services across Tasmania. Operating from five base stations, HTS is an integrated statewide service that transports low-acuity, medically stable public patients without charge to, from and between THS facilities when the patient's condition precludes the use of alternative transport. Ambulance Tasmania NEPT can transport medium acuity patients, using a patient escort supplied by a THS facility.

The majority of HTS transfers relate to inter-facility transfers and hospital discharges to aged care facilities, supporting the effective patient flow within the public hospital system and reducing demand for emergency ambulances by transporting low acuity patients. With a referral from a health care professional, HTS also provides transport for outpatient appointments and palliative placement or discharge.

As noted above, the THS has a contractual arrangement with a panel of five private providers to undertake NEPT for low-acuity public patients. This panel exists as an overflow service for when Ambulance Tasmania is unable to meet demand. Ambulance Tasmania is the largest provider of NEPT services in Tasmania, undertaking approximately 65 per cent of NEPT work.

From the period I January 2020 to 28 February 2021, NEPT services provided I 756 patient pick-ups from, and 2 186 drop offs to, rural and remote areas, with 15 451 total transfers undertaken during this period. NEPT services cover significant distances in providing patient transfers between major hospitals. During this same period, there were 313 transfers between southern and northern major hospitals; 595 between northern and north-western major hospitals; and 205 transfers between north-western and southern major hospitals.

3.1.4 Aeromedical and retrieval service

The 2018-19 Budget provided funding of $30.3 million over three years to establish a dedicated aeromedical and retrieval service, known as the Helicopter Emergency Medical Service (HEMS), providing additional staffing consisting of flight paramedics and specialist retrieval doctors. In addition, funding of $1.6 million in 2018-19 was provided for capital costs associated with establishing a dedicated aeromedical and retrieval service, including expanded base facilities to accommodate crew on-site and additional road vehicles so the

helicopter crew can respond by road if required. HEMS was fully staffed and operational before 30 June 2020.

Helipads were installed and opened at the NWRH in 2017 and the MCH in 2019, providing a fully connected and integrated statewide aeromedical service with the completion of K Block and commissioning of the helipad at the RHH in mid-2020. The Tasmanian Government has also committed to further increase aeromedical support by installing a new helipad in Dover to support the Esperance Multi-Purpose Centre and a new helipad for the East Coast to be located near the St Helens District Hospital.

In April 2020, a larger range and capacity Bell 412 helicopter was contracted by the DoH to support the anticipated need for more critical care support to regional communities arising from the COVID-19 pandemic, particularly due to the closure of hospitals in the north west region during this period. This current contract is for two years.

The Bell 412 has the capacity to carry two patients, which has been valuable in facilitating patient transfers during the COVID-19 pandemic. The flight range of the Bell 412 helicopter has been advantageous in transport of patients to mainland centres and in the movement of multiple patients from the Bass Strait Islands. [76]

A Question on Notice response from the Premier, dated 7 September 2022, provided detail on the services provided by Government to supplement community transport services:

The 2021-22 Tasmanian State Budget allocated $1.4 million across four years toward Community Transport Services Tasmania and its 400 volunteers so they can continue to support Tasmanians to access care.

A further $500 000 was allocated in the same year towards a Community Car and Coach Fund. The purpose of this funding was to assist communities purchase vehicles to provide local transport for access to essential services, connecting people to employment, education, health and wellbeing services, social and other support networks. There was a particular focus on regional communities where other transport options may be limited.

Through this program, 11 organisations received funding for the purchase of new vehicles including the Bicheno Community Health Group Inc, Dunnalley (sic) Tasman Neighbourhood House and Hospital Care Association of North West Tasmania Inc.[77]

And details of private providers who provided Non-Emergency Patient Transport:

Name of Service	Based Location *All Statewide Services*	Approved Acuity	COVID-19 Approved
St John Ambulance	Hobart	Low & Medium	3 April 2020
Moreton Group	Launceston	Low & Medium	7 April 2020
Medical Edge Australia	Port Sorell	Low & Medium	6 April 2020
Ambulance Private	Hobart	Low & Medium	25 September 2020

[76] Tasmanian Government, 2021, *Submission #72*, pp. 31-32.
[77] Question on Notice Response from the Premier, dated 7 September 2022, p. 10.

The Tasmanian Government also offers a Transport Access Scheme which supports taxi fare concessions and subsidies for eligible persons with permanent disabilities or medical conditional that significantly restrict their personal mobility.

According to the Community Transport Services Tasmania (CTST) submission:

> *CTST is vitally involved in facilitating access for patients to a range of health care services. Prior to the COVID-19 Pandemic CTST was at capacity in terms of delivering community transport under the State Government funded Home and Community Care program (HACC). CTST was delivering some 60% over and above funded outputs. As a direct result, in December 2019, CTST closed its books to any additional state funded HACC referrals state-wide. Prior to making the decision to cease accepting new HACC referrals, CTST over several years made significant changes to its operating model to expand the capacity, namely:*
>
> *• Centralised intake and assessment*
>
> *• Centralised booking model facilitated by new IT platform*
>
> *• State-wide virtual "call centre"*
>
> *• Expanded operating hours*
>
> *The combination of these service innovations means CTST was delivering close to 180,000 transports yearly, representing the upper capacity of what is achievable with current funding. As direct response to COVID-19, CTST opened up referrals to all state-wide consumers. This was made possible by significant decline in demand, consumers prioritisation and additional COVID-19 Emergency funding from both the state and commonwealth governments.*
>
> *Post-COVID CTST is rapidly returning to those earlier levels of activity: it is forecast that the state-funded HACC activity will reach capacity within the 2021 calendar year and will result in CTST again closing its books to new HACC referrals. With regard to transport access for rural and remote Tasmanians, CTST seeks wherever possible to maximise fleet usage through multi-loading passengers (ride sharing) and utilising other service providers such as taxis and public transport operators (Area Connect and others) during periods of high demand.*
>
> *From time to time and with increasing frequency CTST receives transport requests for patients who do not fit eligibility criteria under either the state or federal government funding streams. In these circumstances CTST seeks to provide transport wherever possible without creating an impact on our funded activities; however, as we get closer to service capacity, the likelihood CTST is able to facilitate this transport is diminished.*
>
> *CTST endeavours to meet all requests for transport. To ensure this, CTST requires where possible 3 days' notice from consumers of their intention to travel. This however is not always possible due to the nature of medical appointments and waiting lists – where transport is required within the 3-day window CTST has a process for managing these requests and ensuring priority is given to medical and health related requests.*
>
> *CTST operates a fleet of around 90 vehicles garaged at over 30 locations around the state – the fleet is made up of modified minibuses, people movers and sedans. Vehicles generally*

operate between the hours of 7am and 6pm – with some travel occurring outside of these hours due to the large distances covered by remote and regional vehicles.[78]

According to the Arthritis and Osteoporosis submission:

Recent changes to the Patient Travel Assistant Scheme (PTAS) have disadvantaged Tasmanians required to travel to Hobart from regional areas to access specialist rheumatology and persistent pain management services. Currently, support is only available when travelling to Hobart to access public rheumatology services – not private. However, there are long waiting lists for rheumatology outpatient clinics, and it is also understood that the RHH rheumatology service outpatient clinics will no longer be accepting referrals from outside of the region (it is not adequately resourced to provide a state-wide service). Therefore, those living in the north and north west of the State will be left with no service.[79]

In relation to the King Island experience of PTAS, the Chair asked:

CHAIR *- … What needs to happen with PTAS and access? If you can make three key points about what needs to happen what would they be?*

Ms MAURIC *- One would be to have it GP-centric in so when they do the referral it happens then and there. …*

It would be awesome if you were in the GP, it could go straight through, whichever way they could do that. …

Ms THOMAS *- The understanding that if you were going off the island for a medical appointment that is PTAS funded/eligible, why not let us go to a dentist as well? That isn't PTAS eligible. The flight doesn't cost more if you fly in the afternoon or the morning. You are only paying for the one night's accommodation still but if you could get into the dentist on that day, that saves you the $450 to fly to Burnie to go to see a dentist because the chances of getting into a dentist on King Island are very slim.*

…

Dr SEIDEL *- So you have a referral to a service that is not available on King Island, let's say it is PTAS funded, you can only use it for this particular appointment? It can't be used for any other appointment that is also not available on King Island?*

CHAIR *- You can't go and get your eyes checked?*

Ms MAURIC *- It has to be directly related to that appointment.*

Ms LOVELL *- How do they know you are even going to do that?*

Ms THOMAS *- They will look at the time of your appointment and they will book flights that fit around that appointment. So, if there is availability on a morning flight, occasionally coming out of Launceston for example, there might be three flights in a day, so first thing in the morning, early afternoon, and later in the evening.*

If your appointment is at 10 a.m. in the morning, you can come in on the morning flight, you could leave on the 1 p.m. flight and still meet that appointment and if you were to ask to

[78] CTST, 2021, *Submission #14*, pp. 2-3.
[79] Arthritis and Osteoporosis Tasmania, 2021, *Submission #43*, p. 3.

make that flight home at the end of the day at no additional cost to PTAS so that you could go and get your eyes tested, go and have a hearing test, visit the dentist.

…

***Ms MAURIC** - Also, if you are going through cancer at the moment, we have had some community members where they have a long-term plan and they have to get PTAS every time. There is no continuation. Think of that on top of dealing with your family, leaving your family, all the money, all the care, everything that goes with managing health and wellbeing of an individual, on top of that they always have to go back to the GP.*

***Ms LOVELL -** Do they ever take into account, if you are travelling for treatment that might knock you about a bit, do they take that into account? Or are you expected to get on the next plane and come home regardless of how you are feeling?*

***Ms THOMAS** - Often expected to come home. We were given examples of people who have been sent off the island for hip surgery, knee surgery and the instruction is do not sit for longer than 10 minutes. You can stand up. You can lie down. Do not sit, but you do have to get on the scheduled flight home from Launceston via Burnie into King Island so you are two hours sitting down.*

…

***Dr SEIDEL** - ... For the cancer patient being referred to wherever for cancer treatment, typically a GP would need to do only one referral and not whenever they are going over.*

***Ms MAURIC** - Yes, that's right.*

***Dr SEIDEL** - It should be the same for PTAS, right?*

***Ms MAURIC** - Absolutely. That is what I was saying we could do that one continuation of care. So you go to your GP understanding that this is the plan that you got from your specialist, so we have the PTAS coming through. You don't have to reapply -*

…

***Ms THOMAS** - It is easier for that PTAS approval to roll on when you are operating within Tasmania. If a patient is referred north to Melbourne then it is every single appointment has to be a separate form. There is no exception made; every appointment, separate form.*

***Ms MAURIC** - If that's for specialist care and specialists in the type of cancer that you have, and Melbourne might be our only option, it's a challenge for that person to get that through.*

***CHAIR** - It is also the same for pregnant women. An episode of pregnancy care should extend to the six-week check but it doesn't, does it?*

***Ms MAURIC** - Even the accommodation is challenging. I have had two kids since I moved to the island. Coming across for my first one was easier but for the second one you are not allowed to stay in the designated accommodation because you have a young toddler. So I had to leave my partner, my family, to come across. I had to find my own accommodation because they are not suitable for a younger child. It is commonplace for people on King Island, to have another sibling to come across to have another baby.*

***Ms LOVELL** - Does PTAS cover a support person for a birth?*

***Ms MAURIC** - No, for a period of time, for a couple of days when you have actually given birth.*

***Ms LOVELL** - So you have got to be able to schedule that?*

…

***Mr GAFFNEY** - So your issue is that PTAS needs to be more flexible to make it easier because you do not have anybody there to help navigate?*

***Ms THOMAS** - Just to make it practically possible. The things that you can and cannot claim for on PTAS just feel a bit odd. For example, if you are coming to Wynyard to go to Burnie Hospital, you can claim the taxi either from the airport to your accommodation, or from your accommodation to the hospital but not both.*

You also have to be able to get one of the two taxis that are operating in Wynyard at any given time to make that happen. You can claim mileage for a car but you can't claim car rental. You can only claim a certain amount of money for accommodation. I think in our submission we are included an idea of the places that are available for the money that you are given under PTAS. It is not wonderful. There is not any consideration given, that we were able to identify through this process, to the capability and physical ability of the patient or their support person. Most of the places that you can stay are older style B&B properties, all great and very comfortable, often with steps, often with narrow doorways, not generally accessible for somebody who has limited mobility in almost any way. So how do you make that work? It is very administration- and process-focused rather than patient-focused.[80]

The King Island Council submission included the experience of a Flinders Island Resident:

Example #20.

[Note: This individual is a resident on Flinders Island who contacted King Island Council when they heard we were preparing a response to this inquiry.]

In July I attended two medical appointments in Launceston. As required, my Patient Travel Assistance Scheme paperwork was returned to the PTAS office, on my return to the island. I duly received a receipt from PTAS acknowledging $50 payment for my accommodation. On enquiring why, I was short changed my Cab Charges I was told I had not identified how I used the $75, which was to and from the airport, and from the Eye Hospital to the Cancer Council and from the Cancer Council to Spurr Wing. I was also told that PTAS only paid one way from the airport and I would have to get the Shuttle bus in future.

I then called the Shuttle bus, and was told that under no circumstance would I be picked up at 6.30am. I then went on to the Tasmanian Government, Department of Health and Human Services where I found some very interesting information. This is not put into the paperwork we receive when we get our blue form from our doctors here, but is freely provided online. I have sent a copy to Minister Sarah Courtney, our Lord Mayor, and to another islander who has also had some difficulty communicating with the PTAS office people in Launceston.

[80] Kate Mauric and Helen Thomas, *Transcript of Evidence*, 2 November 2021, p. 81.

However, for those who have also found this situation untenable, I will include the one paragraph which may help you and me fight this injustice.

TRAVEL

Residents of King Island and the Furneaux Islands can claim the cost of a return economy airfare (Island Resident rates), plus the cost of the most economical, appropriate form of transport from the destination airport to and from the medical facility.

I have a third medical trip to attend this month and could then be out of pocket $180. This is not necessarily about the dollars, but it is a principal I am prepared to fight. If rules are changed, we should be informed by those who know what we are required to do. It would probably help if we had a PTAS Coordinator, like King Island, who we could talk to.[81]

K: 'AFTER HOURS' HEALTH CARE

According to the Tasmanian Government submission:

After hours care is provided through a range of state and federal government and private sector services. In rural areas this includes after hours emergency care provided through Ambulance Tasmania and care provided after hours on site by District Hospitals...

The Tasmanian Government also provides funding to support operation of Healthdirect Australia (Healthdirect) which is a joint initiative of all Australian governments. Healthdirect provides access to a range of virtual health services and health information. This includes a health information and advice line for all Tasmanians and visitors to the state. This line operates 24 hours seven days a week, putting people in touch with a registered nurse to help the person decide the best course of action to deal with their health concerns. Healthdirect also operates to facilitate access to after hours GP medical advice. The Tasmanian Government also provides some funding to GP Assist to support the service.

Additionally, the Tasmanian Government has recently announced funding of $3 million in additional support and incentives for primary health services, including local GPs and pharmacies, to provide after hours services for their local communities. [82]

The Health Consumers Tasmania (HCT) submission provided the following comments in relation to the availability and timeliness of health services:

Conversations across the state conducted by Health Consumer Tasmania in 2020 and 2021 have identified the following issues relating to access including the timeliness of receiving health care for rural Tasmanians.

Specific issues included:

• *there is a need for afterhours health care with consumers noting it was effectively non-existent in some rural areas and with urgent rural medical care generally being undertaken through ambulance callouts and emergency departments*

[81] King Island Council, 2021, *Submission #67*, p. 24.
[82] Tasmanian Government, 2021, *Submission #72*, pp. 27-28.

…

• out of hours pharmacy care is also missing in rural areas. Our consumers highlighted that there was no point in being able to access a GP if you still had to attend a major town centre to get a script filled, specific dressings or other pharmaceuticals. GP and pharmacy access afterhours go hand in hand.[83]

According to the late Bill Dermody:

With the housing expansion that's taking place in the Derwent Valley and with the increase of young families who, if people who have been there for 30-odd years can't get on the book at the medical centre, the likelihood is those young families will not be able to get on the books at the medical centre either. With people regularly waiting anywhere from two to six weeks to see a GP at the medical centre and with there being no after-hours or weekend medical or health services in the Derwent Valley or Central Highland communities, this means that the only options that are available are for people to wait weeks to see a GP or call an ambulance or present at the emergency department at the Royal Hobart Hospital.[84]

L: INDIGENOUS AND CULTURALLY AND LINGUISTICALLY DIVERSE (CALD) COMMUNITIES

In response to a request made by the Committee, the Multicultural Council of Tasmania provided the following feedback:

Culturally and linguistically diverse (CALD) are accessing many health services but some are not. Therefore, the waiting period is longer in that case. For example, a non-English speaking patient from Bhutanese community told to us in a community meeting that he waited for 4 years to have his plastic surgery to correct his head movement.

Majority of the Humanitarian entrants and skilled migrants (pathway to permanent residency) have access to Medicare. However, international students don't have Medicare card and should pay gap in accessing health services.

Some communities, like Burmese, have initiated volunteer support services to their community members who have limited or no English language literacy. Some NAATI accreditated (sic) *volunteers are helping non-English speaking members to access the health services, telehealth services, pharmacy, mental health services. Sometimes, they organise community workshops to inform health (and other) related services and information available.*[85]

According to the Tasmanian Government submission:

The Tasmanian Government is committed to continuing to support access to health services by Aboriginal and culturally and linguistically diverse people living in Tasmania. Existing supports include, for example, providing access to professional interpreters (via the THS Interpreter Booking Service) to assist people to access and navigate health services, providing health information in languages other than English, and provision of

[83] Health Consumers Tasmania, 2021, *Submission #56*, p. 6.
[84] Bill Dermody, *Transcript of Evidence*, 19 November 2021, pp. 3-4.
[85] Question on Notice response from the Multicultural Association of Tasmania, received on 13 July 2022.

multicultural awareness training for staff. The Department of Health (DoH) also funds the Australian Red Cross to deliver the statewide Bi-cultural Health Program which assists newly arrived people of culturally and linguistically diverse backgrounds (especially those from refugee backgrounds) to understand and access the health system.

DoH has also developed an action plan targeted at improving Aboriginal cultural respect across Tasmania's health system. The action plan has been heavily informed by consultations with Aboriginal people in Tasmania, the national Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016-2026 and is also guided by the National Safety and Quality in Health Services Standards (second edition). The action plan aims to create welcoming environments across THS sites by improving cultural competency, promoting active participation in personal health and wellbeing, improving the collection of data and strengthening partnerships with Aboriginal health services in Tasmania. It is intended this action plan be implemented across the THS and DoH more broadly. [86]

The South Eastern Tasmanian Aboriginal Corporation (SETAC) submission made the following comments in relation to Aboriginal Community Health:

SETAC is an Aboriginal Community Controlled Health organisation that provides culturally safe primary healthcare, in a culturally safe framework to the Aboriginal Community living in the Kingborough and Huon municipalities. We are a nurse lead, multidisciplinary service that works closely with the Aboriginal Community, delivering primary and allied health services.

We also have strong linkages across the region with other service providers. We recognise that there are many systemic issues with the Tasmanian Health system due to limited resourcing and competing priorities. Below is a list of issues that SETAC faces regularly:

- *Short-term funding that focuses on a bio medical framework and is not responsive to the social determinants of health for people living in the Kingborough and Huon municipalities.*
- *A shortage of services and a qualified workforce that can support people with substance abuse issues, including treatment, counselling, detox and rehabilitation. This combined with the stigma around this cohort and health practitioners or services being at capacity could result in death.*
- *Limited support for people with mental health issues and poor referral pathways that means people are trapped in a system for months.*
- *Public transport is limited and not always accessible to people who have mobility problems, this is further exacerbated by poverty. Community Transport is stretched and is now only for people on Aged Care Packages only; therefore, the capacity for people to travel to health appointment is very limited.*
- *Lack of health services in the region, but also a lack of follow through from services that are based in Hobart but claim to service the whole region. SETAC are keen to work to improve the health of the Aboriginal and broader community in the Kingborough and Huon municipalities, making health services more responsive to the needs of this community and accessible for all.*[87]

[86] Tasmanian Government, 2021, *Submission #72*, p. 9.
[87] South East Tasmanian Aboriginal Corporation, 2021, *Submission #48*. p. 1.

According to the Health Consumers Tasmania (HCT) submission:

> *There are currently four (4) dedicated Aboriginal and Torres Strait Islander health workers in the state… none are male severely disadvantaging the male Indigenous population across the state and in rural and remote areas at a time when it is widely acknowledged that Indigenous populations live with greater levels of co-morbidity and have higher than average death rates when compared to the general population.* [88]

M: MENTAL HEALTH SERVICES

According to the Mental Health Council of Tasmania's (MHCT) submission:

> *People living in rural and remote Tasmanian communities experience challenges accessing local, affordable, and appropriate mental health care. Due to the geographic constraint, isolation and low population levels, models of care in rural and remote areas differ to those offered in more urban settings. This often means rural and remote communities miss out on integrated service responses that meet a range of clinical, therapeutic, or psychosocial needs. The absence of robust local mental health service provision places undue demand on state-operated acute inpatient services. Greater access to community-based support is crucial to addressing an overreliance on Tasmania's inpatient services.*
>
> *Through consultation MHCT has learned that access to community-based mental health care in rural and remote locations across Tasmania is inconsistent. Most communities perceive themselves to be 'under serviced', many of which rely on outreach services that might visit their region a handful of days within a month. Understandably, there are few place-based mental health support services with a visible presence in many rural and remote Tasmanian communities. Whilst outreach models fill critical service gaps and are appreciated by community members, they do not allow for the flexibility required to respond to immediate need in times of crisis. The episodic and fluctuating nature of mental illness means its impact can become more acute or chronic over time, particularly when psychosocial stressors and co-morbidities create multi-layered complexities. Put simply, support needs change over time in a non-linear manner, and this requires flexible integrated service responses which are not consistently available in rural and remote Tasmanian communities.*
>
> *General practitioners (GP's) are often the initial point of contact for those seeking mental health help for the first time. Anecdotal evidence from MHCT facilitated consultations suggest that GP's in some rural and remote locations may not always be equipped with the skills to adequately manage acute or complex mental health presentations. Additionally, there are challenges with the availability and timely access to psychology services in rural and remote communities in Tasmania. There aren't enough practising psychologists in Tasmania to meet demand, and existing psychologists are not evenly dispersed across the state making access in rural and remote locations limited. For example, on the West Coast of Tasmania there are currently no practising psychologists thus people need to travel to Burnie to access psychology services. For many community members this creates too great a barrier. Furthermore, increasing demand for mental health supports has resulted in the*

[88] Health Consumers Tasmania, 2021, *Submission #56,* p. 7.

reduced capacity of many psychology services to accept new referrals. Anecdotally, in some areas of the state, psychologists have had to close their books or have waitlists of up to six months for an initial appointment, during which time there is a risk that a person's symptoms may become more severe and they would require a higher level of support. The recent Federal Government announcements around the extension of Medicare subsidised psychology sessions through the 'Better Access to Mental Health Care' scheme do not address these access issues.

Community members living in rural and remote locations have seen mental health programs or supports come and go over the years due to inconsistent funding and policy. This makes it hard for communities to have confidence that new services will be available long term. It takes time for communities to build trust and engage in mental health services in rural and remote locations, therefore consistency and continuity is paramount to their success. Additionally, the absence of a robust mental health service system in smaller communities creates support gaps that other community organisations are filling. These organisations report that managing mental health presentations is beyond their remit and that their staff do not have the adequate skills and experience to respond effectively. The reliance on other community organisations to fill the gaps created by underservicing is not sustainable as any supports that these organisations are able to provide often relies on tenuous funding models that depend on intermittent grant programs, philanthropy, or sporadic government funding tenders. These issues are indicative of a need to enable local integrated care solutions which utilise existing resources and are accessible for community members.

Moving toward an integrated mental health system

The Tasmanian Mental Health Reform Program strives to transform the mental health system in Tasmania to create access to a world class system of care - an integrated Tasmanian Mental Health System – which shifts the focus away from hospital-based care to support in the community. The Mental Health Integration Taskforce Report contains 21 recommendations which include but are not limited to the vertical and horizontal integration of Tasmania's mental health system, the establishment of integrated service hubs, a hospital voidance program, an integrated suicide response and the creation of new services models of care such as the Acute Care Stream/Acute Care Team. These reforms are currently planned largely for Southern Tasmania with a longer-term goal of state-wide implementation.

The capacity of existing services to provide high quality care is compromised by poor integration between GP's, psychologists, community managed mental health services, public mental health services and community health centres and regional hospitals. A seamless continuum of care in the rural and remote context relies on flexibility and local responsiveness yet there are major challenges with accessing state mental health services in rural and remote Tasmanian communities. MHCT believes there may be opportunities for such communities to take advantage of the current reforms by aligning with the models of care currently under development. This may lead to local level integrated service responses that could overcome some of the existing issues around access to timely and appropriate mental health services.[89]

[89] Mental Health Council of Tasmania, 2021, *Submission #52*, pp. 4-6.

According to the AMA submission (Addendum):

> *Mental health services in rural and remote Tasmania are at best scarce and at worst non-existent. The government cannot increase services for these communities without the necessary skilled workforce to deliver them. It is difficult enough trying to attract psychiatrists to work in urban areas of Tasmania, let alone rural areas. The government would need to offer special financial and other incentives to grow the rural and remote workforce for both doctors and nurses trained in delivering mental health care in order to address the workforce shortage.*
>
> *Access to patients via tele-psychiatry could be enhanced if there were stronger relationships with primary care so that patients could be seen via telehealth facilities within a GP surgery. This way mental health specialists can talk to the patient and their General Practitioner about a treatment plan. Private tele-psychiatrists already have this model of care.*
>
> ***Inpatient resources:***
>
> *Rural and remote areas need more than additional acute hospital beds. Like when treating physical illness, rehabilitation in mental health is an important part of recovery. However, mental health rehab is non-existent in regional areas for chronic mental illness or prolonged recovery cases, e.g. for eating disorders, chronic schizophrenia, inpatient medication changes and adjustments such* [as] *Clozapine. Neither young people nor the older population are adequately serviced in regional areas, that is, there are no age-appropriate beds/ services to cater for their different needs.*
>
> *Day clinics can play an important part in a patient's recovery. Mental health treatment is provided within the structure of day clinics, away from acute wards, but still having the support from the professional teams. There is a lot of research supporting the effectiveness of day-clinics rather than prolonged admissions to the acute wards. Patients attend day clinics for several weeks before being discharged home. Increasing access to day clinics for patients in rural and remote areas, ideally as close to home as possible, would be of benefit to them.*
>
> *Access to allied health in the acute, and subacute inpatient facilities is also important. In regional areas, hospitals do not have appropriate allied health support, such as, daily access to a physio for group activity and/or individual activity. The number of patients with mental illness and obesity (metabolic syndrome) is disproportionally high and yet, for instance, the NWRH does not provide physio support to facilitate health promotion and physical activity as part of the treatment. Instead, people are more or less "locked up" on the ward, having to ring a bell if they want to go for a walk. Similarly, well established Milieu therapy, Art Therapy, Music therapy or Occupational therapy are not available in any of the regional facilities, even though there is evidence in the literature suggesting these therapies are an effective part of the recovery process.*
>
> *Additionally, the absence of adequate space to spend with family or friends during an admission has not yet been addressed in some facilities. It is well known that in many cases, relationships are a key aspect in recovery, especially family relations when supportive. And yet, the NWRH for example, is lacking a reasonable space for families to visit their loved ones while mentally ill.*[90]

[90] AMA, 2021, *Submission #52 (Addendum*), pp. 2-3.

The Royal Flying Doctor Service's submission outlined the Mental Health Program:

> *The RFDS's Mental Health Program is a free service for people living in remote and rural areas of Tasmania in the areas we operate in.*
>
> *The mental health program was established in 2017 with initial funding from Primary Health Tasmania. In early 2019 we commenced a new mobile youth mental health* [program]*; this new program is due to funding provided by the Commonwealth to the RFDS nationally.*
>
> *The program expanded to support youth aged between 8-16 years of age living in rural and remote areas of Tasmania, as this was identified as the area of greatest need.*
>
> *The Primary Health manager and the team of physical and mental health workers identified the demand for high quality, effective services to be delivered, and co-designed in consultation with clients and stakeholders a program to cover a gap for clients who would not normally be able to access mainstream mental health services.*
>
> *Accessibility is often a barrier for rural and remote community members and the success of programs in these areas relies on working with key community groups and general practitioners (who are our primary referrers) as well as having a skilled and mobile workforce that can provide these services. Allowing consumers to self-refer also decreases any barriers to accessing services.*
>
> *Successful accreditation against the National Safety Quality Health Service Standards and certification against the National Mental Health Standards has formed the foundation for RFDS to consolidate, expand and develop new programs, ensuring they are high quality, safe and client centred.*
>
> *Accreditation provided the foundations to develop and implement a quality management system and to ensure our staff and clients were partners at every step of this journey.*
>
> *RFDS Tasmania now has robust systems in place to evaluate, audit and report on program deliverables and meet contractual KPI requirements.*[91]

The RACGP submission noted an inequality in health outcomes for people living in rural and remote areas. In relation to mental health services, the RACGP submission stated:

- *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.*

  …
- *Very limited psychiatry in rural Tasmania and there is a huge need.*[92]

According to Connie Digolis, Mental Health Council of Tasmania:

[91] Royal Flying Doctor Service, 2021, *Submission #53*, pp. 13-14.
[92] RACGP, 2021, *Submission #65,* p. 6.

…In January and February this year, we travelled around the state, including the islands, to hear from rural communities about their concerns and access to mental health supports and services.

In St Helens, we heard that if someone is in suicidal distress they are often taken by police or ambulance to Launceston General Hospital for assessment. However, admission to hospital isn't guaranteed and, if not admitted, the person needs to find their own way home. One community member explained that there's a saying in this town, don't have a mental health crisis between 5 p.m. Friday and 9 a.m. Monday.

Equally, on Flinders Island, we heard that if someone is in suicidal distress the air ambulance will transport them to the LGH. However, if the person isn't admitted, they will need to find their own way back to Flinders Island.

In Smithton, we heard there are not many health professionals or support workers in the area and, of those workers in the area, there's no consistency or opportunity to build relationships to support their health and recovery. We also heard that most services are in Burnie, which causes barriers due to transport.

Similarly, in Queenstown, we heard of very limited services and social supports, with most of these services being outreach only. We heard that if a person needs to access services in Burnie the cost to travel is one barrier, but they may also need to pay for overnight accommodation in order to attend that appointment. This means that access to service is simply unavailable to many who cannot afford the travel and accommodation expenses.

On King Island, we heard that there are very limited clinical options, with locums coming in, there's also inconsistency and the need for people to constantly repeat their story. Additionally, we heard there's limited understanding in the community of when services would be coming to visit the island.[93]

Ms Digolis noted access to after-hours mental health services is very limited in rural areas:

In the examples we heard the most about, it was about getting that initial assessment and potential admission and that was only available via an urban hospital, especially if we we're talking after hours or weekends. Often, a GP wasn't available. They may call a CATT team or the Mental Health Service and the next point of contact for them is an urban hospital.[94]

The Women's Health Tasmania submission made the following comments in relation to Mental health services:

Across the board, women told us about the lack of coordination between health services, and between health and allied services which made complex care management difficult. Women around Tasmania often contact Women's Health Tasmania seeking mental health professionals who will bulk bill to deliver GP initiated mental health plans. These professionals are extremely rare, and in addition psychologists have long waiting lists.

Women reported high levels of mental ill health in their communities, particularly identifying grief, loneliness, anxiety and depression. Rural women also report that mental health issues still carry significant stigma in rural areas, which impacts on the mental health

[93] Connie Digolis, MHCT, *Transcript of Evidence*, 30 November 2021, p. 43.
[94] Connie Digolis, MHCT, *Transcript of Evidence*, 30 November 2021, p. 46.

of individuals. Other forms of stigma, such as that associated with socio-economic disadvantage and LGBTIQ+ identity also affect the mental health of individuals.

The women we consulted wanted initiatives to help support good mental health in rural communities. Their suggestions included initiatives to promote positive mental health and prevent mental health problems, early intervention when problems developed, better access to mental health services, and action to address the stigma experienced by particular groups of people.

Women living substantial distances from emergency departments have also reported to us their worry about the potentially significant consequences of emergencies and the additional stress this places on them as parents of infants and young children. People in the areas of Central Highlands, Derwent Valley, Geeveston/Dover, Triabunna/Bicheno and Forestier/Tasman are more than 50 kilometres from the nearest emergency department and the emergency departments they are nearest to are located within rural facilities, staffed by generalist providers.[95]

Sue Heart, Trauma Awareness Network Australia (TANA) describes preventative program to deal with complex trauma to alleviate the health burden:

We are about trauma awareness, and we want an Australia-wide public mental health promotion campaign, with a pilot in Tasmania.

Mental illness and substance use disorders are ranked equal second in the Australian Burden of Disease Study 2018 key findings, published in August 2021. A burgeoning global evidence base reveals that adverse childhood experiences, or ACEs, contribute to most of our major chronic health, mental health, economic health and social health issues.[96]

We proposed Tasmania as a pilot to help alleviate the health burden, educate the general public in the science of complex trauma, adverse experiences and their impact as well as the science of benevolent childhood experiences, positive childhood experiences. ... This inoculates against the development of future illness related to toxic stress and is what builds resilience in a community. This is all based on science.[97]

According to TANA:

TANA's solution to addressing availability of mental-health services is that we are funded to provide training for building a Trauma-Informed Community of Care across Tasmania. We are aware of some work already being undertaken in our systems, and we support all of it, however, it is must be recognised as a four-stage process that begins with trauma-awareness. Trauma-aware individuals and groups becomes trauma-sensitive, then trauma-responsive. Being trauma-informed is when policies and practices that are trauma-sensitive and responsive are the norm.

We can train both the service providers and the general public, and we can provide opportunities for service providers to train their own people, with an evidence-based

[95] Women's Health Tasmania, 2021, *Submission #22*, p. 6.
[96] Sue Heart, TANA, *Transcript of Evidence*, 26 November 2021, p. 36.
[97] Sue Heart, TANA, *Transcript of Evidence*, 26 November 2021, p. 38.

program that has gained significant traction in the United States. The science is clear. When adverse experiences are left unresolved or unmitigated by a supportive caregiver, especially in childhood while the body and brain are still physically developing, they do not go away. They remain stored in the body, manifesting as elevated stress states, which obviously create a state of dis-ease; of being not-at-ease. The body develops disease when the stress load is maintained, failing to return to homeostasis. When a child is constantly on alert for potential threat, and living in a constantly stressful environment, they experience toxic stress. This causes physical health problems that are often exacerbated throughout the lifespan.[98]

Connie Digolis, Mental Health Council of Tasmania made the following comments in relation to trauma informed practice across all levels of care:

Ms DIGOLIS *- We are seeing significant moves being made within public mental health services to implement trauma-informed practice across all levels of care. It would be fair to say that the community service sector speaks similarly. There is certainly a lot of research which supports that; it could be appropriate knowledge, understanding and experience for any service to be able to employ that kind of response to people who are presenting to their services.*

We don't have a consistent approach yet across community support services, but I am sure that if we were to look at ways to improve access to that professional development and learning, we would actually see that taken up quite strongly.

CHAIR *- If there was a more consistent trauma-informed approach to people with mental health challenges, do you think this might help to keep people out of our acute system more? You still need to have the services in the community, I appreciate that, but do you think that would have a significant impact?*

Ms DIGOLIS *- Absolutely. I think we can see a lot of examples. Again, a lot of research points towards trauma-informed care making a difference to how the person is actually going to respond, and then be able to calm, and to those assessments to come into train. As I said, for many people in suicidal distress, admission to hospital isn't the best option for them, so this would support that kind of approach.*

CHAIR *- In terms of helping more of our health workforce and frontline response to be more trauma informed, whose responsibility is that - in terms of that professional development, additional training? Where do you see that fits?*

Ms DIGOLIS *- We think that is something that probably needs to come into the joint workforce development strategy, which is sitting in Rethink for next year. We can't look at growing the workforce without looking at upskilling the workforce, and looking at all of those areas that need to be looked at to ensure we are providing contemporary best practice care across all levels of services.*

In our submission we do talk to some additional work around prevention and early intervention, and some of the mental health literacy work that needs to happen in our broader population to help people understand how to recognise when somebody might be

[98] Trauma Awareness Network Australia, 2021, *Submission #71*, p. 2.

becoming unwell, and how to intervene earlier, before it has become a situation that might be dire. There is also work we need to do in communities as well on that question.

***CHAIR** - A community informed about trauma would be beneficial broadly, not just to the health workforce.*

***Ms DIGOLIS** - Yes, absolutely, especially as we start looking towards the community service workforce, to some of those community organisations like men's sheds, neighbourhood houses, family centres - those touchpoints for people who may have community members coming into their services who may not be doing as well as they can.*[99]

According to Diana Wilson, retired lecturer, researcher, writer and visual arts practitioner, in her submission:

Health facilities should work to becoming more trauma aware, that is particularly pertinent when people who live with mental health issues are required to relive over and over their trauma as they recount it to countless people in the health service.[100]

According to the Tasmanian Government submission:

People with severe mental illness can receive treatment from GPs, private psychologists and other allied health providers, private psychiatrists and publicly operated mental health services with many people accessing more than one service. The Tasmanian Mental Health Services delivers a range of community and in patient-based services to Tasmanians with severe mental illness state-wide, including in rural settings. The Mental Health Services Helpline is a central point of contact of entry to Mental Health Services for all Tasmanians, providing advice, assessment and referral 24/7 via an 1800 number. In 2019-20, 71.5 per cent of people with a mental illness had their needs met by the Tasmanian Mental Health Service. This was above the target of 63 per cent.

The Tasmanian Government is committed to providing the best possible mental health care to all Tasmanians and recognises the importance of mental health as a key factor in enabling people to participate in their communities and live full lives. Significant investment has been made through the 2020-21 Budget and through 2021 State Election Government commitments, to deliver well-integrated and flexible mental health and alcohol and other drug services for the entire community. Over the 2020-21 Budget and Forward Estimates, $595.5 million will be invested in state-wide mental health services, and a further $26 million in mental health and alcohol and drug services through the 2021 State Election.

For example, the Tasmanian Government has recently announced investment of an additional $41.2 million over four years to fully fund Phases One and Two of the Government's response to the Child and Adolescent Mental Health Services (CAMHS) Review to support young Tasmanians to receive the best possible mental health care. This additional funding will include implementation of:

A second service to be established for children in Out of Home Care.

A second service to be established of the Youth Early Intervention Service.

[99] Connie Digolis, *Transcript of Evidence*, 30 November 2021, p. 7.
[100] Diana Hardy Wilson, 2021, *Submission #11*, p. 1.

Capacity of Perinatal and Infant Mental Health Service to be further increased and enhanced.

Establishment of a state-wide Youth Forensic Mental Health Service.

Establishment of eating disorders day treatment programs.

Securing appropriate contemporary facilities for community outpatient services.

Further, the 2020-21 Budget includes $1.2 million for community mental health support initiatives, as well as $2.1 million for community organisations to support individuals experiencing mental health difficulties associated with issues arising from the COVID-19 pandemic. This includes funding for organisations such as Rural Alive and Well to provide support for Tasmanians living in rural communities, with a focus on older Tasmanians. This has been supported by a further $2.25 million over two years committed through the 2021 State Election.

A total of $7.83 million has been committed through the 2021 State Election over three years to continue and expand innovative new services put in place through the COVID-19 pandemic, including increasing the capacity of a "Tasmanian Lifeline" to deliver a mental health phone triage service. This builds on the capacity of communities to look after their mental wellbeing by training and supporting regional coordinators and community engagers to engage with, and target, mental health literacy through local government, clubs and community groups, with a particular focus on youth and older Tasmanians.

Through the State Election, the Government also committed $40 million for the first stage of a new Mental Health Precinct, adjacent to the NWRH, to be completed in 2025. A further $8.5 million has also been committed over two years to fund a Mental Health Hospital in the Home pilot in the north west to enable people who may have otherwise been hospitalised, to receive intensive, short-term support in their own home. This pilot will be guided by learnings from the southern service.

The Government has also committed to recruitment of a locally based mental health specialist for the Circular Head region, with recruitment commencing in the First 100 Days implementation plan. This specialist will provide mental health counselling and outreach, as well as suicide awareness and prevention, with a focus on young people.

… building a best practice, integrated model of mental health services across the state remains an ongoing priority for the Tasmanian Government.[101]

During the Budget Estimates process, the Premier in his capacity as Minister for Mental Health and Wellbeing provided the following update on the CAMHS review:

***Mr ROCKLIFF** - We have welcomed - as I've said before - and accepted all the recommendations of the CAMHS review, and the government's response is a turning point in the delivery of integrated Child and Adolescent Mental Health Services in our state for children, adolescents, their families and carers to better navigate the mental health system.*

We have committed some $45.2 million in total to fully fund our responses to phase 1 and phase 2 of the CAMHS review report and its recommendations. The reforms to be delivered

[101] Tasmanian Government, 2021, *Submission #72*, p. 28.

are extensive, including changes to the CAMHS structure, practice, and culture, and will address current service gaps with a particular focus on our most vulnerable young people with severe, complex mental health needs.

To date, the following progress against the CAMHS review report recommendations has occurred. We've established a new state-wide CAMHS executive group and project team led by a state-wide specialty director and a state-wide group director. We're scoping work with business cases, completed to deliver three specialist services: a youth mental health service; an intensive mental health service for children in out-of-home care; and youth forensic mental health service as well.

Consultation has commenced with a wide range of stakeholders across government and the community sector including consumer peak bodies to inform service development. Negotiating an MOU between CAMHS and the University of Tasmania to create a centre for mental health service innovation to drive continuous service improvement, professional development research, and program evaluation. Several child and adolescent psychiatrist positions have been established and are being recruited to. CAMHS marketing documentation has been developed, identifying the variety of positions available in the service and opportunities for professional growth.

We've got targeted recruitment strategies which are being developed, focusing on child and adolescent mental health professionals from a range of disciplines. International recruitment efforts are yielding positive results as well, with an international CAMHS nurse recently arriving in Tasmania and several other CAMHS nursing and allied health visas have been granted. I'm also pleased to say from this week, the capacity of CAMHS at the Royal Hobart Hospital, as I believe I mentioned earlier, will be expanded with the extension of staffed hours until 10 p.m. seven days per week to respond to child and adolescent mental health presentations and inpatient needs. Under previous arrangements, CAMHS were available at the hospital Monday to Friday between 8.30 a.m. and 5 p.m., so that's very welcome.

The expanded capacity will support the emergency department paediatric areas, with clinical liaison and assessment in hours with CAMHS not previously available. It's anticipated that the extended service will contribute to reduce wait times in the ED for young people in the evenings and on weekends and potentially reduce the length of admission as well. The CAMHS team will also, where appropriate, provide a seven-day follow-up to child and adolescent mental health patients after discharge, and the expansion is an important step in building a more responsive and accessible service.[102]

In relation to the PACER program, the Premier provided an update during the 2022 Budget Estimates process:

***Mr ROCKLIFF** - Last year's budget, we committed some $5.1 million over two years to pilot the innovative mental health co-response model in southern Tasmania. It commenced operations in January this year. It is comprised of police officers, paramedics, mental health clinicians, providing that rapid response to mental health crises in the community.*

[102] The Premier (in his capacity as Minister for Mental Health and Wellbeing), *Transcript of Evidence*, 7 July 2022, pp. 133-4.

The objective is to ensure that people in mental health crisis have access to timely and appropriate mental health care, are dignified and respectful. To receive a less restrictive, and compassionate response which enables them, where possible, to remain in the home, in the community, and avoid preventable mental health presentations to the ED, and links them to community-based mental health supports where appropriate; increased service capacity via training and education in relevant specialist skills.

I'll just repeat the figures. In the 17 weeks of operation, that's responded to callouts of 486 people with a number of conditions - I mentioned them today - suicidal ideation, psychosis, depression, anxiety, and confusion, incoherence. Welfare checks were also conducted. The PACER team also handled a number of phone consultations with family members and other police or ambulance units as well, and the majority, around 75 per cent of these people, were supported to remain in the community as opposed to having had attended the Royal Hobart Hospital.

You mentioned the $9 million allocated in your question. That's to ensure a permanent service will be in southern Tasmania, which is very welcome. We're expanding the model for mental health emergency response that suits the needs of the north-west community, and that'll be developed and piloted from January next year as we progress to a more state-wide service model.

It operates between 8 a.m. and 10 p.m. seven days a week across two shifts for your interest, responding to mental health-related jobs from Sorell to [New] *Norfolk and Kingston as well. And it receives their work from Triple 0 calls, and when Triple 0 is called, Ambulance Tasmania conducts a secondary triage process to determine if the job is appropriate for a PACER response. Once dispatched, the Tasmanian police radio dispatch assumes oversight of PACER, and the establishment of our new PACER team follows what has been a successful pilot in the ACT, with 90 per cent of people who were seen by the PACER team able to stay in the community. The numbers have increased in recent times, creeping up above that 70 per cent and more. We would* [like] *to see the 90 per cent that was in ACT here in Tasmania.*[103]

And further, in relation to mental health diversions away from emergency departments:

***Mr ROCKLIFF** - … Around 75 per cent of those have been cared for in the community, and PACER's for people experiencing serious mental health episodes, who have otherwise not had to present to an emergency department.*

In the first 17 weeks of operation PACER responded to callouts of 486 people … The number of conditions ranging from suicidal ideation, psychosis, depression, anxiety, confusion, incoherence and welfare checks were also conducted.

***CHAIR** - This is the number who were diverted away from the DEM at this stage particularly?*

***Mr ROCKLIFF** - The callouts were 480-486 people…*

…

[103] The Premier (in his capacity as Minister for Mental Health and Wellbeing), *Transcript of Evidence*, 7 July 2022, p. 136.

Mr ROCKLIFF *- were supported to remain in the community as opposed to having to attend the emergency department at the Royal Hobart Hospital. So that would be 73 per cent of 486 people.*[104]

A Question on Notice response from the Premier provided the following details in relation to the utilisation and outcomes of the PACER initiative:

PACER is comprised of Police Officers, Paramedics and Mental Health Clinicians, providing a rapid response to mental health crises in the community.
The objectives of PACER are to provide people in a mental health crisis with:

- *Access to timely and appropriate mental health care in the community.*
- *A dignified, respectful, least restrictive and compassionate response that enables them, where possible, to remain at home and avoid preventable mental health presentations to the Emergency Department.*
- *Links to community-based mental health supports where appropriate.*

PACER has responded to call outs to 929 people to date with a number of conditions ranging from suicidal ideation, psychosis, depression, anxiety, and confusion/incoherence. Welfare checks have also been conducted.

The PACER team also handled a number of phone consultations with family members and other police or ambulance units.

The majority, 77 per cent, of these people were supported to remain in the community as opposed to having to attend the Emergency Department at the Royal Hobart Hospital.[105]

In relation to the inter-hospital transfer policy, the Premier, Kathrine Morgan-Wicks and Professor Tony Lawler made the following comments during the 2022 Budget Estimates Process:

CHAIR *- Minister, you did mention, I think in your opening comments, about the inter-hospital transfers not needing to go through the EDs of receiving hospitals, where it's clinically indicated. Is that happening right across the board now?*

Mr ROCKLIFF *- Yes, it is. The inter-hospital transfer policy is an initiative of the department's statewide access and patient flow program, which is also implementing priority projects to improve capacity across our health system. Typically, a patient is transferred to a different hospital due to their need for a higher level of care, or admitted to a health facility closer to their home.*

Currently, when a patient is transferred, they are often required to be readmitted to the destination hospital through the ED, which can cause delays. This new policy has been developed with key stakeholders to deliver a consistent statewide pathway for transferring patients, and means patients who arrive from another facility will not be required to be readmitted through the ED.

…

[104] The Premier (in his capacity as Minister for Mental Health and Wellbeing), Kathrine Morgan-Wicks, *Transcript of Evidence*, 7 July 2022, p. 136.
[105] Question on Notice Response from the Premier, dated 7 September 2022, p. 11.

Ms MORGAN-WICKS *- Through the Minister. There have been some suggestions in the media that this is not a new policy. Certainly, this is the first time that we have had a statewide inter-hospital transfer policy that is directing the chief executives of the hospitals to have direct admission for transfers. In trying to formulate the policy - and Professor Lawler was actually instrumental in bringing that together - we did pick up every single and multiple transfer protocols, processes, many of which were inconsistent.*

But what we have heard time and time again, every time I go to the Launceston General Hospital ED - from the head of the ED, Dr Lucy Reed; talking to the ED registrars; talking to nurses in the ED; and, importantly, talking to the paramedics who stand or sit on the ramp - is that this is a significant issue, particularly at the Launceston General Hospital. Transfers will sit and ramp - and that is time, either on the ramp, or taking up a bed in the ED, while they're waiting.

This is going to be quite a significant change and we are trying to undo decades of practice to actually do it. It may be a little bit bumpy over the next few weeks, but I just wanted to reiterate that this is the new state-wide policy, and I don't know if Tony might also add to that.

Professor LAWLER *- … What we've done is we've actually gone and spoken with clinicians within the emergency department, clinicians within Ambulance Tasmania, and recognising that we have some systems in place that introduce inefficiency and they introduce potentially a risk.*

There has not been a state-wide inter-hospital transfer policy. There has not been a state-wide inter-hospital transfer protocol. We have had some specific elements that relate to issues such as time critical transfer. Patients who need to be getting to Hobart for neurosurgical or vascular surgery, they just go and you sort out the bed later. If you're transferring somebody from the Mersey or the North West Regional to the Launceston General, it's one health system, it's a wall-to-wall transfer where the corridor involves an ambulance trip and is 200 kilometres long.[106]

[106] The Premier (in his capacity as Minister for Mental Health and Wellbeing), Ms Kathrine Morgan-Wicks and Professor Tony Lawler, *Transcript of Evidence*, 7 July 2022, pp. 133-4.

N: OTHER

Disability

The Health Consumers Tasmania (HCT) submission notes:

> *Rural health consumers living with disability advised us that:*
>
> - *they had fewer dedicated and state funded advisors or support people than elsewhere. This was particularly noticeable for people living with Kennedy's disease*
> - *they had unequal physical access in their own communities. One option suggested that a condition of all community based grants that they only be distributed to organisations that demonstrated accessible community facilities*
> - *were more often misdiagnosed, received late diagnosis, had limited access to specialist support/hospitals and allied health that exacerbated poor health outcomes*
> - *medical health professionals did not always have time to communicate with people living with a disability to understand their needs*
> - *reactions to pain experienced might be interpreted as 'behaviours of concern' and causes were not always investigated*
> - *they were sometimes subjected to unnecessary judgements not based on ability in some situations, particularly relating to child care and pregnancy*[107]

Clinical Associate Robyn Wallace, Physician in Internal Medicine, made the following comments in relation to access to services for people with an intellectual disability living in rural areas:

> ***Ms WALLACE*** *- I will say straightaway that what we do for the health of rural general population, we do for the rural population for adults with intellectual disability. That is my main message. It is not the other way around what we do for people with intellectual disability, we do for the general population. …*
>
> *My statement is more about the problem and how we can potentially go about it. On one hand here, I have the Australian Commission on Safety and Quality in Health Care and on the other hand I have the NDIS Quality Standard indicators. There is a big distance between them and we need to bring them together, because we are going to involve health professionals and we are going to involve disability support people. There is a big grey area there.*
>
> *…*
>
> *Looking at the literature on people with intellectual disability living in rural areas, the main messages are they want to life in 'my chosen place'; because they are getting older, or they are adults, they do not want to have to move out of their own place, necessarily, if the services they want, the accommodation and the support is in the area they choose, which may be their rural area. This comes up as adults with intellectual disability age and leave their family home, perhaps into supported accommodation. And we have ageing groups, parents. We have fewer group homes available in the rural area, and we have less choice for disability support options, and this comes up all the time. It is very relevant for health.*

[107] Health Consumers Tasmania, 2021, *Submission #56*, p. 7.

The families may not be IT-literate; there are problems with seeking disability options and working them out. The NDIS is much more complicated in an isolated area. There is less support and less access, and some do not know about the NDIS even now. There are issues in the rural areas, such as people with intellectual disability if they move out of their family home, they are more likely to live in aged care facilities. This is in the literature. I have not undertaken this study in Tasmania, but that comes up - younger people with intellectual disability living in aged care facilities.

We have carer burn out, loving parents; although there are a lot of positives about having family members with intellectual disability, there is a practical issue of being a carer all the time as well. It is tiring. Telehealth is less available as well, and the knowledge of the health system, that issue of health literacy, which is so important in the health commission standards. Partnering with consumers, involves health literacy which involves knowledge of health itself plus knowledge of the health system. Those two elements of health literacy which are difficult.

On top of that, or turning now to the health issues themselves among people with intellectual disability, there are high rates of medical problems. We know that. There are high rates of sensory impairment, so getting an eye check, does not have to be an ophthalmologist, but an optometrist, is more difficult in a rural area. Getting a hearing assessment - if you are living with a vision and hearing impairment and you are not able to express it, or is not detected, that is additional disability for you. The consumer report that was submitted here outlines the numbers, and, from the hearings, I imagine you know all about the lack of workforce in the health arena.

What I am suggesting is when, the minister's vision of health care in rural Tasmania comes up, when it is at the hospital area, at the district hospital area, when we go through the national clinical governance or the standards that have to be put up in that health arena, and that health setting - it involves consumers, managers, and clinicians. We also think well, what about consumers with intellectual disability? Consumers in that sense also means carers and the disability sector; the managers, the managers of the hospital, what does it mean for them in terms of the operational issues they have to instigate to make their hospital friendlier for people with intellectual disability?

***Dr SEIDEL** - Can I ask you a specific question? We talked about the smaller hospitals and their occupancy rate, do you believe or have you received information that it's because of standards issues? Standards aren't met. Occupancy rates are much lower than they could have been because, due to workforce or other issues, the standards as outlined by the commission can't be met?*

***Dr WALLACE** - The standards are not met.*

***CHAIR** - In any hospital?*

***Dr WALLACE** - In any hospital in Tasmania. They're not specifically met for people with intellectual disability. There are no reasonable adjustments in place in clinical services for people with intellectual disability. The literature is there. We know about reasonable adjustments for palliative care, we know about reasonable adjustments for diabetes management. People with intellectual disability, we know communication strategies. There is no centre or contact for people with intellectual disability in the clinical sense in any hospital in Tasmania.*

...

There's not much new to do; it's bringing together known information and plans. They have to be duly checked for the standards in three levels; the consumers, the managers and clinicians. When you break it down like that, and you go through each of the eight standards, for example, from the health perspective, then it's manageable. It's not this great big amorphous thing, and how are we going to approach it? It's already there. We've just got to apply the known literature for people with intellectual disability and our known local situation in Tasmania. So, it's doable.[108]

Ms Wallace highlighted the following issue in the disability and health sectors:

Though my comments have previously been received courteously, at this point there is little in the way of practical change in disability (non-NDIS and NDIS) and health sectors and still a complete absence of interface between the sectors, which work to substantially reduce both the well-known preventable poor health outcomes experienced by adults with intellectual disability when they are unwell and the associated high preventable inefficiency in costs of disability support and health care. There are still all too frequent examples where Tasmanian adults with intellectual disability do not receive standard treatments for particular health conditions received by Tasmanians without intellectual disability either because they are not offered the treatment by health professionals/ systems and or they do not have adequate levels of disability supports required for them to participate in and access the required healthcare treatment. The end result is that adults with intellectual disability die unacceptably prematurely compared to their peers without disability and experience preventable suffering from inadequate healthcare treatments and or disability supports to help them obtain those treatments.

Our future healthcare in Tasmania must embrace means by which adults with intellectual disability of all ages, NDIS participant or not, city, regional or rural living, can have access to and participate in the best possible healthcare that is available to Tasmanians without disability to extend their length of life as well as quality of life. Fundamentally, this means that both current provisions of disability supports and health services must undergo some adjustments. To define and design these alterations, disability support services, health services and people with lived experience of intellectual disability (people themselves with intellectual disability, their families and close friends) must work together.[109]

LGBTIQ+

According to the Working it Out submission:

There are currently no dedicated services that meet the specific health needs of LGBTIQ+ Tasmanians.

Working It Out is funded by the division of Public Health, within the Department of Health, to provide generalist prevention and wellbeing services (1:1 support, peer groups, advocacy, education etc). Core funding supports approximately 3 staff, though this is typically

[108] Associate Professor Robyn Wallace, *Transcript of Evidence*, 30 November 2021, pp. 96-7.
[109] Robyn Wallace, 2021, *Submission #2*, pp. 2-3.

supplemented with short-term grants and funding for other programs, including those in schools and aged care.

3 days a week of direct support is provided from Hobart, and under 2 days a week (13.5 hours a week) are provided in both Burnie/Devonport (combined) and Launceston. Support is also provided online, and via the phone, helping to meet the needs of people living outside urban areas. However, with such limited services, meeting the needs of people living in rural communities is difficult.

While LGBTIQ+ people can and do access mainstream health services, experiences can vary. Poor experiences, or fear of a poor experience, can lead to very low levels of service access.

Nationally, the Private Lives 3 study showed that although mainstream medical clinics were the most frequently accessed health service by LGBTIQ+ people in the past 12 months, they had the lowest proportion of participants who felt that their sexual orientation or gender identity was very/extremely respected (58.6% and 37.7%respectively) (Hills et al., 2020).

Of particular note is that only one third of trans and gender diverse participants reported feeling that their gender identity was very/extremely respected at a mainstream medical clinic (37.7%) or hospital (35.4%) in the past 12 months.

The proportion of participants who felt very/extremely respected was higher for those who attended a health service that caters only to LGBTIQ+ people or a mainstream medical clinic that is known to be LGBTIQ+ inclusive.[110]

Tamara Reynish, mental health professional and Doctoral Candidate at University of Tasmania, provided a submission to the inquiry which applied research findings to the terms of reference of the current Inquiry:

Tasmania has the highest rate of General Practitioner (GP) consultations for mental health issues per capita (Ahmed et al., 2017). Notably, 89.7% of my survey participants saw a GP for help with general mental health issues. However, only, 57.1% found that the GP knew how to help them. Twenty (out of 33) interviewees saw a GP for help with general mental health issues; 14 had negative experiences pertaining to educational or attitudinal bias.

Primary Health Tasmania (2016) found that 66% of Tasmanian GP's did not consider themselves adequately trained in mental health, which corroborates my participants' poor GP experiences. Health professionals' lack of mental health training impacts subsequent help seeking and can worsen or cause mental health issues (Mastrocola, Taylor, & Chew-Graham, 2015).

<u>Uptake of rural and regional mental health services:</u>

As usage of mental health services was an inclusion requirement, 98.7% of survey participants and 27 (of 33) interviewees reported seeing a mental health professional in rural or remote Tasmania at some point in their life. However, at the close of data collection, 75.6% of survey participants and 29 interviewees were not currently seeing a mental health professional in rural or remote Tasmania. Restated, all 111 participants had reported experiencing a mental health issue (e.g., grief, financial difficulties, discrimination, stigma)

[110] Working it Out, 2022, *Submission #79*, pp. 4-5.

or diagnosis (e.g., Post-traumatic Stress Disorder, Bipolar Disorder, Schizophrenia), yet 88 participants were not engaging with care at the time of data collection. Indeed, some participants reported historical (rather than current) issues; those few participants felt formal care was not required.

The many barriers that most of the remainder of participants encountered with both services and providers explain their low engagement. An exploration of some barriers as framed within the terms of reference follows.

Availability and timeliness of health services, including mental health services:

Availability and timeliness to access mental health services was a barrier. That is:

- *65.1% of LBGTIQA+ participants indicated that they could not get a mental healthcare appointment as soon as they needed support*
- *52.3% of LBGTIQA+ participants and 66.7% of kink-oriented participants reported experiencing long waitlists, meaning they either relied on negative coping mechanisms, their mental health worsened, and/or they withdrew from help seeking.*[111]

According to the Women's Health Tasmania (WHT) submission:

For women living in rural areas getting appointments with specialists presents two specific problems. The first is getting appointments. The second is getting appointments at times when they can get community or even public transport to attend them. Long waiting lists for appointments with specialists mean that these service providers offer little flexibility about appointment times.

Transgender women report that endocrinology appointments for support around hormone therapy are difficult for people not living in Launceston or Hobart. Transgender women have reported to us that they highly value the Sexual Health Service – the main publicly funded access point for transgender people who want to explore medical gender affirmation. Through this service women report they can access endocrinology specialists, psychiatry, and other support. (Although based in Hobart and Launceston the Sexual Health Service offers an outreach service in the north west.)

The lack of services in rural areas has serious consequences. The inability of women outside Hobart to access surgical terminations of pregnancy is a significant issue raised by women living in rural and regional areas in our surveys. Currently the public hospitals in Burnie and Launceston provide no access to women for non-medical surgical terminations. These procedures are only available through private providers in Hobart and at North West Private Hospital, and to a limited degree through the Royal Hobart Hospital. Difficulties accessing information about these services and in accessing these services is a significant, ongoing problem.[112]

In a Question on Notice response from the Premier, dated 7 September 2022, the following information was provided with regard to access to surgical terminations across the state:

[111] Tamara Reynish, 2022, *Submission #81*, pp. 4-5.
[112] Women's Health Tasmania, 2021, *Submission #22*, p. 5.

Surgical terminations have continued to be available to Tasmanian women throughout the COVID-19 pandemic in both the public and private sector.

Throughout the COVID-19 pandemic, the Department of Health has continued to support health promotion and preventive health strategies, and to work with non-government organisations to adapt provision of services that are focused on Tasmania's most vulnerable women.

These services cover a broad range of health needs, including information on contraception, pregnancy, and termination.

From early October 2021, an updated referral pathway became operational to enable general practitioners and other prescribed health providers to refer women seeking a surgical termination to a public hospital in the North or North West.

Surgical Terminations are now available at the Royal Hobart Hospital, Launceston General Hospital and the North West Regional Hospital, ensuring equitable access across Tasmania to enable women to access this procedure close to home.

The Tasmanian Government, via the Women's Health Fund and the Youth Health Fund, also provides funding to assist women to access contraception and termination care outside of the public system. This includes access to medical and surgical terminations, and to long-acting reversible contraceptives.

If they choose, Tasmanian women are able to travel both intra- and inter-state for these services, with financial support available through the Department of Health's Patient Travel Assistance Scheme to enable this.

Tasmanian hospitals do not routinely collect or report data specifically identifying or distinguishing all episodes where patients are admitted for induced surgical terminations:

- *Patient information systems group information in accordance with the Australian Refined Diagnosis Related Group classification, used in all Australian hospitals. This classification does not differentiate between incomplete spontaneous abortion (miscarriage) requiring surgical intervention, and induced surgical termination.*
- *For admitted patients, a principal diagnosis is recorded and that does provide some information on the indication for each procedure. However, this data is reliant on hospital coding and does not always provide specific information to identify whether the termination was induced or spontaneous.*[113]

Aged Care

The RDAT submission made the following comments in relation to aged care:

Continuing to enhance communication with primary care providers will improve aged care outcomes. When RACF patients are admitted to hospital they come with unique challenges and extensive comorbidities. Their GP is likely to be the best source of information and well-placed to be actively involved with the care delivered in hospital. Communication between the admitting consultant and the primary GP would be beneficial to clarify health status, goals of care, and any advanced care directives, and would help plan transition back to the

[113] Question on Notice response from the Premier, dated 7 September 2022, p. 12.

community. Whilst admitted, comprehensive geriatric review and input from specialist clinical nurse consultants would be a beneficial service for the Tasmanian Health Service to offer appropriate patients. On discharge, a medication summary, separation summary and verbal clinical handover to the GP and RACF will help avoid adverse clinical events by ensuring continuity of care.[114]

The Dementia Australia submission stated:

> *People living in rural and remote communities are more likely to have restricted access to health services and other supports, which are crucial to maintaining a good quality of life for people living with dementia, their families and carers. Restricted access to supports and services can have numerous impacts to people with dementia, their families and carers, including delayed diagnosis, poorer access to information regarding dementia, and limited access to a range of quality dementia supports and services. People living with dementia, their families and carers often report challenges accessing medical care, allied health services and palliative care.*
>
> *People living in rural and remote areas deserve to have equitable access to services and be supported to remain living in their local community throughout their experience with dementia. Living with dementia brings challenges for all people with a diagnosis and those who care for them. These challenges are compounded if a person lives in rural and remote areas due to geographic isolation, travel distances, and limited services and resources.*
>
> *The key concerns and challenges for people with dementia, carers and service providers in rural and remote Australia include:*
>
> - *assessment, diagnosis and management of dementia*
> - *education and awareness of dementia*
> - *opportunities for social engagement and community participation for people with dementia and carers*
> - *access to community, respite and residential aged care*
> - *access to specialist support services*
> - *limited choice of providers*
> - *cost of transport for specialist services*
> - *availability of culturally appropriate services and supports*
> - *workforce capability and capacity.*
>
> *When individuals with dementia also experience other barriers to care, such as their location, ethnicity, sexuality or socio-economic status, access to quality care becomes exponentially more difficult. The availability of dementia care is difficult for those living in rural and remote areas due to their geographical isolation, a shortage of health care providers and patchier access to health services, as well as socioeconomic disadvantage, which limits their ability to access specific specialist services.*

[114] Rural Doctors Association of Tasmania, 2021, *Submission #30*, p. 5.

A barrier to quality health care for some people impacted by dementia in rural Tasmania is not knowing what services are available in their area. The community health centres, which used to be a source of this knowledge, no longer provide this function in some towns.[115]

According to the Dementia Friendly Tasmania submission:

Dementia Friendly Tasmania Inc held an Ageing Wonderfully Well Expo at Kettering on March 19th 2021, the second of three within Kingborough area, the first being pre COVID in August 2019 at Kingston Hub. 76 people attended the expo seeking information from stall holders on services and supports available to assist them to continue to live independently as they age.

Incidental conversations with attendees raised a number of issues of concern for many people within the lower channel community, such as:

- *Difficulty accessing sufficient support to assist them to live independently, wait times*
- *Difficulty making appointments with GP services - often 3-4 weeks*
- *Distances involved in accessing after hours medical care*
- *Wait times at RHH for essential surgery, hip replacement, colonoscopy etc*
- *Limited aged care placement options within their community*
- *Insufficient staff in aged care facilities to provide support for residents to remain engaged and active both physically and mentally.*[116]

[115] Dementia Australia, 2021, *Submission #20*, pp. 5-6.
[116] Dementia Friendly Tasmania, 2021, *Submission #31*, p. 1.

TERM OF REFERENCE 3

BARRIERS TO ACCESS TO:

A) **AMBULANCE SERVICES;**

B) **PRIMARY CARE, ALLIED HEALTH AND GENERAL PRACTICE SERVICES;**

C) **NON-GP SPECIALIST MEDICAL SERVICES;**

D) **HOSPITAL SERVICES;**

E) **MATERNITY, MATERNAL AND CHILD HEALTH SERVICES;**

F) **PAIN MANAGEMENT SERVICES;**

G) **PALLIATIVE CARE SERVICES;**

H) **PHARMACY SERVICES;**

I) **DENTAL SERVICES;**

J) **PATIENT TRANSPORT SERVICES;**

K) **'AFTER HOURS' HEALTH CARE;**

L) **INDIGENOUS AND CULTURALLY AND LINGUISTICALLY DIVERSE (CALD) COMMUNITIES;**

M) **MENTAL HEALTH SERVICES; AND**

N) **OTHER**

Barriers to access of health care in rural Tasmania is multi-faceted and relate to a range of matters including:

- higher rates of residents living in low socio-economic circumstances and poverty;
- lower levels of literacy, including health and digital literacy;
- inadequate access to high speed internet;
- higher cost of:
    - health services;
    - transport to access services;
    - digital technology and access;
- geographical distance to metropolitan health services; and
- lack of suitable housing for health professionals in rural and remote areas.[117]

[117] West Coast Council, 2021, *Submission #63*, p. 2.

A: AMBULANCE SERVICES

According to the Health Consumers Tasmania submission:

> *Consumers reported that even where services were available access was difficult for many; untimely; not linked; difficult to navigate and lacking in health connectors.*
>
> *4.1 Ambulance Services*
>
> *• Consumers highlighted that ambulances were called for both urgent medical and emergency services because there was no after-hours medical service available. When calling for urgent medical matters, consumers were concerned that they may be 'taking away' services from someone in more urgent need of medical assistance*
>
> *• If the consumer had multiple comorbidities and needed frequent medical assistance, ambulances staff were not always responsive to their needs on site.*[118]

The Committee heard the Ambulance Service relies on volunteers in some rural areas. Mr Shane Johnson, Franklin, made the following comments*:*

> *I have been contacted by five volunteers or ex-volunteers in this process and they are all experiencing the same frustration, or different frustrations. One stated to me, 'We are getting smashed with town work. Night shifts have changed, with many more stand-bys in Kingston.'. This is the practice in which the Huonville ambulance gets shifted to Kingston when the Kingston ambulance is called away and they wait on standby there rather than in Huonville. He further quotes:*
>
> > *Once we're in Kingston or called into town, we are sucked into the vortex of town work. This means going to Collinsvale, Richmond, Geilston Bay or delivering babies in Glenorchy.*
>
> ***Dr SEIDEL** - And these are volunteer ambulance officers from the Huon Valley?*
>
> ***Mr JOHNSON** - That's right. These aren't paid paramedics. Obviously, there's a paid paramedic with them but the paid paramedics can't get around without the volunteer.*
>
> > *Fatigue management is being affected and there is less coverage on the roster. Fewer people are putting their hands up. We don't mind getting smashed doing Huon Valley work, as that is what we signed up for.*
>
> *Another recently retired 18-year serving ambulance volunteer related to me that the situation is getting far worse. She's just retired. Recently she rang for an ambo for her elderly mum suffering chest pain; the wait was five hours. Three weeks ago she helped an unconscious gent with a defibrillator fitted pacemaker who collapsed in the main street of Huonville, the wait was two hours. This is somebody with a clear medical condition. In the last years of her service she even resorted to using her own vehicle to attend to incidents.*
>
> *However, one of her main concerns is the welfare and the care of the volunteers. The system is founded on them and if they are not there, then there is no service. She believes that fatigue management is not being addressed. No one is checking whether volunteers have recovered between their day jobs and their shifts or whether they have had adequate sleep. She is*

[118] Health Consumers Tasmania, 2021, *Submission #56*, p. 6.

concerned that the system is relying on fewer and fewer people who repeatedly fill the gaps in the roster. She described to me one gent who, whenever there's a gap in the roster, he gets off his tractor from the paddock and he comes in and he fills that gap. That's what the system is being held together by.

… A member of the Huonville Fire Brigade advised me that they are being called on five to six times a year to provide support for medical emergencies. These are life-threatening situations; they get called on for those. And this is when ambulances are already unavailable because they're off doing something else. Following a lengthy communication process through Ambulance Tasmania and then the TFS, it's often 20 minutes before they even get into their truck to then try and get the first responder or paramedic. The person who spoke to me said that he'd been personally involved in three cardiac arrests, two of which the interventions were unsuccessful but one patient was saved.

…

***Mr JOHNSON** - Let's resource the service so that the standards that we set are met. We don't expect them to be the same standards as the metro, and I don't know what they are, how long the ambulance service is required to get to a call out but we need to know what that standard is. As a first step the practice of sending the Huonville ambulance to Kingston on standby needs to stop. It's having a deleterious effect on the fatigue of the officers, both paramedics and volunteers. I am told they can be woken at 1.30 on a Sunday night, 'We need you to go to Kingston'. They may not get a call out from Kingston and then they just drive back to Huonville.*[119]

Mr Robert Cassidy, Bothwell, made the following comments in relation to the volunteer ambulance workforce:

***Dr SEIDEL -** You made some reference to paramedics in your submission. You stated paramedics should be salaried and not expect a volunteer to be traumatised, verbally abused and assaulted.*

Is that something committee members have talked to you about, that volunteer ambulance officers are being abused and assaulted? Is that an issue?

***Mr CASSIDY -** It's there in the paper, it's there in the media. It happens in the emergency department at the Royal Hobart Hospital. It happens on the wards. I think it is a silly notion to have volunteers stacking ambulances. Paramedics, ambulance drivers, and ambulance attendants, they should be paid positions. There is a lot of training involved.*[120]

Minister Rockliff and Mr Joe Acker, CEO Ambulance Tasmania, made the following comments when questioned in relation to the volunteer Ambulance workforce:

***CHAIR** - …. We heard from some of our rural smallest services where they have a high reliance on volunteers, that because of the nature of the demand in other areas, volunteers are being taken from the community they are volunteering to, and then required to go to a neighbouring municipality. They did not agree to volunteer there because that is not their community as such. …*

[119] Shane Johnson, *Transcript of Evidence*, 8 November 2021, pp. 44-5.
[120] Robert Cassidy, *Transcript of Evidence*, 26 November 2021, p. 33.

So, volunteers from the Huon are sitting at Kingston because the Kingston crews are over at New Norfolk, for example. …. From what we have heard, a lot of these ambulance volunteers are feeling disenfranchised by being required to fill all these gaps they feel should be covered by an increased number of paramedics, for example.

***Mr ROCKLIFF** - … we currently we have some 420 volunteer ambulance officers assisting Ambulance Tasmania. Recruitment is ongoing and we have commenced work with the Volunteer Ambulance Officer's Association on a memorandum of understanding to work together on an attraction, retention and also importantly training and support for volunteer ambulance officers as well. That is about a $50 000 commitment. I commend all volunteer ambulance officers.*

…

***Mr ROCKLIFF** - … We will continue that engagement quite clearly. I might have mentioned before in other forums, an example of what you speak of is King Island. I met a couple of volunteer ambulance officers on the island recently at the opening of the upgraded King Island District Hospital. Support is required for our volunteer ambulance officers, particularly in those smaller communities, because they may well be called out to a very serious episode, a crash or whatever it might be and quite likely know the person. This is an area that should, and will, and is requiring -*

***CHAIR** - Which will lead me to the next area which is mental health.*

***Mr ROCKLIFF** - increasing attention but in terms of deployment models, Mr Acker, can you inform the committee?*

***CHAIR** - And how do you determine station size and that sort of thing?*

***Mr ACKER** - I want to share the minister's respect for our volunteers. We couldn't do without them; they provide an invaluable service to our communities across the state. They also provide an opportunity to be fiscally responsible and financially responsible to the community. We have engaged ORH, which is called Organisational Research in Health, to do a five-year retrospective look at the calls that Ambulance Tasmania has responded to. That helps us identify the demand in each community. As communities have higher volumes of case load then we do know that it starts to significantly impact the volunteers' workloads. That's the stations that we identify for moving to career stations, as we recently have just done in New Norfolk. The New Norfolk station is now made a paramedic-only career station due to the high volume that we are seeing there.*

The data that we are looking for in the next 10 years will also be informed by ORH looking at evidence through the ambulance response data and that will identify where we are moving to future career paramedic stations and moving volunteers to other lower volume stations. We make this decision based on evidence.

… the deployment model that we do use is a demand deployment model to ensure that we are responding appropriately to high acuity patients. We would be wanting to have quick response times when patients are suffering severe medical and trauma emergencies and we move ambulances from low volume stations to higher volume areas where the next call is likely to be happening. As you suggest, Chair, that is impacting volunteers because they are moving from their communities to provide coverage. We monitor that and we are working

closely with our volunteers to ensure we're meeting their expectations, as well as working every day to meet the performance of our system.[121]

The Premier made further comment in the 2022 Budget Estimates process:

> ***Mr ROCKLIFF*** *- … There are around 450 volunteers for our Ambulance Tasmania, and voluntary officers who are of course integral, as you say, to the provision of emergency medical responses in rural and remote communities. At the last election, in fact, we committed $50 000 to the Volunteer Ambulance Officers Association of Tasmania, and this funding has supported Ambulance Tasmania and the Volunteer Ambulance Officers Association to undertake a significant reform project to better support the recruitment, retention, and training of volunteers.*
>
> *… AT is working directly with those volunteers and the Volunteer Ambulance Officers Association of Tasmania to explore options for the future. I think as you highlighted, a high number of volunteer ambulance officers were identified as vulnerable to COVID-19 due to their age and health status, and have not been able to work in rural and remote communities.*[122]

The Tasmanian Government submission stated:

> *The Tasmanian Government is committed to improving ambulance response times across Tasmania and easing demand pressures on paramedics in rural and regional areas. Contemporary and well-resourced ambulance services are key to supporting rural health services and providing timely and professional care and transport for patients in rural communities.*
>
> *The 20 18-19 Budget allocated additional funding of $14. 9 million over four years to recruit an additional 42 paramedics to reduce overtime costs, increase ambulance responsiveness, and reduce fatigue in rural and regional areas around Tasmania. A program was endorsed to employ the new positions across the state over a four-year period, with placements of the positions informed by extensive statewide consultation with key stakeholders including paramedics, volunteers, local council representatives, community members, and unions. So far, additional paramedic positions have been allocated in rural and regional areas including Wynyard, Dodges Ferry, Bicheno, St Helens, Longford, George Town and Beaconsfield.*
>
> *Additionally, as part of the 2021 State Election, the Tasmanian Government has committed to recruit a further 24 paramedics in rural and regional Tasmania over the next four years, with the following specific initiatives:*
>
> - *Two new paramedics each for St Helens, the West Coast and the North East.*
> - *Three new additional paramedics for New Norfolk.*
> - *Three new paramedics at the Sheffield, Dodges Ferry and Campbell Town stations, providing 24/7 paramedic coverage.*

[121] Minister Rockliff and Joe Acker, *Transcript of Evidence*, 30 November 2021, p. 85.
[122] Premier Rockliff, *Transcript of Evidence*, 7 June 2022, p. 104.

In addition to bolstering paramedic numbers, the Tasmanian Government is also investing in infrastructure to support the needs of ambulance services in rural and regional communities. Key projects include:

- *The construction of a new state-of-the-art ambulance station in Burnie. Planning is currently underway for a new Burnie station, that will provide greatly improved facilities including dedicated staff meeting facilities, a bigger garage to ensure that service vehicles do not have to park outside, and better parking and disability access.*
- *A new station has been completed at a new site at Campbell Town. This project has delivered a new, contemporary ambulance station at the southern end of Campbell Town and includes accommodation for relieving paramedics.*
- *The construction of a dedicated training room at the Smithton station and a new two-bedroom unit for relief staff.*
- *Ambulance Tasmania upgrade projects have been completed at Deloraine, New Norfolk, Huonville, Zeehan, George Town and St Helens Stations, with further upgrades planned or under construction for Dodges Ferry, Queenstown, Bridgewater, Longford, Beaconsfield, Bicheno and Oatlands.*
- *Planned establishment of Double Branch Stations in Sheffield, Dodges Ferry and Campbell Town.*

As a result of the COVID-19 pandemic, Ambulance Tasmania is completing a strategic review of the Rural Ambulance Station program projects. This review is important to ensure that lessons learned during the COVID-19 response are incorporated into the new facilities.[123]

Paramedic Emma Thornley stated:

I grew up in Dover down south so I am most definitely a local. I have been employed by Ambulance Tasmanian since 2001. I am a physician assistant with a master's qualification through the University of Queensland School of Medicine. I am a post-graduate lecturer in paramedicine at UTAS. I am the first paramedic practitioner to be employed in Tasmania. I practise as part of a multi-disciplinary team alongside RNs and nurse practitioners, paramedics, GPs and rural generalists. Hopefully, soon I will be going to Ouse with that team which, believe it or not, represents a career highlight for me.

Twenty years of working in Tasmania as a paramedic has given me some keen insights into how people in the community really live and how things have been on a trajectory towards crisis since I began my career in health in 2001. This is the unique thing about paramedics: we spend all our working days in and out of people's homes and lives so we have a unique insight into the impacts that the failures in the health system have on the Tasmanian community.

I'd like you to be aware that paramedics are the only health professionals who are educated and trained to practise exclusively in the community. We are not trained to practise in hospitals or clinics. If we were to shift to that environment we need the extra education. We are trained to practise in the community.

The college believes we are an underutilised resource for understanding the issues and developing the solutions. Some of the inescapable truths that paramedics have recognised

[123] Tasmanian Government, 2021, *Submission #72*, pp. 37-8.

are things like ramping, which is a complete waste of resources, it is dangerous and it is not patient focused. Bed block and ED overcrowding are largely the result of patients not having access to appropriate and timely care in a community.

For the same reason ambulance callouts are predominantly non-emergency cases. Anecdotally and statistically we know that about 90 per cent are non-emergency cases. Most concerning for me is that many of the critically unwell patients whom we do attend are only in that situation because of the lack of early intervention in the community. It was missing. This is especially true in rural and remote areas. Associate Professor Ruth Stewart, whom we follow keenly as the Rural Health Commissioner says,

> *Rural and remote people have often been wrongly described as stoic. They soldier on with ill health until they can't go any longer.*

Paramedics will tell you Ruth is correct.

Any paramedic can also tell you where a majority of the issues originate from. We understand the population demographic has higher needs for primary health care services. We know there is a lack of after-hours services because we fill that gap. There's a lack of bulk-billing services; there is a lack of primary and urgent care centres, facilities and infrastructure. There is a lack of transport options, even public transport in rural areas is an issue for health. Extended waiting times to see your own GP goes sometimes into weeks. If you think you're going to go to another GP, think again because they're not taking new patients.

Worth noting, as if this doesn't sound disastrous enough, these issues are compounded if you are, for example, a patient who is a single parent, you're homeless, have a disability, victim of intimate partner violence, you're culturally and linguistically diverse, you have low literacy skills or you're Aboriginal. Paramedics see this every day. We at the College of Parademic Practitioners advocate for paramedics being able to gain an appropriate education to be able to deliver the knowledge and skills that have been identified as most lacking in our rural communities. We understand this community; we live and work locally, and we have done the work to make ourselves ready to be part of the solution.[124]

B: PRIMARY CARE, ALLIED HEALTH AND GENERAL PRACTICE SERVICES

According the Health Consumers Tasmania (HCT) submission, cost is a barrier:

> *Almost 50% of Tasmanians face out-of-pocket expenses when visiting a GP – the highest rate in the country outside the ACT. In 2016-17, approximately 10% of Tasmanians delayed or did not receive health services due to cost creating a significant burden on the health system. When early interventions are missed patients and the health system may experience an increased burden of disease and cost.*[125]

Access is also a barrier. According to the Rural Doctors Association of Tasmania (RDAT) submission:

[124] Emma Thornley, *Transcript of Evidence*, 8 October 20-21, p. 2.
[125] Health Consumers Tasmania, 2021, *Submission #56*, pp. 7-8.

Increased access to primary healthcare can be facilitated by adequate remuneration of rural doctors as well as supporting the increase in other members of the primary care team with support to extend premises to provide more consulting space and support the payment of services provided by others such as practice nurses, and allied health care providers. Also needed is collaborative support of efforts to increase those willing to work in rural areas starting from intake to training in medicine, nursing and allied health. The Rural Generalist Program is a key facilitator of increasing FTE GP services in rural areas, and hence the increased access to primary healthcare in these areas. Rural Generalist doctors need to be supported by emergency medicine and retrieval experts who can provide timely advice. Investment in a comprehensive emergency telehealth network (i.e., bringing the emergency specialist to the bedside) would assist with peer support, collegiality, clinical guidance and support care in local communities; keeping patients connected to their supports. The consistent message from community general practice is that the MBS rebates for patients are set below the cost of the running a general practice. Therefore, it is of no surprise that Tasmania has some of the lowest bulk billing rates in the country. The State Government needs to continue to advocate to the Commonwealth to increase the MBS rebates or provide an alternative means of funding general practice to incentivise better chronic disease management as an alternative to '6-minute-churn' medicine.[126]

Mr Judah Morris, RFDS, provided an example of overcoming the access barrier in relation to cardiac health:

***Mr MORRIS** - .... For example, we run cardiac rehab programs. We will often be in town not for that specific reason, but we will have people come up to us and through simple conversations they will realise that in the hall next door we run a weekly cardiac rehab program which they need. Again, they probably thought they would have to travel to Launceston or Hobart to access those services. There might be some of those services directly in that town, but we know that when people aren't fully engaged with the health system they are missing out on the full variety of services.*

***CHAIR** - Is that a communication thing - they don't know what is there?*

***Mr MORRIS** - Completely. For example, if they have had an admission at the LGH, or a lot of GPs we see might be locum GPs in the regions who might not understand the different services such as ours that are available in the region. You really have that disconnect of what they can potentially access.*[127]

In relation to Exercise Physiologists (EP's), Anita Hobson-Powell ESSA, made the following comments:

Today, I guess, we are here to talk about the underutilisation and the lack of recognition of the exercise physiology workforce in rural Tasmania. As of 31 December 2020, there were 114 exercise physiologists across Tasmania. Many of the EPs are in the outer rural areas including Burnie, Wynyard, Devonport. Based on a survey done earlier this year, about 48 per cent were

[126] Rural Doctors Association of Tasmania, 2021, *Submission #30*, pp. 5-6.
[127] Judah Morris, *Transcript of Evidence*, 2 November 2021, p. 14.

working in private practice and others were working in fitness centres, gyms, higher education or within the workers compensation space.

Currently there are no exercise physiologists working in the Tasmanian health care sector or within the rural communities' health centres. The Northern Territory is the only other state or territory in Australia that does not currently employ an exercise physiologist in their public health system. This does leave patients with many conditions that will benefit from appropriate exercise interventions delivered by an exercise physiologist to seek services and will have to go privately, at their own cost, using Medicare or a Department of Veterans Affairs or compensations to access the services. There are some services being commissioned by Primary Health Tasmania, but they are sporadic and limited in their access.

Since we started this submission, we understand there has been a restructure at the School of Health Sciences at UTAS around the clinical exercise physiology degree and their last intake of students was in 2019 which means there is no longer an under-graduate pathway for an exercise physiologist in Tasmania.

They are considering whether they will do a masters program, but at this point, it is not. The difficulty has been in recruiting exercise physiologists into the program because there is a lack of employment opportunities.

As you are aware, the proportion of Tasmanians [that] *have a chronic condition including cardiovascular disease, arthritis, cancer, asthma, and a lot of these are related to overweight or having obesity, and exercise physiologists treat many of those conditions.*[128]

Mr John Kirwan and Mr Judah Morris, RFDS, noted the following in relation to EPs:

Mr KIRWAN *- … in primary care we will employ physios, EPs and exercise scientists and we could see a model where a generic allied health assistant could be supervised by them. Getting TAFE back into training those sorts of staff. In Nicole's area we can see dental assistants being skilled up, as they are on some mainland areas, to provide additional work, again, under the supervision of a dental therapist or dentist in areas like aged care so we can provide a service within a safe model.*

CHAIR *- How many EPs do you employ?*

…

Mr MORRIS *- Currently, we have five EPs and one starting in a few weeks. Across our physical health program, we have a team of ten which includes EPs, physiotherapists and health science backgrounds and we have a team of roughly ten mental health workers.*

CHAIR *- With EPs being unregulated or effectively self-regulated, does that present barriers for not being registered under the Australian Health Practitioner Regulation Agency, for example?*

Mr MORRIS *- They are registered under Exercise & Sport Science Australia. Even though it is separate from AHPRA they still have a governing body. One of the challenges has been we*

[128] Anita Hobson-Powell, ESSA, *Transcript of Evidence*, 2 November 2021, p. 89.

know they are not particularly well-utilised in the healthcare system. This is why you see some of those barriers to cardiac rehabilitation and some of those different areas many people are familiar with - a physiotherapist helping you with your knee injury because that is something you access in a public system. Some of those other critical health services, if they are not there as part of the traditional model people might not even be aware of access in their community.[129]

The Workforce 2040 report which provides a detailed analysis of the allied health workforce, made the following key finding:

The allied health professional (AHP) workforce in Tasmania is an essential part of the health professional workforce. Despite our population being older, having higher levels of chronic disease and disability, Tasmania has lower rates of many allied health professions than other jurisdictions in Australia. Superimposed on this, the distribution of the AHP workforce across Tasmania is not equitable with the North West region facing workforce challenges across most allied health professions.

The reasons for this are many and include:

- *The opportunity to complete entry-level training in allied health professions is very limited in Tasmania.*

- *The opportunity to participate in professional development is limited in Tasmania, meaning qualified allied health professionals are usually required to travel interstate to engage in professional development.*

- *The career pathways for senior allied health professionals in Tasmania are limited by a lack of career structures, succession planning and the relatively small size of many of our allied health professional workforces.*

- *The implementation of the National Disability Insurance Scheme has had a significant impact on Tasmania's allied health workforce.*

With the important role of allied health professionals in supporting people with a disability, there has been a need for greater numbers of allied health professionals and a movement of some professional groups from the public to the private sector. This will need ongoing monitoring; to ensure community needs are being met and staff are well-trained and supported. Some individual allied health professions are found in significantly lower numbers in Tasmania. These include occupational therapists and chiropractors.

…

Training pathways into allied health professions in Tasmania are limited. This has a significant impact on the workforce and its capacity to meet the health needs of the community. Most allied health professionals are educated to a bachelor's or master's degree level. Psychology and pharmacy are the only professions with a compulsory postgraduate requirement, resulting in longer training times. … The lack of available entry level training in Tasmania has a significant impact on attracting a workforce to Tasmania and limits

[129] Judah Morris, *Transcript of Evidence*, 2 November 2021, p. 24.

opportunities for Tasmanians who want to train in skilled professions but may not have the capacity – financial or otherwise – to move interstate.

In addition, professional development courses are also limited, meaning that qualified allied health professionals are often required to travel interstate to engage in professional development. A lack of professional development opportunities could also be a deterrent for a qualified allied health professional accepting a position in Tasmania.

Education and training are core to an effective health workforce, as well as being an indicator of wellness in the community more broadly, with socioeconomic disadvantage having a strong link to poor health outcomes. Only 43 per cent of eligible Tasmanians completed school to year 12 in 2015, considerably less than in Victoria (78 per cent) and in Australia generally (72 per cent).

Consultation for this report indicated that it is already difficult to attract graduates back from the mainland to fill Tasmanian allied health positions (particularly senior and clinical leadership roles) – it is likely that without a focus on a 'home grown workforce' of some description, this will become increasingly difficult as other states and territories are also targeting the allied workforce to meet health service and NDIS-related demand.

The development of additional education and training pathways is an opportunity to both build an allied health workforce and provide opportunities for young Tasmanians to enter allied health professions.

ALLIED HEALTH EXPANSION PROGRAM

The University of Tasmania is currently developing its Allied Health Expansion Program to better support the allied health labour force needs in Tasmania. In collaboration with government, health professionals, industry and local Tasmanian communities, the University of Tasmania is creating education and training programs which assist entry-to-practice qualifications in allied health and help practitioners with ongoing studies and professional development opportunities. The Allied Health Expansion Program is being led by the College of Health and Medicine's School of Health Sciences. They are expecting to offer several postgraduate courses in 2022, including physiotherapy, occupational therapy, and speech pathology.

… there is a lower density of physiotherapists and occupational therapists in Tasmania compared to Australia; by introducing training pathways this is likely to improve over the next five years … Creating a local supply is obviously only part of the solution - there still needs to be attractive jobs in all sectors for graduates to move into and a strong workplace culture and effective working arrangements to retain them.

PROGRESSION AND FLEXIBILITY

Education and training play an important role in upskilling and reorienting the workforce to manage emerging health needs, like responding to the COVID-19 pandemic. An example of this is in upskilling physiotherapists to assist in critical care environments with ventilatory therapies. With fewer allied health professionals per 100,000 population than the national average … and an increasing demand for chronic illness care, it is essential that Tasmania's

community needs are supported by an education framework allowing for career entrance, progression and change.[130]

According to the AMA submission, the barriers to allied health include:

Similarly, there is a shortage of THS allied health and community services too. For instance, a recent referral to a private and public occupational therapy service for a palliative care client in Ulverstone led to the referrer being advised of a three-month wait. Another of our doctors lamented the apparent lack of psychologists, among other allied health services, to support rural practice.[131]

According to the Exercise and Sports Science Australia (ESSA) submission:

Currently there are no ESSA accredited exercise professionals working in the Tasmanian Health Service or within their rural Community Centres. This leaves many with conditions that would benefit from appropriate exercise interventions delivered by ESSA accredited professionals to seek services privately at their own cost (with some limited Medicare, veterans affairs or other compensable scheme support), or through some of the commissioned work that Primary Health Tasmania is able to achieve. These types of arrangements can be sporadic or extremely limited in duration or number of services available and patients may not receive the appropriate exercise programs for the longevity of their condition. Tasmania will continue to produce graduates from the UTAS exercise science and exercise physiology programs, but without a recognisable career path option within the public health system these graduates may leave the state or alter their career path. It would be a big disappointment to have those with appropriate skills and qualifications be underutilised in the effort to create a healthier Tasmanian community.[132]

C: NON-GP SPECIALIST MEDICAL SERVICES

According to the Arthritis and Osteoporosis Tasmania submission:

Primarily the barriers to accessing specialist rheumatology services include:

- *no public rheumatology services available in north and north west regions*
- *inadequately resourced public rheumatology services (exacerbated by unfilled positions) o unacceptably long waiting lists for public rheumatology outpatient clinics at RHH*
- *the rheumatology service at RHH is by all accounts no longer accepting category 2 and 3 referrals from outside the region*
- *multiple and confusing entry points for those needing to access a rheumatologist*
- *cost of accessing private rheumatology services prohibitive for those on fixed, low incomes (initial visit ranging anywhere from $385-$405)*
- *tyranny of distance in having to travel to Hobart to access specialist rheumatology services.*[133]

[130] https://www.health.tas.gov.au/publications/health-workforce-2040-allied-health (accessed 4 July 2020).
[131] Australian Medical Association, 2021, *Submission #52*, p. 4.
[132] Exercise and Sports Science Australia, 2021, *Submission #35*, p. 3.
[133] Arthritis and Osteoporosis Tas, 2021, *Submission #43*, pp. 3-4.

Jacquie Slyp, CEO Arthritis and Osteoporosis Tasmania, made the following statements regarding barriers to accessing services:

> ***CHAIR*** *- On a similar, but another barrier, you talked about referral to tertiary care. It is on page 5 of your submission. You talked about early diagnosis and that access to specialty services is critical to avoid or limit irreversible joint damage. You also make the point here that, the PBS mandates six-monthly rheumatologist reviews to all patients receiving high cost medications.*
>
> *These are the patients who have been lucky enough to get on a rheumatologist's books, if you like, and so, that requires them having six-monthly reviews, which I assume means meeting with the rheumatologist, not just saying, 'yes sure, continue'. This is 25 per cent of the rheumatology practice for the patient population there, that comprises 25 per cent. Clearly, a number of appointments for the rheumatologists we have are being taken up with these people having repeat visits. I am not saying that it is not important, because they are, some of them are novel medications, I am sure; some of them are very expensive, some of them can be toxic, as other medications can. Is that a particular barrier that needs addressing, or is that purely that we need more rheumatologists in order to meet the need? What is the issue there?*
>
> ***Ms SLYP*** *- The issue there, my understanding, is that you do not see a rheumatologist in the public system unless it is done through the outpatient clinic. That is the only access that you have. The medications they are talking about are what they call the new biologic medications. Tasmania has a much lower uptake of those. I would say that that correlates with the fact that you do not have the specialist access. Therefore, we are denying people access to something that can make a significant difference. If they get the right combination of treatment, there is even talk of remission in some inflammatory conditions. That was never heard of when I first started 20 years ago. There have been enormous steps forward, but we are not able to access those.*
>
> *Most of the people they would see urgently through the outpatient clinics are newly diagnosed children. The decks are cleared for young people with inflammatory arthritis so we can get them in as soon as we can, but those pathways still take a long time.*
>
> *In answer to your question, I would say a lot of people just do not access those. If they do get the new biological medications, they go without everything else to pay for that specialist appointment in the private sector.*
>
> ***CHAIR*** *- Those who do manage to get them are mostly through the private sector, not through the public?*
>
> ***Ms SLYP*** *- Those do, and they're the ones who go without other things in their lives to cover those appointment costs.*
>
> ***CHAIR*** *- You noted that the current waiting time for non-urgent cases is 769 days. Referrals are apparently no longer being accepted, so it becomes a never-ending number. The estimated wait time for semi-urgent cases is 139 days, and for urgent cases, 175 days. Am I to assume that the urgent cases are the children and young people who are still waiting 175 days?*
>
> ***Ms SLYP*** *- And adults as well. If you are experiencing flares, you cannot get those flares under control until you get in to see someone to really nail it. In the meantime, those people are in really difficult situations. Most of them, as I have said, have inflammatory conditions and are in the workforce. They would be in the up to 45 to 47 years age group. They are the ones that are nursing, who can't do their shifts because they are in so much pain - that type of thing. There are so many people who aren't on those, because -*

CHAIR *- It is only the tip of the iceberg.*

Ms SLYP *- That's right. People just don't bother making appointments. GPs don't make the referrals because there is no way of getting through. We get that message all the time. The GP says, look, there is such a waiting list that it will be months or a year or more before we get in. That's the reality. I really do feel for those people who have nothing in their kit bag. Osteoarthritis is even worse, because nothing new is happening in that space.*

CHAIR *- You also talk about, under part B, Primary care, allied health and general practice services - and you have spoken a little on this already - how there is no coordinated framework for delivery of arthritis and related musculoskeletal services across the state. You said there are significant benefits to be gained from expanding the rheumatology nurse practitioner role. Do we currently have rheumatology nurse practitioners, and how many - or not?*

Ms SLYP *- We have one person part-time, and recently a second person has come into the role, so together one full-time equivalent. That person is almost 100 per cent of the time busy in the outpatient clinics, or in emergency as well when people come in there. It is at least someone to go there. On top of that, they are also available to respond to GP inquiries, but that isn't well known. A lot of research has gone into this around the country, showing those positions can improve service delivery and save money. It takes a long time to be trained up in those positions, but certainly, cost-effectively, that's a good way to go.*[134]

Diabetes Tasmania is an example of an organisation tackling not only the barriers but even the availability of services across the state. According to Minke Hoekstra and Myles Clarkson-Fletcher:

Ms HOEKSTRA *- .... Diabetes Tasmania is a charity and our purpose is to work with the community to prevent and reduce the impact of diabetes. We are in a position to talk about some of the challenges faced by some rural and remote Tasmanians in our service delivery. We know about the demographics of rural and remote Tasmanians in that they are twice as likely to be admitted to hospital or die because of their diabetes. Their diabetes rates are higher, their risk factor rates are much higher than their city counterparts. As a state-based organisation we are funded to provide clinical services state-wide. We have been able to do that over the last three years more effectively for people in rural and remote areas because of some changes we have made to our internal structure - the way we receive referrals and look after people.*

Access is one of the big barriers that has come up for people living out of the main centres. Myles can talk a little bit more about that. One of the things we have done over the past few years is to change the way people can access our clinical services, their face-to-face or one-on-one appointments with diabetes educators and dieticians rather than relying on GP referrals. We know there are towns without a regular GP, locums or no GP at all, so people can now self-refer, allied health professionals can refer, GPs can refer and we now triage the referrals to provide the best care for the patient. ...

We also hear past speakers talking about the importance of a multidisciplinary team. That is something we have tried to provide more by appointing both a social worker and a nurse practitioner to our clinical services. This provides more of that holistic care that people, especially in remote and rural communities, can't access because of lack of specialists or waiting times. We also have our telephone health coaching program, the COACH Program, which is one way we have been very effectively able to support people at risk of diabetes throughout Tasmania. We have just been promised ongoing funding for two new streams of that program for heart health and women who have had gestational diabetes. That will

[134] Jacqui Slyp, *Transcript of Evidence*, 30 November 2021, pp. 8-10.

help us to bring people into a multi-disciplinary type of care that's delivered by telephone, so it's far more accessible.

…

***Mr CLARKSON-FLETCHER** - … The main point of our submission is to highlight how our organisation is an example of tackling not only the barriers but even our availability of services across the state. Diabetes, we know, is about self-management. Ideally, we're teaching people how to look after their diabetes; it's a chronic illness.*

How people access that education, how they access that support is really tricky in rural communities. We have three main hospital centres that provide specialist care. The GDMs is an example of that care not always being accessible for everyone, either geographically as they can't come in and attend appointments all the time or the pressure that is on the hospital system itself.

Our model of care and what we're developing is aimed at trying to overcome some of those barriers for rural communities by providing access to dieticians, diabetes educators, the specialist health services, as well a nurse practitioner, which has proven in a very short period of time to be very effective. We have a social worker that underpins our team environment.

What we've identified and what international guidance would highlight is the need for psychosocial care. It's all very well for us to ask someone to look after their diabetes but if they are facing other pressures, other priorities in their lives, it's very difficult to make those changes or to commit to self-management. Diabetes has never been able to be managed by one person alone or via a GP on their own, they need that specialist support.

One of the problems is you can't continue to supply the number of diabetes educators across the state considering the growth of diabetes in the state. We have one of the higher rates of diabetes, we have one of the highest rates of insulin use per capita. With diabetes we talk about the 5.4 per cent prevalence but it is very age related. Some of the work we've done in aged care has shown that within residential aged-care facilities it's almost 25 per cent. But we're looking at 40 per cent of people in their 70s and 80s. That's a huge number and it's not just the numbers, it's the complexity of care that becomes the challenge.

Access, as Minke was highlighting, is one of the issues to specialist care. What happens in primary care, in rural areas especially, because of the lack of access to specialist care, there is a burden on GPs, for example, to start someone on insulin. It is not a very easy medication to start because it doesn't just take one appointment. You have to teach someone how to use the device, you have to teach them how to monitor, you have to teach them how to stay safe. Then you need to adjust that dose. No insulin dose should stay the same over time.

So how do you implement that? How is it funded, through MBS? We need to see access to diabetes educators. Telehealth with videoconferencing is one thing we've introduced, resources to support practice nurses, to support GP's, so we can work in an integrated team care environment across the state.[135]

Mr Clarkson-Fletcher elaborated:

***Mr CLARKSON-FLETCHER** - … I'll give you a quick history of what we did. The first thing we introduced back in 2019 was a triage system. One of the issues around access is relying on GP referrals and asking GPs to then decide what service the person would need. We introduced a triage system, so any referral comes through to us and that health professional in the triage team will phone the person with diabetes and talk through what they might*

[135] Minke Hoekstra and Myles Clarkson-Fletcher, *Transcript of Evidence*, 20 August 2021, pp. 2-3.

need. It's taking the time to meet the person over the phone and decide what service will best suit them. Telephone was the first step. The second thing was when COVID hit we very quickly were able to transition to a telehealth-based care out of necessity. Traditionally what we would do was send a dietician or diabetes educator out to rural clinics every four or six weeks. That means you can only access our services in a very limited window of time. It also meant we had to allow for drive time, travel time, so it limited the number of people you can see. Telehealth has opened up not only how flexible you can be, you can see an educator anywhere in the state and our wait-times have gone from nine weeks to now seeing someone within two to three weeks. That has improved our access, it also means our failure to attend rates have dropped because people can conveniently access through telehealth, and we are able to see more people within a day, because we have reduced the travel time.

But, what you highlighted is exactly the problem we have. We recently did a group education session in Bruny Island, not one of the people had an email address nor access to the internet. We still have to provide face-to-face clinics and that is something we continue to do. What we are able to do better now is, rather than sending our technicians in at set dates, we are able to put people into a waitlist for a face-to-face visit, and we actually get better attendance rates by then lining up that clinic according to need. We can target our face- to- face care according to need. The issue is not just the technology issue; there are people, especially old people, whose hearing ability excludes them from using the new technology, so we are very mindful of that.

I think, the other important member of our team is our engagement team. So, we have people, representatives in the state who go out and meet with GP clinics, pharmacies and community groups to discuss these issues. We are aware we have presence in the community even though we are not always sending clinicians out as we used to do.[136]

The RACGP identified COVID as a barrier to accessing non-GP specialists:

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. [137]

D: HOSPITAL SERVICES

The Premier, in his capacity as Minister for Health, provided details regarding safe staffing during the 2022 Budget Estimates process:

***Mr ROCKLIFF** - ... Tasmanian Health Service statewide district hospital safe staffing working group was established in February 2018 to research and develop a staffing model for the 13 Tasmanian district hospitals. The model is designed to provide the flexibility required to staff individual Tasmanian district hospital sites to meet their specific mix of inpatient, emergency, outpatient and residential aged care activity.*

Last year's budget provided $18.3 million in funding over four years for that model. The model has now been implemented, with a 12-month trial underway and formal evaluation

[136] Myles Clarkson-Fletcher, *Transcript of Evidence*, 20 August 2021, pp. 5-6.
[137] RACGP, 2021, *Submission #65,* p. 2.

occurring periodically. The model commenced on 27 June last year with the working group continuing to oversight both the implementation and evaluation processes.

A key issue associated with the implementation of the model has been the lack of staff to ensure district hospitals operate in line with the model, reflecting the market challenge of clinical staff recruitment and retention in rural and remote locations. This funded staffing model will improve access to safe and appropriate clinical care and services at rural sites optimising the use of rural inpatient beds.[138]

According to the Rural Doctors Association of Tasmania (RDAT) submission:

District hospitals need to be adequately resourced and staffed to ensure maximum utilisation. The District hospitals not only provide step-down care, but they can also be the primary site of care for selected medical conditions within the scope of practice for the practitioner and the site. Rural district hospitals have seen an increase in inpatient activity and complexity of patients. As pressure builds in Tasmania's major hospitals, there is a push for increased utilisation of rural inpatient beds. RDAT supports utilising rural hospitals and rural generalists to their full capacity, however, adequate staffing and resourcing is needed for this to occur. For example, as the number of emergency department presentations to rural hospitals increases, District hospitals will require dedicated staff for emergency presentations; currently the staff attending to emergency presentations in District hospitals are taken away from the care of inpatients. Also, the district hospitals are not funded for increased numbers of emergency presentations, drawing resources from existing block funding for the facility.

Rural Generalists with an extended scope of practice and special skills in a variety of areas staffing the hospitals would mean more complex patients may be able to be managed. Support from non-GP Specialist services, via telehealth or outreach services would assist. Adequate allied health particularly physiotherapy and occupational therapy, as well as nursing staff with generalist skills are also essential. This supports robust emergency care, inpatient care and rehabilitation. RDAT would suggest further discussions between our organisation, the Australian College of Rural and Remote Medicine and the state Department of Health to further develop the role of the District Hospitals in the Tasmanian Health Service as they are currently underutilised, under-resourced and underfunded. The number of rural beds combined in the state is equivalent to a regional base hospital and these could be used more efficiently to deliver the right care, to the right patients, by the right healthcare team, closer to home.[139]

According to the Health and Community Services Union (HACSU) submission:

HACSU has participated in a project within the THS called District HiTS (District Hospitals in Tasmania Staffing Model). This review commenced in 2018 and all but finished in 2020, after which there was a determination that rural nursing staffing overall was inadequate for the activity. Rather than immediately moving to fix the staffing levels, a business case had to be developed. All parties believed that this would be rudimentarily approved,

[138] Premier Rockliff (in his capacity as Minister for Health), *Transcript of Evidence*, 7 June 2022, p. 95.
[139] Rural Doctors Association Tasmania, 2021, *Submission #30*, p. 4.

however, these business cases were overall rejected by the budget and finance processes and the District hospitals in the majority remain under resourced.

District hospitals have reduced in size, and locations over a long period of time, once thriving local facilities have been closed or centralised or have become a shell of what they once were. As an example, New Norfolk Hospital no longer provides urgent or emergency care in any capacity. Hospitals which once well served a rural community have either closed. Most district hospitals have reduced services.

Emergency departments are specifically designed to provide immediate trauma stabilisation services whilst waiting on patient transfer to a more suitable facility (nominally the 4 urban hospitals, MCH, LGH, RHH, NWRH). It is extremely common for a patient who presents at a district hospital such as St Mary's or West Coast, to be taken ASAP to another facility, usually via an ambulance. Staffing at these district hospitals is focused on their residential care role with less than half the hospital staffing provided for acute/inpatient care.

The 2-year average (July 2017–June 2019) was 57,030 days of patient care within all 13 district hospitals, of which 31,039 of these days were residential care. There is little capacity to surge within the district hospitals. Staffing is often comprised of permanent part-time or permanent full-time staff only. Access to casual staff is a challenge and often when engaged these workers either a) don't live within the community or b) already are engaged at their preferred hours anyway. This leads to utilising overtime mechanisms to surge when needed, which is often not available.

The busiest district hospitals are Campbell Town, Midlands, Beaconsfield, and West Coast (Queenstown). HACSU is very concerned about regional access to hospital services. Waiting lists for residential care are often extraordinary long, with regional residents often being required to go to a commercial facility for respite and long-term care (and often these are only available in urban areas). Approximately 600 people a year present to emergency departments at district hospitals with a serious event at Category 1 or Category 2. Another 2500 present with Category 3 presentations. The vast majority of these cases will receive a transfer normally to the Big Four hospitals within 3 hours of presentation at the district hospital. Ambulance Tasmania paramedics would rarely take a patient to a district hospital, but volunteers may (despite the fact that volunteers are normally required to wait for a paramedic to transport patients). Most of these higher category presentations are "walk-ins" who are driven by a family member or another community member.[140]

According to the King Island Council submission:

The services provided at the King Island Hospital & Health Centre are greatly appreciated by the King Island community.

There is a perception that the King Island Hospital administration staff have a general lack of information about visiting services, off-Island specialists, PTAS, and other health-related matters that a patient or other community member might reasonably expect those staff to have. It is assumed by many that this is at least in part because such information is not readily shared with administration staff on King Island by the department, and because

[140] Health and Community Services Union, 2021, *Submission #45*, p. 8.

there are frequent changes made to visiting specialist schedules and the complexities of the PTAS system.

Patients travelling to North West Regional Hospital are not provided with any contextual information about what they should expect when staying in the hospital accommodation, such as the lack of easy access to shops and food outlets. The North West Regional Hospital Accommodation Information Handbook in the DHHS website was last updated in 2011 and references the accommodation units being under construction). More staff – including nursing staff – need to be trained on using the X-ray machine so that we are not taking up the time of the doctor for something that can be done by nurses elsewhere in the State.

Pathology services are provided at the King Island Hospital on a weekly basis. However, these are reliant on flight schedules off the Island to get blood samples to the testing facility in mainland Tasmania. Changes in scheduling mean changes in clinic availability. As the pathology clinic operates on a drop-in basis, rather than fixed appointment times, a change in schedule can mean significant confusion for patients who won't necessarily find out that the clinic's day and hours of operation have changed until they arrive at the hospital.[141]

E: MATERNITY, MATERNAL AND CHILD HEALTH SERVICES

According to the Rural Doctors Association of Tasmania (RDAT) submission:

Rural maternity services are the lifeblood of many rural health services in Australia. Tasmania is now limited to only three birthing units in the state. In the recent past many rural hospitals safety birth 50- 100 babies per year with the skill mix of rural generalists and local midwives.

The position of the Rural Doctors Association of Australia is:

- *Quality and safety must underpin the provision of maternity services in rural and remote areas.*
- *Rural women have a right to safe, high-quality maternity services as close as possible to where they live.*
- *The continuing trend toward downgrading or closure of rural maternity services must be halted and reversed.*
- *A highly skilled workforce is necessary to provide sexual, reproductive and maternal health care for rural women, and manage obstetric emergencies when they arise.*
- *Models of care for rural maternity services must be fit-for-purpose for their communities.*
- *A continuing decline in rural health infrastructure, including for maternity services, has negative consequences for the health and safety of rural people and, more broadly, on rural communities.*

Access to safe, high-quality women's health services that deliver contraceptive, safe termination of pregnancy services, preconception, antenatal, perinatal and postnatal care provided by a well-trained and supported workforce diminishes the health risks for rural women and their babies. We note that, in Queensland, rural maternity services have been re-

[141] King Island Council, 2021, *Submission #69,* p. 4.

established in a number of rural towns where the removal of those services had not demonstrated improved outcomes (as had been the justification for this action) but had in fact been to the detriment of local women and their families. Workforce training, recruitment, retention and development strategies are necessary to ensure the ongoing provision, maintenance and sustainability of rural maternity services.[142]

F: PAIN MANAGEMENT SERVICES

According to the Australian Pain Society (APS) submission, the common barriers to recovery in the acute phase of healing, related to delayed timeliness of health services include:

- *Lack of information for the patient in the acute phase of their tissue injury/usual recovery time frames. Many injured workers find the use of procedural medical language difficult to understand, and that there is a lack of information and often misunderstandings about their condition and rehab focus, which leads to dissatisfaction with treatment and return to work plans. Procedural language needs to be translated and understood so that workers know how to use it in their personal management of the rehabilitation and return to work process.*
- *Lack of skills by the treating GP in recognising Physiotherapy as an essential need for the injured worker as soon as possible after initial physical injury (staying at home leads to catastrophising, fearing the worst, fear of their pain causing avoidance behaviours, and lack of understanding about when to stop resting and start actively mobilising or exercising).*
- *Lack of skills by the treating GP in recognising those injured workers who are at high risk of transitioning from acute to chronic pain and the need for early psychological intervention. If psychosocial factors are ignored, the elevation of pain from acute to chronic may be accelerated. Psychosocial factors should be recognised as important factors in the severity of injury, the effect on a person's quality of life, and ultimately the length of recovery.*
- *Lack of availability of psychologists on the north west coast who have experience in chronic pain management.*
- *For some patients with 'red flag' injuries: such as a severe cervical or lumbar vertebral disc protrusion causing considerable neurological weakness in a limb, the system fails them as they may have to wait until they have had two opinions from spinal specialists, plus an occupational health physician before funding is given for surgery, when, if they had not been under the workers compensation scheme they would have more likely have received a referral for emergency surgery via the Department of Emergency, or by using their private health cover, and gained significantly more positive outcomes. Often non-medical case managers can override a specialist's advice with regards to emergency surgery and delay funding for years, causing increasing disability and high risk of the patients never returning to the workforce.*[143]

[142] Rural Doctors Association of Tasmania, *Submission #30*, pp. 6-7.
[143] Australian Pain Society, 2021, *Submission #25*, pp. 5-6.

Common barriers to recovery in the chronic phase of care, related to delayed timeliness of health services

- *Some injured workers have case managers who are based interstate, who (pre COVID) fly patients interstate to receive an assessment from an independent medical examiner on behalf of the insurance company. For these patients, it is mandatory for them to travel from their rural community to an alien environment away from their family and support. This can be overwhelming for the worker who is unfamiliar with flying or with the built-up city environment. Workers perceive the insurance company of using their rules and legislation to test for compliance and worthiness, and that it is assumed that they are' fraudulent' or 'malingerers' until they have proven otherwise. They feel that any lack of compliance is then used against them as validation of their 'fraudulent' behaviour. This then reinforces the worker's need to adopt an adversarial role. In these cases, there is often a lack of contact between the case manager and treating doctors/specialists, causing further delay in the receival of appropriate management.*
- *Often non-medical case managers don't recognise the need for pain education and won't fund it, therefore the patient misses out on multidisciplinary pain management.*
- *For those workers who are allocated funding for multidisciplinary pain management, there is a lack of services on the north west coast that provide pain management services for workers compensation patients.*
- *Social support has been found to improve the psychological well-being and quality of life of patients suffering from chronic pain. Lack of social support in the work environment tends to negatively affect pain severity.*
- *Despite evidence supporting the notion that chronic pain is not necessarily attributed to delayed tissue healing or tissue damage, there is still ongoing confusion for the workers compensation patient as he is treated under the medical model, when it is more the psychosocial influences rather than the originally injured tissue that is driving the patient's pain. This happens due to lack of understanding from the case manager, rehab provider or treating practitioners that treatment should be geared towards managing the psychosocial influences rather than focussing on looking for the 'damaged tissue' with unnecessary scans, tests and procedures.*
- *There is often major discontent between the patient and key stakeholders within the workers compensation system, related to lack of information, the view that their injuries were not believed to be legitimate, and the lack of attention and respect they received from these stakeholders. Some insurance doctors are often rude, sarcastic and arrogant (Kenny 1995b).*[144]

According to the King Island Council submission with regard to pain management services:

- *No specialist pain management care provided on-Island. All chronic pain patients are required to fly off-Island for specialist support when they are able to get a referral. The closest pain management clinic is in Melbourne – travelling interstate for medical treatment raises additional questions with PTAS administrators and brings in more eligibility criteria, which makes the process more complicated and challenging for patients.*
- *Physio, chiropractic and other alternative care options can be effective in pain management. There are no providers resident on the Island for these services and only*

[144] Australian Pain Society, 2021, *Submission #25*, pp. 6-7.

limited visiting specialists arranged through the hospital. Referrals to these specialists off-Island are not eligible for PTAS support.[145]

G: PALLIATIVE CARE SERVICES

According to the Palliative Care Tasmania submission:

> *Palliative care provides relief of suffering through early identification, assessment and treatment of pain and other problems, including physical, psychosocial, and spiritual needs for those who have been diagnosed with a life limiting illness. Currently in Tasmania, around 4,500 people will die each year. The great majority of these deaths (around 4,000) are what is described as 'expected' or 'predictable' deaths, that includes many people who have had life-limiting conditions or have been elderly and frail. It has been estimated that up to 90% of people with life-limiting conditions would benefit from, or need, palliative care. This need will increase by 135% over the next 30-40 years.*
>
> *The Productivity Commission describes this country as facing a tsunami of palliative care cases. Tasmania can expect a greater proportion of people aged over 65, increasing rates of dementia and deaths from dementia, and multi-morbidities requiring much more complex care.*
>
> *Regional and rural communities on Tasmania's East Coast have the highest proportion of older Tasmanians. Triabunna - Bicheno (29%), reflecting its popularity as a place to retire. This was followed by Forestier - Tasman (27%) and St Helens - Scamander (25%).*
>
> *Not all Tasmanians who need palliative care have access to services when they need it and where they need it, particularly at home and in community settings. These gaps are most pronounced in under-served and vulnerable communities, including rural communities.*
>
> *Since 2012 the years lost to disability due to non-communicable diseases have increased. The largest patient cohort are those with non-complex needs where care is provided by primary care and generalist palliative care personnel. Those patients with complex needs will require the care of a multi-disciplinary team and involve specialist palliative care services.*
>
> *This will only worsen as we see increases in demand in the coming years if we do not act now. Investment is needed in palliative care and advance care planning, particularly through increased availability of community-based palliative care.*
>
> *Investment in palliative care makes economic sense. People living with a life-limiting illness who receive palliative care, compared with those who do not, have fewer hospitalisations, shorter hospital stays, reduced use of Intensive Care Units and fewer visits to Emergency Departments (EDs). They can remain in their communities and receive the care they need, rather than experiencing periods away to receive care, which can result in condition decline, particularly for those suffering with dementia.*
>
> *It is important to note that delivery of palliative care services is not just a role for the health care system or palliative care specialist services – it also includes significant contribution from informal and community supports surrounding a person with a life limiting illness.*

[145] King Island Council, 2021, *Submission #67*, p. 5-6.

That is why it is critical we focus on developing community-based care options into the future.[146]

According to the Rural Doctors Association of Tasmania (RDAT) submission, barriers to access to palliative care services include:

The majority of Palliative Care delivered by medical practitioners is by GPs. It is well known that most Australians want to receive Palliative Care in the home, but unfortunately a significant number die in hospital, and for rural patients, away from their local communities. The opportunity to maintain skills through the PEPA program is an excellent initiative for GPs, as well as Palliative Care Nurse Educators who can provide advice and a sounding board for GPs. The Specialist Palliative Care Service in Tasmania is high quality, however, is under resourced to respond to Tasmania's ageing population and increased chronic disease burden. For example, in the North-West there is an under-resourcing of 1.0 FTE Staff Specialist in Palliative Care. This affects the health service's ability to provide high quality inpatient and community care. In terms of recruitment and retention, the North-West region has trained over 10 GPs in 6-12 month training terms to upskill in Palliative Care, with some obtaining an Advanced Skill in Palliative Care and working as a Rural Generalist in this area. RDAT advocates for continued investment in Palliative Care and end of life care at home and in the hospital. This is especially important with the initiative of Palliative Care beds at the Mersey Community Hospital. Specifically, in the district hospitals, spending has been undertaken to improve Palliative Care spaces and the Department of Health should be congratulated for this. Continued education and training for district hospital staff will be required for long term success of Palliative Care in rural communities.[147]

According to Colleen Johnstone, CEO, Palliative Care Tasmania:

Some of the barriers that people face is that they want to be supported at home, however home is defined. It could be your house in the suburbs, it could be your residential aged care facility, it could be your disability share house. This is really tricky to provide in Tasmania. For example, in Tasmania in the last weeks of life the preference for home care falls from 90 per cent to 52 per cent and this is mostly due to issues relating to symptom control and management. While people want to die at home, they don't feel supported to do that and the most common place of death for dying Tasmanians is still hospital with about 40 per cent of our dying Tasmanians still dying in our three major hospitals.

…

We have key workforce shortages across these segments and this impacts the ability of our dying rural Tasmanians to access palliative care. We have a lack of skilled workers, particularly in nursing and medicine. We had this before the COVID-19 pandemic hit and the pandemic has just exacerbated the situation. We don't have consistent 24-hour access to palliative care service. At the moment in Tasmania we have a phone number. I understand that the Government has invested funding to address that situation but as we speak now if you are dying in Smithton, it is unlikely that you will get after-hours support.

[146] Palliative Care Tasmania, 2021, *Submission #17,* pp. 4-5.
[147] Rural Doctors Association of Tasmania, 2021, *Submission #30*, p. 7.

We have a lack of nurses for one-on-one care at end of life. We have a lack of skilled workers in age care and allied health. Age care is the second largest place of death in Tasmania, and in Australia. We have a lack of care coordination. Because we do not have care coordination in palliative care, when people are discharged from hospital they feel like they are falling off the cliff. They don't know how to access services. They don't know what services are available. The don't have somebody that can wrangle services for them.

There is a high turnover in our workforce, particularly among support workers. We have a lack of palliative care skilled mental health professionals. We have a lack of carer respite. We also have a lack of career pathways into our sector for carers. Our unpaid carers learn an invaluable amount of skills when they are caring for their dying loved ones. We also have a lack of mental health support for carers.

Regarding our system issues, we do not have 24-hour palliative care services. It is very difficult to work outside the Tasmanian Health Service.[148]

According to Dr Maxine Glanger, Palliative Care Tasmania:

People who are dying and their families require care and support, 24 hours a day, seven days a week. There are a number of challenges in providing palliative care to those living in rural and remote Tasmania.

The provision of palliative care in the rural areas of Tasmania is variable. In rural Tasmania palliative care is mostly provided by GPs, community and palliative care nurses and residential aged care staff. Specialist palliative care services support GPs in their provision of palliative care but do not have workforce sufficient to take over the care entirely. These various combinations of health professionals and services create disparities in access and quality of health services for rural and remote patients. It also means it is difficult to determine exactly who delivers palliative care in rural and remote Tasmania.

Some patients can be admitted to a specialist inpatient unit, others only have the choice of dying in their local hospital or aged care home if home is not an option.

There are many positive features of providing palliative care in our rural and remote settings. Local services and local practitioners offer a sense of familiarity, community and continuity and ANZSPM wishes to see equitable, consistent and high-quality provision of palliative care across our whole population.[149]

Dr Glanger described the difficulty in recruitment of palliative care specialists:

I was recruited to the position in June and at the end of July we lost our other palliative care specialist who was a gentleman who had come to the position about a year or 18 months before. He had come from Melbourne. That is part of the problem about not training people locally is that people come down for a change and then have commitments that pull them back to the mainland.[150]

[148] Colleen Johnstone, PCT, *Transcript of Evidence*, 30 November 2021, p. 26.
[149] Dr Maxine Glanger, ANZSPM, *Transcript of Evidence*, 2 November 2021, p. 48.
[150] Maxime Glanger, ANZSPM, *Transcript of Evidence*, 2 November 2021, p. 54.

Since the PCT's submission and passage of the 2022/23 budget, additional funding was provided to support the work of Palliative Care Tasmania. Extra resources will be needed into the future due to the growth of palliative care demand.

H: PHARMACY SERVICES

According to the Pharmaceutical Society of Australia (PSA) submission:

> *The challenges in accessing health care in rural and remote areas are due, in part, to the tyranny of distance. Shortages in Tasmania's rural and remote healthcare workforce also contribute to reduced access to the services that Tasmanians need to maintain good health and manage their medicines. By 2027, without intervention, it is estimated there will be as few as 52 pharmacists per 100,000 people in regional and remote areas, compared to 113 pharmacists per 100,000 in major cities. Lower levels of access to health services mean Tasmanians in rural and remote areas generally experience greater burden of disease and have poorer health outcomes. Further highlighted is access to general practitioners being less in rural and remote areas. Pharmacists in these areas provide a range of support to the residents that cannot be underestimated, despite there also being a lack of pharmacists in these areas. This is further compounded by the disproportionate health challenges experienced by the population in these areas and the multitude of medications needed by these people. The rate of unintentional drug-induced deaths in rural and remote areas is higher than in capital cities and increasing at three times the rate. Between 2011 and 2018 unintentional drug-induced deaths increased by 15.9% in rural and regional areas compared with 3.6% in capital cities.*[151]

According to the Pharmacy Guild of Australia (PGOA Tas) submission, barriers include the pharmaceutical scope of practice:

> *Genuine health reform and significant cost savings can be delivered through the better utilisation of community pharmacists. International experience shows that there are both significant savings and improved health outcomes by following two key principles:*
>
> *1. Removing regulatory restrictions which inhibit health practitioners from practising to the full extent of their capabilities;*
>
> *2. Allowing patients to choose who provides their primary health care, particularly in the case of chronic disease management. Community pharmacists provide a range of primary health care services beyond dispensing that are crucial to the health of Australians.*
>
> *These services help patients achieve positive health outcomes and cover, for example, advice to mothers regarding the use of medicines while breastfeeding; sexual health and contraception advice; assessing ailments such as minor wounds and sporting injuries and providing assistance to elderly and other people regarding the health system and their access to social welfare and other community services.*
>
> *As a 2014 report by the Grattan Institute stated, pharmacists are among the most trusted of all professionals, are found in most communities throughout Australia and are accessible to*

[151] Pharmaceutical Society of Australia, 2021, *Submission #39*, pp. 1-2.

patients without a long wait. Yet, compared to several other countries, pharmacists in Australia are still not able to practise to their full scope of practice.

The main gaps are in areas such as the administration of vaccines, therapeutic substitution, continued dispensing, prescribing and laboratory testing. Australia lags behind countries with equivalent economies and health systems including Canada, the UK, Ireland, the USA and New Zealand where there are examples of these practices being undertaken by pharmacists. Appendix one [Appendix B of this report] *demonstrates the variances when comparing Australia to other OECD countries. As stated in the International Pharmaceutical Federation (FIP) Vision statement 2020-2025 "…the COVID- 19 pandemic has demonstrated the essential role of pharmacies and pharmacists in our communities and their ability to innovate healthcare solutions. We must ensure their role continues to be recognised beyond the pandemic."*

The National Competency Standards Framework for Pharmacists in Australia 2016 define scope of practice as "…a time sensitive, dynamic aspect of practice which indicates those professional activities that a pharmacist is educated, competent and authorised to perform, and for which they are accountable." … The Competency Standards give pharmacists the accountability to prescribe, dispense, administer, and review medicines as they form the basis of what is considered the acceptable standard of contemporary professional practice in Australia. It is through state and territory legislation, that the authority is given for pharmacists to prescribe, dispense, administer, and review medicines. It is this legislative authority that also currently restricts pharmacists from practicing to their full scope. The scope of practice for the pharmacy profession as a whole is defined by the competencies described in the 2016 Competency Standards. As professional practice evolves and the profession matures to meet the needs of the health care system, and society in general, so do the competency standards due to their dynamic nature and regular review cycle. The capacity of the competency standards to support and enable professional practice and growth over time is invaluable to champion full scope of practice for pharmacists now, and in the future.[152]

Pharmacist Belinda Bird and Monique Mackrill, appearing on behalf of the Pharmaceutical Guild of Australia (Tasmania), detailed a number of pharmacy schemes which remove some of the barriers to accessing pharmacy services:

***Ms BIRD** - … Something Primary Health Tasmania could fund is to provide a safety net for practices so they could leave six appointments open each day, for example. If these weren't filled, by some miracle, there'd be an ability for them to top up the fees they've lost by keeping that open. A program like that would be an absolute game-changer in rural communities.*

The other thing is encouraging GPs and supporting them to use tools like My Script List. Instead of the patients getting a prescription, they have a list of all their authorised prescription items in the Cloud. They can go to any pharmacy, the pharmacy can get permission to log in and see what they have been prescribed, and then supply it based off that. I don't know if you know this, but the average 70-year-old takes 12 tablets a day - and then there's injectables, patches and things like that on top of that.

[152] Pharmacy Guild of Australia (Tasmanian Branch), 2021, *Submission #42*, pp. 6-8.

It is a huge issue to manage all that paperwork. A lot of appointments are taken up with people going back for that one thing they forgot to ask for when they were there a month ago. There are some really common-sense things that, if we could get everyone on board with, would take out the red tape and bureaucracy that's getting in the way of clinical work.

***Ms MACKRILL** - What Belinda is referring to with the active script list is basically the second phase of e-prescriptions. So, you've got the token, and the next phase was to consolidate that. Older people get a token, and what generally happens is that they walk in and say, I've got this thing on my phone; the doctor said you'll know what to do with it. The pharmacist is spending that time explaining what happens. There's no paper prescription, or you're printing out the token for them. Having initiated the active script list means they don't have to worry about anything when they go to the pharmacy; it will all be there. They can see everything.*

It's a bit like that 'scripts on file' thing, where pharmacists had drawers of prescriptions - but it exists in the Cloud.

***CHAIR** - I think that grew out of COVID-19, predominantly, or was it available before?*

***Ms MACKRILL** - It was fast-tracked through COVID-19. They really sped it up, which added an extra burden to doctors and pharmacists, because so much was going on in that space.*

***CHAIR** - I am interested in the minor ailment scheme. Do you believe the majority of pharmacists in the state would be willing to participate in that sort of scheme?*

***Ms MACKRILL** - They would if there was wraparound remuneration. What we generally see happen is that pharmacists will do some of these first-aid things - people come in on a Sunday, receive treatment and they don't pay for it. It's kind of like, thanks for that.*

***Ms BIRD** - It's $4.95 for the dressing.*

…

***Ms BIRD** - I don't know if any of you have needed to utilise a community pharmacy. I am sure, Bastian, you have a really good understanding of how we keep the seams together. Unless you really needed us, you don't know what we can and will do. It's just what we do. We have a service value, so we subsidise all those services ourselves.*

***CHAIR** - Who should fund that?*

***Ms MACKRILL** - It could be recognised at a federal level if they said something; a bit like the federal level should really remunerate pharmacists for NIP vaccines. At the moment it is done through GPs, they get the payment for administering the NIP. The NIP is provided free. In Tasmania, we are going to get access to NIP for the flu season into the future. I have had a chat with the minister and that has been put on the table. We can do it privately; for example, a 65-year-old comes in and we can say we can give you your NIP vaccine for influenza but it will be $20 - or whatever it is going to be - because there is no equivalent of the MBS item.*

Through COVID-19 we have seen that happen, because that is how the COVID-19 injection has been remunerated for pharmacists. Our state Government should be pushing COAG to recognise that pharmacists should be remunerated under a similar system to what is happening now with the COVID-19 vaccine to provide national immunisation program vaccines to all those people that need it.

Two of the largest potentially preventable hospitalisations in the state are due to vaccine preventable diseases - pneumonia, flu, and others like UTIs. If the federal government was to fund pharmacists to provide those; but what is happening is that when pharmacists log onto the Australian Immunisation Register (AIR), they are looking for the history for COVID-19 vaccines because that is the protocol. You can see the gaps. … That ends up kicking back into the state system, putting people into hospital and costing a fortune. It is $4500 a night for a hospital stay and it is not the best place to end up.

***Ms BIRD** - It's such a different model in pharmacy, it is so opportunistic. You talk to someone about something else and they will say, 'have you got your flu vaccines', or 'have you got the COVID-19 vaccinations', 'do you want to do it right now?' There is no way. We are seeing a lot of people where otherwise it was a huge mental burden to get online and book an appointment, as well as the barriers to actually get into a clinic in town. They are in the pharmacy doing their normal shopping anyway, so we can get them vaccinated. It has been amazing. I will steal Mon's good news, which is that a million COVID-19 vaccinations have been delivered through pharmacy as of today. We have only had it for three weeks.*[153]

I: DENTAL SERVICES

In response to questions about staffing of dental clinics in rural Tasmania, Mr Dale Webster, Deputy Secretary, Department of Health and Mr Rick Monty, Acting Group Manager, Oral Health Services Tasmania, provided the following comments with regard to workforce shortages:

I'm very pleased with the efforts by the team in oral health over the last six months. We've been on a particular recruitment process, which has actually allowed us to recruit a number of dentists, eight in total in one selection, which topped us up at that point. Also, because of the additional funding we've been able to attract additional graduates this year.

In addition to, with the changes in how we're dealing with the pandemic, we were able to restart our student program this year, so all of those will mean that we've actually been able to increase the number of services available throughout 2022. One particular area of concern is dental therapists and we are working on a strategy to increase the number of dental therapists as well, but I'm pleased to say that the number of dentists that we have in the state in oral health services has dramatically increased over the last few months.

***CHAIR** - With regard to the strategy to improve the number of dental therapists… What does that strategy look like?*

***Mr WEBSTER** - It's working with the providers of the training to start with. The strategy with our dentists is obviously we attract graduates and students … - James Cook University, for instance, sends students down. We need to do that with dental therapists as well. The second part of it is making Tasmania attractive. The particular program we ran for dentists*

[153] Belinda Bird and Monique Mackrill, *Transcript of Evidence*, 7 October 20-21, pp. 19-20.

involved dentists who have moved to Tasmania, in our rural areas, who actually then did the promotion of 'this is the place to come and work' and it worked. It was a short, sharp program that actually allowed us to fill up our dentist vacancies at that point, which is really pleasing. We will replicate that for the numbers that we need there.

***CHAIR** - How many vacancies are there in both dentists and with dental therapists across the state? Where are the vacancies geographically?*

***Mr MONTY** - There are always staff who come and go, but the area with most need at the moment is northern Tasmania. We have four or five vacant therapy positions. That's out of about 12 or 13 that we would normally have working in the service, so it's quite significant. At the same time the graduate program, which Dale mentioned, has topped that up by two, or three in the north. We are looking at a mid-year graduate intake for therapists in the north as well and we're currently advertising our statewide recruitment campaign and we're hopeful to get another therapist to start early this year.*

I think it is important to note as well that any parent who contacts us from any part of the state to request an appointment will get an appointment straight away. Every clinic is still operating. There are no waiting lists for children, so while we're behind in staffing in the north there is no impact on general children community care.[154]

J: PATIENT TRANSPORT SERVICES

According to the Community Transport Services Tasmania (CTST) submission:

Prior to the COVID-19 pandemic CTST had seen a 43% increase in the number of HACC transports performed each month from 2016. Comparatively, the number of funded CHSP outputs had grown 4 times over the same period, doubling the number of funded outputs. This increase in funded outputs accommodated growth in both CHSP (directly) and HACC (indirectly) service delivery with HACC benefitting from the increased capacity that accompanied CHSP growth. Demand for CTST services continues to grow in both the CHSP and HACC categories.

Prior to COVID -19 CTST was delivering 60% over its HACC funded outputs on a monthly average basis and was delivering 7% over its CHSP funded outputs on a monthly average basis. Because of this, CTST was unable to take new referrals for HACC (state-wide) and new referrals for CHSP (Southern Aged Care Planning Region). As CTST approaches capacity post-COVID, these restrictions on new service referrals will once again be necessary for the state funded HACC consumers.

Not all requests received by CTST fit the narrow eligibility requirements for subsidised transport of the CHSP and HACC funding programs, in these circumstances CTST is required to recover the full cost of delivering the service from the passenger regardless of their financial means. In some circumstances passengers may be able to claim a reimbursement from the Patient Travel Assistance Scheme (PTAS) however they are required to pay for their transport up front before making such a claim.

[154] Dale Webster and Rick Monty, *Transcript of Evidence*, 17 February 2002, pp. 9-10.

Insufficient booking time particularly when being discharged from regional hospitals– over recent years CTST has experienced a steady increase in demand from hospitals requesting same day patient discharge. This creates challenges due to:

• Lack of client intake information

• Lack of referral from funding agency (my Aged Care)

• Inability to deliver service due to capacity constraints.

Remoteness in and of itself can be a barrier to accessing both transport and after-hours services – due to the large travel times required, hospital appointment times regularly need to be adjusted to meet travel restrictions such as daily driving hour limits and reasonable start and finish times for volunteers. This is most pronounced in the North West of the state where attendance in Hobart is often required for appointments – with many CTST passengers making the round trip in the same day.[155]

The King Island Council submission highlighted a number of patient transport barriers:

- *Allied health, general dental and orthodontic services, cosmetic services, IVF, experimental treatment and services that do not satisfy the "nearest specialist service" definition are not eligible for PTAS support, even when not available on King Island.*
- *PTAS protocols do not account for the need to travel to and from accommodation where the specialist appointment requires an overnight stay, nor circumstances where multiple appointments may be required at one or more medical facilities over the course of a few days. This represents a significant cost to patients, as well as additional stresses due to a general lack of taxis in the Burnie area.*
- *Travelling to and from medical or health services off-Island can be challenging, for mobility, safety, financially, cognitively reasons. Proximity of accommodation and hospitals can be difficult to negotiate.*
- *PTAS will pay up to $66 per night per person for accommodation where an overnight stay cannot be avoided…*
- *The PTAS reimbursement rate does not consider the real cost of accommodation for travelling patients, particularly those who have poor mobility, can't use stairs, need an accessible bathroom, need quiet to recuperate, or are travelling with other dependents who need to be accommodated as well.*
- *Many community members who need access to off-Island services or to go away for surgery, such as a hip replacement, broken bones, cancer treatment, dementia, can't afford the outlay for the trip and/or the treatment. The result is these community members often have to wait while they try and raise finances, seek a loan or try and navigate the PTAS appeals process, meanwhile living in pain and distress.*
- *The information available on the DHHS website is not regularly updated and is difficult to navigate. One document refers to mileage reimbursement rates for the period 1 July 2014 to 30 June 2015 and "Island resident rates" for airfares between the Island and mainland Tasmania. The only RPT airline with scheduled flights between the Island and mainland Tasmania is Sharp Airlines. No resident fares are available on this airline.*

[155] Community Transport Services Tasmania, 2021, *Submission #14*, pp. 3-4.

- *The need to have GP sign off for each off-island appointment in order to claim PTAS support takes up appointment times that could otherwise be used to address actual health issues.*
- *Specialist appointments to address symptoms arising from chronic conditions are being rejected by PTAS administrators for financial support because of a perceived overlap with ineligible services, e.g. dental.*
- *The PTAS protocols state that "patients who do not hold a Health Care or Pensioner Concession Card are required to pay the first two nights' accommodation costs. Noting that the cost of living on King Island is ~20-25% higher than our North West coast neighbours, it is likely that a number of residents have a lower disposable income than Health Care Concession Card holders on the coast and yet are still expected to cover two nights' accommodation costs simply because of the flight schedules that service King Island.*
- *PTAS protocols always refer to the "nearest appropriate specialist medical service". For King Island residents, the "nearest" is often not in Tasmania but in Victoria.*
- *PTAS Administration staff attitude is to override the medical advice and directions from GP's or specialists, without them understanding community members conditions, medical history, emotional network, family unit and economic status. How can it be their choice where to travel for medical specialist appointments?*[156]

K: AFTER HOURS' HEALTH CARE

According to the Rural Doctors Association of Tasmania (RDAT) submission, barriers to access to 'After hours' health care include:

> *Adequate remuneration for on call and adequate numbers of doctors to share in the on call is essential. Doctors need to feel supported after-hours by having a critical number of practitioners on the roster to prevent burn-out. Utilisation of GP Assist type services as primary on call and then having a local doctor as secondary on call may be useful for areas that need to have regular rostering of on call doctors. The Urgent Care Centre Feasibility Report 2019 identified UCCs as a feasible service model for Tasmania. There are barriers and opportunities for implementing a model of urgent care in Tasmania. Doctors with the skills to manage emergencies will be needed.*
>
> *Rural Generalists are well placed to manages such centres. There needs to be adequate numbers to share the workload, and adequate remuneration for after-hours work. Collaboration with the local THS facility will be required to ensure that patients who have presented to a healthcare facility for their ailment will be able to be transferred and managed in the most appropriate location in a timely manner. For example, a patient presenting to the emergency department that can be more appropriately cared for by an urgent care centre. Similarly, a patient attending the urgent care centre who is having a heart attack will need transfer to the nearest larger facility that can attend to that type of ailment.*[157]

[156] King Island Council, 2021, *Submission #67*, pp. 7-9.
[157] Rural Doctors Association of Tasmania, 2021, *Submission #30*, p. 8.

L: INDIGENOUS AND CULTURALLY AND LINGUISTICALLY DIVERSE COMMUNITIES (CALD)

The Multicultural Council of Tasmania provided the following feedback:

> *All the public health service providers have access to translating and interpreting services to CALD communities. However, some private service providers, for example GP visits, Specialist visits, Mental health services, they either don't have access or are not aware of translation and interpreting services. One Afghani Community member explained it is very hard to get appointment with the GP and Specialists and need to wait a long [time].*
>
> *Cultural factors in accessing health services are different in CALD communities' origin countries and Australia that have hindered to get right services at the right time. For example, one Nepali patient had issue on her stomach but she couldn't access specialist doctor (Gastro-Enterologist) without GP referral. Appointment to GP was not straightforward either, need to wait for a longer time.*
>
> *CALD community members are not aware of patient transport services. They said, if they could access those services that would allow patients' family member to go for work or do household chores instead of waiting for patitents* (sic)*.*
>
> *Some public health service providers and private clinics have recruited CALD staffs and specialists. For example, Mowbray Clinic and Launceston Medical Centre have Nepali, Indian, Iranian, Chinese doctors and other staffs. However, sometimes gender specific requirements of the CALD members hinders to access their services either. Also they have only a limited time to explain their problems.*[158]

M: MENTAL HEALTH SERVICES

The Mental Health Council of Tasmania (MHCT) submission highlighted a number of barriers to meeting the mental health needs of Tasmanians:

> ***Promotion, Prevention and Early Intervention (PPEI)***
>
> *Absence of prevention and early intervention supports*
>
> *An underlying principle of any functioning contemporary mental health system is that everyone should have access to appropriate levels of supports at early stages to prevent longer term mental illness. Currently, in many rural and remote communities across Tasmania, there is an absence of local community based early intervention supports at any level. If this continues, we can expect poorer mental health outcomes in regional areas because the services are not there, or access is too difficult. Ultimately it will lead to people becoming increasingly unwell and being sent out of their community when their condition has worsened to seek mental health care in one of Tasmania's urban areas - a less than ideal outcome. In addition, the impacts of the pandemic have increased the need to provide all Tasmanians with access to information and supports that help them maintain and improve their mental wellbeing.*
>
> *Limited awareness of local supports*

[158] Question on Notice response from the Multicultural Association of Tasmania, received on 13 July 2022.

Consultation sessions recently facilitated by MHCT provided an opportunity to gain an understanding of public awareness and perception of mental health services and other supports. During consultation sessions it became clear that many members of the public were unaware of the services and supports available to them in their community. In rural and remote communities, having an awareness of what supports are available commonly depends on personal connections with community members who have knowledge about specific services or programs. There were many instances where a community member suggested a need for a particular service, program, or initiative in their region, when in fact it already existed within their community.

For the rural and remote communities where some services and supports are available, community members reported it is difficult to know where these are or how to find information about them. They have found that when searching online there is misinformation about service availability or how to access the service (e.g. referral criteria or process). Most participants agreed that until someone is diagnosed with mental illness, they (client and family members) are not aware of the services available. At each location consulted, participants spoke of the need for a central information point to provide information about all available mental health services and supports in their location (inclusive of social support/activities). These same concerns were noted in MHCT's submission to the Senate Community Affairs References Committee inquiry into the accessibility and quality of mental health services in rural and remote Australia where 78% of respondents highlighted the challenge of knowing what supports are available as a barrier to accessing support.

Stigma

In many rural and remote towns in Tasmania mental illness is still an off-limits subject. As a result, people experiencing mental health difficulties find that stigma prevents them from being open about what they are going through. Stigma tied to self-reliance and stoicism is engrained in local community cultures. In small communities it is also difficult to maintain privacy and confidentiality. MHCT have learned that people experiencing mental health difficulties, especially men, are reluctant to attend services out of fear of being identified, which they perceived would bring shame from their community. There is a need to normalise help seeking for mental health difficulties to encourage all people to access support. Seeking help early would strengthen a preventative health approach.

Affordability challenges

MHCT has heard from community members and service providers about the difficulties in accessing primary health services due to gap payments and upfront costs for general practitioner (GP) appointments and private psychology under the Better Access to Mental Health Care Scheme. Young people are particularly affected, with MHCT hearing that access to bulk-billing GPs along with transport barriers, are key factors limiting young people's capacity to access support. Access to Psychologists is equally difficult for people on low incomes and those who are experiencing financial stress. The Short-term Psychological Intervention (STPI) program commissioned by Primary Health Tasmania provides access to psychological therapy for those who cannot afford to pay the associated fees to see a private psychologist through the Better Access to Mental Health Care program. MHCT has heard

from several service providers, that expansion of this program may well provide greater access to those both on low incomes and those who are experiencing financial stress.

Transportation challenges

Transportation barriers to accessing mental health services are commonly raised by people living in rural and remote communities who are often required to travel long distances to see health professionals incurring additional travel and accommodation expenses. Public transport networks are non-existent or less extensive in many towns and can be expensive. Consultation participants have reported that public transport can cost up to $37 for one return trip via Tassielink bus service. Depending on the time of an appointment, a person may have to stay overnight in an urban area (i.e Burnie or Launceston) therefore they also need to budget accommodation costs. People on low incomes and young people may not have the means to access adequate transportation to attend an appointment. MHCT has heard from one provider of a young person who missed their appointment as they were unable to afford the petrol to get to the office location. Such circumstances should not hinder access to necessary mental health supports.

…

Lack of access to general practitioners skilled in mental health

General practitioners (GP's) are often the first point of contact for those seeking mental health help for the first time. MHCT have heard of community member experiences where GP's have provided inappropriate or inadequate responses to their mental health concerns. It has also been reported that some GP's have difficulty responding to clinical risk and prefer to divert their clients in mental distress to emergency services in urban areas. Additionally, it has been reported that some GP's have difficulty knowing about local support services they could refer into. This is likely due to GP's being too busy to partake in local service provider networks or attend other networking opportunities to better understand the support services they can refer into that might become part of an integrated care plan. Investment in mental health training and professional development is needed to support GPs to be able to respond to competently and confidently to mental health presentations. Early identification of symptoms and the development of a treatment plan by a local GP would help members of the public receive early intervention support before their symptoms become so acute that they have to access mental health services outside of their community.

Difficulty accessing specialist clinical mental health care

There are times when family members and community-based service providers identify that a person either has a high need for ongoing specialist clinical support or hold significant concern around imminent risk that a referral to either the state operated mental health services' Crisis, Assessment and Triage Team (CATT), Adult Community Mental Health Service (ACMHS) or the Child and Adolescent Mental Health Service (CAMHS) is the safest and most clinically appropriate option. Community members and service providers are reporting that these specialist clinical mental health services are extremely difficult to access in rural and remote communities across Tasmania. Unfortunately, for some GP's, psychologists and community managed mental health service providers this means their most at-risk clients (who they believe meet criteria for CATT/ACMHS/CAMHS intervention) have not been accepted for specialist support. Since specialist clinical mental health support

for complex mental health issues such as psychotic disorders, mood disorders, eating disorders or personality disorders is not available in many locations across Tasmania community members need to travel to urban hubs such as Burnie, Devonport, Launceston or Hobart to attend appointments. This is unreasonable and leads to poor access to or engagement with vital clinical and therapeutic mental health supports. Community members have requested better access to specialist mental health services and would prefer to receive support from clinicians based in their communities rather than travelling unreasonably long distances. Accessing appropriate mental health supports commensurate to client need would prevent community members' mental health deteriorating to the point where they are required to attend the already overburdened emergency services in Tasmania's urban areas.

Difficulty accessing mental health crisis and distress support

In many rural and remote locations across Tasmania there is no support option available with the flexibility to respond immediately to acute mental health crisis and which can assess and effectively manage that presentation without deferment to another service. In urban hubs in Tasmania community members have access to a Crisis Assessment and Treatment Team (CATT) who have capacity to provide outreach mental health crisis support. However, this option is not available in the majority of locations across Tasmania. Whilst the southern CATTs provide outreach (CATTs attend the location of the person to be assessed), this is mostly limited to the greater Hobart region. MHCT members based in the other regions in Tasmania advised that, from their experience, CATTs do not perform outreach consistently, instead meeting consumers at the emergency department of the North West Regional Hospital and Launceston General Hospital or at Spencer Clinic for triage assessment.

Outreach enables mental health triage assessments to be performed at a consumer's residence. The rationale for the outreach function of CATTs is that, during an outreach assessment, CATTs often determine that the consumer requiring assessment does not require acute admission. If CATTs do not perform outreach, this has the effect of increasing the burden on regional hospital emergency departments, because every consumer in need of mental health triage assessment is required to attend the Emergency Department. It is also burdensome on family members and emergency services who are required to transport a person with a compromised mental state to the nearest emergency department, this process often strains relationships, and can lead to increased distress for all involved.

…

Suicide is among the top ten leading causes of death in rural and remote areas in Australia yet in rural and remote locations in Tasmania there are few local services that can effectively respond to someone in suicidal crisis, particularly outside of standard business hours. At present many people in suicidal crisis in rural and remote locations are being referred to emergency departments in urban areas however depending on the circumstances hospital admissions for persons in suicidal crisis are uncommon. For example, if someone is in suicidal crisis in St Helens, an ambulance will transport them to the Launceston General Hospital for assessment. They may not meet the criteria for an admission, and thus will need to find their own way back to St Helens. Community members find this process frustrating because there are multiple steps involved (usually attend GP – refer to ambulance - attend ED – assessed by CATT team or other MH clinicians – possible admission) which requires the patient to

repeat their story several times before they reach the admission stage. Those who are not accepted for an admission after going through the abovementioned process report this experience as invalidating, distressing and frustrating.

Furthermore, attending emergency departments it is not always necessary or appropriate. An effective local response in situ, in combination with follow up support would provide a more adequate and effective intervention.

Enabling local integrated responses in rural and remote communities

There are challenges with mental health workforce skills and capacity in rural and remote communities. Certain well-positioned services are natural sites for rural and remote community members to receive support for mental health needs, such as general practitioners, community health centres or regional hospitals. However, these services often don't include health professionals who are trained to effectively assess and manage mental health presentations. Travelling long distances to urban areas to access skilled mental health clinicians is burdensome for the consumer, and costly and unsustainable for urban inpatient and other services. Given this, existing health professionals operating in local services should be equipped to effectively respond to and co-manage mental health clients in their communities.[159]

The AMA submission (addendum) highlighted a number of barriers to the provision of mental health services:

Community setting:

The acute care teams in the regional areas do not have adequate staffing to urgently review patients of all age groups presenting with acute matters at an Emergency Department (ED). Hence, the young and elderly are seen by already stretched community treatment/case management teams, resulting in scheduled appointments for other patients being cancelled at the last minute and patient appointments deferred until urgent. A vicious cycle occurs that promotes only the urgent and acute presentations, with early intervention treatments unable to be provided. This is in contradiction to the aim of facilitating treatment more and more in the community to manage patients earlier in their illness thus preventing their deterioration and the need for the more expensive acute care.

Insufficient staff numbers in the Mental Health acute care team also results in patients having to present to the ED rather than being seen at home or at a GP practice, where they might have discussed their mental health concerns initially. It would be less disruptive for the patients if the acute care team could attend GP practices or be available for phone consults. It would also be preferable to be able to send patients to an acute care team clinic for assessment rather than to an ED for assessment.

Community teams are lacking the infrastructure of subspecialised services, such as a local dementia team for older person's mental health, or a specialised trauma service for young people and minors in out of home care. The default situation for patients who fall through the cracks, is to be admitted into a hospital. There is, for example, no acute residential care setting for children with acute trauma, so these children are admitted to hospital. This often results in prolonged admission due to the lack of safe residential care facilities that could manage

[159] Mental Health Council of Tasmania, 2021, *Submission #38*, pp. 8-13.

behavioural issues arising in the context of acute or chronic trauma. Research has shown for decades now that the most important treatment for children with trauma are safe and stable relationships, not hospitals (Dan Hughes et al, Dan Siegel at al.). Meeting the Maslow hierarchy of needs for severely traumatised children is crucial prior to commencing any treatment approach. Staff in community residential care need adequate training based on trauma informed care, not just a disability approach and need to understand that trauma itself is not necessarily a mental illness. It might however, become a mental illness if not managed appropriately. Therefore, a holistic approach, including all stakeholders of the community in this care approach is crucial. The CAMHS reform report addressed the need for a children trauma mental health service but did not consider the need for a holistic approach with other departments.

There is also the issue of the cost of care for those in the community, rural or otherwise. GP visits cost money: ED visits are for free. One of the issues behind overflowing ED's and access block is that GP visits are too costly for patients within the lower socio-economic groups, resulting in delayed visits or not visiting health practitioners at all. This often worsens a health issue, or a mental health issue that could have been treated easily and quickly with early intervention, instead resulting in a complex and urgent presentation. If at least the first 1-2 visits per quarter to the GP fell under a different funding/cost structure, it maybe that in the long term, it would result in the reduction of some ED presentations. A small state like Tasmania could trial such an approach to see if it did make a difference on health outcomes and reduce the cost for the health system overall.

Another issue that cannot be ignore is that of staff burnout. The community service staff, in the absence of appropriate resources and only basic training, especially in regional Tasmania, are easily burned out as they constantly have to think outside the square to provide the best possible care for their patients, that is not anywhere near the gold standard. The higher stress levels at work in regional areas due to difficulties of covering leave arrangements results in a much higher turnover of staff and higher use of agency nurses and locum doctors. Added to this, often community services also lack adequate supervision structures for junior staff or don't meet the accreditation standards for training, and therefore are less attractive to attract or retain junior doctors.

NGO's:

While the rise of Non-Government Organisations providing mental health services is commendable, a single funding structure would assist to prevent duplication of services and funding of services that do not have trained medical staff providing evidence-based treatments. Areas of need should be identified first, prior to an NGO being provided government, state or federal, funding. NGO funding needs local coordination and not federal programs imposed on a community that do not meet the needs of that community.

NGO's services should also be measured on KPI's like government services. Regular data should be required to establish the effectiveness of the dollars spent now and the positive effect on the community. E.g., studies that show early health education at school might increase health literacy and general health earlier in life but will have similar costs in the health sector later in life (retirement age) just with other types of presentations (more hip replacements etc.). However, what these studies don't incorporate is the fact that a healthier young person with higher health literacy skills at an early age has much more chance of an education that is

more likely to lead to employment and secure housing and less likely to lead to early dependency on a disability pension or NDIS, and less likely to result in substance use disorder. But most importantly, early intervention, especially in the first 2000 days, has the best chance to break through the intergenerational cycle of trauma, mental illness, poverty, and interactions with the youth justice system.

The current NGO structure, in the absence of additional government community services equal to NGO's, leads to "cherry picking" of patients, leaving the most complex and severe patients to an over stretched public system, without adequate services. This results in repeated re-admissions to hospital as the "only safe place" for the patient.[160]

According to the Health Consumers Tasmania submission, cost can be a barrier to accessing mental health services:

- *Our stakeholders have also noted that rural health consumers are not accessing allied health professionals due to cost barriers, lack of awareness or access issues who could potentially prevent or mitigate long term health problems (for example: musculoskeletal issues, mental health issues, wound care and management, physiotherapy).*

- *To ensure a community-centred approach to health care that empowers health consumers to take an active role in their health and wellbeing community-driven health hubs located across the rural and remote towns would work well. Ideally, most services would be bulk-billed, or provided for low cost through GP-managed care plans. Our stakeholders felt that these centres should not be reactive and sit there waiting for people to come when a problem becomes acute. Rather, they need to be 'community connectors' and be proactive in health promotion and service provision.*[161]

In the context of complex trauma and post-traumatic growth, the Trauma Awareness Network submission highlighted the following as barriers to accessing mental health services in rural areas:

> *Along with the obvious barriers to mental health services in rural and remote areas, such as distance, TANA's solution addresses the barriers of social anxiety and social isolation, and shame and stigma. With the known root cause of complex trauma, TANA's work offers people relief from the burden of shame. One of our partners in the USA articulated it well, stating that in her work in trauma-informing prisoners, their reaction is overwhelmingly one of relief as they realise that what happened to them was not their fault. Once we begin the conversation, the barrier of avoiding help-seeking, which older males are particularly notorious for, is penetrated and often quickly dissolves once trauma-awareness is gained. TANA's work can open the door for people to seek the professional help they need. It is empowering. TANA offers education, not advice, creating informed help-seekers who understand that they must take responsibility for doing the work of healing, as they are supported by service providers in the community. We work with an empowerment model, rather than a victim orientation, and keep our participants forward-looking, aspiring for better- for themselves and their families. It is common to see this awareness lead to a firm*

[160] Australian Medical Association, 2021, *Submission #52 (Addendum*), pp. 2-3.
[161] Health Consumers Tasmania, 2021, *Submission #56*, p. 8.

decision to be the one who breaks the cycle of intergenerational transmission, leading to better health outcomes at a population level.[162]

In the context of access to health services for LGBTIQ+ Tasmanians, a barrier to access is knowledge of inclusive health services. Mr Rodney Croome and Dr Ruby Grant, appearing on behalf of Equality Tasmania noted:

It only occurred to me last night when I was reading this that I still have the same GP as I had when I lived in Hobart, who I visit when I'm in Hobart regularly. I thought, why is that? It hadn't really crossed my mind before but I think it's because I don't know which GPs on the north-west coast and particularly in Devonport, I would [have] received respectful and inclusive service from if I was to avail myself of their services.

I am sure there are doctors who would be really inclusive and supportive of LGBTIQ+ patients but I don't know who they are. It's already difficult enough to get onto a doctor's waiting list in Devonport. I probably wouldn't have a great number of choices. So I realised when I was reflecting on this that in fact I am one of these people who isn't sure about inclusive services and, as a result of that, I keep a GP in Hobart, which I have the luxury of doing because I'm in Hobart regularly but, of course, not everyone has that luxury.[163]

Dr Ruby Grant elaborated:

In much of the research that I've done, I've been researching LGBTIQ+ health in Tasmania for the last five years. I've conducted a number of studies, both with members of the community and with health practitioners as well, including in rural areas. The main thing that's coming through is that in an ideal world, wouldn't it be amazing if all health care providers and anyone who goes through medical school, for example, did have a lot of training around the needs of LGBTIQ+ people, particularly trans people in this case? That's probably not going to be likely that everyone is going to be able to do that or have the need to do that.

The main thing that both practitioners and community members emphasise is the need to have doctors who have those base skills in terms of being able to sensitively and affirmingly treat and engage with LGBTIQ+ patients being able to, yes, ask some questions but also having those skills to be able to do their own research. Like, 'Okay, yes, you know what? I don't know all about this but I'm going to work with you to find out the best pathway for you.'. ...

In terms of a model for how do we do this in rural communities, yes, as you say, it might not be feasible to have some huge bells and whistles - a LGBTIQ+ health clinic in every rural town in Tasmania. We've been talking a lot about various different approaches and what community members would like, do we need specific LGBTIQ+ services that have out clinic capacities, do we have a network of practitioners that is a bit more formalised who are experts who can then also mentor other clinicians in certain areas as well?

I do believe that the Sexual Health Service does a bit of that already, which is great. Those are the kinds of things that would be really great, to be setting up these kinds of networks of practitioner services and with strong connections to community groups as well. Excellent

[162] Trauma Awareness Network Australia, 2021, *Submission #71*, p. 3.
[163] Rodney Croome, *Transcript of Evidence*, 18 May 2022, p. 3.

services that demonstrate best practice in LGBTIQ+ inclusion, and also in training for inclusive practice for practitioners like the Kentish Clinic. Those services are things would really go a long way.[164]

PhD Candidate Tamara Reynish outlined the barriers to accessing mental health services in rural Tasmania:

Participants cited roughly 100 barriers to accessing mental health services in rural and remote Tasmania …. For brevity, I will present three: stigma, cost, and mental health professionals shortcomings.

Stigma: For all participants, stigma was a strong predictor of psychological issues and resulted in isolation and identity concealment. Stigma was also a barrier to help seeking. One in two Australians experience mental health issues in their lifetime (Australian Institute of Health and Welfare, 2020), yet despite this prevalence, 92.9% of survey participants agreed/strongly agreed that there is stigma around having a mental health issue, and 80.8% agreed/strongly agreed that there is stigma around getting psychological help. Efforts in the state to offset this significant systemic barrier are minimal. In 2021, of the 61 anti-stigma initiatives operating nationally, only 6 were occurring in Tasmania and of those 6, only 3 were ongoing or organised by Tasmanian organisations (Morgan, Wright, & Reavley, 2021).

Partial decriminalisation of sex work in Tasmania does not prohibit the sale of sex, but it perpetuates degrading assumptions about sex work, denies sex workers' their basic human rights to be free from violence and discrimination, and adds to considerable stigma against sex workers. Sex work participants reported experiencing:

- *public stigma, when society endorsed prejudices that manifested as discrimination*
- *whore stigma, derision towards people who combine sex with gain*
- *mental health professional stigma, when a practitioner had attitudinal bias and felt disparagement that presented in a counselling session*
- *systemic stigma, when legislation (i.e., partial decriminalisation) limits access to human rights and opportunities*

Cost: Almost 70.0% of participants indicated that they could not afford mental health care. Relatedly, the administrative effort of having to secure mental health treatment plans and the high cost of private health insurance were also barriers for roughly 46.0% of participants. Significantly, same-sex attracted and gender diverse people were found to be more likely uninsured (Jenkins Morales et al., 2014; Stotzer et al., 2014). Inability to afford care can worsen mental health and is a risk factor due to the strong causal relationships between poverty, homelessness, and psychological distress (Australian Bureau of Statistics, 2016; Australian Psychological Society, 2015).

Mental health professional shortcomings: Mental health professionals were responsible for the vast majority of reported barriers to care. Many of their shortcomings were educational; that is, almost 75.0% of participants saw a mental health professional who needed the participant to educate them; who was unaware and untrained in helping people with

[164] Dr Ruby Grant, *Transcript of Evidence*, 18 May 2022, p. 4.

diversities. This placed an undue burden on a population already experiencing disparities, resulted in care avoidance, and caused or worsened participants' psychological state. Participants also encountered mental health professionals who were sexist, heterosexist, cissexist, biased, and/or who refused to treat them upon disclosure. This attitudinal bias prevented help seeking and caused or exacerbated mental distress.[165]

Tamara Reynish made the following recommendations:

> *1. Universalise mental healthcare in Tasmania: To give all people 'determinative importance' (Sedgwick, 1990) and to facilitate responsive, inclusive care that adheres to all people's human right to healthcare, government should render the state's mental healthcare system fully inclusive or universalise it; that is, state government should:*
>
> > *a. Work with education facilities in the state (e.g., UTAS, TAFE) to ensure that cultural competence, inclusion, and trauma-informed care and practice are mandatory and sizable components of all mental health-based curricula (Similar curriculum advancements made in Canada, for example, could be adopted locally).*
> >
> > *b. Work with education facilities in the state (e.g., UTAS, TAFE) to ensure that mental health, cultural competence, trauma-informed care and practice, and inclusion are mandatory and sizable components of all curricula for students of medicine and physical health.*
> >
> > *c. Work with local branches of health professionals' governing bodies (e.g., Australian Association of Social Workers, Australian Psychological Society, Australian Health Practitioner Regulation Agency) to ensure enforcement of and adherence to the state's Anti-Discrimination legislation and mandatory, ongoing professional development that includes cultural competency, inclusion, trauma-informed care and practice.*[166]

The King Island Council submission provided an example of an individual who had been unable to access care:

> *My brother in law was becoming unwell. He had a history of mental ill health and was again displaying behaviour which was unsafe to himself and his loved ones. We were trying to get help for him from health services and from the police, but it was a very slow and unsatisfactory process. The police were unable to section him because he didn't meet the criteria at the times, they saw him – there was no one who could give us the help we needed on the Island.*
>
> *Then the police were called to his house due to reported disturbances in town and a disturbance at home. He was trying to hurt himself, to hurt others and he had caused significant damage to property. Police took him to the King Island Hospital but did not section him, so it was up to the family to finally persuade him to self-admit to a Burnie mental health facility. He stayed there for 4-5 days and then discharged himself. He was allowed to leave the facility without any communication to health services, police or associated support services on King Island. He arrived back on King Island on a Friday to find that his partner*

[165] Tamara Reynish, 2022, *Submission #81*, pp. 5-6.
[166] Tamara Reynish, 2022, *Submission #81,* pp. 7-8.

had left the house with their two young children due to fears for their safety while he was unwell. No professional support was available on Island and he was still very unwell.

He hung himself that weekend.

A THS package detailing potential support options for him on-Island came in the mail on the following Monday. It was too late.[167]

The Pharmacy Guild of Australia (Tasmania) submission highlighted the role of pharmacists in mental health and service provision:

Significant regional variation in mental health services exist in Tasmania and in line with trends being experienced by general practice in Tasmania, members of the Guild have highlighted increased presentations of people seeking help for mental health conditions in community pharmacy.

It has been recognised that early intervention and preventive strategies can reduce people accessing emergency services as their only option. Receiving early and timely access to support services, particularly with a shift from hospital focused care to community-based support, is documented as a goal as part of long-term mental health plans in Tasmania.

Pharmacists are acutely aware of medication safety in relation to potential harms caused by prescription medication. Self-poisoning with prescription medication is a particular problem in Tasmania, with the state recording highest rates of prescription opioid and benzodiazepine overdose in Australia. The most common drug class used in drug poisoning suicides in Tasmania were sedatives and hypnotics (26.52% of cases), the majority of which were benzodiazepines (22% of cases).

In recent years many pharmacists in Tasmania have undertaken nationally recognised Mental Health First Aid for Pharmacist courses. We estimate that over 200 pharmacists in Tasmania have undertaken this course. During 2020 in collaboration with Primary Health Tasmania, the Pharmaceutical Society of Australia and the Black Dog Institute, the Guild embarked on a pilot project "Advanced Suicide Prevention Training for Pharmacists".

A suite of tools has been developed including training webinars to coach pharmacists on how to recognise and respond to someone experiencing suicidality and referral resources to identify services where people can receive help. The Guild believe that appropriately trained community pharmacists should be formally recognised and remunerated as part of locally initiated early intervention strategies.

An important part of any suicide prevention program is reducing access to lethal means or "means restriction". This refers to making an effort to limit or eliminate the ability for a person at risk of suicide to access the means to carry out their suicide plan. A research project being undertaken in conjunction with the pilot by the Curtin University has identified where means restriction in a pharmacological context could be initiated by pharmacists. Typically, prescription medications used in overdoses are opioids and Benzodiazepams.

[167] King Island Council, 2021, *Submission #67,* pp. 16-17.

Currently a program exists known as 'staged supply' where medication services can be requested when the prescriber determines that a patient may be at risk if they were to obtain a full PBS supply of the nominated medicine. Typically, a person who is on staged supply presents daily (sometimes multiple times depending on the dosage requirements) to the pharmacy for their medication.

The service is of particular value to patients with a mental illness, drug dependency, or who are unable to manage their medicines safely. Staged supply is part of the remunerated Community Pharmacy Agreement programs and is governed by 'rules' under the program including a maximum number of people per month a pharmacy can claim for provision of this service. The service can only be offered to people who hold a current, valid, government-issued concession and have been referred for a staged supply service by their prescriber.

Community pharmacists are not made aware by prescribers why staged supply has been initiated nor are they able to initiate staged supply based on their knowledge and understanding of a person's condition.

The Guild believes that a state funded system could run in parallel to the current Commonwealth system where pharmacists could determine the benefit of initiating staged supply for a person as part of means restriction, working with the prescriber to manage potential suicide by overdose. The benefit of this proposal is attributable to the daily interaction the person has with the pharmacist - a community based qualified healthcare practitioner – who is able to closely monitor change in behaviour and provide feedback to the GP.[168]

The National Rural Health Alliance submission noted the following in relation to expenditure on mental health services:

Nationally, state and territory governments contribute the largest slice of expenditure on mental-health-related services – $6.4 billion in 2018–19. This was followed by the Australian Government who contributed $3.6 billion (not including their contribution to public hospital costs), then private health and other third-party insurers (who altogether contributed $584 million).

In terms of expenditure on mental health services, Tasmania also ranked poorly. For example, in 2018-19, Tasmania had:

- *The lowest per capita expenditure on community mental health care services ($77.46);*
- *The second lowest per capita expenditure on specialised psychiatric units or wards in public acute hospitals;*
- *The second lowest per capita recurrent expenditure on specialised mental health care services ($212.84); and*
- *The lowest indirect expenditure (overall and per capita) on specialised mental health services, including mental health research and promotion, service development, etc.*

[168] Pharmacy Guild of Australia (Tasmania), 2021, *Submission #42*, pp. 4-5.

Another possible indicator of concern with Tasmania's mental health services is an apparent over-reliance on mental health-related medications. Tasmania has the highest per capita expenditure on Australian Government funding (mainly through the Pharmaceutical Benefits Scheme) for antidepressants, sedatives, antipsychotics and other mental health medications.[169]

N: OTHER

Rural Doctors Association of Tasmanian (RDAT) highlights health literacy as a barrier:

Health literacy starts with basic literacy. In rural areas there is a lack of basic literacy, making self-management, and some preventative care approaches difficult for many patients whose reading and writing skills are poor. Basic education for adults, with increased literacy classes, group sessions on health issues and information given in a simple easy to understand way would be helpful.

Community health hubs to assist families in basic shopping/cooking/budgeting skills would help prevent many health issues. Efforts to extend year 11 and 12 education to rural students is applauded. Support of regional education initiatives delivered by tertiary education providers is called [for] noting access has improved a great deal with on-line delivery ramped up due to COVID-19.

Support for community-based approaches such as those trialled in the anticipatory care project is to be encouraged e.g., Neighbourhood houses, Aboriginal Health Centres, Local Government Council initiatives, general practices. Many useful ideas came from this project but funding then disappeared.

Support for within-primary school efforts such as expanding the HealthLit4Kids initiative. Heightened support of the work of 26TEN is advised.

Improving health literacy overall will help members of community understand any attempt by the government to educate them on the various health pathways. A key strategy for the government will be communicating to the public what services general practice can deliver and how they can prevent presenting to the emergency department with conditions that can be managed in general practice. Another key strategy will be helping the public understand the preventative health measures that are applied to the individual over a life course e.g., lipid management, blood pressure management and disease prevention (ischaemic heart disease, diabetes, chronic kidney disease and chronic obstructive pulmonary disease).[170]

Disability

Associate Professor Robyn Wallace made the following observations in relation to barriers for those with an intellectual disability:

***Dr WALLACE** - I think the dream is that every clinician, every manager, has a better view of people with intellectual disability and more competency. Over time, if there're models around, eventually it will pick up and be absorbed into the general clinical community. For*

[169] National Rural Health Alliance, 2021, *Submission #21 (Addendum)*, p. 1.
[170] Rural Doctors Association of Tasmania, 2021, *Submission #30*, pp. 8-9.

example, I think how far people have come with indigenous health, how far they've come with non-English speaking people. At first it was a big ordeal, and how do we cope with it? Now virtually every clinician in any situation across Tasmania would have a bit of a feel or know where to look for resources and it wouldn't be unusual.

***CHAIR** - Why is it a problem with intellectually disabled individuals?*

***Dr WALLACE** - I feel it's multi-factorial. There's an ethical thing where, incorrectly, this group's attributed low social worth. Knowledge and intelligence are regarded as very valuable assets. They are in a low socioeconomic status group; … and that is associated with lowered health literacy. The disability supports which are meant to open up the world for people with intellectual disability and let them participate in the mainstream are not there when it comes to health. It's just not working.*

I can work out a disability plan with a patient, what disability supports they need to access and participate in the health care…. They go to the hospital and either the support worker is not allowed in or there's a fight between health and disability about who's going to fund it.

The COAG agreement between the state and national NDIS states that if a person needs disability support for their behaviour or their cognition, then it is funded by NDIS.

***CHAIR** - Is that with regards to the location?*

***Dr WALLACE** - Yes, in regards to the location. I think in real life, there is room for some sort of sharing. That's another issue but it's a real practical issue of funding.*

People with intellectual disability might be dropped at the door when it's recognised they're not well and dropped at the door of the ED or Smithton District Hospital or St Helens Community Centre and support workers aren't there and doctors aren't magic. With disabilities, we need to have a history, we need to examine the patient and the patients need help to participate in that normal health process. Our services need to be adjusted to make them friendlier; to have a place for the bed for the carer to sleep, to have meals there for them. That can be done everywhere.

In particular, at the moment there's no way of reaching the supports in the rural area very well, the same as there's no way to reach the clinicians. It's harder to reach them. I think the main hospitals are providing a source of expertise. It's the same thing you do for anyone else, except with these regional adjustments. It's not a brand-new topic, it's not as if intellectual disability is the illness. They could have heart, lung or rheumatology; it just makes the process of accessing health, understanding what the diagnosis is and carrying out the management is more difficult.

Most people with intellectual disability need disability support. This provides the standards, the rights and responsibilities of people with intellectual disability, including in health. They provide governance and operational management for the service providers, they talk about the provision of supports, they talk about access and participation in health care but it

doesn't happen. You've heard about the disparity of health outcomes for people living in rural areas; it's probably even worse for people with intellectual disability.[171]

North-West resident Leigh Winn highlighted wheelchair access as a barrier to accessing health services:

(a) Tasmania Ambulance, for reasons stated as OHS, are unable to take the manual wheelchair of patients dependent on these. This especially applies to fixed framed manual wheelchairs. Having to effectively leave your legs behind causes significant distress and anxiety due to complete loss of independence and ability to self-care.

(b) Mersey Hospital has no patient rooms set up for independent living by those in wheelchairs. Shared rooms have no bathroom access. Single rooms there is no bathrooms with appropriate safety/grab rails. The only safe toilet access is for a patient to go down to the ground floor, near ED, to access a disabled bathroom.[172]

The Premier provided the following response, in a Question on Notice Response, dated 7 September 2022:

The Mersey Community Hospital (MCH) operates three admitted inpatient units. The Rehabilitation Services Unit (RSU) has twelve single rooms with private bathrooms. The RSU was built in 2019 to provide care for rehabilitation patients - many of whom have impaired mobility. The RSU includes an independent living area and two rooms equipped for care of bariatric patients.

The Close Observation Unit was built in 2010 and is a six-bed unit with two single rooms and a four bed open planned ward. There are three bathrooms - all equipped for mobility impaired patients.

The Medical Ward has a mixture of shared and single rooms. Each single room has a private bathroom and each shared room has either a combined shower/toilet OR separate toilet and shower. There is a combination of assist rails across all bathrooms.

A review of disability access within the hospital was conducted in 2021. Minor modifications were made to public access bathrooms including installation of additional handrails for both left and right handed impairments.

To ensure that the Medical Ward bathrooms comply with the requirements of the Disability Discrimination Act (ODA), a capital works request was submitted in March 2022 for construction of a DDA compliant bathroom on Medical Ward.

The future upgrade of the Medical Ward is part of the funded capital investment program at the MCH and planning for these works has commenced. Planning and concept schematics produced to date include provision for Level 4 Geriatric Services in a redevelopment of the existing Medical Ward in line with the Tasmanian Role Delineation Framework and Clinical Services Profile Matrix.

[171] Associate Professor Robyn Wallace, *Transcript of Evidence*, 30 November 2021, pp. 3-4.
[172] Leigh Winn, 2021, *Submission #3*, p. 1.

The MCH Medical Ward will be based on the guidelines contained in the Australasian Health Facility Guidelines and will continue to provide existing essential health services to the North West of Tasmania for all age groups and with various levels of ability.

The design addresses access and will therefore meet accessibility standards under the Building Code of Australia, DDA and workplace safety requirements.

Construction is anticipated to be completed towards the end of 2025. However, completion of the Medical Ward depends on the timing of completion of the capital works on theatres, endoscopy, and outpatient areas, which is currently underway.[173]

LGBTIQ+

According to the Working it Out submission there are a number of barriers to accessing health services for LGBTIQ+ Tasmanians in rural areas:

A lack of access to either dedicated LGBTIQ+ health services, or LGBTIQ+ inclusive mainstream health services remains a significant barrier to accessing health services for LGBTIQ+ Tasmanians in rural and remote areas.

Not only is there a lack of dedicated LGBTIQ+ services, or a lack of surety about the inclusiveness of mainstreams services, there can be additional barriers such as the fear of outing oneself in communities with low and well-connected populations.

People in rural communities can also experience higher levels of minority stress, associated with internalised homophobia (feelings of self-loathing, fear and shame) and concealment (a fear of being discovered) compared with their metropolitan counterparts (Bowerman, 2020).

Accessing mental health services is a key area of concerns for LGBTIQ+ Tasmanians. The 2021 state government survey into the needs of LGBTIQ+ people (Dwyer et al., 2021) found that a properly funded mental health and suicide prevention strategy and services, including LGBTIQ+ specific services, and measures to ensure safety and inclusivity in mainstream service provision, was a key priority.

Other issues of concern noted in the literature include the provision of adequate services to meet the needs of gay men in relation to HIV prevention and support (Lea et al., 2017); and the lack of awareness of and support for the health needs of trans and gender diverse and intersex populations in Tasmania (Grant et al., 2021).

While online services might appear to be a ready answer in relation to mental health service provision in rural and remote locations, not all people can or want to access services online, and they may not meet the specific needs of rural communities. Bowman et al., (2020), for example, found that LGBTQ youth in rural areas are likely to have sensitive, customised needs that are not easily addressed by an en masse approach to internet-based mental health care. Developers and providers of online supports need to take account of the challenges of negotiating availability, anonymity, privacy and connectedness.[174]

[173] Question on Notice Response from the Premier, dated 7 September 2022, pp. 15-16.
[174] Working it Out, 2022, *Submission #78*, pp. 5-6.

Tamara Reynish outlined a number of barriers experienced by LGBTIQA+ people, sex workers, and kink-oriented Tasmanians in rural and remote Tasmania:

> *There were common barriers in these rural and remote communities. There were simply no mental health services, or where services did exist, most of those were not tailored to serve people who are LGBTIQA+ or they were too expensive. Another issue was that they were run by faith-based organisations. Many participants reported that they avoid faith-based organisations due to their history of persecuting people who are different or have alternative ways of being and doing. Another barrier was too few staff and long waitlists.*
>
> *My results also show that psychologists, psychiatrists, counsellors and social workers in rural and remote Tasmania are, for the most part, culturally incompetent, so that is to say they are untrained and biased against people with alternative sexualities and genders or people who work in the sex industry.*
>
> *Some mental health professionals were even openly insulting, openly discriminatory, and even refused to provide care to my participants. These barriers are not only unethical, unprofessional, and violate the state's own anti-discrimination legislation, but they bred help-seeking avoidance and prevented people from looking for care and they also, again, worsened mental health.*
>
> *To put my findings into context, let us consider some national research into LGBTIQA+ people. I am specifically speaking about Private Lives and Writing Themselves In by Hill et al, which you have heard about from the other parties presenting and making submissions to this inquiry. Those national studies do not give a representative picture of mental health of LGBTIQA+ people in rural and remote Tasmania. That is, as I demonstrated in my written submission, and will restate here, my research shows much higher levels of psychological distress, depression, anxiety, and suicidality in rural and remote LGBTIQA+ Tasmanians than in their national counterparts.*
>
> *LGBTIQA+ people, sex workers, and kink-oriented Tasmanians in rural and remote Tasmania have a pronounced need for dedicated mental health care due to much discrimination, stigma or lack of access. This inquiry could make all the difference. You have the opportunity to erase health and geographical disparities and provide rural and remote populations, access to quality mental health care.*[175]

In relation to barriers experienced by sex-workers, Tamara Reynish stated:

> *Sex work is somewhat legal in the state. It's still legislated but it has been decriminalised in Victoria and in other parts of the country. People who have to conceal their identity, conceal their jobs, conceal or hide who they are, that has been proven over and over again to harm and hurt people's mental health. You know the proverbial, 'Hi, how are you? What's your name?' 'Tamara.' 'What do you do for a living?' I can't answer that if I'm a sex worker, and I automatically have to start my relationship with you as hiding and concealing and being uncomfortable.*
>
> *A vast majority of people who are transgender, for example, dabble in sex work so that they can afford to pay for any changes or alterations that they wish to make to themselves, their dress and their body, medical or otherwise. Also, young people in this terrible housing*

[175] Tamara Reynish, *Transcript of Evidence*, 18 August 2022, pp. 2-3.

market - people engage in sex work to pay rent. If we're not normalising that and we're not acknowledging that it's a large part of people's lives, then I think we're really remiss because sex work isn't hidden and it shouldn't be hidden. That's another thing that I think people would benefit from, instead of concealing it but making it more open, because the more we have to hide, the more it hurts our psychological makeup.[176]

Aged Care

According to Dr Kim Atkins' submission:

> *In 2015 The Tasmanian Department of Health made a submission to the Australian government Aged Care Financing Authority (ACFA) on government operated aged care facilities in Tasmania. In that submission it was noted that, due to the well-known problem of market-failure, the Tasmanian government is the provider of last resort in remote areas of Tasmania, and that current funding levels from the Commonwealth were inadequate. Small rural and remote residential aged care facilities have quite distinctive sets of circumstances that make them very different to large or city-based facilities. In Tasmania, some of the circumstances that have a detrimental impact upon access to, and the cost of residential aged care services include:*
>
> - *Small population centres*
> - *More rapidly ageing populations*
> - *Poorer quality housing*
> - *Lower property values*
> - *Geographical isolation*
> - *Distance from service hubs*
> - *Fewer transport options*
>
> *In 2021 little has changed. Currently in Tasmania, people in residential aged care in remote areas live in a mixed facility rural hospital where their care is provided by nurses who are also rostered on to provide sub-acute care. Not only is this inappropriate to a residential setting, the Tasmanian government's financial contribution to supporting aged care is constraining its ability to support sub-acute care to those populations. This is exacerbating a cycle of worse access to services and worse health outcomes for everybody, and is further contributing to known health status disparities between people living in rural/remote and people living in urban areas.*[177]

According to Ms Kylie Miskovski, National Policy and Strategy Advisor at Dementia Australia, Vincent Poisson and Pat Barnes, appearing on behalf of Dementia Australia, there are a number of barriers facing people living with dementia:

> ***Ms MISKOVSKI** - People living with dementia are high users of health care services. They often have comorbidities so they are not just presenting to health services because of their dementia diagnosis and symptoms. Regardless of what people with dementia are being treated for, it is essential that health care providers understand dementia and how to support people living with dementia and their carers.*

[176] Tamara Reynish, *Transcript of Evidence*, 18 August 2022, p. 7.
[177] Dr Kim Atkins, 2021, *Submission #10*, p. 2.

Some of the key issues for people living with dementia and carers in rural Tasmania include delayed diagnosis, lack of referrals and access to support services, transport accessibility, health care workforce capability and capacity. As outlined in our submission to this inquiry, Dementia Australia advocates for: healthcare workforce development and training, particularly for GPs and allied health professionals; effective telehealth technology, noting that there are limitations in telehealth for people living with dementia; adequate transport to access local health service and support; dementia enabling environments in hospitals and other healthcare settings; and developing dementia at family communities to build greater awareness and understanding of dementia. Thank you.

…

***Mr POISSON** - … Our primary concern is the different age diagnosis. Our observation is that people in Tasmania tend to get it done quite late in the progression of the disease, which then means that they access our services and other services at a fairly progressed stage. This is quite problematic because then the interventions that we can put in place and the support that we could put in place are quite limited by then.*

For example, we have a Living with Dementia program which is typically targeted at people at the early stages of the diagnosis and provides a group setting to provide cycloid education to the person with dementia and their carer. We see that in Tasmania we are not getting a lot of breakthroughs or demand for this. Our observation has been that it is because most people who access our centres are already past that stage. When we compare it to other states, that program is extremely popular. That is a fairly complete example for us. …

***Ms BAINES** - … I am privileged to be at the coalface. I have been discussing with families. caregivers and people living with dementia, what it's like for them and what their needs are.*

I was in Bicheno on the east coast of Tasmania last week and it came through very strongly how much the community is depending on volunteers to support people living with dementia, mainly women.

The volunteers, led by one particular lady, have been able to set up a support group for people living with dementia and the community health service there has provided a facility. I discussed with them what their needs are. I think what came through strongly was that while the volunteers turn up every week faithfully, they do feel a little exploited. It's sad that there isn't more real support up there. Family carers are saying that they would really like more education and support, particularly over weekends and after hours. Dementia Australia does, in fact, offer online counselling till 8 o'clock in the evening but they're saying that it's at weekends and after 8 o'clock when they really feel they're without support. I think this is probably also COVID-related, that everybody's feeling more isolated than they were before.

Another thing that came through from Bicheno is that although we're talking about telehealth and online support and online information about dementia, people in that community are not necessarily computer literate or have easy access to computers. I was told that an internet centre was closed down and that they no longer have a way of getting support to get onto the internet. So, that clearly is an issue. I'm sure it's not just Bicheno that suffers from this.

A real problem that is in our report that was reinforced again is the fact that our clients living with dementia have mobility problems. Some have dementia-related Parkinson's and Lewy body dementia, some have vascular dementia related to strokes, but they are expected to get to the specialists, not the specialists to them. This is a massive problem. In Bicheno they say there's only one volunteer driver to take them. So, we've got a double access problem. An access problem that it is very stressful for someone with advancing dementia to have to go to Hobart or Launceston, but also there isn't an easy way of getting there either. So, transport is an issue.

It is also an issue on the west coast of Tasmania, as we said in our report, where they don't even have dental services for people. That is a real issue with dementia because quite special dental care is required as dementia advances.

So, support for carers; the issue of volunteers. There aren't enough local coalface support workers. I'm wondering whether there's the capacity for government to provide some kind of training. It would probably have to be online but the people who would be support workers, are usually computer literate. Is it possible in the rural towns of Tasmania to train some of these volunteers in certificate III in aged care in one of the Wicking dementia care diplomas or degrees to make a greater set of local people who are able to support the people living with dementia.

A volunteer group in Bicheno already has six clients using it, in a small town of 990 people. It's only been going for about five months now. So, I imagine that there will be more people in that community. There are, of course, people in Swansea living with dementia too, who are not yet accessing that one. Swansea also has a volunteer group that wants to get an art group going. The key person, her husband's living with dementia.

I think it is very important to remember - and people mention this to me - that in small country towns, a lot of people are not on large incomes. People have quite modest incomes, particularly those who are retirees, and wouldn't think about how to support them and not expect them to do everything themselves.

Obviously, dementia-friendly communities are out there, encouraging communities to become self-sustaining in their support for people living with dementia. …

Another quick positive is that community transport seems to be improving. It is getting very good in Hobart, but obviously community transport is still an issue in the more distant little towns.[178]

The Dementia Australia submission highlighted the challenges:

Although some people do have positive experiences, broadly the health system is challenging for people impacted by dementia to navigate and, in their experience, there is generally a lack of understanding of dementia. We need a health care system that is equipped to respond to the needs of people living with dementia, their families and carers.

The Tasmanian Government needs to be prepared to respond to the growing number of people with dementia living in rural and remote areas. They need to work collaboratively with the Tasmanian Primary Health Network (PHNs), Tasmanian Health Service, aged care

[178] Kylie Miskovski, Pat Baines and Vincent Poisson, *Transcript of Evidence*, 19 November 2021, pp. 8-9.

sector and people who are impacted by dementia to understand the key issues facing people with dementia in rural and remote areas. Dementia plans are required to improve services and supports across rural and remote communities. Specifically, these plans should include reference to:

- *Funding workforce development and training for GPs and allied health professionals working in rural and remote locations, specialising in all forms of dementia and dementia care. This needs to include incentives to attract and retain qualified professionals.*
- *Developing the most effective telehealth technology to support people living with dementia and their carers living in and remote communities.*
- *working with the transport sector to ensure adequate transport is available to ensure people living with dementia and their carers are able to access local health services and supports.*
- *Working with Dementia Australia through initiatives like Dementia Friendly Communities to build community awareness and understanding of dementia to enable support and understanding and reduce stigma.*
- *Exploring options to make funding and service delivery more flexible for people living with dementia, their carers and families in rural and remote communities.*[179]

Housing Availability

Lack of suitable housing has been identified as a barrier in the recruitment of staff.

Ms Fiona O'Keefe, Divisional Chair of the Tasmanian Division of Occupational Therapy Australia noted:

> *While education and training are important elements of any workforce plan, it is important to understand there are other significant factors influencing recruitment. Particularly, these include … scope of practice, housing shortages, visa and sponsorship assistance. Comparable remuneration is a big issue, working conditions, relocation support and other recruitment incentives.*[180]

Mr Phil Edmondson, CEO of Primary Health Tasmania:

> *From my perspective, the rural health service issue in Tasmania has long been marginal. There are a variety of reasons for it. In the public sector it is about distribution, affordability of resources, workforce challenges, population expectation, system balance and about the design of services and solutions. In the private sector it is about workforce recruitment and retention. It is about business viability, access to education, housing and work for clinicians and clinicians' families.*[181]

Dr Helen McArdle, AMA:

> *If I talk a little more broadly than just general practice, it is things like housing, schools for children and jobs for their partners, whoever they are. I have more experience of the acute*

[179] Dementia Australia, 2021*, Submission #20*, p. 15.
[180] Fiona O'Keefe, *Transcript of Evidence*, 3 November 2021, p. 2.
[181] Phil Edmondson, *Transcript of Evidence*, 2 November 2021, p. 60.

system in the north-west but if the partner isn't able to get a job that they like and the children can't go to a school that they like, the people may be there for a year and they are gone. That is in a city like Burnie, which is different to Queenstown. To attract a GP to Queenstown - as we know Ochre provides the service there - if they have school-age children or they have a partner with a profession that's not easily accommodated, then they will not stay. You then add in the housing problems, in some settings, buying into a practice and then maybe having to sell a practice, it's is a real disincentive.

I know in some of the mainland states, I always forget what it is called, something like 'easy come, easy go', the council basically owns the surgery and the houses the doctors live in. The GPs come and run the practice for three to five years. When their children are in high school and they need to move, they then don't have to sell everything; they don't have to sell the properties or the practice. They can just go and then the council maintains it and they get someone else in. That certainly has worked in some rural mainland areas.[182]

Cr Anita Campbell (Central Highlands) notes there is a Council house which is provided to the current GP in her municipality:

***Mr GAFFNEY** - Is there any accommodation associated in the Highlands with health services because down the west coast sometimes they used to provide accommodation.*

***Ms CAMPBELL** - There is a little bit at the Ouse Health Centre, not a lot, but there is.*

***Mr GAFFNEY** - Nothing in Bothwell?*

***Ms CAMPBELL** - There is a council house that is provided to the current GP to provide accommodation if someone needed it so that would be available.*

***CHAIR** - Like a locum?*

***Ms CAMPBELL** - A locum or if a GP wanted to stay there or if the nurse practitioner who works for the private practice at Bothwell. It is available and there are rentals that could be made available.*[183]

Dr Ross Lamplugh, Ochre Health, described his organisation's flexible approach in the context of providing accommodation for health care professionals:

One of the things we do is we remove some of that bureaucracy about payments, about having to attend meetings that aren't always that useful, about some of the attitudinal stuff. We get in between that. I've seen doctors arguing and leaving town because they've had issues with the hospital. I've seen them leave town because they've had issues with the local council. Another example, we were in Coonamble. Before we went there the council provided a house for the doctor. For a couple of years, the doctor had been complaining about the house and actually left. … I said, 'We don't want a special house for the doctor, we

[182] Dr Helen McArdle, *Transcript of Evidence*, 7 October 2021, p. 14.
[183] Anita Campbell, *Transcript of Evidence*, 2 November 2021, p. 5.

just want a house that one of your staff would live in, because this is patently not -'. Luckily for us, the engineer put his hand up and said, 'Yeah, I said I wouldn't live in that house.'

…

***Dr LAMPLUGH** - … We also can buy accommodation in a way that others can't. Scottsdale, as an example, where we were having trouble recruiting our second senior doctor into Scottsdale, and accommodation was an issue. In the end we bought a really nice four-bedroom house in Scottsdale with nice views, and suddenly we were able to recruit a second good doctor into Scottsdale.*[184]

[184] Dr Ross Lamplugh, *Transcript of Evidence*, 17 May 2022, pp. 5-6.

TERM OF REFERENCE 4

PLANNING SYSTEMS, PROJECTIONS AND OUTCOMES MEASURES USED TO DETERMINE PROVISION OF COMMUNITY HEALTH AND HOSPITAL SERVICES

The Australian College of Rural and Remote Medicine (ACRRM) submission made the following statement regarding workforce planning and policy:

> *When properly funded and intelligently designed using rural-centric models rather than urban-based planning, rural health services provide excellent health care which meets community need and a substantial longer-term Return on Investment. This is particularly the case with the Rural Generalist model of practice.*
>
> *Planning and policy should be designed with the ultimate goal of providing each community with a high-quality, locally-based system of medical services supported by a sustainable number of in-situ medical practitioners and a strong health care team.*
>
> *Unfortunately, where services are over-stretched, they can be made scapegoats for a system that is not necessarily fit-for-purpose. There is also a tendency for services to be closed or downgraded where there are concerns about quality and safety, rather than prioritising the retention of the service and proactively working to improve capacity. Both scenarios reduce access and undermine community and practitioner confidence, making [it] more difficult to attract and support a skilled and sustainable health workforce.*[185]

When questioned on workforce succession and planning, Dr Helen McArdle and Dr John Saul provided the following comments:

> ***Ms LOVELL** - You mentioned before, Dr Saul, that Tasmania is 100 GPs short. Is there a formula or a best practice ratio? What would be the ideal GP to population ratio?*
>
> ***Dr SAUL** - I could probably give you 30 different figures for 30 different areas in Tasmania. It depends on the way the GP practises as well. We have GPs at the Lauderdale surgery where I work at who practise as if they are in an inner-city area. Yet at Lauderdale we have GPs who do their own after hours, do their own palliative care, do their own nursing home patients and practise in a semi-rural area in a semi-rural way.*
>
> *So, the ratios vary completely. As I said before, we have people in areas of Tasmanian who have not travelled more than 30 to 40 kilometres from home in the last 10 years, so it makes it hard to say.*
>
> *…*

[185] Australian College of Rural and Remote Medicine, 2021, *Submission #36*, p. 3.

Dr SAUL *- Good supply creates plenty of demand. At Swansea at the moment we have a cracking couple who perform magnificent medicine who attract patients from Triabunna and Bicheno. They have a practice group that desperately needs another GP as per our documentation. That is because they offer such a crackingly good service that they attract so many patients to their surgery. Each area has various factors and it is a hard one to put a figure on it.*

Ms LOVELL *- Is there any formal obligation or responsibility at any level of government to ensure that there is a GP - For example, we have had instances we have seen recently in Tasmania over the last few years where we have had practices closing down, doctors retiring and entire regions potentially being left without a GP. …. Is there anyone who that responsibility falls with? …*

Dr SAUL - *No, there isn't but in the same breath I have seen some good activity from government to help where it has to. Each GP effectively runs as a small business. Each GP is primarily funded by Medicare, federally funded as running their own small business. As the bureaucracy has increased the challenges just keep building. Having said that, I have nothing but compliments for where governments and councils have come in and tried to find funding to prop rural general practices, but they are very ad hoc, confused funding arrangements.*

…

CHAIR *- I saw in Smithton when that incident occurred Ochre came in, but you also have to look after Smithton Hospital so there had to be negotiations at state and federal level.*

Dr SAUL - *We are working on crisis funding at Nubeena at the moment. We are getting very well subsidised for the first year, it trickles away quite quickly. Heaven help us when we have to negotiate year four because these small two-doctor rural practices, even with state government support for the Rural Medical Officer award, they really need additional top up funding to survive. Very few of them are functioning without a lot of charity work done by the doctors, a lot of unpaid work done by the doctors.*

Ms LOVELL *- I have a question about finding GPs to work in some of those rural and regional areas. You have talked about some of the challenges in your submission. Funding can be an issue but isn't always; sometimes there can be good incentives and GPs can be paid quite well. What are some of the other challenges that you are hearing about from doctors? …* [186]

Dr McArdle identified challenges including access to suitable housing, schooling and employment for partners in the recruitment of rural GPs.

Dr Saul added:

> *Having said that, it is a case of just trying to find that unique tipping point. We have recruited a doctor by finding a home for two Alsatians. We are working on a doctor and the key bargaining point will be finding a job for his wife, as well as two Jack Russells. We're just looking at all alternatives and how we can recruit. We talk of councils propping places up*

[186] Dr Helen McArdle and Dr Saul, *Transcript of Evidence*, 7 October 2021, pp. 13-14.

as well, but we must note that we've got a health system in crisis on the east coast at the moment, except for Swansea, …

***Dr SAUL** - There's no succession plan for Swansea at the moment; and that's an area where you add 10 or 20 years and we've got the same problems as everywhere else.*[187]

Dr Gabrielle O'Kane and Luke Sartor, NRHA made the following comments in relation to workforce planning:

***CHAIR** - … Have we done enough workforce planning work to understand the demographic of the workforce, not just GPs, but broadly across rural health? And if we do need more, what do we need to know before we can actually take real targeted action?*

***Ms O'KANE** - … There has been some workforce planning in the medical space, but that hasn't been released yet at the national level; it will be released about January next year.*

For the other professions, across the board, there hasn't been a huge amount of workforce planning going on, and allied health and nursing professionals are certainly looking for that sort of workforce planning.

Some of the issues that come up with the allied health space is the groups that are registered and those that are self-regulating allied health professionals. There is so little data on those self-regulating groups: the social workers, the speech pathologists, the dieticians and several others. There's very little workforce planning in all of that. Do you act on anything now or do you wait until all of that happens? My view is that you start doing things now. You can push toward making sure that planning happens. You can make some improvements in that area for Tasmania.

At the same time, we know, rurally, it wouldn't matter where you went, you'd be pretty certain that you don't have the workforce that you need. The Primary Health Networks are very good in having some needs assessment about what the communities need. With that, we are fairly certain you'd be able to identify the health professionals that need to be in place to address some of those issues. I think they have to be done in tandem.

Where Tasmania is probably worse off than other states and territories is your training programs and having sufficient training programs for all your health professionals within your state. What often happens, having taught in a couple of different nutrition and dietetics programs within universities on the mainland, is that we used to get quite a few students who had come from their undergraduate training at the University of Tasmania and then they do their postgraduate training on the mainland and they stay. They're not necessarily going back. That's an issue for Tasmania, more specifically.

I know you have a rural health, is it a UDRH, a university department of rural health, that Judy Walker is director of. You do have that, which I think is a great resource, but I know that in many of your nursing areas there's not the sort of training that needs to be there. Like nurse practitioners, for example.

…

[187] Dr Helen McArdle and Dr Saul, *Transcript of Evidence*, 7 October 2021, pp. 13-14.

Mr SARTOR *- I can say, it's more of a broader comment, it's the question, do you wait until you have the information and then act; or do you begin to act and gather information while you're in the process of implementing a solution?*

Four local council groups have submitted submissions for this inquiry. There is strong momentum at the local level to implement solutions to the workforce challenges they face individually within the councils. It needs to be a multi-pronged solution that involves not just one primary stakeholder group such as the PHN but also local governments and the state government to help drive the change. The proposal for the rural area community control health organisations is one solution, to have that level of organisation integrating the different bodies within the health system in Tasmania and more broadly within other states to try to tackle these workforce shortages. I understand that within Health Workforce 2040 there is a lot of work in regard to planning and projections for the workforce. It is promising.

Tasmania has an advantage in being a relatively small state with more than half a million people and it can work with some of the administrative efficiencies and coordination that go with being a smaller state and having fewer of the local health networks and only a single PHN. So, that's just some comments in regard to some of the advantages that are there for Tasmania.[188]

Dr Meg McKeown, RDAT, made the following observations in understanding the needs of rural communities:

Dr McKEOWN *- The first thing that needs to be done is that needs assessment. You can't just march into an indigenous community in the Northern Territory and know how to fix it. It is the same for this. You need to ask the elders what they need. We need to ask the people of Ouse what they need. People ask me, in your medical needs assessment program for people living without a home, how do you work out what they need? I have this amazing thing we do. We ask them and they tell us. We need to ask and we need to find that out and, of course, not every community is the same. I have lived on the west coast, the north-west coast and I have come across the border into the south and that is different.*

Dr SEIDEL *- In your role as the RDAT vice president, how are you progressing the rural generalist model in training pathways, having the placements in hospitals, ensuring that we can train people in anaesthesiology? … How are we progressing now?*

Dr McKEOWN *- The Rural Generalist Pathway in Tasmania needs to be ratified and funded and off the ground.*

Meanwhile, in ACRRM we have some funding, luckily, to train people on the Rural Generalist Pathway and it's an independent pathway - registrars with ACRRM. If you are a Tasmanian GP registrar you can get funded training through ACRRM but the model in Tasmania is difficult. There's a different employer from the north to the north-west to the south so I have to quit my job in Hobart to apply for a job in the north-west if I work for THS and there's not one employer model.

Every time I move into private practice I lose my other job in public practice and it's difficult. I did that model when I trained in my rural generalist. I had to keep losing my job and hoping

[188] Gabrielle O'Kane and Luke Sartor, *Transcript of Evidence*, 20 August 2021, pp. 5-6.

that I got the next job. I went to Antarctica and came back and couldn't get back on the program. It's still pretty much like that. RDAT advocates for a one employer model for the rural generalist pathway to be well funded, for rural generalism to be recognised in Tasmania and we support ACRRM's new pathway.[189]

Paramedic Emma Thornley made the following observation in relation to workforce planning in the context of paramedics:

> ***Dr SEIDEL*** *- You mentioned the University of Tasmania currently does train paramedics and you mentioned you are also employed by the university as a senior lecturer. Do you think there is an interest by the university to actually offer a masters course similar to what Deakin University is currently offering, considering we already have plenty of graduates and there seems to be demand for qualification? …*
>
> ***Ms THORNLEY*** *- Deakin were amazing stepping forward first. But I feel at the moment Tasmania is the 'little engine that could'. We could really create a model here, with the education and the workforce planning and the paramedic organisation finally being recognised as a valuable member of the healthcare workforce. We really could do something which might have an impact nationally. I can't comment on the university's stance at this point except to say that they are aware that in paramedicine at the moment they are producing more university graduates than there are jobs.*
>
> ***Dr SEIDEL*** *- Within the Tasmanian ambulance system?*
>
> ***Ms THORNLEY*** *- Yes, absolutely.*
>
> *…*
>
> ***Ms THORNLEY*** *- The university produces all these undergraduate paramedics. They need to do a transition to practice internship in an ambulance service. If they don't do that within two years they need to reconsider their degree and probably do another one. They often go back and do nursing or they go on to another profession altogether so we lose them from health. So, there's this waiting room that's packed at the beginning of the paramedic career. They're having trouble getting in. Then when they're in the rates of being injured, psychologically and physically, are really high. Once you're injured your choices are: if you want to continue practising in health you either have to go back and study another degree in another field of health altogether; or you leave and move on away from health; or you stay in the ambulance service if you want to continue to practise clinically, the very place that injured you. There's no way to move out.*
>
> *What we're doing here is pulling the plug at that end to enable paramedics with experience and who've served their time there and who choose to decide to forge a career in primary health care to be allowed to move out, gain the education they need and move off into the primary health care workforce where it's so needed. That's also going to free up space in that environment for graduates to come on board.*[190]

As noted under Term of Reference 5, the Government has introduced legislation to allow paramedics to work in settings outside Ambulance Tasmania.

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[189] Dr Meg McKeown, *Transcript of Evidence*, 26 November 2021, pp. 14-15.
[190] Emma Thornley, *Transcript of Evidence*, 8 October 2021, pp. 9-10.

In correspondence to the Committee, the Premier provided the following update:

> *During the recent Budget Estimates hearings, a number of comments were provided concerning opportunities for paramedics to undertake a broad range of health care roles across the health sector. In the United Kingdom, Canada and the United States of America, paramedics are embedded as a health care workforce within hospital and community settings.*
>
> *We also discussed a proposal to pilot the employment of paramedics in the Launceston General Hospital, noting the issues in being able to successfully recruit nurses, particularly in the Emergency Department. At this time the proposed pilot is still being developed and the Director, Operations at the Launceston General Hospital is working with the Chief Executive, Ambulance Tasmania to bring together key stakeholders to explore what is required to facilitate this initiative.*
>
> *Recognition of the term 'paramedic' outside of employment in a statutory ambulance authority is an important component in diversifying and recognising the role of paramedics in the broader health care sector. Proposed changes to the Tasmanian Ambulance Service Act I 982, under the current Health Legislation (Miscellaneous Amendments) Bill 2022, will enable the term 'paramedic' to be recognised outside of Ambulance Tasmania, including with private providers of ambulance services and in hospital and community settings. This Bill is currently before the House of Assembly and a briefing will be provided to member of the Legislative Council once it has been passed by the Lower House.*
>
> *As the pilot program is still being developed, there is limited further information we are able to provide the Inquiry as this time. We certainly look forward to progressing a pilot as discussed at Budget Estimates and the improvements this may bring for patient outcomes.*[191]

In the context of palliative care, Dr Maxine Glanger and Dr Rosemary Ramsay appearing on behalf of ANZSPM, made the following statements:

> ***Dr GLANGER*** *- The north has a place in the Melwood unit that is accredited for the diploma, but it is funded and operated by the Department of Medicine at the LGH. It is a rotation for medical registrars, not accessible for GPs, however, we hope sometime next year to have a community-based registrar place up which will be accredited for the diploma. Those applications are in place as we speak.*
>
> *…*
>
> ***CHAIR*** *- Where are the ones in the north-west based?*
>
> ***Dr RAMSAY*** *- They are based at Burnie with the specialist palliative care service. Currently, we have one registrar who is doing a diploma. In 2022 there will be three registrars; two are approved for the diploma and all three are approved for extended skills and advanced skills for both rural colleges. Not all for the diploma, but that application is still pending for the third position.*
>
> ***Dr GLANGER*** *- May I make a comment referring to your question about whether there are enough palliative care specialists? Presently, there are not because we are trying to recruit*

[191] Correspondence from Premier Rockliff to the Sub-Committee dated 12 July 2022.

and cannot get anybody. Part of the problem is a vicious cycle that arises because it is very difficult to get your training centre accredited for advanced training to make new specialists if you cannot get specialists to train the new specialists. We are caught in that little cycle at the moment.

***Dr SEIDEL** - Why can't we get them? Is it a culture thing or is it just we have not planned properly, it is not attractive, it is a funding thing, salary? What are the limiting factors here that we cannot get the trainees, the quality supervisors we need for the specialist pathways and for the diploma pathways for GP specialities?*

***Dr RAMSAY** - All the things you said are combined, that the remuneration within the THS, from my understanding, does not compete with some of the other states and you cannot really supervise if you do not have enough senior people to supervise these young inexperienced doctors. This is because it is a very precious thing they are doing and it has a huge impact on them. You cannot just leave them unsupervised and will not pass the college's committees. Partly it is planning.*

***CHAIR** - I am probably stating the obvious, but we need to recruit palliative care specialists ahead of trying to roll out further training, because of that is there a shortage nationally, globally, or is it that they just do not want to come here?*

***Dr RAMSAY** - I think there is a small shortage nationally, but it is my view there probably has not been enough planning going forward down the list in terms of priorities.*

***CHAIR** - You are saying it is a workforce planning issue?*

***Dr RAMSAY** - Yes, I am saying that.*

***CHAIR** - ...Is that something the state should be addressing or is it someone else's role to address?*

***Dr RAMSAY** - It would be my understanding that would be the state's role.*

***CHAIR** - Have you in your capacity had discussions with the state about actually being much more proactive in this space?*

***Dr RAMSAY** - Certainly.*

***CHAIR** - What has been the experience and the outcomes? ...*

***Dr RAMSAY** - It seems to take a long time, but my understanding is there should be some more workforce, particularly in the north-west early next year and in lieu of that, there's a locum support for an extra position. That position is not one that could be put towards the College of Physicians as a suitable supervisor.*

***CHAIR** - They are not?*

***Dr RAMSAY** - No, because they are only there for two months or two weeks.*

...

Dr GLANGER *- Both services rely heavily on locums, which makes it impossible to train future specialists.*[192]

Colleen Johnstone, CEO Palliative Care Tasmania, made the following comments during a public hearing:

Dr SEIDEL - *The Government proposed a rural health workforce unit located at the Mersey Hospital. Are you involved in workforce planning for palliative care?*

Ms JOHNSTONE *- The Tasmanian government, as part of their Tasmanian Palliative Care Policy Framework, has a strategy called Strengthening Communities of Care, that is a palliative care workforce project. One of the key outputs from that project that we have been involved in is the state of palliative care summary report, which was released last week. ... That report looks at what our palliative care workforce looks like in Tasmania. It breaks it up into those four segments, it looks at the key workforce challenges across those segments. This has been provided to the Department of Health and they will use this as part of their revision of the Tasmanian Palliative Care Policy Framework and should feed into their workforce policies more generally.*

... I would be asking the minister to lobby in Canberra for those pieces involving remuneration for GPs and pharmacists. We cannot get the community palliative care piece right unless the federal government looks at the MBS items and ensures that those people who work in palliative care are appropriately remunerated.[193]

Kathrine Morgan-Wicks, Secretary Department of Health provided the following comments regarding planning systems and projections, highlighting the Health Workforce Strategy 2040:

What Health Workforce 2040 has done, is said right, we have collected all the data and statistics in terms of our health workforce, and we are looking right across what we have today, what is actually required in 2040, and what the gap is, and how do we bridge that gap in terms of strategies. We have just received the funding in the last Budget under our health workforce strategy to pursue this work, so it is in early days of development.

We have nurse practitioners, but Health Workforce 2040 is about how do we formalise and be more strategic about where we are going to create positions and attract these highly qualified nursing practitioners. [194]

The Premier (in his capacity as Minister for Health) made the following comments during the 2022 Budget Estimates Process regarding the body of work currently being undertaken by Government to address workforce challenges:

Mr ROCKLIFF - *... Our Health Workforce 2040 was released in September last year. It's a long-term strategy aiming to shape a health workforce that meets the needs of Tasmanians now and into the future, look after those who dedicate their careers to looking after others, and provide opportunities to support our health professionals to follow their career ambitions.*

[192] Dr Maxine Glanger and Rosemary Ramsay, *Transcript of Evidence*, 2 November 2021, pp. 50-1.
[193] Colleen Johnstone, *Transcript of Evidence*, 30 November 2021, p. 10.
[194] Kathrine Morgan-Wicks, *Transcript of Evidence,* 30 November 2021, pp. 21-22.

Health Workforce 2040 incorporates input from consumers and health professionals and includes up-to-date data sets available at the time of release. Implementation of the strategy action items has commenced. Funding of $15.7 million over four years was provided in the 2021-22 Tasmanian budget to support the implementation of the Health Workforce 2040.

The funding will support workforce development, upskilling, more efficient recruitment, leadership, management training and capacity building, and the development of new and innovative health workforce models.

Funding has been provided to the responsible business units across the Department of Health for specific projects that will progress actions outlined in the strategy. The workforce planning unit will report annually on implementation of the strategy. The first annual report will be prepared for the training, education and workforce sub-committee of the department's clinical executive in September this year. …

…

***Professor LAWLER** - I'm also happy to speak a little further on the Health Workforce Planning Unit. I think the question was asked whether the Health Workforce Planning Unit is an ongoing activity…..*

***Professor LAWLER** - I'm pleased to say that it is. It's one of the units that sits within my group. It's led by Dr Ruth Kieran, who has a long history in health workforce planning and strategy. As the minister has highlighted, its remit in part is to oversee the delivery of some of the key strategies within Health Workforce 2040, and will be reporting on an annual basis. In terms of some of the elements that sit within its scope of responsibility, it's working with other groups across the department, including the Chief People Officer and people in culture on developing culture and health leadership to establish a health leadership program for existing and emerging clinical leaders, and also to establish and manage the Future Health Leaders Forum.*

One of the things it has delivered is the Health Workforce 2040 strategy itself. That was an output of the Health Workforce Planning Unit. It's important to note that it's a truly multidisciplinary document that looks across provisions in terms of what our current situation and our ongoing need into the future will be, to establish and fund Aboriginal health worker traineeships to build the Aboriginal health worker workforce. In fact, Dr Kieran is in the north of the state today involved in meetings to establish that.

Also to develop north-west health workforce planning that is responsive to our service demands and aligns with Health Workforce 2040, which specifically highlights that some of the greatest challenges we face are outside metropolitan areas, and also to review the accommodation options working alongside the infrastructure groups to review the options that support the recruitment or retention of health professionals and students in rural Tasmania.

In addition to delivering the health workforce strategy itself, and the various elements underneath it, there's a strong element of collaboration with professional leads, such as our Chief Nurse Midwife and our Chief Health Adviser on some of the specific challenges facing professional groups working with the operational leads within community, mental health and wellbeing, and also our hospitals and ambulance service on some of the elements that

present specific challenges there. Also responding to challenges as they arise and some of the opportunities that we have in front of us, including building our Aboriginal health workforce.[195]

The Committee sought a response from the Minister regarding the stated shortage of GPs, the engagement of nurse practitioners and education and training:

> ***Mr GAFFNEY*** *- We heard recently from the AMA, saying that they had a shortage of 100 GPs… We talked about other models from other countries. If you look at New Zealand, in 2017, 2018 and 2019 there was a 30 per cent increase in nurse practitioners; they've been fast-tracking 50 nurse practitioners a year now for the next so many years.*
>
> *…*
>
> *The fact that UTAS doesn't have a master's degree in nurse practitioners is a real concern… when it's a 2040 goal or aspiration and you have nurses out there who want to have that capacity …*
>
> ***Mr ROCKLIFF*** *- We have made some inroads in terms of allied health and UTAS in recent times… I can assure you we are not going to be looking at 2040 and saying we will have that then. This is about scoping what we need now and into the future in terms of demand on services.*
>
> ***Ms MORGAN-WICKS*** *- It's the difficult place around the funding of health care in Australia. In the THS, we cannot fill the gap of primary care service and provision. I am unable to confirm the number of general practitioners being quoted by the AMA, and otherwise accept it as given, but in relation to the number of general practitioners and the primary care support, we do our best in the middle - so between the primary care sector and between our aged care sector - to provide public health services that are at many times within reach into both the front end and aged care sector.*
>
> *In terms of our nurse practitioner roles, we are looking at the application and use of nurse practitioners within the Tasmanian Health Service with the health services that we provide but noting that the Office of the Chief Nurse and Midwife is actually developing that framework. We work very closely with Primary Health Tasmania in relation to the types of skills, the practitioners, expansions in the scope of practice that we can help Primary Health Tasmania to support.*[196]

Ms Pam Doole, Clinical Chief Advisor Nursing, Office of the Chief Nursing Officer I Te Tari o te Tapuhi Rangatira, provided the following detail regarding New Zealand's experience:

> ***Ms DOOLE*** *- I will give you a little bit of background about the role in New Zealand. It was established under government support, the conservative government at the time in the late 1990s wanted to unleash the potential of nursing so did a taskforce. The outcome of that taskforce was to establish the nurse practitioner role. The first nurse practitioner was registered in 2001 and there was quite slow development in that first decade and they were often supported to become nurse practitioners through public hospitals and district health*

[195] The Premier (in his capacity as Minister For Health), Kathrine Morgan-Wicks, *Transcript of Evidence*, 7 June 2022, pp. 66-7.
[196] Kathrine Morgan-Wicks, *Transcript of Evidence,* 30 November 2021, pp. 21-22.

boards. So often nurse practitioners ended up in quite specialised nursing roles to do with chronic health conditions like diabetes et cetera but the role was originally determined to be a role that would provide access to health care for people in vulnerable communities. In New Zealand this is particularly our Maori and Pacific communities but it is also acknowledged that there are other vulnerable communities. Rural communities are definitely seen as having less access to health care and as our GP workforce ages and moves more into the central cities, the nurse practitioners are definitely filling a gap in that sector.

We are also noting that nurse practitioners are having a bigger and bigger role in our aged residential care sector as well as GPs providing less care in that sector and it differs across the country. I guess what has happened in recent times in the last decade is we have seen a lot of the legislative and funding barriers being removed for nurse practitioners to fully function in what we call primary health care so they have exactly the same payments for general medical services. Also, for our accident compensation corporation payments. That is a fund that is set up for anyone who is injured through a home, work or recreation accident and that is all funded separately through that no-fault scheme -

***Ms LOVELL** - Sorry to interrupt. When you say the same payments under those schemes, do you mean the same payments as GPs, for example?*

***Ms DOOLE** - Yes.*

***CHAIR** - To clarify, your accident compensation scheme, that is capped, isn't it? … There is a limit to how much anyone can claim for any injury?*

***Ms DOOLE** - Yes. For the rehabilitation in a primary care setting, that is pretty straightforward. There are schedules of payments but when people are going for higher levels of compensation there definitely is quite a different process that the corporation uses for those people. I think that is all I want to say on that.*

***CHAIR** - … What about the legislative barriers that were there that needed to be removed to enable nurse practitioners to work across that scope?*

***Ms DOOLE** - I suppose there are things, particularly with the Medicines Act, so nurse practitioners became designated prescribers with a broad list in 2005 and in 2013 they became authorised prescribers which means they have the same prescribing rights as general practitioners. The scope of practice was broadened in 2017 and a lot of statements were put in that scope of practice to recognise that nurse practitioners can order diagnostic tests. They can be the lead health care provider and they can admit and discharge from hospital. So, we deliberately put in those statements and their scope of practice so it was clear that their legal role was higher than that of a registered nurse and that they could function as independent health care providers.*

We have a capitation section - funding for general practice. Nurse practitioners can access that and they can own their own general practices and we do have some nurse practitioners who are practice owners and they will often ask GPs to come in to do locums. Particularly if they are in a rural area, they might ask a GP to come one day a week to see particular patients who need that level of GP care.

***CHAIR** - Sort of the reverse of what we are seeing here.*

Ms DOOLE - *I think that's a decision that's been supported by both major parties: that we need to have an enabling health workforce. There is so much demand, and there is growing demand with an ageing population. There are moves to allow professionals, not just nurse practitioners, but all health practitioners to work at the top of their scope. Sometimes the professional groups don't always agree with the direction, but importantly, I think the ministry has stayed on track with the vision despite some pushback from some professional groups.*

CHAIR *- …*

… I'm interested in how New Zealand, whether it's the parliament, or the minister for health or whatever, smoothed over some of those barriers - and I'm sure they were real barriers at times - from some of the medical professions and perhaps others. Could you explain more about how New Zealand was successful in making quite significant progress in a relatively short space of time?

Ms DOOLE - *One of the other pieces of work the ministry has done is to put forward some omnibus legislation to change the term 'medical practitioner' in a number of acts to 'health practitioner'. That work took about six years to be enabled. So, I think it's doing work over time: having all that work go through the health select committee, allowing different groups to make submissions but also keeping an eye on the purpose, which is about enabling access to care for patients, for people.*

Framing what is done to be for the benefit of the public is really important. Sometimes there are different responses. I have found in the medical profession in New Zealand that there are groups that are willing to go with new models. Some are more cautious and some perhaps are against change, but trying to make alliances with the groups who can see the benefits, telling the story that the sky hasn't fallen when changes have been made; in fact, it's actually better for everyone. I think the medical profession can see this. Sometimes they just have a problem with nurses they don't personally know extending their scope. We have a track record now where I don't think there have been any significant harms to patients through nurses extending their role through registered-nurse prescribing all through the nurse practitioner role.[197]

The RACGP submission made the following comments in relation to 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.*[198]

The Committee discussed the challenges facing organisations supporting members of the community with a range of chronic health conditions who rely on government funding to support their work. In comparison with government introduced programs, these organisations need to

[197] Pam Doole, *Transcript of Evidence*, 17 February 2022, pp. 2-3.
[198] RACGP, 2021, *Submission #65*, p. 5.

reapply frequently for funding to meet the needs of their members. The Committee sought a response regarding the evaluation of government initiated programs and the ongoing needs of NGO's providing support to Tasmanian health consumers.

> ***CHAIR*** *- Minister, it is important to evaluate these things against performance measures that are meaningful, otherwise you keep spending money with things that might not be having the desired effect. …*
>
> ***Mr ROCKLIFF*** *- I agree with that. If I put my mental health hat on, and the HASI project that was undertaken in partnership with Colony 47, supporting people with mental illness, in accommodation provision. That was piloted, evaluated and it is now being implemented for a range of criteria that supported people with mental illness.*
>
> ***CHAIR*** *- The reason I am asking some of this minister, is that a lot of these programs are put in as pilots, and they are evaluated, and some of them do not continue, some do. Many of the organisations we have talked to that provide services to the community, whether it be Dementia Australia, the Arthritis Foundation, basically have to reapply for their funding every three years, and that makes it difficult for them to focus on their core business.*
>
> *When something is proven to work, let us say it is Hospital in the Home, for example, and you continue to fund it, why don't we use the same approach with some of these organisations that are supporting their communities with diabetes, dementia, with rheumatoid arthritis? If they have proven themselves, why do we keep asking them to spend a significant amount of time with very limited resources begging for money?*
>
> ***Mr ROCKLIFF*** *- Point taken.*[199]

The Committee notes that some Government departments, such as DPAC in the area of prevention of family violence, have revised the length of those contracts. During the 2022 Budget Estimates process, Minister Petrusma stated:

> *Addressing family and sexual violence is a top priority for the Tasmanian Government, as well as myself as minister. My role is to help coordinate the delivery of our 40 actions across government, under our second action plan, Safe Homes, Families, Communities. It's now also to oversee the development of our third family and sexual [violence] action plan, to be released in July.*
>
> *While my ministerial colleagues are responsible for their own actions as part of the 40 actions in their individual portfolios, through its coordinated governance that is an award-winning model we work collaboratively to integrate and influence an activity. In this Budget I am especially delighted that we will be delivering an historic increase in recurrent core funding, as well as five-year contracts for our nine frontline specialist family and sexual violence services.*
>
> *We will be providing $75 million in funding over the five years, which is a 37 per cent increase in core funding. Through this investment, our services will have greater certainty and increased operational capacity to respond to the demand needs of victims/survivors now and into the future.*

[199] Minister Rockliff, *Transcript of Evidence*, 30 November 2021, pp. 29-30.

…

***Mrs PETRUSMA** - So, for the benefit of the members, their core funding has now been increased by about 37 per cent. It is now ongoing funding. This is the first major uplift in 30 years. It's a big increase.*

Talking to services, what came across is that short-term funding, while it was welcome, led to somebody coming on for three months and then having to go and having to stop the clients. PESRAC's recommendation was strongly that we need to have long new contracts. When I had Human Services, three-year contracts drove me insane.

We're going five-year funding so there's long-term certainty. This is a permanent increase to core, so the Family Violence and Counselling Support Service will have a permanent increase to its core funding. It can increase staff to where it needs to be. It stops those peaks and troughs, otherwise the waiting list will go down, then they'd have to put off staff because the funding ended. I just want it to be constant so that over at least the next five years they can schedule in leave, long service leave, and they can bring in extras.[200]

The Committee sought information regarding patient outcomes related to the Hospital in the Home program. Minister Rockliff, Professor Tony Lawler and Ms Morgan-Wicks provided the following comments:

***Mr ROCKLIFF** - My understanding is that Hospital in the Home, firstly, can take pressure off the hospital system, and secondly, I think there is evidence to support that people recover more quickly with Hospital in the Home.*

***Prof LAWLER** - That's right. Through you minister, there is a reduction in the almost inevitable consequences of a prolonged hospital stay … and the potential for nosocomial infection and other complications.*

…

***Ms MORGAN-WICKS** - … In terms of the pilot, and in my conversations with the chief executive of Hospitals South on the use - and I've also met with the departmental head, Paul McIntyre - in relation to general medicine referrals to Hospital in the Home, actually training our clinicians to be comfortable in terms of the referral from a patient that they are able easily to access within a hospital environment, to actually referring patients comfortably into Hospital in the Home.*

Occupancy itself in a pilot program is one of our key indicators, whether we are able to fill the 12 beds, and certainly it has been a slower uptake that we have experienced in the southern trial. We have been working together in that education, training, comfort and support, to make those referrals through to a Hospital in the Home environment.

***Mr ROCKLIFF** - The criteria would be the readmission rate, as well.*

…

[200] Minister Jacquie Petrusma, *Transcript of Evidence*, 8 June 2022, pp. 16-18.

Mr ROCKLIFF *- Also, we are looking at expanding across the state, on the north and the north-west, as part of that $52 million commitment to do so in care in the community.*[201]

With regard to evaluation of the Hospital in the Home program, Ms Morgan-Wicks stated:

> *Noting that this still remains in draft, we are still formalising that through our evaluation and feedback process, we are looking at updating the current model of care for Hospital in the Home. Some of the suggested amendments include an increased scope and expansion of the geographical intake area for the south, providing alternative, or alternate clinic locations, and after-hours service. We are looking at the bed numbers and the utilisation, and whether that can be increased. We are looking at expanding to a seven-day model for admissions for the Hospital in the Home. My understanding is that the current pilot operated on a Monday to Friday, or five-day admission service.*
>
> *We are looking at whether we can update and expand our referral pathways into Hospital in the Home. And I note, for example, the development of a flexible referral arrangement with general practitioners to refer in, and avoid an unnecessary emergency department presentation or inpatient admission. Do we have that direct referral from a GP direct into Hospital in the Home? That is the type of feedback that we are currently considering from stakeholders in relation to that service.*[202]

According to the Tasmanian Government submission:

> *Through the Our Healthcare Future reforms, the second stage of the Tasmanian Government's long-term reform agenda, the Tasmanian Government is committed to building a highly integrated and sustainable health service for the future. The Our Healthcare Future reform program is focused largely on the achievement of connected care that is well balanced across Tasmania's acute, subacute, and primary and community health sectors, and on the provision of care in the most appropriate settings.*
>
> *The Our Healthcare Future reform program proposes three key areas for improvement: 'Better Community Care', 'Modernising Tasmania's Health System', and 'Planning for the Future'. Under these key areas are a range of initiatives, many of these initiatives will also have benefits for those living in rural and remote areas of the state. These initiatives focus on areas such as (but not limited to):*
>
> - *workforce planning, including partnerships with training and education providers*
> - *increasing support for primary health care professionals in caring for people with complex conditions in the community*
> - *increased access to telehealth and the introduction of virtual care solutions*
> - *improving information and communications technology (ICT) infrastructure; and*
> - *increased and formalised mechanisms for provision of expert clinical advice to support service planning.*
>
> *The Our Healthcare Future reform program also includes a focus on strengthening the consumer voice in health planning. It is important the voices of people living in, and/or*

[201] Professor Anthony Lawler, Minister Rockliff and Kathrine Morgan-Wicks, *Transcript of Evidence*, 30 November 2021, pp. 82-3.
[202] Professor Anthony Lawler, Minister Rockliff and Kathrine Morgan-Wicks, *Transcript of Evidence*, 30 November 2021, pp. 29-31.

providing services to rural and remote areas of Tasmania are heard to enable future planning and initiatives to be best targeted to meet local needs. A public consultation process was undertaken on the Our Healthcare Future discussion paper, to help guide future planning and a number of submissions were received from a broad cross section of the community, including consumers, clinicians, professional groups, service providers, advocacy groups, policy experts and academics. The Department has completed an analysis outlining the key themes to emerge from the submissions which found:

- *wide support from respondents for the overarching themes of the reforms proposed in the Consultation Paper*
- *strong support for patients to be treated in the community setting where possible and appropriate, and for greater emphasis on preventative health*
- *an acknowledged need for digital transformation, long-term infrastructure and workforce planning to improve access to services and support new models of care.*

The next step in the Our Healthcare Future reforms is to co-design a new long-term plan for healthcare in Tasmania. The plan will point the way towards a more sustainable health system for the future, focused on achieving better outcomes for consumers, their families and carers now and in the future.[203]

The Tasmanian Government submission elaborated on a number of project and initiatives designed to improve patient outcomes:

The Tasmanian Government has supported a range of projects and initiatives designed to improve patient outcomes, support innovative models of care and maximise the efficiency of our rural hospitals, particularly focusing on subacute care pathways. Some examples include:

- *In late 2017, the Government increased clinical staffing and enhanced the service model at the New Norfolk District Hospital so patients could be transferred from the RHH to receive subacute and rehabilitation care. This model relies on a nurse practitioner assisting the admitting geriatrician and local GPs in rapidly assessing patients transferring from the RHH and managing increased occupancy.*
- *A recent pilot at Deloraine District Hospital to develop a subacute rehabilitation model of care considered how providing subacute rehabilitation beds in district hospitals allows patients to leave acute beds in a major hospital in a timely way and receive subacute rehabilitation care in or close to their own community. The benefits identified from this pilot included a significant saving in bed days at the LGH and a reduction in the number of avoidable presentations in the emergency department.*
- *Building on the work at the Deloraine District Hospital, DoH has initiated a further 12-month project titled 'Improving Subacute Pathways to District Hospitals', which commenced in December 2020. This project aims to manage subacute presentations more effectively, improve patient flow through the LGH, increase bed occupancy at district hospitals and provide subacute care closer to where people and their support networks live. The project will also support integration of subacute, acute and primary health services through an expanded scope of care at district hospitals and future workforce planning.*

[203] Tasmanian Government, 2021, *Submission #72*, p. 39.

- *Adequate staffing is an essential component of increasing occupancy, providing safe and appropriate care and staff recruitment and retention at district hospital sites. The District Hospital Safe Staffing Model (District HiTS) was developed in 2019 to provide the flexibility required to staff individual district hospital sites to meet their specific mix of inpatient, emergency, outpatient and residential aged care activity. District HiTS provides a minimum staffing complement for sites and flexibility to increase staffing in times of increased occupancy and acuity. This model commenced on a 12 month trial at the end of June 2021.*
- *Additionally, the Tasmanian Government has committed funding for additional staffing at several district hospitals across the state, including the North East Soldiers Memorial Hospital, West Coast District Hospital, New Norfolk District Hospital, and St Helens District Hospital.*

Projects and initiatives such as these acknowledge the challenges of increasing service demand in Tasmania's larger acute care facilities and the associated implications for district hospitals in terms of patient flow, length of stay and increasing demand for higher acuity care and subacute care.[204]

Primary Health Tasmania (PHT) provided the following in its submission related to planning for rural health care provision:

Health service provision in rural and remote Tasmania evidences a salient story of poor long-term planning that has led to piecemeal services, reactive political solutions, disconnected services and an inequitable distribution of funding. We can no longer purport to run a contemporary health system if instead of all striving to a shared whole of community system vision, we are constantly pushed to be making reactive decisions that merely plug holes or extinguish spot fires.

Further, opportunities in the past to effectively engage the broader sector, communities, consumers and importantly service providers and clinicians have been constrained.

Tasmania is now ideally placed to plan with a long-term view as the population data and growth projections are well known. Government – and not just health – have a good picture about what is coming in terms of our health outcomes and their challenges. We recognise that there are a number of current state government planning processes underway including for workforce, ICT, and infrastructure but we caution there is a risk of siloing or nullifying actions if decisions on the elements that evidence a well-functioning system are not integrated.

The mental health sector has some excellent current and progressive examples of collaborative and comprehensive service planning between industry, not for profits, government, community and consumers. This commitment to a whole-of-state plan paves the way for many partnerships and co-commissioning opportunities with an agreed platform for regional service integration and a model for future services that will be informed by the National Mental Health Service Planning Framework.

This will ensure the most effective and judicious use of scarce resources and enable an environment that engenders integration and effective communication. A key platform of the

[204] Tasmanian Government, 2021, *Submission #72,* pp. 34-5.

plan is to ensure all Tasmanians, irrespective of where they live, should have an equity of access to mental health care. Rethink 2020 was released in 2020 and this has been followed with a detailed Implementation Plan with the system partners Primary Health Tasmania, Tasmanian Department of Health, Tasmanian Health Service and the Mental Health Council of Tasmania.

All state planning must start with strong governance – health system governance must be more inclusive of primary care and community care and local community representation to ensure health system challenges are identified and solved using skills, knowledge and expertise of those working both in and alongside the Tasmanian Health Service and the Tasmanian Department to (sic) *Health. This includes those working in public and private sectors with strong rural and regional expertise.*[205]

The Committee received significant evidence regarding workforce planning and the opportunities.

Katie Pennington, CRANAPlus called for a clearly delineated rural and remote nursing pathway in Tasmania that is applicable across all sectors and supported through regulatory measures, and if required, credentially:

Queensland and Victoria both use the well-established rural and isolated practice nurse model, also known as RIPERN. RIPERN model is also supported and endorsed through AHPRA, so you can apply for a RIPERN endorsement, which is then recognised by organisations through their policies and procedures and through state-based medicines and poisons legislation. This enables nurses to work with that advanced scope of practice where they're appropriately prepared.

New South Wales has a different model, it's called nurse designated emergency care and it's really only applicable in the urgent and emergency care environment. That's not endorsed at a national level through AHPRA but is regulated and credentialled through state-based mechanisms.

Both of the models evolved out of research that pointed to nursing stress, medical stress and patient dissatisfaction with time to access service in rural and remote areas and have led to improvements in that.

Having worked in other states with an advanced scope, when I moved back to Tasmania in 2018 I became deskilled. My scope of practice has been reduced and yet I can see the need that if I were able to maintain those skills and that scope, I could directly and more significantly contribute to the need for healthcare services on the east coast of Tasmania.[206]

Pharmacists in Australia are still not able to work across their full scope of practice. Please refer to Term of Reference 2(h) and 3(h) for more evidence relating to pharmacists, and in particular the legislative authority that currently restricts pharmacists from practicing to their full scope.

Joe Acker, Minister Rockliff, Dale Webster and Kathrine Morgan-Wicks provided the following detail in terms of increasing the scope of practice of health practitioners:

[205] Primary Health Tasmania, 2021, *Submission, #74*, pp. 10-11.
[206] Katie Pennington, *Transcript of Evidence*, 8 October 2021, p. 28.

Mr ACKER *- Through you, Minister, there is a lot of opportunity for paramedics to increase their scope of practice in Tasmania. We're all aware that paramedics only became regulated under AHPRA in 2018, so still a relatively new nationally regulated health profession. The acts and regulations have not been amended in many states and territories across Australia, like ours. That's because paramedics were primarily associated with the ambulance services.*

In Tasmania since 2013 we've had extended-care paramedics. These are paramedics with advanced training. They can provide things like suturing, administration of antibiotics, tetanus shots, clearing catheters and those other important primary health initiatives. We have in the state 19 trained extended care paramedics, with six full-time equivalents. Right now, three in Hobart and three in Launceston.

Dr SEIDEL *- They're working exclusively for Ambulance Tasmania though, aren't they?*

Mr ACKER *- Through you, Minister, yes they are currently only working for Ambulance Tasmania, which is part of the restrictions of the act. We have just recently employed a senior pharmacist to help us look at the Poisons Act and regulations to understand opportunities to make amendments and to work with the PSB on opportunities to have not only ultimately prescribing rights by paramedics but dispensing abilities by paramedics. That's again, within Ambulance Tasmania.*

Ambulance Tasmania is committed to advancing the scope of the practice of paramedics within the ambulance service. As a paramedic professional, I see incredible opportunities for the paramedic profession to play a major role in Tasmania outside of the ambulance service. As we've seen mostly in other countries, the UK for example, Australia is still evolving in terms of having paramedics work independently outside of state ambulance services.

…

Dr SEIDEL *- …* [Minister] *Are you committed to create a chief paramedic officer role within the next, let's call it, three years of your Government, or are you just open to looking into it?*

Mr ROCKLIFF *- It's under active consideration and I'm waiting advice. ….*

…

Mr WEBSTER *- The context of this is a regulated health profession from 2018. We need to develop the profession of paramedicine and we need to take our time and not rush to answers as to things like paramedic practitioner as an answer to something which is an evolving profession. As Mr Acker said, we are looking at extended care paramedics, we are looking at the greater level of community paramedicine and issues like that that need to be worked through in some detail.*

Secondly, amendments to the poison's legislation, putting on my hat of public health, we need to consider the broader implications of that, rather than an amendment that suits one part of the workforce that might have different consequences. We need to put all that together as a package. Regarding the role of chief paramedic, a lot of this doesn't rely on the role of chief paramedic. The role of chief paramedic is around clinical governance and the framework of clinical governance. That's an important step. All these other things have to happen as well. We aren't talking about something we can do in six months. We're talking

about an evolving health profession. We need to make sure that we're getting the best evidence about how we evolve that profession.

…

***Prof LAWLER** - I think Dale's comment goes to the intrinsic role, potentially, of the chief paramedic in clinical governance within Ambulance Tasmania, working with Ambulance Tasmania, but across the state - not that this would be responsible for a de novo development of a clinical governance framework, because as you say, there is one in place.*

It is important to note that all of the other issues that are being discussed are not waiting for the chief paramedic officer to be developed. This is a role that could potentially add value to discussions. Obviously we need to be clear around the interface, overlap and interactions between a chief paramedic officer and the Ambulance Tasmania structure itself.

I would like to acknowledge that Neil Kirby, who is a former chief executive of Ambulance Tasmania, has done some work in scoping out that role. As has been mentioned a few times, as a regulated profession under AHPRA, paramedicine is actually quite young. There is only one other jurisdiction I am aware of that has a named chief paramedic officer.

We have worked in discussions with that jurisdiction in understanding how that position adds value. There are opportunities to provide the same kind of chief clinical leadership in paramedicine to complement the leadership within Ambulance Tasmania, similar and parallel to chief medical officer, chief medicine provider, chief allied health adviser - those roles that provide key advice that is potentially independent of the service delivery arm, but works closely with the service delivery arm on opportunities to improve governance and to improve service delivery.

The role of the chief paramedic officer will obviously have a strong input to developing models of care, and strong input into the clinical policy and guidelines, but also recognising-

…

***Prof LAWLER** - and working at the full scope of practice, in the same way we see the chief nurse and midwife contributing to discussions around nurse practitioners, and the chief allied health adviser contributing to discussions around extended-scope allied health professionals.*

The role itself has some value. There is still a significant amount of work that needs to be done around scoping and clearly understanding it, but it is not something that is sitting there and holding back other works that are being done.

***CHAIR** - You mentioned about nurse practitioners.*

***Mr ROCKLIFF -** I was going to highlight the Health Workforce 2040 strategy. As part of Our Healthcare Future, nursing and midwifery, page 26 talks around nurse practitioners. I am advised that the Office of the Chief Nurse and Midwife is establishing a statewide framework for nurse practitioners, creating a model of care that is ideally suited to the value of the nurse practitioner role. Rural or remote is a key context for this work and in fact, the work is being led by the Nurse Midwifery Leadership Group, which includes Ms Downie, who was at the table before.*

***CHAIR** - Have you a particular number in mind of nurse practitioners who could be deployed around the state and particular areas? ……..*

***Ms MORGAN-WICKS -** As part of Health Workforce 2040, which received funding in the last Budget, we are establishing those nurse practitioner candidate pathways. We are completing the HR policy around that, and work now begins on the models of care and the creation of positions to support those models - and I regularly talk to the nurse practitioner in the emergency department at the Mersey Community Hospital, for example.*

At the moment, we have nurse practitioners located around diabetes, burns, wound care, aged care, palliative care, ComRRS, oncology - but what the minister has mentioned is that [we] have probably been putting them in as they have been developed, noting the Master's level study that is actually required to become a nurse practitioner, and that is noted in the health workforce strategies. With the number of positions that we get in any one year through interstate study - because it is not offered here in Tasmania - we really did need that framework, which was not just about a local hospital attracting a particular nurse practitioner role to it, so we can look in a more formalised and strategic sense as to where we should try to attract nurse practitioners to help in terms of the offered workload in those particular areas.

***CHAIR** - So if I am right, Minister, and correctly hearing the Secretary, this is being worked out now. You do not have targeted areas that are being scoped out. Is that right?*

***Ms MORGAN-WICKS** - Through you, Minister. I think we have close to 30 nurse practitioners already employed in the Tasmanian Health Service, and we have them in a variety of different roles.*

What Health Workforce 2040 has done is said right, we have collected all the data and statistics in terms of our health workforce, and we are looking right across what we have today, what is actually required in 2040, and what the gap is, and how do we bridge that gap in terms of strategies. We have just received the funding in the last Budget under our health workforce strategy to pursue this work, so it is in early days of development.

We have nurse practitioners, but Health Workforce 2040 is about how do we formalise and be more strategic about where we are going to create positions and attract these highly qualified nursing practitioners.[207]

The Rural Doctors Association of Tasmania (RDAT) submission calls for an increase in teaching opportunities for the medical workforce:

As a product of increased medical student and junior doctor interest in rural medicine, many of our rural general practices are now limited in the space that they can provide teaching opportunities. The Rural Doctors Association of Australia has provided a budget submission to the Commonwealth Department of Health to increase the number of Rural Junior Doctor Training Innovation Fund places from the initial 50, to 400 Australia wide. Rural general practices are going to need to have access to infrastructure grants to improve facilities. The reason that this is so important is early prevocational exposure to rural general practice is a strong predictor of long-term training and retention in the rural workforce. The Rural

[207] Joe Acker, Minister Rockliff, Kathrine Morgan Wicks and Dale Webster, *Transcript of Evidence*, 30 November 2021, pp. 71-4.

Junior Doctor Training Innovation Fund (RJDTIF) that enables early years doctors to continue a teaching and learning "immersion" in rural general practice needs to be adequately funded to ensure that practices are not further financially penalised for supporting this very beneficial project. We note that this project receives no support from the State Government.[208]

[208] Rural Doctors Association of Tasmania, 2021, *Submission #30*, p. 13.

TERM OF REFERENCE 5

STAFFING OF COMMUNITY HEALTH AND HOSPITAL SERVICES

Primary Health Tasmania's (PHT) submission noted:

> *In relation to health workforce and retention – Tasmania has an ageing health workforce that is not evenly distributed across the state with supply in regional areas greater than supply in rural and remote areas. There are ongoing difficulties recruiting and retaining GPs in rural locations. There are some health professions where shortages are particularly apparent in rural locations – specialists and the dental workforce are examples.*[209]

The Committee visited a number of health facilities throughout rural and regional Tasmania. A range of issues were raised including a lack of peer support and backup for doctors in the regions, a lack of locums and allied health professionals to support the general practice, a lack of professional development opportunities, declining scope of practice, inadequacy of infrastructure to ensure effective healthcare through the use of digital technology, and inadequate funding to cover the costs of running a general practice.

Dr Ross Lamplugh, Co-Founder Ochre Health, noted the large number of locums engaged in this sector, and some of the associated challenges:

> ***Dr LAMPLUGH*** *- It's much more than the money. If you want to solve the problem in the short-term - if I opened a new café in Hobart and I wanted the best staff in Hobart to come to work for my café, obviously, to drag them across I would have to pay more than whoever was currently paying them. We have to solve the problem in the short-term and keep working on all of those other things because I don't know if it's not sustainable to pay remote GPs what they should get. I don't even know if it's what they should earn. It's enough to encourage them to be there.*
>
> *For example, during COVID-19, let's say we run 15 communities. We have only missed two days of on-call across 15 communities with all of the challenges of border closures, last-minute refusals of travel applications, doctors getting COVID-19 and various things like that.*
>
> ***CHAIR*** *- That's across New South Wales and Tasmania?*
>
> ***Dr LAMPLUGH*** *- Yes. It would be a handful of shifts in two years we've missed but we've been paying twice as much for locums as we used to pay because at the moment there's a crisis and we've had to respond to that crisis. In the short-term, during COVID-19 we didn't have time to sit down and decide what can we do. Should we offer the doctor a new four-wheel drive and send them on more holidays or do whatever to fill those last-minute gaps? We had to meet the market and it's a simple business rule that if you want people, you've got to meet the market.*[210]

[209] Primary Health Tasmania, 2021, *Submission #64*, p. 6.
[210] Dr Ross Lamplugh, *Transcript of Evidence*, 17 May 2022, p. 2.

Dr Lamplugh was asked to comment on the challenges associated with attracting medical professionals to a general practice where providing medical cover to the local district hospital is also required:

> ***Dr LAMPLUGH*** *-… I suppose that comes back to us a little bit as well, that we've got a group of doctors so that we can - I'm not quite sure why, I think the HSMs in the hospital have got a lot to do, and a lot of them will tell you that most of their day is taken up with just trying to fill their roster with doctors. Sometimes doctors can drive you crazy, someone who is earning several hundred thousand dollars a year complaining about money gets under most people's skin, especially if that person is earning a third or a quarter of that.*
>
> *I have also seen - and we had this situation in one of our towns recently - where we had to have a chat with one of our GMs who was complaining that a doctor who we'd asked to work an extra shift because another doctor hadn't been able to turn up because they had COVID-19, we'd asked this guy to do five days in a row instead of three. The doctor said, 'I am only going to do that at the higher locum rates that I know you pay someone else.'*
>
> *We often hear this with local doctors, being irritated that they know locums are being paid more than they are. We actually fell into the same error with that doctor for the sake of a couple of days. We had an argument about his pay and luckily, we were able to pull back on that pretty quickly and fix the problem.*
>
> *Some of that comes from understanding. Don't get me wrong, but when I left Bourke, I look back at some of the correspondence I had written to health services and I probably should have been deregistered. I was so angry, hurt and damaged, and I was obviously so tired, that I was letting things irritate me that shouldn't have, writing stupid letters that did nothing. Probably made me feel better, temporarily, while I was writing the letter, maybe.*
>
> *Doctors can get quite irritable and quite tired. Part of our role is to manage those relationships and keep an eye on the doctor and make sure they are not getting overtired. We always have more doctors in our towns after we are asked to manage them when they have had pre-us managing them. That in itself often actually reduced the doctor's income, but it makes them happier and less tired and irritable.*[211]

And further:

> *Locums are definitely being a little bit more precious, the rates are still quite a bit higher than they were pre-COVID-19 for a locum, and the other problem we're facing is that doctors are exhausted. We are seeing in our own business the highest rates of leave amongst our doctor group that we've ever seen in 20 years. We've got more doctors taking leave as a proportion per month than we've ever had. People are feeling a bit like I've helped society navigate the crisis, now it's my time to have a rest, and they are even leaving the profession.*[212]

According to the Tasmanian Government submission:

> *Recruitment of health professionals, particularly in regional and rural areas, remains a significant challenge for Tasmania. This contributes to the unequal distribution of the health professional workforce across the state, with the north west in particular having lower*

[211] Dr Ross Lamplugh, *Transcript of Evidence*, 17 May 2022, p. 8.
[212] Dr Ross Lamplugh, *Transcript of Evidence*, 17 May 2022, p. 17.

numbers of allied health professionals, medical professionals and nurses and midwives than other areas of Tasmania. For example, in southern Tasmania there are approximately 600 allied health professionals per 100 000 people, compared to approximately 400 per 100 000 people in the north west.

While there have been significant steps taken to address this issue, recruitment and retainment of health workforce in rural and remote areas remains an ongoing challenge. There are also indications that reforms in other service sectors, such as in the introduction of the National Disability Insurance Scheme (NDIS), has had some unintended workforce distribution impacts, with movement of qualified professionals from the non-disability sector into NDIS roles. Again, these issues are more pronounced in rural and remote areas where there are existing 'thin' markets and already small workforces.

From a primary health perspective, Tasmania has seen improvements over the past six years in the number of GPs across Tasmania. As demonstrated in the Report on Government Services, Tasmania has had a 10 per cent increase since 2014 -from 95.9 FTE GPs per 100 000 Tasmanians in 2014 to 105.4 FTE GPs per 100 000 Tasmanians in 2020. Despite these improvements, the state remains below the national average, with attraction and retention in rural and remote communities an ongoing challenge. Additionally, a significant proportion of practising GPs are over the age of 60, which foreshadows an imminent worsening of workforce challenges, and must be incorporated into workforce projections and responses.

While advances in telehealth … have helped, telehealth consultations are not always appropriate, and are still constrained by the number of health practitioners available to provide services.

Recognising these longstanding challenges, the Government's long-term workforce strategy, … includes a number of proposed actions that are focused on improving health services in rural and remote communities. Additionally, the Tasmanian Government has committed to support the retention and recruitment of rural doctors in the North West by establishing a new Rural Medical Workforce Centre at the MCH. This new Centre will drive the Rural Generalist Training Pathway in Tasmania and provide a crucial local specialist workforce pipeline.

While acknowledging the impact of demographic and geographic factors, as well as known challenges for service delivery and access in rural and remote areas, providing high quality health services to Tasmanians living in these communities is a key priority of the Tasmanian Government.[213]

The ACCRM submission described the benefits of the rural generalist practice:

RGs work in a range or combination of settings including private general practice, primary health care clinics, hospitals, Aboriginal Community-Controlled Health Organisations (ACCHOs), and retrieval services. They will have an advanced skill on one of a range of areas such as obstetrics, emergency care, mental health, palliative care or anaesthetics.

Social and economic benefits of rural generalist practice include:

[213] Tasmanian Government, 2021, *Submission #72*, pp. 14-15.

- *Improving local access to procedural, emergency and other advanced skills which are most needed in rural communities including mental health, indigenous health and palliative care.*
- *Reducing health care costs for both governments and patients*
- *Reducing need for patients and their carers to travel with an associated reduction in costs and risks; social dislocation; and enabling patients to access local social and other support from their families and communities*
- *Maintaining social capital and a range of medical and other skills within the community*
- *Increasing retention of a skilled medical workforce and the associated infrastructure and support services within the communities where they are needed*
- *Reducing the risk of a spiralling loss of services which results from a declining scope of practice; reduced skill sets; and consequent loss of workforce and infrastructure.*

With the support of the Commonwealth and under the auspices of the National Rural Generalist Taskforce, an application has been submitted to the Medical Board of Australia for recognition of Rural Generalist Medicine as a specialist field within general practice. This would result in doctors with appropriate Rural Generalist qualifications being registered as such with the Australian Health Practitioner Regulation Agency within the discipline of general practice.[214]

Primary Health Tasmania further noted in its submission:

- *There is much opportunity through the current work underway in Tasmania (Health Workforce 2040) and supported by corresponding workforce planning nationally as part of Australia's Long Term Health Plan, to expand upon solutions and address better workforce integration, particularly to help solve access challenges across rural and regional communities. This involves challenging:*

  - our tendency to silo roles and service planning based on tradition or professional 'protectivism'

  - workforce models that are based on historical need and configured through the lens of episodic care, rather than focusing on current and projected integrated care need

  - traditional payment models and approaches to care, which can lead to, and in some cases reward, unnecessary escalation and referral of care to higher acuity/cost services

  - community belief that hospitals are the "safest" place to be to get high quality care.

- *Tasmania has already made moves to explore extension of some of these 'traditional' professional boundaries through the development of allied health assistant roles*

[214] Australian College of Rural and Remote Medicine, *Submission #36*, p. 2.

and work to evolve the 'rural generalist' model, and this work needs to continue with urgent strategic and policy intent.

- *Tasmania's highest profile challenge is our ability to recruit and retain a viable private/public workforce mix – particularly in rural and regional locations where the economics of contemporary health care make service sustainability even more challenging. There are opportunities to look at 'blending' a visiting and locally based workforce, with allied health assistant type roles, to support access (face to face and via digital solutions) to the health professional workforce. There would be local economic and social benefit in this type of approach.*

- *Aside from strategies to address the recruitment and retention challenges that clearly plague some regions in Tasmania, there are also opportunities for us to challenge some of the traditional boundaries and limitations that constrain our workforce from delivering to the full scope of their trained capacity and capability.*[215]

The General Practice Training Tasmania (GPTT) submission provided background regarding the General Practitioner workforce in Tasmania:

> *The Tasmanian Department of Health provides a snapshot of the 2018 GP workforce in Tasmania. The State had a headcount of 631 GPs (or 576 fulltime equivalent GPs). The trainee headcount was 143. The number of medical graduates has been increasing in recent years but more medical graduates are choosing non-GP specialties as a profession, and the growth of GP registrars has slowed.*
>
> *• Profile*
>
> *In the period, 2013-18, there was a 12% increase in the headcount of general practitioners in Tasmania. The average age of Tasmanian GPs is 54 years old and there is an almost even gender split (48% female, 52% male). Tasmania has an ageing general practice workforce. In 2018, 27% of GPs in Tasmania were over 60 years old. In 2018-19, 29% of full-time equivalent Tasmanian GPs were aged 55-64 years old, compared with 25% for the Australian total. Based on this data (and assuming that if GPs begin to retire around 65 years), the number of GPs leaving the workforce will likely exceed those in training in the medium term.*
>
> *• Distribution*
>
> *Data for 2019 shows that the Australian rate of full-time equivalent GPs per 100,000 population is 117.7 (which includes vocationally registered GPs, non-vocationally registered GPs and trainees). In Tasmania, the rate is lower at 106.0 per 100,000. The rate in Tasmanian inner regional areas is 112.2 (c.f. 114.9 for all Australian inner regional areas). The rate in Tasmanian outer regional, remote and very remote areas is 90.8 (c.f. 100.6 for all Australian outer regional, remote and very remote areas). Data on employed headcount per 100,000 shows a marked difference in distribution across the three Tasmanian health*

[215] Primary Health Tasmania, 2021, *Submission #64*, p. 13.

regions. The employed headcount rate in the South is 139.7, the North 99.3, and 96.5 in the North West.[216]

According to the AMA submission:

Simply put, we do not have enough doctors both available and with appropriate skill sets to fill the demand for rural areas. The reality is that doctors with young families and working partners are more likely to be tied to city environments.

"We cannot find a doctor to come to our surgery to work. The owner and HR have been looking for more than a year. The workload is here. Please come!" (GP West Tamar)

AMA Tasmania is aware that there is, for example, a need for one FTE doctor at the Tasman Medical Centre. Swansea urgently needs locum support and one FTE - this is especially so with a new aged care facility to be built over the next few years. Bicheno has just lost one FTE doctor and is desperately in need to recruit another. Triabunna has just had a resignation, so also needs one FTE doctor. Overall, there are four FTEs needed from Bicheno to the Tasman. This region is not alone.

Much of the state is struggling to attract General Practitioners into their communities, and the shortage of GPs is not just in rural areas. For example, the two bigger population centres in the North West of Tasmania, Devonport (postcode 7310) and Burnie (postcode 7320), have experienced GP shortages for the past few years, making it difficult for patients to access a GP for routine care. Most GP clinics around the state have "closed books", and patients must travel to find a GP. A key issue for attracting doctors to a rural area is that of income for GPs. Income in rural areas is no higher and, at times, less for rural practitioners. Only with Government and local council support are incomes more competitive.

Reliance on Medicare payments only, even with some government locum support for the rural beds, most practices in Tasmania run at a considerable loss when established GPs take holidays, or professional development study leave. ".. I came (to Tasmania sic) for my own reasons, knowing that I could find a job when I got here. I would have liked to have cloned myself into three doctors within the first three months of my being here. There is a huge mainland immigration (myself included): where are the doctors in that immigration? Hobart and Launceston, not rural. Why aren't doctors coming: (why would you move to only earn 60-65% of billings in frustrating circumstances when you can earn 70% on the mainland with a good referral base? Why move from a private billing practice, where you might privately bill 30-40% of patients, to a practice where I privately bill about 5% of patients? Why move from a good education for your children within a short bus ride to an area where a "Good education" is at least 60 mins on the bus each way or more to a better school.) I do not have the answers to the questions. I do know that I am currently happy that I made the move, but that educational factors for my children are a huge concern. I receive so much positivity from my patients, thanks, appreciation, AND the professional satisfaction of trying to do the right thing by them. However, it is not easy, and I am often frustrated and in fear for my patients for the future." (GP Northern)

Succession Planning

[216] General Practice Training Tasmania, 2021, *Submission #37*, pp. 1-2.

Without increased incentives to attract GPs into rural communities and proper succession planning being put in place within practices, access to general practice in rural areas will only worsen. A GP in the West Tamar region, a case in point, said that there are two GP Practices covering that region: one with one fulltime GP, who is approaching retirement, and the other, which is only open four days a week. Appointment spaces are always full, with a two to three-week wait for an appointment. Added to this is that it is not uncommon for GPs not to accept new patients, therefore where do they go for medical attention? They either have to travel or not receive expert medical attention.[217]

According to the Australian College and Rural and Remote Medicine (ACRRM) submission:

There is an acknowledged maldistribution of medical practitioners in Australia. The doubling of the number of Australian medical graduates has led to an oversupply of doctors in urban areas but has done little to address shortages in rural Australia. Australian trained medical graduates today are less likely to work either as general practitioners or in rural communities compared to graduates in previous decades and rural areas continue to remain substantially dependent on International Medical Graduates doctors, who comprise almost half of the general practitioner workforce in rural areas.

This maldistribution translates to fewer staff and also lack of continuity of care where communities rely on short-term, temporary or locum practitioners. Reliable and sustainable heath care is a cornerstone to community resilience and the loss of services, or loss of trust in service provision, can create a downward spiral in terms of establishing sustainable local staff and resources.[218]

With regard to staffing levels, several concerns were expressed regarding the number of GPs in various rural locations.

Dr Robert Newton, GP, locum to the practices at Triabunna, Swansea, Bicheno, St Marys and Ouse over the last 8 years, expressed concern over staffing levels at each of those GP services:

It has become clear that each of the GP services mentioned above are in need of at least one extra permanent partner. That need has become more urgent over the past year as practitioners are leaving the practices with no replacements being arranged.

Those left to maintain responsible medical services are expressing concern to me that they fear "professional burn out" and inability to be enthusiastic for the work.

A series of locum services to these rural practices is necessary at least in the initial stages of solving the problem. It is possible that some of them might find that a more permanent presence in the practices becomes attractive.

The reasons for GP's not wanting to establish themselves in rural communities are several. Any partner they may have might find living in such a community unattractive. The distance from a tertiary medical hospital might be a daunting prospect as some medical conditions need urgent, immediate attention which can be stressful when are on your own and lacking confidence.

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[217] Australian Medical Association (Tasmania), *Submission #52*, pp. 3-4.
[218] Australian College of Rural and Remote Medicine, *Submission #36*, p. 2.

Life in urban practices has the attraction of time off, other practitioners the share the work load, as well the social outlets available. [219]

Community members David and Sally Wimbridge, in their submission, expressed concern regarding the number of full time GPs in the Huon Valley, the need for an ambulance station in Cygnet, dentist and mental health clinic.[220]

Community member Jennifer Hadaway, Dover raised concern:

We only have three doctors, but that won't last; we usually have two. We don't have capacity for just ordinary, everyday GP contact. We also don't have capacity for allied health. We don't have any support at all in Dover for mental health, and a lot of these people will arrive with those sorts of problems…. I would like to see - and I have talked about this to a number of other people - the equivalent of a health hub in Dover. I would like to see an expansion of the general practice to at least three GPs. We have two at the moment, who share a week's work. They are available between 9 and 5. Both of them will go out of their way and have done, and will visit, if there is an emergency in the community that they can alleviate and not send to Hobart. I know that happens.

The big problem I suppose is that anything that does occur, especially after hours in the evening, creates enormous difficulty in terms of transport. Once it gets dark it's nearly impossible. The locals themselves hate driving that road. They would prefer not to go. For that very reason again we end up with some people who are critically ill who just don't get to hospital.

I would like to see that hub contain practice nurses as well as the GPs. I would like to see at least visiting ancillary services, for example, hearing, vision, podiatry, possibly physiotherapy - all of which used to be there, when we first moved to Dover. They are no longer there.[221]

Community member, the late Bill Dermody (retired nurse), in his submission, raised concerns on behalf of residents in the Derwent Valley/Central Highlands communities:

That people are waiting up to at least 2 weeks to see a GP in the Derwent Valley. This became an even greater issue with the retirement of our two most wonderful GP's in Dr Peters and Dr Sweet which meant that, the only medical services in the Derwent Valley was at the Derwent Valley Medical Centre and increased their numbers to over 10,000 residents, that many residents are still attempting to get on their books and many had to travel as fare (sic) as Brighton, Kingston and Sorrel (sic) to find a GP. One of the major reasons for this is the Medical Centre, which is located in New Norfolk, is the only one providing services to the whole of the Derwent Valley community and to some from the Central Highlands community as their only GP practice is in Ouse and it is therefore closer to travel to New Norfolk. There are no After Hours Medical/Health services in the Derwent Valley/Central Highlands communities and for those who are unable to see a GP for weeks in New Norfolk, therefore have no alternative but to present at the RHH Emergency Department or call out an Ambulance. The major reason for this is how New Norfolk is scheduled under Medicare as

[219] Dr Robert Newton, *Submission #4*, p. 1.
[220] David and Sally Wimbridge, 2021, *Submission #8*, p. 8.
[221] Jennifer Hadaway, *Transcript of Evidence*, 7 October 2021, p.52.

MMM2, which is the same as Sandy Bay and Hobart as it is deemed to be a suburb of Hobart, not the hub of the Derwent Valley. [222]

Central Highlands Councillor Anita Campbell expressed concern about general practices in the region:

> *We have two general practices - and it doesn't all revolve around general practice - but at the end of the day that is pretty much all we have in the Central Highlands. In Bothwell we only have a GP two days of the week. So that access, it might not even be physically getting someone to go down there, but if you knew you could ring up and get into a doctor Monday to Friday - and I know we don't all get sick just Monday to Friday - but that access, you sometimes have to wait three weeks to get in to a doctor at Bothwell.* [223]
>
> *…*
>
> *It is a combination of travel, mobile technology, telecommunications. In an ideal world if we could have guaranteed basic medical coverage on regular days, when you know that you can, even if you can't be there Monday through to Friday, if you know it is going to be spread out over Monday, Wednesday, Friday, that even makes a difference.*[224]

In her written submission Councillor Campbell stated:

> *Without support from the State Government and ongoing support from the Central Highlands Council, GP services in this area* [Central Highlands municipality] *would most likely cease to exist. We would like to continue to guarantee our residents security in this area, even though it is usually not the responsibility of local government. We look forward to working with State Government representatives to ensure the continuity of medical services.*
>
> *On the days when the practices are not open, the pressure on other health services is increased, including the Midlands Multipurpose Centre at Oatlands as well as centres at New Norfolk, Brighton and of course the RHH.*[225]

Since receiving this evidence, the Sub-Committee notes the Ouse Medical Centre has now closed.

Community member Diana Wilson expressed concern regarding services in North East Tasmania:

> *Health outcomes in North East Tasmania, [Dorset] are challenging due to several factors, including 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 walk-in facility in Scottsdale and Bridport; earlier, in Derby; now GP services are solely provided by Ochre Health; who have been overwhelmed by the 3000+/– patients who have been left without an immediate alternative and reliable GP service. Ochre already had a poor reputation for high turnover of locum GPs; plus long waiting times for appointments; all of which results in absence of opportunity to establish continuity of care; additionally lack of sufficient number of consultation rooms impacts on their service provision.*

[222] Bill Dermody, 2021, *Submission #9*, p. 1.
[223] Anita Campbell, *Transcript of Evidence*, 2 November 2021, p. 3.
[224] Anita Campbell, *Transcript of Evidence*, 2 November 2021, p. 4.
[225] Central Highlands Council, 2021, *Submission #23*, p. 1.

…

The use of locums manifests as a lack of continuity of GP[s] and this cannot and does not provide continuity of care. [226]

Former Brighton Councillor Sonya Williams expressed a view that Brighton needs an integrated Medical Centre to meet the demands of the growing population, help overcome existing problems with service provision and could offer integrated primary health care including x-ray and scan facilities.[227]

Strahan resident Dennis Smith expressed concern regarding the lack of a regular doctor in Strahan:

Only locums are available and then only 3 days per week. I am 71 years old and although in general good health in (sic) is worrying that I have to wait sometimes for days in order to see a doctor, and then to find I need to explain my situation "yet again" to someone new.[228]

Hon Tania Rattray MLC, in her submission detailed a number of concerns held by her constituents with regard to North Eastern Soldiers Memorial Hospital (NESMH):

- *No admittance to the hospital for persons under the age of 18 years – this is a significant negative impact on a rural community when local ambulance services are intermittent and also the recovery process for a child being long distances away from family is of concern.*
- *Physio services are only provided once a week and this nowhere near adequately meets the needs of the community.*
- *Increasing demand for A&E services due to the significant increase in visitors to the area who ride mountain bikes, which cause multiple injuries and are requiring the services of both road & air ambulance, along with accident and emergency admissions (both at Scottsdale & St Helens). The staffing at the NESM Hospital appears to be so paired (sic) back that there will be a lack of confidence in the community around the ability to meet rural health needs.*
- *Regarding the dedicated ambulance service located at Scottsdale time and time again I am reliably informed that there is often wait times of over an hour for an ambulance to attend a call out due to no ambulance available (required at Derby Mountain Bike Trails) with a backup ambulance having to come either from Georgetown or the Launceston station. I am aware of a situation where a person living in the town centre of Scottsdale waited 3 hours for an ambulance in the early hours of the morning due to required rostering of break times for the ambulance staff, I am sure you can imagine the stress that this situation caused to the person requiring the ambulance services and their family waiting for these services to arrive.*

Another constant issue that is raised by the community is the lack of access to GPs and other

[226] Diana Wilson, 2021, *Submission #11*, p. 2.
[227] Sonya Williams, 2021, *Submission #12,* p. 1.
[228] Dennis Smith, 2021, *Submission #6*, p. 1.

health professionals including mental health services. Both Scottsdale and St Helens have OCHRE practices and the not only the churn of GP locums causes anxiety amongst the community, but also the wait times to see a GP can be anywhere from days to weeks.[229]

Peter Barns, CEO HR+, in his submission highlighted the need for systematic workforce succession planning for all rural health facilities:

While finding a new medical services provider is the responsibility of the Department of Health, HR+ has been involved with all transitions over the last 20 years. It is rare for the transition to be planned and organised. Transitions have occurred at: King Island, Flinders Island, Smithton, Queenstown/Roseberry (sic)/Zeehan/Strahan, Deloraine, Scottsdale, St Helens, St Marys, Bicheno, Swansea, Nubeena, Dover/Geeveston, Bruny Island, New Norfolk and Campbell Town.

Our involvement has been as simple as introducing the previous providers to interested parties and as complex as providing and managing the medical services on King Island for the State Government while the two-year tender process was completed. New, permanent providers (as opposed to long-term and never-ending locums) have been found in each case, with a mixture of private, corporate and community models in the mix.

This success is unique in Australia, as our contemporaries in other jurisdictions have acknowledged. The outcomes are sometimes the result of hard work, sometimes of being in the right place at the right time and sometimes just down to being incredibly lucky. We know, however, that eventually we and the Department may not be able to find an alternative provider for a particular transition.

We are unaware of any plans within Government to deal with that scenario, and we believe it would be prudent to have both succession and contingency plans documented for each site. While we are happy to be responsive, agile and flexible in the way we work with both the Department and the community, we acknowledge there is a limit to what we can achieve.

In light of the above, we would recommend that all rural health facilities develop medical workforce succession plans and contingency plans for a transition failure. We appreciate that not all current medical services providers would want to participate in designing their own exit, but likely-scenario plans can be created where that is the case.

HR+ is committed to working with the Department to find sustainable solutions for each community. While it can be very exciting to find a solution out of nowhere, we believe it may be more prudent to know what to expect and plan for it.[230]

Luke Sartor, Policy and Research Officer, National Rural Health Alliance (NRHA) made the following comments:

Tasmania has the highest rate of medical practitioners in the country who are determining to finish within less than 10 years. Almost a quarter of the workforce is in that situation. That is their intention.

It shows that need for succession planning, for considering the future. It looks as though Health Workforce 2040 - the Tasmanian Health Service's longer-term strategy in terms of

[229] Hon Tania Rattray MLC obo constituents (residents of Dorset), 2021, *Submission #7,* p. 1.
[230] HR Plus, 2021, *Submission #32*, pp. 1-2.

the health workforce - does recognise the staffing challenges and where there are shortages, particularly certain health professionals, allied health professionals and nursing sub-specialties.[231]

The NRHA submission makes a number of relevant recommendations:

- *Increase the investment in health infrastructure and workforce capacity in rural areas to broaden the scope of the primary health care system for patients. This includes developing professional capacity to utilise telehealth, potentially through the Tasmanian Department of Health's TAZREACH office.*
- *Utilise existing local infrastructure in outer regional and remote Tasmania to provide a range of primary health care services, with additional capacity for a limited range of acute care services when required.*
- *Provide more training pathways for specialists and paramedics to encourage a locally grown pool of acute care workers and specialists across Tasmania.*
- *Work closely with the Commonwealth on pathways for rural generalism within the state, including the locations of rural generalist coordination units, and approaches to support more allied health rural generalists.* [232]

According to Occupational Therapy Australia (OTA):

> *The public occupational therapy workforce full time equivalent (FTE) is insufficient to meet community need and is insufficient to support the health system. This is regrettable, as improved access to timely occupational therapy can reduce overall healthcare spending. Furthermore, subsequent challenges in recruiting to occupational therapy vacancies in the Tasmanian Health System were seen as an opportunity to reduce FTE in the 2019 Affordable Budget Establishment (ABE).*
>
> *As an example, occupational therapy services in the North face a 29 percent reduction in FTE. While staff movement towards private/NDIS practice has impacted on recruitment and retention, it is not deemed to be the key driver. The driver is the dissatisfaction that occupational therapists in the public sector are experiencing as a result of constricted scope of practice. The constricted scope of practice reflects insufficient FTE, throughput expectations and a focus on acute services.*[233]

According to the Occupational Therapy THS submission:

> *There are inadequate numbers of occupational therapists in Tasmania compared with the rest of Australia… Tasmania's Occupational Therapy headcount of professionals is 52.8 per 100,000. This is significantly lower than the national average of 73.8 per 100,000.*
>
> *… The impact of insufficient funding includes:*
>
> - *People of Tasmania have limited access to occupational therapy services*
> - *Reduced scope of practice*
> - *Services are often focused at the high point of acute care, rather than early intervention.*

[231] Luke Sartor, NRHA, *Transcript of Evidence*, 20 August 2021, p. 3.
[232] ACRRM, 2021, *Submission #36*, pp. 13-14.
[233] Occupational Therapy Australia, 2021, *Submission #57*, p. 7.

There is a focus on acute care and hospital beds. Whilst this work is important, we recommend an investment of additional resources to realign service delivery to enable: - more care in the local community, in particular the home - earlier intervention, in particular with instrumental ADLs [Activities of Daily Living] *as the precursor to functional decline - time invested early to enable people to change their health behaviours rather than focus on the consequences of poor health behaviours.*[234]

Representatives from the University of Tasmania made the following comments regarding the allied health workforce:

***Prof BYRNE** - Allied health is a broad mix of professions. Pharmacy is at times identified. Glenn Jacobson can talk to pharmacy, and Lisa Foa can talk to psychology, but the Rural Health Multidisciplinary Training (RHMT) program doesn't mean it's just our students. It means that we're also supporting students from the mainland. In allied health to this point in time, thinking of courses like physiotherapy, speech pathology, occupational therapy, through the RHMT we support students coming to do placement in rural places from other universities; but over the next couple of years we will be offering those courses. Physiotherapy and speech pathology will be commencing this year and occupational therapy next year; clinical exercise physiology next year; and then potentially courses like dietetics into the future.*

We have quite a strong plan in place, supporting place-based education, supporting our students in a whole variety of locations. We see one of the great advantages of Tasmania's rural multi-disciplinary training is to support students from those regions, to undertake their training right across the state.

***CHAIR** - All those physios, OTs, speech therapy, will they be provided in three campuses?*

***Prof BYRNE** - That's right. We'll have across-the-state support. The real opportunity that we have is that we're building these courses as a suite to be built at the same time. It means we're getting that inter-disciplinary learning in place. That across-the-state is really important for us. We want these courses to have a real Tasmanian DNA. We're working very closely with our practitioner partners to build really authentic experiences for the students. It's quite a flexible program that we're building. It is at the masters level, which also then gives us the opportunity to support students from an undergraduate pathway, which means they don't necessarily always need to make that decision early, as to exactly what allied health career they might want to take. That really gives us the opportunity through our bachelor courses right across the university, to give students experiences through a work-integrated learning approach, where the students can experience what it might be like to be in one of these allied health careers. Then they can make that choice as they transition through their bachelor degree. …*

***Prof FOA** - I'm Lisa Foa, I'm from psychology, Head of School, Psychology. Psychology at the university has been very Hobart-centric for a long time and turning out very small numbers of students. We've worked over the last 18 months to two years to revamp that program and move training for that profession. If you want to be a psychologist, it's a masters-based program. They've always been in Sandy Bay. We have a generalist professional psychology*

[234] Occupational Therapy (THS), 2021, *Submission #58*, p. 5.

pathway in the clinical pathway and each of those courses typically took in about 10 students. Very small numbers, very Hobart-centric.

This year we've taken 20 students into each of those courses and for the first time 11 of them are up in Launceston. The plan is that we will now have course work available at Launceston, for the first time, and they can do placements anywhere on the coast, or Queenstown, Swansea, wherever. We're reaching out to practices all around to try to get that breadth of rural exposure. Unlike physio and so on, if you want to be a psychologist you have to do an undergraduate degree that has specified psychology units in it and again that's only been available in Hobart and Launceston. We're now opening that up at Burnie as well.

We had first year students last year and this year second year students at Burnie. Next year we'll have third year and then honours, so we'll have the full pathway available for the undergraduate honours year, in Burnie, as of 2024. As I said, we've started the post-graduate training in Launceston to broaden the coverage of psychology students across the state. We're rapidly expanding and growing our program.

…

***Prof FOA** - …*

If you want to be a clinical psychologist you have to do two years at that master's level and then two years of intern and then you are a clinical psychologist. It's quite a long program and so we recognise we need that place-based education. We desperately need more psychology workforce in the regions and so that's why we have now the undergraduate program at Burnie and we have begun the expansion out of Hobart. We have started in Launceston and the aim is to broaden that out to other satellite areas around the state as well, including Burnie.[235]

And further:

***CHAIR** - Does anyone like yourself or others involved have meetings with the Minister for Health to discuss the needs of our health services …*

***Prof. FASSET** - We do have discussions at all levels and also where we, our vice chancellor and our provost are also involved. When you look across the table, you can see that we are a large college. There are a number of disciplines. We have a number of portfolios. We straddle accreditation requirements, as you would be aware, but also, I think that there is a point in time here when our strategy, which is absolutely committed to improving the health of Tasmanians, is flexible enough, for us to be able to partner where there is that need.*

Questions about what we might do. For many years we discussed allied health, people would often talk to us about how great it would be. Physiotherapy was always discussed, but what it actually takes is a really transformative partnership. That is what Nuala has been leading to get this allied health program off the ground. It is the commitment of our partners. Lots of things are possible, but for us to see that in the vision of the services and the workforce requirements that this state has also means that we need to vision the model of care.

[235] Professor Byrne and Professor Foa, *Transcript of Evidence*, 17 February 2022, pp. 42-3.

Sometimes, when I listen to practitioners talking about extending their scope, I need to situate that in - but in what service and what is that model of care? What else do we need to be changing and working together so that we are not continually talking about if there was a career pathway? …

***CHAIR** -… I know UTAS's job is not to drive legislative change but to meet the needs of our community but I think we need to have a broad discussion about how that could look. If there is not a career pathway is there a place for it and how do we create it? I don't know if anyone wants to add further to that.*

***Prof. BEREZNICKI -** You are right. It needs to happen in partnership. We know from our experience that if we go out on a limb by ourselves with a postgraduate program because we think that this particular aspect of care might be really useful but there are no employment outcomes, it doesn't work.*[236]

Professor Lawler and Premier Rockliff made the following comments in relation to allied health:

***Prof LAWLER** - …It is important to note that all of the other issues that are being discussed are not waiting for the chief paramedic officer to be developed. This is a role that could potentially add value to discussions. Obviously we need to be clear around the interface, overlap and interactions between a chief paramedic officer and the Ambulance Tasmania structure itself.*

…

We have worked in discussions with that jurisdiction in understanding how that position adds value. There are opportunities to provide the same kind of chief clinical leadership in paramedicine to complement the leadership within Ambulance Tasmania, similar and parallel to chief medical officer, chief medicine provider, chief allied health adviser - those roles that provide key advice that is potentially independent of the service delivery arm, but works closely with the service delivery arm on opportunities to improve governance and to improve service delivery.

…

***Mr ROCKLIFF** - We have made some inroads in terms of allied health and UTAS in recent times … which has been very positive, as I understand it. I take your points on board. I can assure you we are not going to be looking at 2040 and saying we will have that then. This is about scoping what we need now and into the future in terms of demand on services.*237

Fiona O'Keeffe, Divisional Chair, Occupational Therapy Australia:

Regrettably, at present there is a significant under-investment in OT services in rural Tasmania. According to all of the OT chiefs, there is certainly a shortfall in actual numbers, even when the positions are all filled.

Enhancing health outcomes and health delivery systems also requires greater recognition and support for quality-based education and training for the allied health professions. We

[236] Professor Fassett, *Transcript of Evidence*, 17 February 2022, pp. 50-1.
[237] Professor Lawler, Premier Rockliff and Kathrine Morgan-Wicks, *Transcript of Evidence*, 30 November 2021, pp. 20-2.

welcome the postgraduate training planned by UTAS in the next few years, and we have been heavily involved in that.

While education and training are important elements of any workforce plan, it is important to understand there are other significant factors influencing recruitment. Particularly, these include - and this is information I have heard from members with my own ears - scope of practice, housing shortages, visa and sponsorship assistance. Comparable remuneration is a big issue, working conditions, relocation support and other recruitment incentives. These incentives could be particularly valuable in rural Tasmania's health system.

One of our big concerns is that when staffing levels become critically low, as they are now, therapists can only respond to crises, and their ability to work effectively using their full skill set just can't happen. This leads to low job satisfaction, and people exit the public health system to go into private practice, which is much more satisfying because you can control what you do.[238]

The Committee explored incentives or other schemes that could be used to attract a skilled workforce.

Peter Barns, CEO HR+:

Income potential? That kind-of works the other way. Locums will ring us up and say, 'I'm interested in doing a locum at St Helens and I want $2500 a day'. We say, 'That's sweet, but we can give $1900 a day'. 'But I earn $2000 on the mainland'. I'll say, 'Feel free to find St Helens on a map on the side of New South Wales because that's what you can do'. If people want to come here then the income difference doesn't make a great deal of difference.[239]

Dr Rosemary Ramsay, ANZSPM:

I think it's a matter of selling the region and selling the lifestyle for the whole family, the spouse and the doctor. It's also giving them something very special to do here. The option of research and education within the Rural Clinical School could be something that attracts them.[240]

The Committee was provided evidence regarding the Rural Generalist Model.

According to ACRRM:

Rural Generalism and the National Rural Generalist Pathway

The Rural Generalist (RG) is a medical practitioner who is trained to meet the specific current and future health care needs of Australian rural and remote communities in a sustainable and cost-effective way, by providing both comprehensive general practice and emergency care and required components of other medical specialist care in hospital and community settings as part of a rural healthcare team.

RGs work in a range or combination of settings including private general practice, primary health care clinics, hospitals, Aboriginal Community-Controlled Health Organisations

[238] Fiona O'Keeffe, *Transcript of Evidence*, 3 November 2021, p. 2.
[239] Peter Barns, *Transcript of Evidence*, 2 November 2021, p. 29.
[240] Rosemary Ramsay, *Transcript of Evidence*, 2 November 2021, p. 57.

(ACCHOs), and retrieval services. They will have an advanced skill on one of a range of areas such as obstetrics, emergency care, mental health, palliative care or anaesthetics.

Social and economic benefits of rural generalist practice include:

- *Improving local access to procedural, emergency and other advanced skills which are most needed in rural communities including mental health, indigenous health and palliative care.*
- *Reducing health care costs for both governments and patients*
- *Reducing need for patients and their carers to travel with an associated reduction in costs and risks; social dislocation; and enabling patients to access local social and other support from their families and communities*
- *Maintaining social capital and a range of medical and other skills within the community*
- *Increasing retention of a skilled medical workforce and the associated infrastructure and support services within the communities where they are needed*
- *Reducing the risk of a spiralling loss of services which results from a declining scope of practice; reduced skill sets; and consequent loss of workforce and infrastructure.*

With the support of the Commonwealth and under the auspices of the National Rural Generalist Taskforce, an application has been submitted to the Medical Board of Australia for recognition of Rural Generalist Medicine as a specialist field within general practice. This would result in doctors with appropriate Rural Generalist qualifications being registered as such with the Australian Health Practitioner Regulation Agency within the discipline of general practice.

With its key components of a supported training pathway and increased national recognition for the Rural Generalist model of practice, the NRGP has the potential to make a significant contribution to the sustainability of the rural and remote medical workforce; minimise the reliability on locum services; and increase and the range of services which can be delivered safely and effectively in rural and remote areas.

ACRRM is a longstanding champion of Rural Generalism in the state/territory, national and international arenas and College Fellows are trained to the scope of RG practice. The College is strongly committed to building a national rural and remote workforce with a Rural Generalist skill set, in the belief that provision of a national network of Rural Generalists will significantly contribute to providing rural and remote communities with sustainable, high-quality health services.

ACRRM Fellowship is single best predictor of a long-term rural medical practitioner outcome. In turn, there is a positive correlation between rurally-based training and exposure to rural practice, and enrolment in the College Fellowship program. Increased numbers of FACRRMs make a significant and long-term contribution to the rural medical workforce, given that College Fellows are trained to a Rural Generalist skill set to practise safely and confidently in rural areas.

Workforce Planning and Policy

When properly funded and intelligently designed using rural-centric models rather than urban based planning, rural health services provide excellent health care which meets

community need and a substantial longer-term Return on Investment. This is particularly the case with the Rural Generalist model of practice.

Planning and policy should be designed with the ultimate goal of providing each community with a high-quality, locally-based system of medical services supported by a sustainable number of in situ medical practitioners and a strong health care team.

Unfortunately, where services are over-stretched, they can be made scapegoats for a system that is not necessarily fit-for-purpose. There is also a tendency for services to be closed or downgraded where there are concerns about quality and safety, rather than prioritising the retention of the service and proactively working to improve capacity. Both scenarios reduce access and undermine community and practitioner confidence, making more difficult to attract and support a skilled and sustainable health workforce.

Implementing Rural Generalism in Tasmania

ACRRM strongly commends the Rural Generalist model as providing a rural-centric model which can meet the health care needs of communities in Tasmania, improving access to health care services and minimising the need for people to travel to larger centres for treatment. This is particularly important given that roads can become impassable in winter, making travel difficult, and socio-economic factors which mean that many people may not be able to afford the cost of travel and accommodation away from home.

The College notes the Rural Generalist training initiatives that are already under way within the state and recommends that training initially focusses on the Mersey hospital as a training hub. This would provide much-needed procedural services in this section of the state and serve as a springboard for the rollout of services to other areas and facilities.[241]

Rural Doctors Association of Tasmania (RDAT) supports the rural generalist model:

The Rural Generalist Training Pathway needs to be adequately invested in to ensure Tasmania is producing rural generalists for the future care of Tasmanian Rural Communities. Investment in Rural Generalist Allied Health Professionals to ensure allied health provision of care to rural communities should also be carried out in Tasmania.

The University of Tasmania Rural Clinical School has been graduating new doctors since 2007. Very few have returned to continue a career in the north west (or indeed in rural Tasmania generally). RDAT would welcome a review of the University of Tasmania's medical student intake policies and consider other strategies that may make the University of Tasmania more "fit for purpose" in addressing the medical workforce needs of rural Tasmania.[242]

Professor Tim Strong and Associate Professor Lizzi Shires, UTAS made the following comments regarding rural generalism:

***Dr STRONG** - … In thinking about some of the impediments beyond the underpinnings of a scope of practice, there are also the health service models that we have got. You've talked about registration, the Poisons Act that underlies prescribing rights. There is also the whole legislative issue of Medicare item numbers and the funding in practices. So, one of the issues*

[241] Australian College or Rural and Remote Medicine, 2021, *Submission #36*, pp. 2-3.
[242] Rural Doctors Association of Tasmania, 2021, *Submission #30*, pp. 9-10.

with practitioners is not that they wouldn't necessarily be welcome in practice settings; the additional skills and the workforce and the support I think is almost always going to be very welcome. A practitioner, a person, a body in the bush is incredibly valuable. But for practices in our setting, which are essentially run as small businesses, to sustain the engagement of practitioners does require some business thinking. With a very limited set of item numbers particularly for nurse practitioners, there isn't the financial sustainability for practitioners to run without additional support, which then becomes state government support because the federal government support is run through the item numbers which are constrained.

Those are some of the impediments. Others are around credentialing. …But the development of that professional pathway from training opportunities through governance and oversight right through to employment is very nascent, it's young.

I guess questions around bolstering general practice in particular communities are inevitable. In a community that has lost a general practitioner, the question would have to be do we replace that service and the depth of the service? Can we replace it through a practitioner model? I think there would be no doubt there can be enormous value in the presence of a skilled and trained practitioner; but whether we are talking about the same thing, in terms of a community need, I think is a more difficult question.

***CHAIR** - But it would open up pathways if that was a more common practice; not just to lose your GP, for example, but to find that the demand has grown in that area, the population has increased or whatever.*

***Dr STRONG** - And there's a collaborative model of different skills I think would be optimal ...*

***Dr SHIRES** - … I think we train our doctors, our medical students, to work in teams, but essentially a general practice is actually a private business and therefore there's no mechanism to employ those people.*

***CHAIR** - No, it is up to the individual practice.*

***Dr SHIRES** - Not just the practice … we have practice nurses and different people who work with us, but you have to look for funding opportunities to get them. At various times we've had people with extended scope of practice coming in and working with us, but then that funding goes and then we haven't got our extended skills nurses, or psychologists, or whatever. It is thinking about how we pay for primary care services differently. That's probably the most important thing around that whole scope.*

…

***Prof SHIRES** - Different countries do things in different ways, and certainly there are different models even within Australia around rural practice. Like Denis* [Dr Denis Lennox] *was saying, up in Queensland where you've got much more state investment in rural areas, or you've got your Aboriginal corporations that can also employ people as well as their doctors and they have quite diverse sets of skills. There are different models even within this country and then there are different models outside this country around how you employ people rurally, but I think essentially that is quite an important aspect of the things. It's*

probably beyond UTAS, but if you're looking at career pathways and opportunities for people they need to have jobs to go to.[243]

The RDAT submission continued:

> *Ensuring the Mersey Community Hospital successfully transitions to a Rural Generalist model will be critical in ensuring staffing and continuity of care in the North West. This requires a well-resourced Tasmanian Rural Generalist Training Pathway, using the Mersey Community Hospital as a training hub. This would then supply Rural Generalists to other District Hospitals around the state. For adequate RG training and sustainable RG practice, this would require the Mersey Community Hospital to work towards providing a range of medical services including RG/midwife maternity services, RG anaesthetic services, RG surgical/endoscopy services, RG adult internal medicine services, RG led palliative care services, RG paediatric services, RG rehabilitation services, RG mental health services and RG led emergency medicine services. The training required should be developed not in isolation, but in conjunction with the NWRH and LGH.*
>
> *To undertake Rural Generalist Training in Tasmania there needs to be specifically designated jobs for doctors in certain prevocational rotations (emergency, paediatrics, obstetrics & gynaecology and anaesthetics). There then needs to be adequate training places for Advanced Skills Training; this can be in many areas including emergency, anaesthetics, obstetrics & gynaecology, palliative care, mental health, adult internal medicine and retrieval medicine. Once a Rural Generalist has qualified there still needs to be the ability to maintain skills by rotating back through bigger centres for intensive periods of upskilling.*
>
> *Maintaining continued connections with specialists at the North West Regional Hospital would ensure excellent standard of care, good support for the model of care at the Mersey and ensure consultants at the North West are working at the top of their scope of care. This should assist in staffing both facilities as well as assisting in staffing of district hospitals in the state.*
>
> *The work to achieve this also require a good industrial agreement in which these staff are employed with adequate incentive to work in Tasmania.*[244]

Dr Gabrielle O'Kane, CEO, National Rural Health Alliance (NRHA):

> *Well, rural generalism started in Queensland. It was a state government initiative to get the rural generalist pathway for medicos up and running. With rural generalism, there's an opportunity for GPs to have two sub-specialties. That's what a lot of that work is all about. I can see that in Queensland it seems to be working quite well. We're very supportive of that and the National Rural Health Commissioner, Ruth Stewart, is very supportive of the rural generalist pathway because it enables people to get the necessary experience and training to cover all the generalist things that people working in rural areas need to be able to undertake. Regarding the allied health generalist pathway, there is a component of academic work that's linked to people's day-to-day work. It is trying to build their capability, and their ability to work in a generalist fashion, but it is also about having mentoring arrangements with more senior allied health professionals in their rural areas. All of these*

[243] Professor Strong and Professor Shires, *Transcript of Evidence*, 17 February 2022, pp. 52-3.
[244] Rural Doctors Association of Tasmania, 2021, *Submission #30*, pp. 9-10.

things are really designed for peer support, and there is real benefit in doing that. I think it has some real strengths, particularly for retention of people into rural areas.

For nursing, the medical workforce and allied health, people need to be professionally supported, no matter where they work - and in rural places that can be very isolating. So, these are the strengths of the generalist pathway. It supports people to get a better understanding of what it means to work in rural areas, certainly giving the doctors scope in those two different subspecialties. It makes a huge difference to those rural communities to have someone who may have obs and gynae, or may be an anaesthetist, as part of that rural generalist pathway.

Because it started earlier in Queensland, I think that is where it is strongest at the moment, but these things have been rolled out in other parts of the country, and I can see some real applications of it being useful in Tasmania as well.

…

… It is interesting how the set-up in Queensland is quite different to the set-up in New South Wales. It has been an interesting observation. The way some of it has been explained to me, in Queensland the rural generalist is employed by the state government, and they do both hospital services in a small rural hospital, as well as GP services. … In my understanding, that is working quite well; I think it is still undergoing evaluation.

From what I understand, in Queensland there tends to be more of an emphasis on working within the hospital and doing some GP work. In New South Wales, … the GP works generally tends to work in their GP practice, but then has VMO rights within the small rural hospital. It tends to work in a slightly different way in those kinds of environments. It could even be different in other parts of the country as well.[245]

Dr Dennis Pashen, General Practitioner, West Coast:

It has been interesting that the rural generalist model that we developed in Queensland as a way of reversing the skills decline in rural and remote health has been now adopted by both nursing interstate and also allied health. A number of allied health people are now talking about generalism in allied health. Rural allied health people are perceiving that specialisation in their allied health field is an inhibitor to rural services: to call it specialisation and sub-specialisation is the enemy of rural health services. The more people who flowed into those areas, the less available they are to rural communities.

We have significant improvement in communities that have adopted the rural generalist model for their facilities. We have a broader range of services provided by the rural generalist. We have a better cost effectiveness from the rural generalist. For example in medicine, if you have someone who is anaesthetically trained, they will do an anaesthetic, they will do an anaesthetic clinic and they can anaesthetise for the surgeon. And the time when they are not doing that, they will be working and taking their anaesthetic skills into the emergency department or into the ICU or special care wards within the hospital. You are not only increasing the services, you are maximising the availability of those skills within your hospitals without paying additional funds. In Kingaroy, Atherton, and the twenty odd rural hospitals that are now rural general hospitals in Queensland have been seen to be

[245] Dr Gabrielle O'Kane, *Transcript of Evidence*, 20 August 2021, pp. 7-8.

running more efficiently and more effectively. The health dollar goes further within those environments.

It also applies, for example, to our remote area nurses. When you bring them into the hospitals, they are effective in the wards. If they have midwifery, they can work in midwifery; they can work in the wards; they can work in the emergency department and bring those core basic skills, plus their community knowledge into that environment. It makes the flow-through of hospitals much more efficient and effective.

***CHAIR -** … how do you make it easier for that pathway to be taken by people to a more generalist approach and the rural generalist doctor or nurse?*

***Dr PASHEN-** The thing that turned the corner for rural generalism in Queensland was the development of the legislative and industrial framework around the model. Dr Denis Lennox, who was the medical advisor to the rural medical section within Queensland Health, was aware of a paper that had been written a number of years before about the career structure for rural medical superintendents who were often what are now the rural generalists before that concept was developed. He develops with the help of the industrial people within Queensland Health that framework and that was also facilitated through the legislation so these people had a structure. They had an educational framework provided for them that was remunerated and was enhanced within the legislative framework of Queensland Health. It came into credentialing within the areas and role delineation of the hospitals. This was essentially the turning point which made it work.*[246]

And further Dr Pashen noted:

… in Tasmania it's not massively expensive. You've now got a Commonwealth funded hub in Burnie that does all the student and rural generalist training; that's already funded. You need positions to be funded; training positions in anaesthetics, emergency medicine and obstetrics are the three major ones. You need other programs like palliative care, pain management, and other advanced skills placements to be funded within the system. A lot of these already exist and the additional funding is not the issue.

The problem in Tasmania with a lot of these things is that people get to that stage of getting their advanced skills, and there is no end point for them. They can't, for example, stay as the senior rural generalist within the hospital, and do rural generalist work within, say, north-west or Launceston, or Royal Hobart, without treading on some subspecialist's toes. Certainly, the opportunity to turn Mersey and Burnie into rural generalist hospitals was there.[247]

Dr Denis Lennox described the experience of establishing the rural generalist system at Longreach, QLD:

***DR LENNOX -** …So, then we established a pathway of training and what became evident in this process was up until that point, a few Australian graduates who were tracking to rural practice found their own way there. They developed their own pathways, if you like, to obtain that outcome. We recognised that we needed to establish a pathway that made a very clear, supported, tracked, highway in effect, to practise as rural generalists in*

[246] Dr Dennis Pashen, *Transcript of Evidence*, 17 February 2022, pp. 25-6.
[247] Dr Dennis Pashen, *Transcript of Evidence*, 17 February 2022, p. 30.

Queensland. Career navigation was crucial and we began that process at medical school, becoming enrolled with medical skills to develop the interest of medical students.

James Cook University probably rose to the occasion on this more than any of the universities in Queensland, but Griffith University picked it up subsequently as well, and it makes enormous sense that we are active in recruiting a potential rural generalist workforce at medical school level. So, the interest and passion are developed at that level and medical schools provide the opportunity for the students to begin experiencing exposure and training in those rural generalist contexts.

The career navigation process continued on. Rather than just allowing the medical students and graduates just to stumble along on their own way, we provided each of them who committed to this pathway with colleagues who would oversee and guide them up, it was a one-to-one engagement. We had a number of support medical staff, career advisers and mentors that each of the trainees from medical school was attached to, who followed them right through with the development of their career. Because, of course, these are the years in which they are navigating significant other challenges which might impede or help them towards the end goal of winding up in rural practice. Partnering, children, children with health issues which turned out to be a very common problem - we discovered that when we actively managed that situation, some people who were passionate about finding themselves in rural practice, who seemed to be encountering absolute opposite things to that pathway, we managed to get there anyway.

One classic example. I remember a young lady with enormous passion to do this whose husband was a policeman, found she was headed off at the pass because her husband contracted cancer. This required him for a period to be in a larger centre for accessing radiological and other cancer treatments. So, we modified the pathway for this lady, and we stayed with her on the course of her husband's treatment and recovery from cancer. The pathway was purposely designed for her around her family circumstances. In that period of time, I think three children arrived as well. So, there were delays to her progress. Eventually, she completed, he recovered, and she went on to a flourishing career in Kingaroy. In fact, she became a leader in rural generalist services in that context. Building general practice, et cetera. So, career navigation is crucial.

The second part of it is that we have promised to the graduates that they will get further, faster. We copped some criticism for this, that we had developed an elite pathway. Within the medical profession, within student ranks, there was concern that why should rural generalists get favour out of the others? We said, 'well, you might see it that way, but my perspective is that we are giving rural communities particular consideration, because they have long suffered due to the lack of doctors. They have long suffered by the medical pathway not delivering the workforce.' So, in my view, it is entirely justifiable to provide an elite pathway for rural generalists.

So, we established positions in hospitals that were dedicated in the early postgraduate years to rural generalists, in which hospitals are committed to give a range of terms to them in advance of others in the junior workforce. They were given privileged access to training opportunities in the pathway, and crucially, at the other end, I developed a pathway on the basis that if we received five years of valuable service at the peak of their career from each of our rural generalist graduates, I would be satisfied. In other words, we didn't expect that

they would necessarily remain for the whole of their career in a rural location and that's become a crucial part of the whole concept.

If a young medical student thinks that we're drawing them down a pathway which has become a dead end and if they get themselves here they've got no options and they can go nowhere else, then that becomes a huge impediment to actually going there in the first instance. So we have a significant number of rural generalists now who have provided valuable service as rural generalists for five, six, seven or so years and at that point have chosen to move into specialist training in the discipline of their specialist training interest and are now practising as respiratory physicians, addiction physicians, emergency physicians, anaesthetists and obstetricians.

In other words, we have tracked them down a pathway where they've provided valuable service to us and then when their family circumstances mean they can no longer remain in a rural location, they have options. Their success in tracking into specialist training has been remarkable. That's been an important part of the offering so the development of that pathway has been absolutely crucial.

That's been formalised to some degree. I don't think the national rural generalist pathway is quite as sophisticated yet probably as the Queensland pathway but nevertheless, there is recognition of that at a national level, a national rural generalist pathway is in place.

The National Rural Health Commissioner has responsibility for oversight of that and I think they are working with the College of Rural and Remote Medicine and the College of General Practitioners at the moment to progress the special-funded pathway to rural generalist practice through the Commonwealth.

***CHAIR** - Are other risk mitigation measures that are important?*

The other important thing is the funding model for this. If you have 25 doctors servicing a population of, say, 5000 people, or whatever it is, then clearly the private practice model is not going to work because you're not going to make money, or all of them, potentially.

In that circumstance, who steps up? Is it the feds that pay for the funded general practice aspect of that? Is it the state? …

***Dr LENNOX** - They are very pertinent questions and they took a lot of work. What became apparent is that the Commonwealth is a funder of general practice. It is not a manager of general practice. It is not even a manager of general practice service although I notice that there are some reforms they are contemplating on that front at the moment.*

The crucial issue from the Commonwealth was whether they would accept a reform which involved integrating a general practice with hospital-based practice and that it could occur in such a way that would not be in breach of the Medicare Act. So it required state initiative and I think that's probably still the case but it became evident in the process that the Commonwealth supported us in the process but it required substantial work on the State to make some changes.

Queensland has long had and I think all states - I'm pretty sure Tasmania has the same - an arrangement for specialist staff employed in hospitals to have granted private practice. This

has been a longstanding arrangement. It is not in breach of the national health insurance legislation. There's a special provision that provides for this to occur.

We tracked very carefully that whole process in Queensland in relation to general practice. It required a good deal of, and sometimes fairly challenging negotiation with stakeholders, but eventually we arrived at the situation that we would actually implement the provisions of the Queensland industrial relations, the agreement for medical staff in Queensland, to enable rural generalists to practise privately as well. They are granted private practice. What we did though was to ensure that in a rural location that this was all thoroughly joined up so there was an existing private practice and there have been various models we had embarked upon over the time. ….

The very first model we developed in Longreach, for example. There was an existing private practice in the community at risk of closing. We established a contract with that practice. It was a contract between the Health Service Board and the practice.

…

***Dr LENNOX** - The state brokered it but the contract was between the local health service board and the practice. We drew up the contract for them so it was in state authorised form by which the practice would receive workforce supplied by the hospital so all the doctors in that community were employed by the hospital as salaried medical officers.*

***CHAIR** - Paid for by the state, the Queensland government?*

***Dr LENNOX** - They are salaried by the hospital. Their salary arrangements provide them a grant of private practice. By agreement they can practise privately and the hospital in effect contracted with the private practice to provide the private practice option for them. In other words, the practice had a guaranteed supply of general practitioners into the practice and what that did, of course, resulted in a major shift from hospital-based services to general practice services. There was a massive increase in chronic disease management, flourishing allied health services but a thoroughly integrated system.*[248]

The Committee invited Professor Andrew Wilson to share his experience from the development of the Queensland Strategy (Rural Generalist Program).

***CHAIR** - Thank you. I will start off by talking about the rural generalist. We have a fledgling process here in Tasmania based at the Mersey Hospital. Our previous witness, Dr Denis Lennox, was talking about establishing their system in Longreach. He talked about the transition for those who have been working in rural areas for a long time, and paying them at the outset and then giving them certification or accreditation or whatever was required to register them as rural generalists.*

Do you think that paying rural generalists as a specialist in their own right, once they are trained - not the ones you are bringing into the system - is making a difference? I would like to explore that a bit further in terms of how that then applies to GPs who haven't trained as rural generalists. …

[248] Dr Denis Lennox, *Transcript of Evidence*, 31 March 2022, pp. 20-3.

Prof WILSON *- I will make a few comments around that because it's important to see the fuller context for this, not just seeing the award in isolation. Yes, we need to remunerate people appropriately and yes, we need to recognise that these people have developed a mix of skills which in some cases are certainly difficult to reproduce these days. There is a role for doing that.*

In Queensland, as Denis probably explained, we had an interim sort of award which sat between our awards which were for hospital-employed doctors and the specialists' awards. There was a range of reasons for that which we can go on to, but it increased the remuneration in a big way. However, the most critical parts of it weren't how much they were paid, because most of these doctors are reasonably well paid. The biggest part of the award and, in my view, the most important part of the award, was the fact that we guaranteed them that leave. We guaranteed them the weekends off a month, we guaranteed them the annual leave and we guaranteed them their professional development leave. That was so attractive that we were inundated with people who wanted to switch over once that program was attached.

In fact, had there not been a change of government it is my belief there would have been a substantially greater number of practices in Queensland where people would have moved over to a model which wasn't where they would all become staff specialists, but one where there would be a much more mixed relationship in relation to that.

Queensland has this model which allows people in those sorts of settings to have a mix of payments. They get a salary from Government, but they also got a proportion of the earnings that they had through MBS billing, through private practice billing as part of that, and it also made it very attractive.

There needs to be some creativity in the way we start to think about funding this. It has certainly moved a long way, from when I had similar sorts of responsibilities here in New South Wales in the late 1990s and early 2000s. There was a situation in far western New South Wales where there was a small number of doctors - I can't remember the exact number, but we are talking fewer than 20 doctors - who worked in that area. When you looked at the MBS billings and what they were getting, and special payment arrangements and what they were getting from the state government, a large amount of money was being paid into those areas. There is no doubt in my mind, that if we had been able to find a way to bring the Commonwealth and the states together to fund those positions - if we found some way to get that shared funding arrangement - that we could create very attractive remuneration for people to work in those rural areas. Not necessarily aiming for people to be there forever, but building packages which incentivise them to stay for periods like five or ten years. There could be a remuneration which may have a bonus, for example, at the end of that time. Not a $20 000 bonus but a $100 000 or $200 000 bonus - the sort of thing that will attract the sorts of graduates we see today, who may well be carrying substantial debt when they graduate from medical school.

CHAIR - *Just on that model, that has been used in various forms to say well, a certain population should have a certain number of GPs. It is one GP to 1000 people, as a ballpark. We heard from Dr Lennox that does not work in a rural environment; it actually can have a perverse outcome. Would you like to talk more about that?*

Prof WILSON - *I won't say those sorts of ratios are plucked from the air; but we compare health systems and we look at the number of doctors that people have in one place compared to another and it is a sort of community average of what might be expected. It doesn't necessarily bear any relationship to access to health care for people. If you don't have any bulk billing service within a rural community, then it doesn't really matter how many doctors you have there, there is a group of people who are going to be disadvantaged and unable to access that service because they can't pay the co-payments. You have to think about it in terms of access.*

The other thing is that we need to be flexible and we need to think more broadly about how we utilise the available health staff. At the moment, our system is built around doctor billing. If your system, if your town, is staffed by a private practitioner then basically most of his or her income has to come from billing arrangements. If you have other competent primary health care practitioners in that town, how do they get paid? Who is going to pay them? We need more flexible arrangements for remuneration which allow for other people to provide those services in conjunction with whatever medical staff are there.[249]

Professor Wilson noted:

Multidisciplinary care is the norm for most chronic and complex conditions. We have to think creatively about how we achieve that in rural and remote settings and I think this is one of the roles that virtual services can help in supporting our on-ground services.

Developing a professional workforce for rural and remote services has to start at the beginning of the training pipeline. …

The reality is that given the population distribution, most students will come from metropolitan homes so we need to find a way to make rural practice interesting and attractive for all students from the start.

When we were developing a rural workforce strategy in Queensland, we were very focused on this. We had to look at all aspects in the pipeline from talking to students before they entered a professional program, very early engaging with students in their programs - in their undergraduate programs - getting them involved in things like clubs that were focused on rural workforce, offering opportunities for them to go early - even before they got into their clinical training to rural settings to see what was happening, all the way through that pipeline through to their specialist training.[250]

Kelli-Anne Jolly, CEO Vic/Tas CEO Heart Foundation called for innovation in the workforce structure:

…we need to think about who the workforce is, and be a little bit more innovative in the way we think about that.

We do get a bit caught up in disciplines, rather than looking at it in a much more multifactorial way. It is really about creating a flexible, collaborative and integrated workforce that can open up and adapt and work together to look at different models of care,

[249] Professor Andrew Wilson, *Transcript of Evidence*, 31 March 2022, pp. 31-2.
[250] Professor Andrew Wilson, *Transcript of Evidence*, 31 March 2022, pp. 28-9.

look at new technologies, to really support different innovation, and tailor that to community and individual need.[251]

…

The other thing that we have seen is that you've got to bring the community with you. I think there are some entrenched views in the community. We've seen that with some qualitative work that we did with some patients about referrals. If the cardiologist tells them to do something, they'll do it, but if a nurse does, it's like 'nah'. It's that sense of having to bring the community along with the change in the model, not just the professionals.[252]

Minister Rockliff made the following comments:

While nurse practitioners, as you would appreciate, are not a substitute for a GP necessarily but they can increase access to health care for rural and remote communities. The Tasmanian Rural Generalist Pathway Coordination Unit is open to having a more multidisciplinary approach. There is a range of different nurse-led models of care that have been utilised in differing sized communities around the country. These include services in rural and remote areas, walk-in centres and urgent care centre models in larger centres and there is potential for Telehealth as I have discussed already today, including remote digital health monitoring services to augment these types of services.[253]

Professor Denise Fassett, Executive Dean, College of Health and Medicine, University of Tasmania stated:

We are really pleased to be here today to participate in this inquiry. As a collective, we all come together with the aim of transforming health outcomes for the Tasmanian community and we do that through health professional education and research. We also are closely aligned and part of the university's strategy, which has a very strong place-based mission. We see that as critically important when you are thinking about rural and regional communities in Tasmania. That has given us some wonderful opportunities which we can speak about today, including in Burnie with our new campus.

We aim to bring about an intergenerational change in workforce capability. The way we are doing that is thinking about systems and system improvement and understandings of systems.[254]

When addressing the question of educational core programs available at UTAS, Professor Fassett stated:

***Prof FASSETT -** Previously, when you were asking the question, we were answering around 'have we got a course?', 'could we have a course?', which is an entirely different question to 'do we need nurse practitioners?' or 'what would be the models of care?' and so on. I think I heard, in listening, that conflate somewhat.*

A nurse practitioner course would be, just as we heard from Belinda in paramedicine, these courses really need to be thought about in partnership with the state. If the state and the

[251] Kellie-Anne Jolly, Heart Foundation, *Transcript of Evidence*, 19 November 2021, pp. 26-27.
[252] Kellie-Anne Jolly, Heart Foundation, *Transcript of Evidence*, 19 November 2021, p. 29.
[253] Minister Rockliff, *Transcript of Evidence*, 30 November 2021, p. 70.
[254] Professor Denise Fassett, *Transcript of Evidence*, 17 February 2022, p. 38.

university can identify the need, there is nothing to stop us having these courses. In fact, we developed one previously but we didn't get to the point of offering that. The possibility for the university to do these things is there.

One example would be Belinda, here she is, talking from New South Wales. Sometimes when we have struggled in Tasmania to absolutely have the course or the workforce that is required - sometimes a crisis in Tasmania is six people missing and that is big and it is a crisis, so they need six more emergency nurses or whatever it might be. For us to get post-graduate nursing programs into our university, we have done a partnership where we can offer courses into another state. That way we are able to get those economies of scale, if you like, but it has allowed us to really grow in that post-graduate sphere.

There are many ways the university can bring to the table various models, in partnership, to meet what this state needs. But the vision needs to be clear. What is the vision? What do we need for the future? Because we are talking about the health of our people and turning that around, and we need to understand how we would do that.

I think Tasmania has an incredible advantage in terms of being able to get everyone together to model the care that might be required into the future. But I think what happens is that the conversation splinters off into professions. The health professions are really good at siloing and being very active in their silos. They are interprofessional and they do collaborate but, instinctively, it is hard when you are managing all the other professional requirements that you need to consider.

Certainly, with our RHMT (Rural Health Multidisciplinary Training) program, with the review that is being conducted there, there is more of an emphasis needed in interprofessional, and the way that all of my colleagues that sit around the table here are really working hard together to think about what is it the community requires in terms of care and how can we work together. Because it's actually at the edges of each discipline, I believe, where the innovation - and that is probably what you are hearing in New Zealand because they are very innovative, I think.

It is that innovation, the blurring of the boundaries, where you really find the inspiration to create different models of care and a different way of thinking. I think we have been stifled for a long time by thinking about things in the same way.

So, when we talk about -Tracey mentioned with our research and she talked about impact - we are really saying there that sometimes we don't really capitalise on what we have already got, and come together. Just someone else creates something else in a different region in Tasmania but you already have that model. We are not very clever for a small island with a reasonably small population, one university, one health system. We should be able to serve our population better than we do.

***Ms LOVELL** - Denise, following on from that, in terms of course delivery and planning of the course delivery, is there any consultation or collaboration with TAFE, for example, or other service providers that takes place to try to address that, so we are maximising those opportunities for people.*

***Prof FASSETT** - Yes, there is deep engagement with TAFE and, of course, Sonj has been working with thinking about enrolled nursing, that separation where you have enrolled nursing, which is entirely different to doing a Bachelor of Nursing. However, one does get credit into a Bachelor of Nursing. So Sonj has been forging relationships there.*

Certainly - you might want to say something about that, Jim - through our university sort of college model, and our associate degrees, diplomas and so on, we have been able to articulate through. Because that is what you require - education across that spectrum. Yes, there is deep engagement with TAFE.[255]

The Australian College of Paramedic Practitioners (ACPP) submission calls for innovation in the Tasmanian Health Care setting, particularly in areas of medical shortage:

Paramedics and Paramedic Practitioners enhance the work of medical practitioners, nurse practitioners and allied health in a range of clinical setting, but particularly in Primary Healthcare

Paramedic Practitioners as medicine prescribers, diagnosticians, and directors of treatment can work in a team or if necessary, can practice independently if the services of medical practitioners are not available in a particular location.

Paramedics can be immediately introduced into locations at risk and be trained on the job while completing Paramedic Practitioner studies. Paramedics can already provide advanced clinical practice.

Paramedic Practitioners do not want to compete with doctors, and in fact, if PPs want to advance further, are encouraged to leave the Paramedicine Profession undertake medical training to become a medical practitioner.

Paramedicine is an old and well-established health profession. Paramedics are already available in many areas of Tasmania that have no doctors.

With a mix of simple innovative, changes to clinical practice, expectations and legislation paramedics can be a solution to the health problems within the Tasmanian rural health system.[256]

And further the ACPP submission recommends:

- *Engage key and expert stakeholders such as the ACPP to help implement a Primary Healthcare Paramedic and Paramedic Practitioner Model into Tasmania.*
- *Work with the University of Tasmania School of Medicine to implement a Paramedic Practitioner post graduate training program (at Master/Doctor (AQF 9, 10) and accredited by ACPP, which can articulate into medicine) like the Deakin University School of Medicine model.*
- *Either implement Paramedics/Paramedic* [Practitioners] *directly into the health care system or pilot programs into rural Tasmania, community health, primary healthcare, and hospital Urgent Care services to evaluate the services of Paramedics and Paramedic Practitioners.*

[255] Professor Denise Fassett, *Transcript of Evidence*, 17 February 2022, pp. 54-5.
[256] Australian College of Paramedic Practitioners, 2021, *Submission #34*, pp. 2-3.

- *Convert Ambulance Tasmania ECPs* [Extended Care Paramedics] *into Paramedic Practitioners and allow PPs to practice inreach and outreach services in Hospitals, Emergency Departments, Urgent Care Services and Primary Healthcare Services decreasing ambulance dispatch and Emergency Department presentations.*
- *Implement legislative changes to allow Paramedics and Paramedic Practitioners to practice to the full scope of their practice in Tasmania, outside of the employment of Ambulance Tasmania and in all clinical settings.*
- *Lobby or gain consensus through COAG to persuade the Federal Government to implement changes to Federal law to allow Paramedics and Paramedic Practitioners access to the MBS and PBS.*
- *Begin employing Paramedics and Paramedic Practitioners into clinical settings as soon as possible by recruiting locally or internationally from the United Kingdom.*[257]

ACPP details the paramedic practitioner model:

> *Based on proven UK model, paramedics completing an approved Master's degree can work in a range of practices including: Ambulance Services, EDs, Specialists, Community settings, General Practice etc. PPs in the UK have prescribing rights, can order tests, imaging and treatment. Proposed that PPs will be able to convert to medicine with a conversion degree. PPs have a generalist scope of practice and can practice in any area of medicine. The PP model is extremely cost effective…*
>
> *Tasmanian Legislation would require amendment to support a PP Model. This would include: Tasmania: Poisons Act 1971 and Regulations, Mental Health Act 2013, Public Health Act 1997, Human Tissue Act 1985, Evidence Act 2001, Workers Rehabilitation and Compensation Act 1988 as examples. Federal Legislation would need to be amended to allow PP access to the MBS and PBS.*
>
> *Cost to State of Tasmania: Minimal:*
>
> *Federal Government Funds: University Education, Primary Care (diversion of patients and there are several potential MBS items that can used by paramedics), and eventual MBS and PBS funding. Both in the UK and Australian models, PP models have been funded by cost saving and have not put a burden of health budgets.*[258]

With regard to the role of paramedics and the option for paramedic practitioners, Minister Rockliff made the following comments:

> *There is currently no classification for a paramedic practitioner…*
>
> *There is avenue to further explore expanded roles for paramedics, however, within hospitals, rural remote communities, metropolitan areas and for specific roles such as vaccinators. Several other states have created community paramedic roles for paramedics to support primary health care needs in rural and remote areas.*
>
> *It is broadly recognised that there are many qualified paramedics across Australia who do not work within ambulance services. Exploring roles for these health professionals across the health sector, particularly with nurse shortages, has the potential to provide what has*

[257] Australian College of Paramedic Practitioners, 2021, *Submission #34*, pp. 2-3.
[258] Australian College of Paramedic Practitioners, 2021, *Submission #34*, pp. 2-3.

been a very valuable skill set and increase the capacity for health services to meet community demand.

The expanded role of paramedics within the broader health sector is ideally undertaken by a professional lead such as a chief paramedic, as established in some other Australian and international jurisdictions. My understanding is that Victoria has a chief paramedic. This role aligns with the chief medical officer and chief nurse positions that look strategically at the evolution of roles and responsibilities for health care professionals across the health care sector.[259]

…

My view is, that we can look at a chief paramedic more in the near future. It is a good role because it is an independent role in terms of that independent view that has the authority to consider the service gaps that you allude to within ambulance, acute and community care and health services. In developing solutions to some of those challenges, I am very open to looking at a chief paramedic role sooner rather than later, notwithstanding legislation in the Ambulance Act and the Poisons Act is a barrier that needs to be undertaken.[260]

During the 2022 Budget Estimates process, the Committee received the following update regarding the development of a community paramedic program:

Mr ACKER *- We've got funding for nine community paramedics, three in each region, which will of course be looking at the more remote places where we can embed them in communities. These are great opportunities for paramedics to work in different roles that aren't necessarily frontline emergency response, but can [provide] lower acuity or primary care. We've also got paramedic opportunities working in our secondary triage space, which is in our communications centre, doing clinical consults with patients working shoulder to shoulder with nurses in that environment as well.*

Recently, we were working with legal services to change the Act so that the Ambulance Services Act will not require the definition of a paramedic to be isolated to only those that are employed by Ambulance Tasmania. So this is something we're really passionate about, because we believe paramedics are a healthy workforce that the state can use in different ways which aren't just specific to ambulances.

One thing that I'm very excited about, and it was actually the Secretary who showed leadership in this initiative, is to work through a pilot project to see how paramedics can supplement hospital staff in Launceston General Hospital. This is where there are a number of vacancies to hire paramedics outside of the ambulance service by the THS to work on a pilot basis to see what services they could provide in a hospital to fill some gaps.

…

Ms MORGAN-WICKS *- … so in terms of paramedics actually being employed by THS, for example, we are looking at that as a pilot for the Launceston General Hospital, noting just continuous recruitment efforts to try and attract nurses to the ED. We can place paramedics, for example, into the ED to try and assist and offload, but it would require the model being*

[259] Minister Rockliff, *Transcript of Evidence*, 30 November 2021, p. 70.
[260] Minister Rockliff, *Transcript of Evidence*, 30 November 2021, p. 71.

carefully worked up in their scope of practice. In speaking to a couple of paramedics, for example, at Latrobe, they were quite excited about the potential for that to occur. …

…

***Mr WEBSTER** - …. In fact, the miscellaneous amendment, health miscellaneous amendment bill tabled in the Lower House includes the change to the Ambulance Act that we're referring to.*[261]

The Minister for Health responded to a letter from the Committee inviting the relevant Departmental representatives to provide further evidence regarding paramedics working within the Launceston General Hospital and relevance of this proposal to the Inquiry:

During the recent Budget Estimates hearings, a number of comments were provided concerning opportunities for paramedics to undertake a broad range of health care roles across the health sector. In the United Kingdom, Canada and the United States of America, paramedics are embedded as a health care workforce within hospital and community settings.

We also discussed a proposal to pilot the employment of paramedics in the Launceston General Hospital, noting the issues in being able to successfully recruit nurses, particularly in the Emergency Department. At this time the proposed pilot is still being developed and the Director, Operations at the Launceston General Hospital is working with the Chief Executive, Ambulance Tasmania to bring together key stakeholders to explore what is required to facilitate this initiative.

Recognition of the term 'paramedic' outside of employment in a statutory ambulance authority is an important component in diversifying and recognising the role of paramedics in the broader health care sector. Proposed changes to the Tasmanian Ambulance Service Act 1982, under the current Health Legislation (Miscellaneous Amendments) Bill 2022, will enable the term 'paramedic' to be recognised outside of Ambulance Tasmania, including with private providers of ambulance services and in hospital and community settings. …

As the pilot program is still being developed, there is limited further information we are able to provide the Inquiry as this time. We certainly look forward to progressing a pilot as discussed at Budget Estimates and the improvements this may bring for patient outcomes.[262]

The *Health Legislation (Miscellaneous Amendments) Bill 2022* passed on 8 September 2022 and received Royal Assent on 20 September 2022. It will commence on a day or days to be proclaimed.

Emma Thornley, paramedic and Board Member of ACPP, provided the following evidence:

I am the first paramedic practitioner to be employed in Tasmania. I practise as part of a multi-disciplinary team alongside RNs and nurse practitioners, paramedics, GPs and rural generalists. Hopefully, soon I will be going to Ouse with that team which, believe it or not, represents a career highlight for me.

[261] Premier Rockliff (in his capacity as Minister for Health) and Joe Acker, *Transcript of Evidence*, 7 June 2022, p. 102.
[262] Letter from Premier Rockliff to Chair Ruth Forrest MLC dated 12 July 2022.

Twenty years of working in Tasmania as a paramedic has given me some keen insights into how people in the community really live and how things have been on a trajectory towards crisis since I began my career in health in 2001. This is the unique thing about paramedics: we spend all our working days in and out of people's homes and lives so we have a unique insight into the impacts that the failures in the health system have on the Tasmanian community.

I'd like you to be aware that paramedics are the only health professionals who are educated and trained to practise exclusively in the community. We are not trained to practise in hospitals or clinics. If we were to shift to that environment we need the extra education. We are trained to practise in the community.

The college believes we are an underutilised resource for understanding the issues and developing the solutions. Some of the inescapable truths that paramedics have recognised are things like ramping, which is a complete waste of resources, it is dangerous and it is not patient focused. Bed block and ED overcrowding are largely the result of patients not having access to appropriate and timely care in a community.

For the same reason ambulance callouts are predominantly non-emergency cases. Anecdotally and statistically we know that about 90 per cent are non-emergency cases. Most concerning for me is that many of the critically unwell patients whom we do attend are only in that situation because of the lack of early intervention in the community. It was missing. This is especially true in rural and remote areas. Associate Professor Ruth Stewart, whom we follow keenly as the Rural Health Commissioner says,

> *Rural and remote people have often been wrongly described as stoic. They soldier on with ill health until they can't go any longer.*
>
> *Paramedics will tell you Ruth is correct.*

Any paramedic can also tell you where a majority of the issues originate from. We understand the population demographic has higher needs for primary health care services. We know there is a lack of after-hours services because we fill that gap. There's a lack of bulk-billing services; there is a lack of primary and urgent care centres, facilities and infrastructure. There is a lack of transport options, even public transport in rural areas is an issue for health. Extended waiting times to see your own GP goes sometimes into weeks. If you think you're going to go to another GP, think again because they're not taking new patients.

Worth noting, as if this doesn't sound disastrous enough, these issues are compounded if you are, for example, a patient who is a single parent, you're homeless, have a disability, victim of intimate partner violence, you're culturally and linguistically diverse, you have low literacy skills or you're Aboriginal. Paramedics see this every day. We at the College of Paramedic Practitioners advocate for paramedics being able to gain an appropriate education to be able to deliver the knowledge and skills that have been identified as most lacking in our rural communities. We understand this community; we live and work locally, and we have done the work to make ourselves ready to be part of the solution.

The College did not do this purely on a whim, we did it because we were following recommendations from the Government. Multiple health workforce reform reports have made the recommendation that one of the solutions is to upskill existing health professionals

to do more in the communities where they live and work, rather than relying on bringing in locum doctors for short periods at great cost.

This sensible, affordable and sustainable recommendation for upskilling existing members of the health workforce has never been considered for paramedics up to this point because we have been routinely excluded from discussions, reviews and planning for the health workforce. Even yesterday I noticed the Health minister was interviewed and commented that he was in discussions with the AMA and the ANMF but there was no mention of any discussions with anyone from paramedicine.

There is a serious misconception that paramedics just work in ambulance services; that ambulance and paramedic are one and the same. This is not the case. Ambulance is an employer and a paramedic is an independently registered health professional. We have been registered with AHPRA (Australian Health Practitioner Regulation Agency) since 2018. We now wish to have the same legislative and government support that other AHPRA registered professionals have to be self-determined and have options about who we work for, what career path we choose and where we want to practise. That way we can evolve as a profession to do what we do best and to serve our community.

In 2018 a paramedic colleague of ours from the north-west coast, Simone Haigh, initiated a senate inquiry into the mental health of first responders. It made multiple recommendations on how to improve the alarming findings from the inquiry. One recommendation was to develop structured career pathways for paramedics to move away from frontline emergency services delivery. This is in line with all the evidence suggesting it is not a career where longevity is healthy.

Given the gaps in the health workforce and paramedics' deep understanding of the issues facing everyday Tasmanians, we at the college believe it is a logical career path for paramedics to be able to gain an appropriate education that prepares them to work in multi-disciplinary teams delivering primary health care in the community.

The college advocates for innovative alternate models of care where health professionals come from backgrounds as diverse and as local as our patients. The international experience from adding paramedic practitioners into multi-disciplinary teams alongside nurse practitioners, GPs and other health professionals has shown that it creates a flexible workforce from differing backgrounds but with complementary strengths who can effectively and adaptively respond to the ever-changing needs of patients in the community.

The current model for health delivery here in Tasmania along with outdated legislation and a lack of government support and recognition for paramedics as independently registered health professionals is preventing paramedic practitioners from even being considered up to this point. The college has developed a robust career structure, education plan and professional standards for paramedics to become effective, affordable and sustainable primary healthcare providers here in Tasmania and nationally.

Our aim is to futureproof ourselves professionally and this means we are not designing a stopgap bandaid but a short and long-term plan to become part of the broader health workforce and to deliver the right care where it is most needed.[263]

[263] Ms Emma Thornley, *Transcript of Evidence*, 8 October 2021, pp. 2-4.

Monique Mackrill, Pharmacy Guild of Australia (Tasmania) provided further comments regarding potential pathways for paramedics:

> *… earlier this year, I think 100 paramedic graduates came out of UTAS. The average career lifespan of a paramedic in Tasmania - I don't know if it's nationally - but here it is five years. They do a three-year degree, they work for five years and then they run away. These are the pathways that you could potentially develop and try to move some of those people into looking at pharmacy into the future - being better connected across the school or schools, to look at the opportunity for people.*[264]

According to Ray Bange, OAM:

> *The Australian health system is a complex amalgam of many service providers operating in conjunction with major hospital facilities, clinics and supporting infrastructure. Commonly overlooked are the resources of research bodies, universities, and the Australian Defence Force, which have been activated during the current COVID-19 pandemic. There is increasing recognition that healthcare is a team effort that benefits from a multidisciplinary approach. Paramedics are well-positioned to be part of such teams in primary as well as higher acuity care. Australia has yet to realise the full benefits of mobilising paramedics and private sector services other than for NEPT and event support roles.*
>
> *In the UK, the private sector makes a substantial contribution to out-of-hospital care with the provision of surge capacity and supplementary mainstream contracted services. This is possible because of the system of service provider regulation under the CQC37* [Care Quality Commission] *and the use of registered paramedics. The current ambulance and NEPT legislation and practice protocols inhibit this level of development in Tasmania. The author suggests the legislative framework instead should facilitate the use of these external resources when needed.*
>
> *…*
>
> *The goals of service integration will only be met if ATas and its paramedics interact with other agencies such as public health and social services; embrace partnerships that foster disaster planning; collaborate in sharing research, data and development resources; engage in joint practice through drills/simulations etc.; as well as working closely with hospitals.*[265]

Associate Professor Dr Belinda Flanagan, University of Tasmania was questioned regarding the evolving scope of paramedic practitioners:

> *It is a bit interesting. Across Australia I suppose there is a little bit of a push for an evolving scope for paramedics. We are not working within a paramedic practitioner model in any state at the moment. Most paramedics are employed by a state ambulance service and there are varied roles within those services such as extended care, intensive care and other service such as where I have come from in Queensland they have a low acuity response unit as well. Other than the industrial sector, the resources sector, they are probably the only existing opportunities for employment for paramedics.*

[264] Monique Mackrill, *Transcript of Evidence,* 7 October 2021, p. 26.
[265] Ray Bange, 2021, *Submission #54*, pp. 15-16.

At this stage we do not offer a specific qualification for a paramedic practitioner as such. There are only two universities in Australia that have recently commenced those degrees, Edith Cowan and Deakin universities and it is not something that we offer at the moment.

***CHAIR** - Is it something that might be considered, bearing in mind that it seems that there is a greater awareness of the perhaps constrained scope of some of the health professions… Do you think that is something that UTAS would consider or look at in terms of the workforce challenges?*

***Dr FLANAGAN** - There has been some concern from the Council of Deans about specific paramedic practitioner courses offered at universities purely because there isn't necessarily an employment pathway and they are very heavily resourced. They are quite expensive to run. I suppose we need to look at what is the actual market for something like that because it is not actually recognised within the health service at the moment.*

It is my understanding that we have a suite of postgraduate courses that we have just undertaken as a review… Now we have got the recent results from that review we are undertaking over the next 12 months, a redevelopment of that postgraduate suite of courses. Looking at the needs for an extended scope is an area that we are looking at.[266]

To support staffing in community health hospital services, the expansion of nurse practitioners in Tasmania was raised in a number of submissions.

The CRANAplus submission expressed concern regarding the underutilisation of nurses:

There has been a loss of community knowledge, professional experience and qualified nurses with the loss of rural and isolated nursing positions. CRANAplus members report these losses negatively impact the delivery of primary health care and community-based care, maternity care (labour and post-delivery care and access to birthing options outside larger centres), antenatal care, early childhood and early intervention care and emergency care. In particular, members have raised concerns that the decrease in early intervention nursing care will significantly compromise long term health outcomes.

Nursing scope of practice – untapped potential

Current models of multidisciplinary care where cost-shifting drives care decisions are eroding the scope of practice of experienced, qualified and competent nurses and midwives. One cited example detailed the case of child health services nurses no longer permitted to make direct referrals to allied health. Instead, nurses must refer to general practitioners for them to make referrals. In addition to decreasing the scope of practice, these strategies fragment patient care and devalue highly experienced and competent professionals' skill and expertise. Complexity in such cases and adds (sic) *a further health burden on individuals and families, negatively impacting patient care and engagement.*

While nurses are the most widely distributed health professionals, external limitations are placed on nursing practice. The disparity between the nurse scope of practice at The Royal Hobart Hospital and Launceston General Hospital and smaller rural and isolated hospital emergency departments provides evidence. Examples include nurse-initiated analgesia and radiological investigations by suitably prepared nurses with suitable governance

[266] Associate Professor Belinda Flanagan, *Transcript of Evidence*, 17 February 2022, p. 47.

mechanisms. Such limitations are impacting the quality of patient care and adding undue pressure on rural GPs.

There is an absence of clear and supported nursing workforce pathways to prepare for extended practice in rural and isolated areas and underutilisation of the Nurse Practitioner role. These are areas of current and future concern for both recruitment and retention.[267]

According to Nurse Practitioner Kerrie Duggan, Cygnet Family Practice, the legislative barriers to the nurse practitioner model include:

Poisons Act

The Tasmanian Poison's Act needs to be updated to align with the prescribing qualifications of NPs. As a NP I can prescribe schedule 4 drugs which include antibiotics and immunisations. Currently I can prescribe antibiotics but not immunisations which have a lower risk of anaphylaxis. Daily, when I consult and administer childhood immunisations, I need to refer to a GP for another appointment to provide a prescription for meningococcal B vaccine. When I have a patient book with me for a whooping cough vaccine, I can give it to a pregnant woman without consulting a GP, but not her partner. I then need to book a GP appointment for her partner to get a prescription.

Workers' Compensation

If you injure yourself at home, I can care for you fully. If you injure yourself at … [work] *I can't. NPs in Tasmania are not authorized to complete the paperwork required by the Tasmanian Work, Health and Safety legislation. In Queensland, timely access to NP services is not an issue because the legislation has been amended.*

MBS

The largest barrier for Australians accessing timely health care is the current limitations for NP from the MBS. There are currently 14 recommendations to changes to the MBS by the MBS Review Taskforce's Final Report which have been held up since February 2019. These recommendations will give Australians … the access they need. Currently, as a NP generating income for my employer for me to receive a salary or a percentage payment as GP contractors do, I can't bill for a home visit, if an appointment takes longer than 40 minutes, after hours or emergency care. There is also a recommendation to increase the remuneration of the current 4 face to face Medicare item numbers which will encourage other RNs to consider the role and reduce the workforce shortage in this area.[268]

The Australian Government established the *Medicare Benefits Schedule Review Taskforce* in 2015, with the Final Report being released in December 2020.

Other barriers identified by Ms Duggan is the reluctance of some medical professional groups to embrace change:

The nature of each professional group or union is to protect their turf. This is the nature of the organization to work for the good of their members. There is strong opposition to any change in the status quo in health care services. This needs to be acknowledged as 'the

[267] CRANA Plus, 2021*, Submission #27,* pp. 2-3.
[268] Cygnet Family Practice, 2021, *Submission #73*, p. 2.

elephant in the room' because it is impacting on accessibility and timely access, especially in rural and remote areas. Speak to any doctor who has worked with a NP and the feedback is supportive and they become strong advocates for the role.

Professional and consumer awareness

A nationwide media campaign is needed to promote the understanding of this role within health professions and our communities.[269]

Ms Duggan explained that New Zealand has made broad legislative change in this area:

In 2016, the New Zealand government made changes to legislation as a direct result of years of active lobbying by the College of Nursing NZ, the Chief Nurses Office and working parties.

Eight separate amendment Acts applied new terminology, replacing the term medical practitioner with health practitioner. The aim of this change was to recognize the advanced knowledge and skills in the wider health workforce which improved access to services. These amendments enabled competent health practitioner to better use their skills for the benefit of the people they work with, the health workforce and the New Zealand health system.[270]

According to Bill Dermody, the introduction of nurse practitioners in regional areas of Tasmania would dramatically improve regional health services and take pressure off major hospitals.[271]

The late Mr Bill Dermody stated:

***Mr DERMODY** - … As an example, two people could present with exactly the same issue; they could both turn up with cuts. The nurse practitioner can then do suturing or treatments associated with that, provide medications, prescribe most medications and administer medication, and provide a certificate. Under the Workers Rehabilitation and Compensation Act, they can't do that in Tasmania, whereas they can in some other states.*

… If someone was to present because they can't see a GP, they [nurse practitioner] *can look at the symptoms, diagnose, admit them to the New Norfolk Hospital or wherever, then liaise with the medical centre until their GP can see them.*

If it was after hours and on weekends, and the person who presented had major health issues, they could admit the person, they could then do a video conference with a doctor at the Royal Hobart Hospital, as an example. If the doctor then determined that the person needed to be admitted to the Royal, all intervention would be taking place until an ambulance was available, and it would mean that the person would be immediately admitted to the Royal Hobart Hospital. This means it would reduce waiting times for people waiting for an ambulance, and it is going to mean better health outcomes, because all the intervention has been done immediately, therefore reduce ambulance ramping and pressure on emergency departments.[272]

Dr McArdle and Dr Saul, on behalf of the AMA, provided the following comments regarding the role and potential of nurse practitioners:

[269] Kerrie Duggan, 2021, *Submission #73*, p. 2.
[270] Kerrie Duggan, 2021, *Submission #73*, p. 2.
[271] Bill Dermody, 2021, *Submission #2*, p. 9.
[272] Bill Dermody, *Transcript of Evidence*, 19 November 2021, p. 5.

> ***Dr McARDLE*** *- As with any membership organization, we have a broad range of views. I would say in general, particularly from the GP sector, there is a reluctance to go down that expanded scope of practice for other health practitioners. My personal view, it is not AMA policy, is that it can work really well if there is a good working relationship, if there is a good relationship particularly, say, with a nurse practitioner and a GP, or a specialist or someone else, where they can work as a team. But there is opposition from a number of our GP members. Emergency physicians, for example, love the thought of having nurse practitioners because they have worked with them and they can see how it works really well.*[273]

And:

> ***Dr SAUL*** *- One of the problems I see is that unless we support solid general practice services, we're going to get a shrinking pool of GPs. We're not going to have that level of training, that 10 years of training, to support this type of service. By all means, you might be able to plug holes here and there, but you're not going to have a solid coordinated service unless we can increase our GP service. You might be recommending something that might help solve a few problems, help fill a few gaps, but it's a bit like emergency funding to reduce the waiting list in the public system. It's only a short-term solution. What we need is really well-trained GPs.*
>
> ***Mr GAFFNEY*** *- I have to go back to the point. Wouldn't having those professionals around a GP who can take on some of those roles and support that GP…*
>
> ***Dr McARDLE*** *- I think that's the fundamental thing about a team, and having a team working as a team, instead of having a lot of silos. The concern in some areas is the silos. You've got a nurse practitioner over there working as an independent nurse practitioner with no relationship to the GP or the specialist in the field they're working in. That's where a lot of the concerns arise.*[274]

Pam Doole, Clinical Chief Advisor Nursing, Office of the Chief Nursing Officer I TE TARI o TAPUHI RANGATIRA provided detail on New Zealand's experience in the establishment of a nurse practitioner model:

> *It was established under government support, the conservative government at the time in the late 1990s wanted to unleash the potential of nursing so did a taskforce. The outcome of that taskforce was to establish the nurse practitioner role. The first nurse practitioner was registered in 2001 and there was quite slow development in that first decade and they were often supported to become nurse practitioners through public hospitals and district health boards. So often nurse practitioners ended up in quite specialised nursing roles to do with chronic health conditions like diabetes et cetera but the role was originally determined to be a role that would provide access to health care for people in vulnerable communities. In New Zealand this is particularly our Maori and Pacific communities but it is also acknowledged that there are other vulnerable communities. Rural communities are definitely seen as having less access to health care and as our GP workforce ages and moves more into the central cities, the nurse practitioners are definitely filling a gap in that sector.*

[273] Dr McArdle, *Transcript of Evidence*, 7 October 2021, p. 8.
[274] Dr McArdle and Dr John Saul, *Transcript of Evidence*, 7 October 2021, p. 9.

We are also noting that nurse practitioners are having a bigger and bigger role in our aged residential care sector as well as GPs providing less care in that sector and it differs across the country. I guess what has happened in recent times in the last decade is we have seen a lot of the legislative and funding barriers being removed for nurse practitioners to fully function in what we call primary health care so they have exactly the same payments for general medical services. Also, for our accident compensation corporation payments. That is a fund that is set up for anyone who is injured through a home or work recreation accident and that is all funded separately through that no-fault scheme -

***Ms LOVELL** - … When you say the same payments under those schemes, do you mean the same payments as GPs, for example?*

***Ms DOOLE** - Yes.*

…

***CHAIR** - … What about the legislative barriers that were there that needed to be removed to enable nurse practitioners to work across that scope?*

***Ms DOOLE** - I suppose there are things, particularly with the Medicines Act, so nurse practitioners became designated prescribers with a broad list in 2005 and in 2013 they became authorised prescribers which means they have the same prescribing rights as general practitioners. The scope of practice was broadened in 2017 and a lot of statements were put in that scope of practice to recognise that nurse practitioners can order diagnostic tests. They can be the lead health care provider and they can admit and discharge from hospital. So, we deliberately put in those statements and their scope of practice so it was clear that their legal role was higher than that of a registered nurse and that they could function as independent health care providers.*

We have a capitation section - funding for general practice. Nurse practitioners can access that and they can own their own general practices and we do have some nurse practitioners who are practice owners and they will often ask GPs to come in to do locums. Particularly if they are in a rural area, they might ask a GP to come one day a week to see particular patients who need that level of GP care.

***CHAIR** - Sort of the reverse of what we are seeing here.*

***Ms DOOLE -** I think that's a decision that's been supported by both major parties: that we need to have an enabling health workforce. There is so much demand, and there is growing demand with an ageing population. There are moves to allow professionals, not just nurse practitioners, but all health practitioners to work at the top of their scope. Sometimes the professional groups don't always agree with the direction, but importantly, I think the ministry has stayed on track with the vision despite some pushback from some professional groups.*[275]

Alison Spicer, RN nurse practitioner student based on the north-west coast and Leahanna Stevens, nurse practitioner in both the public and private sector:

[275] Pam Doole, *Transcript of Evidence*, 17 February 2022, pp. 2-4.

I remain very concerned about the poor access to quality healthcare on the north-west and specifically the west coast. We are currently serviced around 30 per cent by locum GPs and locum doctors within the two services. Ochre provide the services to the regional areas and agencies support the emergency departments and the hospital sectors directly. As someone who has worked alongside doctors and believe me, I believe in doctors, I have two sons who are doctors so I believe in the model, I just don't think that locums are the sustainable answer to the health system.

I would like to direct the committee to look at alternative models of care, I am quite passionate around that, around nurse practitioners, paramedic practitioners… We are out there, we are working really hard. We go through a lot of training and experience to get to the peak of clinical nursing and we need to be considered as a viable, sustainable and affordable solution to the health system. I believe we can fill those voids in GP clinics. I do not believe we should do it alone, I think it should be a multidisciplinary model and we should support a training ground in Tasmania to grow and sustain competence and speciality care in our health sector.[276]

…

***Ms SPICER -** On the last page of my submission I talk about how the legislative system might directly help this. We need to recognise paramedics as health practitioners. At the moment, they are restricted to working at ambulance services. I believe it would take a small legislation change for them to be allowed to be generally employed into the health sector. That would also satisfy the mental health inquiry about paramedics and burnout and PTSD, in terms of ultimately providing career paths for paramedics, which is something we desperately need.*

We need to amend legislation in Tasmania - for example, take out 'medical practitioners' in the Poisons Act, and replace it with 'health practitioner'. We would like you guys to champion us on a national level to be able to change or update MBS and billing parameters for nurse practitioners and allow paramedic practitioners to access those as well.

…

We need to be asking questions at a policy level…. What are we trying to achieve with a locum workforce? Is this the way we need to sustain our health future... I ask you to accept the evidence, as I have reiterated in my paper. I am passionate about this. The opinion of the medical fraternity around alternative models of care is that we are going to bring demise to our patients. The evidence totally contradicts that - twenty years of high scrutiny in the USA.

…

***Ms SPICER -** The doctors' positions that we have heard are that nurse practitioners or alternative models of care would provide a second-tier service, and that by letting us have full prescribing rights or full access to billing and prescribing, we will somehow endanger our patients.*

[276] Alison Spicer, *Transcript of Evidence*, 31 March 2022, p. 1.

The evidence is completely contradictory to that. The evidence over 25 years out of the USA, New Zealand, people who work in those sectors and the patients, is that nurse practitioners are safe, affordable and are effective solutions to health care. In fact, in the USA, you will not see a GP, you will see a nurse practitioner in a family practice clinic. They actually have taken the place of GPs in the USA. New Zealand is very similar. We had the opportunity to speak to the Chief Nurse in New Zealand last week, or a few weeks ago, and she attested to the success of nurse practitioners in GP roles in the regional communities. Again, the evidence is contradictory to what the doctors are telling you.

You also heard that at the start of COVID-19, when politicians wanted pharmacies to be able to administer vaccinations, the RACGP and the AMA protested, saying that would not be safe for patients either, and would cause a lot of problems. Well, in fact, that has been a roaring success and pharmacists have cemented their place in the management of vaccinations forever. We need to give our alternative models of care the same opportunity.

***CHAIR** - … Because the hesitancy remains with some of the medical practitioners, would a transitional staged approach be better in that nurse practitioners become complementary to those practices so you do not have the revolving door of locum GPs, say, rather than trying to establish, initially at least, standalone nurse practitioner clinics?*

***Ms SPICER** - Yes. We acknowledge that people are inherently change resistant and rather than enforce complete change we agree that that would be an appropriate way forward. In Canberra I have just found out recently they have four nurse practitioner-led walk-in clinics in the ACT. They are completely nurse practitioner-led centres and they will refer their complex care back to GPs and that is very successful and they are looking at opening up another four as we speak.*

I agree, in Tasmania we would concede that to work in a collaborative model, as we do anyway, but physically in the presence of GPs would be a way forward. We would love to see some funding for that.

At the moment, GPs have funding availability up to about $25 000 to employ a nurse but that doesn't lay over to employing a nurse practitioner so there's no incentive for GPs to employ nurse practitioners in their clinic. … We only have four billing numbers that we can bill to and none of them include procedures or examinations so we're not a financial viability for GPs at the moment.

***CHAIR** - So, in order to address that there need to be a few things that will need to happen. There needs to be changes to the Medicare scheduling to enable nurse practitioners to be able to charge.*

***Ms SPICER** - Correct.*

***CHAIR** - That way, GPs don't have to directly fund them from their practice.*

***Ms SPICER** - You could do it two ways. You could fund nurse practitioners to work into the GP clinics so provide half a salary or whatever and then if we couldn't get the Medicare Benefits Schedule (MBS) changed in the short term. Ultimately the MBS hasn't been updated since its inception in Australia. We have had four numbers for 10 years and that hasn't changed, largely due to the opposition of medicine.*

CHAIR *- How should it be funded? ...*

Ms SPICER *- Federally, we need to get the MBS billing numbers expanded and state governments should fund trainee positions in Tasmania.*

...

Ms STEVENS *- Yes. It is definitely a federal issue and there are different ways of approaching training and transitioning for sure but there would have to be some statewide buy-in to support that, absolutely.*

CHAIR *- Is training currently available in Tasmania for nurse practitioners to undertake a role that, once completed, would see them in a position to participate in a nurse practitioner-led clinic, for example?*

Ms SPICER *- No, there's nothing. UTAS don't have a course and there are only three candidates. Nurse training roles are called 'nurse practitioner candidates', so that you are actually employed to train to become a nurse practitioner - they're candidate positions. They're inherently unicorns within the health sector and there are three in Tasmania. They are all within the THS - two in the Royal and one at the Launceston General Hospital.*

CHAIR *- How do we increase that? They wouldn't even cover the attrition rate that would exist so what needs to happen there?*

...

Ms SPICER *- My opinion is that we need to follow the suit of New Zealand. If you look at comparative population and demographics, Tasmania should have around 15 training positions per year. UTAS should put on a course to provide that. They should be under scholarship.*

I am currently studying under a federal scholarship through the University of Queensland but that requires me to go out of state so it would be good if UTAS could have the same support. We would have 15 candidates per year, producing 15 nurse practitioners every two years. Meanwhile, the federal government could provide the appropriate billing and prescribing changes that we need, so that would see that filter out into private practice. Nurses will tend to stay and work in rural and regional areas longer and are usually quite happy there, becoming ingrained in the community. That is what I would like to see happen. My model would be an urgent care centre that has funded training positions and that would also take over those Ochre roles and provide a 'hub and spoke' model to the regional areas.
...

Ms STEVENS - *... I think there is a two-pronged approach. There is the private model and there is the supported state model. It depends on which way - there is the incentive that it would be good to have a GP with nurse practitioner model. There should be those incentives there for GPs to train and grow a nurse practitioner within their service. However, they do not have those incentives. I think that needs to be looked at on its own as well.*

In terms of training through universities, nurse practitioners have a whole year internship where they need their clinical hours met. That could be flexible to be done anywhere, but they are usually done within the stream of where they are working and specialising. Take

emergency departments, for example, what we know of very well, there aren't any funded positions for that. ….

I think there is a loss of communication across a lot of multidisciplinary areas about what services the community get. So having a look at what the issues are within that specific community and what kind of specialities do they look for, like chronic health, physiotherapy allied health, nurse practitioners and how we can all work together. An urgent care model could be publicly funded, it could be co-funded, that is what is in my submission, that maybe a mixed model might work a bit easier for everyone.

Nurses and doctors do work really well together. It is a more cost-efficient model as well, long term, looking at the price of locums. Why not invest in nurses to train them alongside … GPs to set up an urgent care model? That is sustainable, where the student nurse practitioner from UTAS can go and spend those hours in that clinic…Setting up those models first needs to be planned.[277]

Ms Spicer added that a suitable model may attract nurse practitioners from the mainland.

The Committee invited comment from ACT, South Australia, Queensland and Western Australia to ascertain progress in implementing a nurse practitioner model of care in those jurisdictions. A summary is provided as follows.

The Chief Nursing and Midwifery Office (CNMO), Western Australia health outlined the Current Profile of the Nurse Practitioner Workforce 2020:

The first two NPs in Australia were endorsed in December 2000. In the last 10 years, the NP workforce has grown.

…

In 2004, the first NP was registered to practice in WA following legislative, regulative, and clinical practice change. NPs are employed over vast geographical distances and diverse sectors.

Change occurred in 2009/2010, allowing NPs to have access to the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS). NPs are legislatively authorised to undertake diagnostic assessments, treat, prescribe and refer patients within their scope of practice.

Historically, to comply with regulation 11A of the Poisons Regulations 1965 for the purposes of section 23(2)(e) of the Poisons Act 1964, NPs were restricted to practice within a Designated Area, approval which was sought from the Chief Executive Officer (CEO) of Health or Delegate on the advice of the CNMO. To be designated the following conditions were required to be met:

- *The NP worked under clinical protocols for the purposes of defining their scope of practice; and*
- *On request by CNMO, information in relation to the operation of the Designated Area and the practice of NPs practicing in the area was to be provided.*

[277] Alison Spicer and Leahanna Stevens, *Transcript of Evidence*, 31 March 2022, pp. 2-5.

From 2005 to 2017 there was steady growth in requests for Designation of Areas for NPs from all WA health domains, including privately practicing NPs seeking to be designated.

Following the enactment of Medicines and Poisons Regulations 2016, the requirement for NP Area Designation by the CEO of Health or Delegate no longer exists. Since January 2017, the clinical governance for all NPs lies solely with the employer and the NP themselves via credentialing processes.

From 2018 – 2020, the WA CNMO undertook a review of the NP workforce with the primary aim to describe and review the current context of the NP role in WA, to identify workforce challenges, to evaluate and highlight current areas of opportunity and to identify and recommend strategies to promote an innovative and sustainable model of NP care. The review also highlighted a significant NP workforce risk in WA with data demonstrating an ageing workforce, a five-year declining growth in NP graduate numbers and endorsements, difficulty in securing employment, system-wide underutilisation and negligible mentoring and succession planning strategies.

2.5 NP Credentialing

Endorsed NPs working within WA Health must be credentialed to practice. Credentialing is a formal process performed by a Health Service Provider (HSP) Credentialing Committee and is managed through the WA Health credentialing facilitation system - CredWA.

Initial credentialing consists of:

- *Verification of credentials - initial review and verification of qualifications, skills, experience and competencies; and*
- *Defining the scope of clinical practice for an NP within a specific health care facility.*

Re-credentialing (Renewal) is formal review of credentials and scope of clinical practice to confirm that a NP has maintained or improved their qualifications, skills, and competencies and that the health care facility still requires, and is able to support, the defined scope of clinical practice. Renewal of credentials and scope of practice must occur at a maximum of five-year intervals.

2.6 Collaborative Arrangement

To allow NPs to practice in a clinical setting they must enter into a Determination of Collaborative Arrangement with a medical practitioner. Collaborative arrangements can be demonstrated by:

- *The NP being employed or engaged by one or more specified medical practitioners, or by an entity (HSP) that employs or engages one or more specified medical practitioners;*
- *A patient is referred in writing to the NP for treatment by a specified medical practitioner;*
- *An arrangement is made between an eligible NP and one or more specified medical practitioners; and*
- *An arrangement recorded in the NP written records.*

2.7 Medicare Benefits Scheme (MBS)

NPs are eligible to participate under the Medicare Benefits Scheme and can render a Medicare rebateable service. To access Medicare arrangements a NP is required to:

- *Have a Medicare provider number with a separate provider number required for each location an NP practices;*
- *Be working in a private practice;*
- *Have professional indemnity insurance; and*
- *Have collaborative arrangements in place with a medical practitioner(s) specified in the regulations.*

Eligible NPs can request certain pathology and diagnostic imaging services for their patients and refer patients to specialist and consultant physicians as required under Medicare arrangements. NP reimbursement remains comparatively low for MBS items at 85% of the schedule fee. There are more than 5,700 MBS items which provide benefits to patients for a comprehensive range of health services, of these eligible NPs have very limited MBS rebateable items within their scope of practice.

NPs employed in the public hospital sector, or working in a publicly funded NP role, are unable to obtain a Medicare provider number, prohibiting them from referring patients privately for MBS items such as radiology, pathology or specialist review (exceptions to this apply to organisations with a Section 19(2) exemption). This restricts the service provided to patients and dictates that the NP must get assistance from a medical practitioner to enable them to refer or request outside the health service when required. Publicly practicing NPs are further required to have on-site arrangements with their radiology providers to enable them to request radiological investigations.

2.8 Evaluating the NP Role

HSPs in WA are encouraged to have robust scopes of clinical practice evaluation to ensure appropriate recruitment to an NP role as matching service need and not to an individual.

Through ongoing evaluation of scope of clinical practice, it is anticipated that the value NPs add in care will be clearly articulated.[278]

Queensland Health provided a summary of initiatives which are currently in practice in Queensland:

Project to establish a pathway for rural and remote generalist registered nurses

- *The delivery of healthcare services in rural and remote Queensland is reliant on a sustainable nursing and midwifery workforce.*
- *Creating a long-term sustainable workforce requires the provision of both opportunities for immersion in rural and remote clinical practice and the right conditions for career development.*
- *In an attempt to address the current nursing workforce challenges in rural and remote locations, the Office of the Chief Nursing and Midwifery Officer and Office of Rural and Remote Health have commenced a joint project to establish a state-wide career pathway for Rural and Remote Generalist Registered Nurses.*

[278] Western Australia Chief Nursing and Midwifery Office, *Submission #77*, p. 6.

- *This project is an investment by Queensland Health which involves the development of a program to provide training and supports specific to the rural context and needs of communities. The project is partnering with key stakeholders across the five participating rural and remote hospitals and health services (HHS).*

The Health Services are:

- *North West*
- *Torres and Cape*
- *Central West*
- *South West*
- *Darling Downs*

- *The project aims to develop a program that will be trialled by 20 registered nurses who have at least 2 years' experience and are employed across the participating HHSs in FY22-23.*
- *It is envisaged that this program will evolve and be utilised as a workforce strategy within Queensland Health to attract clinical expertise and build capacity in rural and remote locations.*
- *Stakeholders have contributed to the design of the six-month pilot program which is aligned with the Queensland Health Framework for Lifelong Learning for Nurses and Midwives … and includes:*

  o a suite of five core learning modules – Working in the rural and remote context; Critical Thinking and Clinical Reasoning; Advanced Assessment Skills; Leadership; and Primary Healthcare

  o elective modules which will be selected by the local health service based on local needs and the Clinical Service Capability Framework

  o underpinning supports including an individualised learning plan, clinical supervision (attached), mentoring and succession planning (attached) and clinical coaching

- *Ongoing co-design and stakeholder engagement is crucial for the development of the program to meet the specific needs of communities and enable care to be provided closer to home by competent rural and remote generalist nurses.*

Transition Support Programs (TSPs)

- *TSPs are contemporary, post registration, clinically focused, continuing professional development programs. These programs are developed at Australian Qualifications Framework (AQF) level 8 for specific cohorts to assist the newly graduated or transferred nurse/midwife to acquire further general and speciality knowledge and skills in a logical, sequenced supported approach to effectively transition to work expectations. …*
- *There are a wide range of these programs, for example:*

  o Adult Intensive Care

  o Paediatrics

- *o Emergency*
- *o Neonatal*
- *o Renal*
- *o Perioperative*

- *These programs are managed within Queensland Health by statewide nurse educator groups coordinated by a State-wide Coordinator, a role rotated through by educators from the specialty practice area. Oversight is by the Nursing and Midwifery Directors of Education forum.*
- *Accessible, same principles of structure and target groups, coordination, and governance*
- *Modules from several TSPs relevant for rural, remote context i.e. bespoke program under consideration.*
- *Graduate Registered Nurses (RNs) and Midwives are either required to undertake TSP as a condition of employment or may be encouraged to undertake on employment.*
- *The Nursing and Midwifery Directors of Education have developed a generalised Enrolled Nurse TSP which does not meet AQF8 standards nor provide for articulation.*

Strength with Immersion Model Programs

- *Strength with Immersion Model (SwIM) Programs are highly successful Queensland Health learning programs designed to strengthen the future of the nursing and midwifery workforce by supporting novice to mid-career nurses and midwives to develop skills in a specialty area or context through clinical immersions.*
- *SwIM Programs accelerate the participant's engagement in learning within an area of specialty practice whereby the crucial elements are provided to assist safe transition into the workplace. They also enable the inexperienced nurse/midwife to function more effectively within a short period of time in the new area of practice to a basic safety standard with supervision.*
- *Registered Nurses from regional, rural, and remote locations have benefited from attending the SwIM Programs. For example, upskilling regional paediatric nurses in chemotherapy administration has enabled the provision of patient care closer to home during the pandemic.*
- *The SwIM program supports learning pathways, including TSPs and are aligned with the Framework for Lifelong Learning for Nurses and Midwives. Since the inception of SwIM Programs in 2014 a variety of clinical learning opportunities have been offered including, but not limited to:*
  - *o Paediatric*
  - *o Neonatal*
  - *o Community Nursing Practice*
  - *o Mental Health*
  - *o Rural and Remote*
  - *o Aged Care*

- *o Perioperative Introductory Program*

- *The programs have adapted during the COVID-19 pandemic and whilst many offer participants a clinical immersion of between 2-4 weeks in a supernumerary capacity, some programs now offer a suite of clinical video's, clinical roadshows, or attendance at workshops (online or face-to-face) followed by support from the facilitator via a learning contract. …*

Nurse and Midwife Navigators

- *Queensland Health has invested in nurse navigator and midwifery roles to ensure patients or women and babies are supported through system navigation including those living in rural and remote locations. The Navigator role works to mitigate barriers and empower vulnerable people in their health journey, working across specialities for those persons who have complex health care needs to ensure person centred care in the right place at the right time. The Navigation role aligns to the four pillars:*

    - *o Coordination of Care*
    - *o Creating Partnerships*
    - *o Improving Patient Outcomes*
    - *o Facilitating System Improvements*

Project to establish rural and remote nursing and midwifery workforce pool

- *Clinical Excellence Queensland has allocated project funds to establish a nursing and midwifery rural and remote workforce pool.*
- *The project will be led by Central Queensland Hospital and Health Service (CQHHS) in collaboration with the Office of the Chief Nursing and Midwifery Officer.*
- *The project will review the re-establishment of a state-wide rural and remote nursing and midwifery workforce pool leveraging the learnings from the previous initiative led by CQHHS.*

Workforce planning

- *Addressing nursing and midwifery workforce shortages in rural Queensland prior to the COVID-19 surge was the focus of considerable effort. The immediate nursing and midwifery shortages sits within the context of historical workforce shortages in regional and rural locations, and a high level of retirement risk within the professions. This has been exacerbated due to the COVID-19 pandemic surge requirements.*
- *A key priority for the Department's Office of the Chief Nursing and Midwifery Officer (OCNMO) is to lead and advance policy that will build the sustainability for the professions of nursing and midwifery workforces for now and into the future. OCNMO is prioritising workforce planning activities to support sustainable nursing and midwifery workforces in rural Queensland.*

- *OCNMO will prioritise development of a midwifery workforce strategic action plan over the period April to June 2022 in response to reports of increased difficulty in recruiting midwives, particularly in some regional, and rural and remote centres.*[279]

The South Australia Health submission outlined the use of Nurse Practitioners in SA:

> *SA Health currently employs one hundred and thirty (130) Nurse Practitioners across thirty-eight (38) clinical specialties, ten (10) Local Health Networks (metropolitan and regional) and several State-wide Services.*
>
> *Established regional Nurse Practitioner models of care operate across several clinical specialties in collaboration with nurses, midwives, medical practitioners, allied health professionals and other rural health care providers. The clinical specialities include:*
>
> - *Emergency*
> - *Mental health*
> - *Oncology*
> - *Adult palliative care*
> - *Diabetes*
> - *Geriatric community services*
> - *Aged care (currently under development)*
> - *Older persons emergency outreach/in reach (currently under development)*
> - *Community outreach-chronic diseases (currently under development)*
>
> *Those working in regional Nurse Practitioner chronic disease models of care, mental health and palliative care, do so in partnership with a comprehensive metropolitan based outreach medical specialist and specialist nursing networks, and regional general practitioner and community nursing networks.*
>
> *Ongoing medical workforce pressures and the growing burden of disease in regional South Australia has seen the emergence of complementary rural Nurse Practitioner led models of care in emergency care in most of the regional LHNs across South Australia. Whilst the rural emergency Nurse Practitioner role draws upon the well-established metropolitan emergency Nurse Practitioner models of care operating throughout Australia, the South Australian regional experience has required a new and adaptable approach to tailor, and fully enable and support regional health system capacity and responsiveness. The SA Health Rural Emergency Nurse Practitioner Model of Care (Attachment 1) was developed to assist with the establishment and growth of the Nurse Practitioner roles in the South Australian regional emergency care context.*
>
> *Informed by the Victorian Nurse Practitioner Collaboratives, the SA Health Emergency Nurse Practitioner Community of Practice was established in late 2020 to provide a vital wrap around for new and emerging regional emergency Nurse Practitioners. Furthermore, it has enabled connections between emergency Nurse Practitioners from across South Australia, providing a valuable clinician network offering education, mentoring and*

[279] Queensland Health, 2021, *Submission #79*, pp. 1-4.

professional support. The SA Older Persons Nurse Practitioner Community of Practice has recently been established and will leverage the same methodology and approach.[280]

The Committee received evidence relating to an alternate model of care based in the Netherlands. Buurtzorg has a nurse led holistic model of care. This model has been expanded into Western Australia and Queensland.

Mr Arnold Strooback, CEO, 'Neighbourhood Care', Buurtzorg Australia, described the model of health care provided by the organisation:

About Buurtzorg Australia - we started in April 2018; officially before that, in 2015 NDIS and also government agencies went to the Netherlands and to other parts of the world and had a look at different models. We can throw a lot of money at it, but if you want to change the outcome, you have to do more than that. That is how the relationship started. Jos de Blok went a couple of times to Australia and gave keynote talks, we did workshops and things. There was so much interest, he decided to set up shop in Australia, and that happened in 2018. But basically, we call it advisory services - talking about the model helping more organisations, if they want to know or want to work in the Buurtzorg way. Working, giving presentations, things like this. The royal commissions went to the Netherlands, with those kinds of elements more on the model.

In late 2020, we started as a care provider. We do that under the banner 'Neighbourhood Care'. If you're a client and you see Buurtzorg, you think, I'm not sure what it is, that is a strange word, and so we decided to change that into an English word. That is when we started, in the midst of the COVID-19 pandemic; what were we thinking! There were complications of course with that, but so far so good. We have experience in remote Queensland, with a client who was interested in the Buurtzorg way of working, really remote. We have - I'm not allowed to say 'remote' about the northern teams we have, it's about 100km east of Perth, and they call it a country area, is that right? I call it country, so it's not remote, apparently. As a Dutch guy, we don't have an understanding about remoteness - what we call remote in the Netherlands is a suburb in Holland. It is a different scale of things.

We started 2020 with a strategic partner in Adelaide, and that's also a Buurtzorg organisation, mainly in NDIS. That's how it started, because NDIS had the most interest in the model and you start somewhere. In Holland it started in aged care and went to disability care and other care. Here, we started in the disability and aged care, and we do a few fee for service in aged care because we're not registered for the aged care packages. Unfortunately, fee for service and people paying it themselves is an increasing situation because the waiting list of 18 months is a problem for many people.

Our experience in the more country or rural areas is that the good thing about the model is that you don't need much; you just need the people who can do the actual work. The back office can be anywhere. The main back offices for services for this remote Queensland organisation, we combined with the back office for our own organisation. That is the beauty of the model. You need a good local team, , and that's the only thing you need. It is relatively simple. Also, we found out that as the Buurt is very important in the Dutch social fabric, there is the same thing in country areas. The community spirit is amazing, the give and take,

[280] South Australia Health, 2021, *Submission #80*, pp. 1-2.

and we're in it together. That works really favourably for the model, it's just a nice fit. You don't have to tell someone in a remote area that community is important; that is in the fabric, they know. Some regions have never been served before, especially in disability care. If you talk about rewarding work, you've got one there; although sometimes NDIS doesn't make it easy and they change classifications again, and those kinds of things, but that's operational.

Despite a neighbourhood approach, distance can still be a challenge, because - again - 'remote' can be very remote in Australia. And of course, the only thing you need is a good team, but sometimes it's not easy to find suitable staff. Health, in general, is a highly regulated market, not only in Australia but in general western countries.

If you are not used to a more corporate environment, where you have to be compliant to things and you have to do some admin, you have to put information in the system, and those kinds of things, if you are not used to that we found out that we took it for granted that people knew. But if, for example, you had been a farm boy for 10 years, the first time you work in a more corporate environment - although it is not very corporate - but administration and education, more formalities, and compliance situation, that is a shock. So you have to take time to do that. It takes a little bit longer to build up a team that really functions. You can see it is all about how people like to work. People like to work like that.

Sometimes you have to do an adaptation. For example, we call it the Buurtzorg light. We did it also in Northam to start with, like, we call it a coordinator, who just - it is not management but to make sure that the rostering is done, because the rostering is done centrally, and get the things going. It is like a phasing, if you start with that, and then you phase more into the Buurtzorg way of working to the next stage, and that works fine.

…

***Mr STROOBACK -** We don't have the real statistics yet, how it works here, because it's relatively small. We have two teams in remote areas, so it's too little to have significant data about that. In the Netherlands you need a population of about 10 000 people to have a team, but that's in the Netherlands. If you look at South Korea it's a completely different ballgame again, and Japan too. So it will be different again in Australia.*

I think the challenge is to find people, especially registered people, to work in a rural setting. We also found out that qualified people are often transient, for example because their partner is working in - especially in Western Australia in the mines. They are there for two years and then they move on to the next mine again, and then suddenly, they disappear. So it's a more transient situation.[281]

…

***Mr STROOBACK -** We have a team of about nine at the moment, and they mainly do disability care, but also a lot of coordination, so we have a support coordinator. She lives in York, close to Northam, also a country area. We try to coordinate all the silos available in Australian health setting, the local hospitals, the hospitals in Perth, therapists, and god*

[281] Arnold Strooback, *Transcript of Evidence*, 1 April 2021, pp. 6-7, 11.

knows what, and GPs, so that is a bit of an extra that we do, and also help people navigate through the system.

...

Mr STROOBACK - *... That is the difference with the city, the metropolitan area, and country is that the Buurt is too big. Also, for staff, we have different rules; for example, commuting is up to x kilometres, and then we start paying you for above that. Otherwise, especially with the petrol price nowadays, it is just not possible. It is normal if you live in country to drive 60 kilometres to the next client. We changed our model to accommodate that, and also, still make sure that it is funded enough.*

Mr DUIGAN *- Are you pursuing being registered to provide home care packages. Presumably that helps the funding and sustainability of your model?*

Mr STROOBACK *- We will look at it in the next financial year, I have to say.*

The threshold is very high at the moment, and also there are a lot of changes. If you look at aged care packages, and NDIS, they are getting more and more together. ....

...

CHAIR *- Are staff employed on a contract? What is their employment arrangement?*

Mr STROOBACK *- Permanent part-time, in general. We have a little clout of casual workers because of COVID-19. Sometimes you start with a casual arrangement. It depends on the flexibility.*

If people say I can only work in the mornings, Tuesdays, Thursdays and Fridays - we don't know sometimes whether that works for the team. I'll start with a casual, and see how we go, if it works. We always try to convert the casuals into permanent part-time, because the teams are really core to the model, and you can only get a good team, if it is a two-way street. If we cannot commit as an organisation, why would people commit?

CHAIR *- You don't have full time staff in the teams?*

Mr STROOBACK *- We have a few, but most people do not want to work full time.*

As long as it works for the team. I am getting involved in some interviews because they ask me, because I have a lot of experience with doing interviews. But the team decides whether it fits and suits the team.

CHAIR *- Are they paid according to the federal award wages? How are their salaries set, or their rates of pay?*

Mr STROOBACK *- We pay award levels. Within awards you can play around the levels you give. In some organisations they would say 2.1, and with us they were going to be 2.3 for example, so we try to be a little more generous on that side. we would also like later on, because in Holland too we are a for benefit organisation. It is not legally known in Australia - you are a not for profit or a for profit organisation. In Europe, you also have the for-benefit organisation, which means that it runs like a business, but the way the dividend is treated is different.*

CHAIR *- Are you classified as a not for profit or a for profit organisation?*

Mr STROOBACK *- For profit organisation.*

CHAIR *- Right, but you are really for purpose rather than profit?*

Mr STROOBACK *- Yes; we call it benefit.*

Mr DUIGAN *- How well do the teams work in different cultural settings across different countries? Do you find that the teams in the Netherlands work very well, but you have to work harder to establish a team that works in Australia, for example; or is it universal?*

Mr STROOBACK *- From every country we hear that it might work in Netherlands but it will not work here. That is not the case. Sometimes it takes longer. I never realised it in the time I lived out here, but the default here is a hierarchical organisation - everything is with layers of management, and instruction down and reporting up.*

In Northern Europe, you do not have those organisations. Government organisations have layers of managements, but further then that the default is now a flat organisation. We found that the employees we hired, have never been exposed to working for a flat organisation. It takes time and trust. There is a strange feeling - won't I need to ask permission? Nope, what do you think should happen?

Go for it. And that's new. We found out it takes a couple of months, and then it won't go back. You see it everywhere. In China as well, you would not expect that but sometimes have a different outcome, the first time I saw a photo with the team in a row together and they're all standing in meticulous uniforms, and one in front of them with a little pet. That does not look like Buurtzorg, but the thing is that role is rotated, so this month you're the front man, the next month I'm the front man. It's basically resolved.[282]

[282] Arnold Strooback, *Transcript of Evidence*, 1 April 2021, pp. 11-13.

TERM OF REFERENCE 6

CAPITAL AND RECURRENT HEALTH EXPENDITURE

According to the Tasmanian Government submission:

> *The Tasmanian Government is committed to building a sustainable health system that provides Tasmanians, regardless of where in our state they live, with the right care in the right place at the right time. The 2020-21 State Budget included $9.8 billion in health spending over the next four years, a record investment by any Tasmanian Government. This is unprecedented resourcing for our health system and is in addition to the $391.2 million capital program being delivered across the state. As we acknowledged at the time the 2020-21 State Budget was delivered, this expenditure includes $600 million of additional funding for the Tasmanian Health Service (THS) over the next four years in a boost to our funding base that will help meet demand in our hospitals and underpin improved health outcomes.*[283]
>
> …
>
> *The Tasmanian Government has made vital and significant investments into the health system. Despite this, demand for healthcare continues to grow, with Tasmania's ageing population and high numbers of Tasmanians living with co-morbid health conditions being major contributing factors. Limited availability and capacity of primary, community and homebased services mean Tasmania still has too many people being cared for in hospital that could otherwise be cared for in the community. Care in the wrong place is not best for those receiving the care (both in terms of their experience of care and health outcomes) and comes at a high cost to the state; approximately $100 million is spent each year on care delivered in hospital that could have been delivered at a lower cost in the community.*
>
> *Through the Our Healthcare Future reforms, the second stage of the Tasmanian Government's long-term reform agenda, the Tasmanian Government is committed to building a highly integrated and sustainable health service for the future. The Our Healthcare Future reform program is focused largely on the achievement of connected care that is well balanced across Tasmania's acute, subacute, and primary and community health sectors, and on the provision of care in the most appropriate settings.*
>
> *The Our Healthcare Future reform program proposes three key areas for improvement: 'Better Community Care', 'Modernising Tasmania's Health System', and 'Planning for the Future'. Under these key areas are a range of initiatives, many of these initiatives will also have benefits for those living in rural and remote areas of the state. These initiatives focus on areas such as (but not limited to):*
>
> - *workforce planning, including partnerships with training and education providers*
> - *increasing support for primary health care professionals in caring for people with complex conditions in the community*
> - *increased access to telehealth and the introduction of virtual care solutions*
> - *improving information and communications technology (ICT) infrastructure; and*

[283] Tasmanian Government, 2021, *Submission #72*, p. 5.

- *increased and formalised mechanisms for provision of expert clinical advice to support service planning*.

The Our Healthcare Future reform program also includes a focus on strengthening the consumer voice in health planning. It is important the voices of people living in, and/or providing services to rural and remote areas of Tasmania are heard to enable future planning and initiatives to be best targeted to meet local needs. A public consultation process was undertaken on the Our Healthcare Future discussion paper, to help guide future planning and a number of submissions were received from a broad cross section of the community, including consumers, clinicians, professional groups, service providers, advocacy groups, policy experts and academics. The Department has completed an analysis outlining the key themes to emerge from the submissions which found:

- *wide support from respondents for the overarching themes of the reforms proposed in the Consultation Paper*
- *strong support for patients to be treated in the community setting where possible and appropriate, and for greater emphasis on preventative health*
- *an acknowledged need for digital transformation, long-term infrastructure and workforce planning to improve access to services and support new models of care.*[284]

According to the AMA submission:

In recent years, the Government has changed its funding model to the Modified Monash Model (MMM). Some areas of Tasmania have been reclassified and are no longer considered rural. For example, Lilydale in the North East is now considered the same as Launceston and therefore is no longer eligible for some Commonwealth incentive funding. AMA Tasmania believes that the MMM has been detrimental to General Practice in Tasmania and would like to see it reviewed.

So far, our calls have fallen on deaf ears nationally.

> *"MMM status is, I believe, part of the problem and leads to a compounding of the factors by negatively impacting on GP availability in rural Tasmania and funding for federal programs. There is a significant shortage of access to primary care on the outskirts of the MMM2 area surrounding Hobart and a complete misunderstanding of the local communities in these areas. There are rural towns without any public transport, which are considered equivalent to central Hobart under the current status. Burnie and Devonport are considered [M]MM3, which appears appropriate this is not about reclassifying areas to a lower MMM rather push for some areas to be upgraded. It is my understanding when MMM was introduced, it was acknowledged that some areas would be disadvantaged by the new system and southern Tasmania would appear to be a prime example of this. There was talk with the election of the new AMA president/VP of taking this forward for challenge, but other priorities have taken over and this appears to have been dropped." (GP Southern)*

Uncertainty of funding for programs catering for rural communities' needs or narrowing the programs' scope also creates unease and a lack of confidence for GPs.

[284] Tasmanian Government, 2021, *Submission #72*, p. 39.

"Of the current programs supporting rural areas there is uncertainty around the future of program I find most helpful for my patients (Corumbene Rural Health) but others which appear well funded, but I don't see any meaningful patient engagement or improvement in outcomes e.g., Brighton Care collective. Others again appear well funded e.g., RFDS rural teen health program but will only accept patients from Central Highlands, at the last time of asking they had a case load of three patients, yet I have several patients in Southern Midlands who would benefit support but don't live in the right LGA." (GP Southern)

Local Council funding and support for General Practice varies greatly. As per an independent report in 2013, Glamorgan Spring Bay Council was levying ratepayers $200,000 per year and contributing much the same in support for Triabunna, Swansea, and Bicheno. This money is used for practice buildings, cars, accommodation, locum subsidies and many other aspects of general practice. The Tasman Peninsula provide a house for the local doctors to use, and the Huon Valley Council provide general practice services in Geeveston. Other communities receive little to any Local Government support.

Variable funding is difficult to manage. With income or benefits from local councils and communities and variable state government funding, and reducing federal funding through Medicare, this is a management nightmare. Consistency would be most welcome for our state's GP management teams.[285]

Dr John Saul, AMA in a public hearing provided further observation:

***Dr SAUL -** The Monash model breaks areas into seven categories, ranging from inner city to the most extreme rural areas. In Tasmania, we now only have about four areas that are categorised as level 7. A lot of areas, including Launceston and Lilydale, have gone down a level. Launceston might be classed as a city but, as I said, one practice has lost up to $100 000 a year.*

***CHAIR** - Talk to us through how changing levels affects the funding that you get.*

***Dr SAUL** - Again, it's hard to understand, Ruth. I find it very difficult and challenging. Effectively, with the Monash model, a lot of areas in Tasmania have been downgraded in their level of rurality.*

***CHAIR** - Which means?*

***Dr SAUL** - Which means less income from funding.*

***Dr SEIDEL** - Dr Saul, can you explain what financial incentives the Commonwealth offers to practices under the Modified Monash Model? In particular, can you explain the support the Commonwealth offers towards bulk billing and the tiered bulk billing incentive? The other is how GPs can be retained. What does the Commonwealth offer and what has changed under the Modified Monash Model?*

***Dr SAUL** - Very little and in a very confusing manner. We get funding from the federal government in terms of the Monash model. Certain areas with increased rural zoning will get more money, more retention grants for GPs, greater subsidies for GPs if they stay in those*

[285] Australian Medical Association (Tasmania), 2021, *Submission #52,* p. 3.

areas, greater bulk billing rates for those areas, additional funding for what we call the SWPE, the Standardised Whole Patient Equivalent, which is a figure that each general practice achieves in terms of consistent patient loads. As a result, in each of the eight or more things it relates to, Tasmania has come off second best and has a reduction in funding.

***Dr McARDLE** - There are some practice incentive schemes, aren't there?*

***Dr SAUL** - Absolutely. They've disappeared for some practices, simple as that.*

***Dr McARDLE** - That went to funding some nurses, is that correct?*

***Dr SAUL** - Yes, it's a constantly shifting base. Often we're just shuffling the same amount of money around different areas.*

***CHAIR** - How are the decisions made around, say, Lilydale, which you've mentioned, or a town like Wynyard? Part of the problem as I understand it from GPs in my area is the way that the catchment area is defined. Is that part of it? How is that worked out? What criteria would see a town, region or an area move from one level to another?*

***Dr SAUL -** Madam Chair, you are asking me to put my head into the mind of a Canberra bureaucrat here. I will do my best.*

It is a complicated process where services are allocated based on distance from a major hospital or from a major centre. No allowance is made for the fact that Nubeena is an hour and a half away from Hobart but by distance of circumference it is only about 40 or 50 kilometres. No allowance is made for Lilydale being well outside of Launceston with a difficult convoluted road that is prone to ice in the morning.

***CHAIR** - The assessment is done as the crow flies.*

***Dr SAUL -** Yes. I have seen this over the years. South Arm was rated as inner city at one stage.*

...

***Dr SEIDEL** - May I ask specifically, Dr Saul? The AMA was supportive of the Modified Monash Model, understanding that the regional context differs quite substantially from state to state. What role did the state AMA branches have to inform the Modified Monash Model? Would the AMA Tasmania consider asking for an exemption of the model when it comes to Tasmania knowing that, for example, Kempton is classified the same as Bridgewater now, which doesn't make any sense to anybody who lives or who wants to practise medicine there.*

The implications are quite substantial. If you are downgrading the Modified Monash Model you are losing out on the bulk billing incentive payment. That means patients that will be out of pocket. If you are downgraded in the Modified Monash Model as a practitioner, it means you will have an income cut quite substantially in all the years to come as well. Saying that, because all medical associations including the AMA, that supported that model from a commonwealth level, it is unlikely to change, isn't it, because you have to change the methodology? What is the AMA Tasmania arguing that we spend?

***Dr McARDLE -** You are correct. The AMA nationally supported the model and in most other states it works well. Ever since people became aware of the impact here we have been*

lobbying the federal AMA to say that we have to do something about this because it is unfair. The way it applies in Tasmania just skews things.

They are not particularly interested in it so we have decided that we need to lobby ourselves in settings like this. When we speak to the minister we raise it; when we speak to the secretary we raise it because, for whatever reason -and it is probably that 'as crows fly' thing - it is distorted here. We have a lot of winding country roads and it is difficult to get about. Whereas in other states you have the big urban centres and then you have the remote centres. You do not have the same mix that we do. We have been lobbying, but federally they are not interested because for most other states it works. An exemption, if that is a possibility, would be excellent.

***Dr SEIDEL** - Do you believe, Dr McArdle, that the Modified Monash Model is not fit for purpose when it comes to Tasmanian health funding for all areas?*

***Dr McARDLE** - That is what we are hearing from our members. The reason I deferred it to John is I do not totally understand its impact.*

***Dr SEIDEL** - It's not fit for purpose for the Tasmanian context, right?*

***Dr SAUL** - It has certainly been detrimental for all Tasmanian GPs.*[286]

According to the Royal Australian College of General Practitioners (RACGP) submission:

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.[287]

Primary Health Tasmania (PHT) noted:

In terms of state funding, the Tasmanian health system is often positioned against a backdrop of increasing and unsustainable investment. In the face of rising demand for health services, Tasmania has a long history of defaulting to increasing investment in emergency and acute care, often at the expense of any substantial, long term, community-based care investment and this particularly impacts people in rural and remote communities.

Specifically, funding for primary care should be identifiable and protected in state budget process and not placed or forced into a competitive space alongside acute care.

The 'pull and push' of state and federal funding is perhaps most acutely felt in rural and remote communities, and small health business viability and sustainability characterises most of the recent decline in access for rural communities. Funding and service provision mechanisms generally tend to be geared for the major population centres and are highly constrained in terms of the flexibility and capacity required to drive service integration in

[286] Dr John Saul and Dr Helen McArdle, *Transcript of Evidence*, 7 October 2021, pp. 3-5.
[287] RACGP, 2021, *Submission #65*, p. 6.

rural and regional areas or respond to the critical challenges associated with sustaining viable primary health business. There are still many barriers that exist that permit genuine opportunities to combine funding 'buckets' and allow co-design and co-commissioning of services which are the most contemporary and efficient ways to share and manage resources and responsibilities. Small communities are often very well placed to bring their own solutions to the table with the right supports and structures and yet there are so many barriers - particularly related to government process – that, inadvertently and despite best efforts, create duplication, service gaps and community consultation fatigue is real when the efforts could be combined through more effective partnerships.

Tasmania needs to urgently explore integrated health service business models that combine funding from multiple sources (including state, MBS, local government and private flows) to sustain rural community access, attractiveness and viability. This is best achieved through co-commissioning of services and pooling of scarce resources.

Primary Health Tasmania's (sic) *advocates for investment that will ultimately benefit all Tasmanians but with the biggest gains for people in rural and remote communities:*

- *invest in developing a sustainable digital health infrastructure and capability*
- *invest in preventive health*
- *invest in innovative models of complex and chronic care that are led by primary care.*[288]

According to community member Jennifer Hadaway:

Capital and recurrent health expenditure are not separate buckets. They are the same budget applied in a different time frame and each should be integrated and supportive of the needs of the other. Government should instigate a community funding model based on locally identified health priorities confirmed by local community consultation.

Some areas of rural and regional Tasmania, including Dover, fall well behind what the community knows is needed because local health issues go year to year unspecified and unbudgeted. Frank discussion by government and the community with health professionals would alleviate the present waste of time and money, the need for local GP's to bargain for basic service funding and the need to address the usual shortfall.[289]

According to Dr Gabrielle O'Kane, NRHA when providing verbal evidence:

The Tasmanian health workforce is less able to meet demand for services, both inside and outside the public hospital system. The state also suffers from an ageing health workforce, impacting on the long-term sustainability of the system.

These issues are persistent in that they are not improving over time. The alliance views this situation as unacceptable. We believe it is important for all levels of government to work together to address this inequity. Fundamental to these issues is a systematic problem: the Tasmanian and commonwealth governments need to collaborate more in the design, funding and management of services across the whole health system. Reducing demand for Tasmania's overcrowded hospitals requires reducing avoidable hospitalisation, which

[288] Primary Health Tasmania, 2021, *Submission #64*, p. 10.
[289] Jennifer Hadaway, 2021, *Submission #50*, p. 5.

would be achieved by strengthening primary health care services by GPs, allied health providers, pharmacists and other community health professionals.

The separation of powers and funding responsibility for hospital services, primary health care and public health activities leads to gaps, duplication and fragmentation in service delivery. Joint planning and funding for health services would help to provide coordinated patient-centred care from a wide breadth of health professionals to address patients' health needs over time.[290]

Mr John Kirwan, RFDS suggested funding on a needs basis:

Funding in our current systems are not needs based. If they were needs based they would address the inequities between rural and remote populations within Indigenous populations and white populations, and they don't. That is a fundamental issue.[291]

Mr Phil Edmondson, CEO Primary Health Tasmania suggested a move away from fee for service model:

We have to be providing an environment and an incentive for practitioners to work more effectively together at the local community level. This notion of 'see me until I can do no more for you, then I pass you on' is great in a normal sort of escalative sense but we could do so much better for people if we had teams of people working at the local level together that stop people from escalating. We make an assumption that escalation is normal and it just happens, rather than actively working to try to prevent people from moving through that system. That can only be done if resourcing at the local level - and we're talking in local communities, regions, rural areas - is provided to support practitioners to work together.

Fee-for-service models are not good for that. They never have been good for that. We need to be looking at how we can blend those payments more effectively to support that notion of team-based care. That's particularly important in Tasmania where our burden of chronic and complex care is huge. It's growing and it's going to overrun us in the blink of an eye if we don't do something more purposeful around that.[292]

According to the Occupational Therapy Australia (OTA) submission:

A key factor which impacts on people's willingness to interact with those delivering mental health supports is the environment in which services are delivered. Housing mental health services in buildings that promote a message of respect would have a positive impact on the community's perception of mental healthcare.

At present, the physical environment of both Community Mental Health Services in the northern region of Tasmania and Child and Adolescent Mental Health Services (CAMHS) sends an indirect message that publicly-funded mental health services are not valued as highly as other medical services.

While significant improvements have been made to the Launceston General Hospital over recent years, there is now a stark contrast between the environments in which medical services and mental health services are provided. This can convey a sense that people with

[290] Dr Gabrielle O'Kane, NRHA, *Transcript of Evidence* 20 August 2021, p. 2.
[291] John Kirwan, RFDS, *Transcript of Evidence*, 2 November 2021, p. 12.
[292] Phil Edmondson, *Transcript of Evidence*, 2 November 2021, pp. 62-63.

mental illness and the staff treating them are somehow less worthy of investment. This can impact the overall willingness, or lack thereof, of people to return and receive treatment in these environments, as well as the recruitment and retention of staff.

OTA understands that the building which houses CAMHS is more akin to an accounting firm than a place where children and their families are welcomed and provided with a health service.

According to OTA members, the building where adult and older person's mental health services are provided is in general disrepair. The roof leaks in various locations and has for many years now. The environment has the feel of a mental health facility of the 1950s rather than the twenty first century. There are holes in the walls in staff toilet areas where the plumbing has been fixed and the wall not patched, toilet cistern lids are missing and toilet roll holders broken. The central courtyard garden is often overgrown.

This reflects a failure to understand the impact that the physical environment has on the provision of a modern mental health service. Clinicians seek alternative buildings at times to see clients or run group sessions, as the CAMHS building is unsuitable. Hospitals could learn a great deal from other mental health services which have done significant work to make environments welcoming and appropriate for the services provided inside.[293]

Professor Andrew Wilson highlighted the need for community engagement in understanding the needs of rural communities:

Secondly, every community location has special features that account for the health care access issues in that locale. This may be issues of remoteness, history of medical services as they existed in that service, specific needs of those communities - for example, with our Aboriginal and Torres Strait Islander communities. So in finding solutions, you need to take, what I call a place-based initiative. You actually have to look at each of those individual sites and think about the issues that are generated in that site.

This was really brought home to me recently, as part of the evaluation of the Virtual Rural Generalist Service here in Western New South Wales where I was shown the rostering records for a range of communities in that area. In that roster it showed the local health care arrangements and it showed where the Virtual Rural Generalist scheme was being used. You could just see this diversity of arrangements across just that one local health district in terms of what was going on. As we talked about it, those local issues just evolved and came out. It really reinforced in me the need to think about this, both from a systems point of view - how we support that - but also from a local point of view.[294]

[293] Occupational Therapy Australia, 2021, *Submission #57*, pp. 7-8.
[294] Professor Andrew Wilson, *Transcript of Evidence*, 31 March 2022, p. 28.

TERM OF REFERENCE 7

REFERRAL TO TERTIARY CARE INCLUDING:

A) ADEQUACY OF REFERRAL PATHWAYS;

B) OUT-OF-POCKET EXPENSES;

C) WAIT-TIMES; AND

D) HEALTH OUTCOME IMPACT OF DELAYS ACCESSING CARE

Much of the evidence received relating to this term of reference, has been outlined under the previous terms of reference. This chapter provides further details related to these matters.

With respect to timeliness of access to health services in Tasmania in relation to outpatient and elective surgery services within the THS, the Tasmanian Government submission stated:

> *… all patients are placed on a waiting list according to their clinical need as indicated by their urgency category (urgent, semi-urgent and non-urgent), regardless of where in the state they reside.*
>
> *The THS is currently progressing a range of initiatives to enhance the management of wait lists in Tasmania. These include an update of state-wide operational policies and protocols, application of patient-focused bookings and implementation of alternative models of care for patients who do not require an acute care pathway. The THS is implementing Health Pathways and Clinical Prioritisation Criteria to ensure alternative models of care are available for people who do not need to take an acute care pathway, including acute and community hospital avoidance strategies.*
>
> *The most recently published figures for both the outpatients waiting times and the elective surgery waiting list numbers reflect the impacts of the national suspension of non-urgent elective surgery in March and April 2020, as well as fewer outpatient appointments during the COVID-19 activity restrictions.*
>
> *While often the first level of contact with the health system, access to primary care can be challenging in rural areas. As Our Healthcare Future recognises, lower levels of available primary and community care may see people present to hospitals for treatment that could have been provided by a primary care clinician. This may be due either to immediate challenges in accessing primary care or, through cost or access conditions, delaying care so that diseases or conditions deteriorate to the point where hospital attendance is required. This may result in hospitalisations that could have been avoided (potentially preventable hospitalisations). It may also result in undue pressure being placed on emergency services in rural areas and emergency departments in urban areas.*
>
> *As noted above, the Tasmanian Government has limited capacity to directly influence the availability of GPs, which is more prominently influenced by Australian Government policy and market factors. However, Our Healthcare Future acknowledges further improvements*

to primary and community care are key factors in the sustainability of major hospitals in Tasmania and improving health outcomes for the community.[295]

According to the AMA submission:

Referral to tertiary care, including:

a. Adequacy of referral pathways.

There are some parts of the system that are working well. For example, the Tasmania Health Pathways has links to palliative care services and is a repository of information for clinicians.

11 Palliative Care - Community Health Pathways Tasmania

The Tasmanian Health Service website has referral pathways for clinicians and patients.

Welcome to Palliative Care | Palliative Care (dhhs.tas.gov.au)

The Tasmanian Health Service Formulary has helpful information about palliative medications. Palliative Care - Tasmanian Medicines Formulary (health. local)

However, referring to Outpatients Clinic is not timely, with patients been left for months and sometimes years for appointments.

Pathways for more urgent care that doesn't need Emergency Departments needs to be clearer and accessible. One doctor put it this way, a patient "might not need ED now, but can't wait six months either – where do I turn?"

b. Out-of-pocket expenses.

Palliative patients living in the North and North West can access a PET scan as part of their oncology tests at either Launceston (out of pocket expense $700) or Hobart (no out of pocket expense for the test, but travel and accommodation costs are covered only in a limited way and a family member must accompany them).

Cardiology is severely under-resourced and overpriced. One GP's experience is that nothing is done at LGH with everything seemingly been referred to The Charles Clinic. Yet, they, too, are overworked and understaffed. Tests are very expensive. LGH needs more cardiology services - aged pensioners can't afford the Charles Clinic. We need to understand why cardiologists don't want to live in Launceston.

Federal Medicare Funding

The Medicare Benefits Scheme remains very challenging for General Practice with multiple billing modes and, in real terms, a falling Medicare rebate. As a result of cost cuts, the Medicare rebate for a standard consultation is now $30 to $40 in real terms, less than what it was when Medicare first started some 30 years ago.

Other blended funding helps with Practice Grants and Care Plans, for example, but again without a strong management structure, practices may be under billing for these. While good medicine is occurring in so many of these areas, if a practice has inefficient or inexperienced management, their Medicare Billing's maybe 10 to 20% less than they should

[295] Tasmanian Government, 2021, *Submission #72*, p. 14.

be. Challenges with Medicare can result in significant reductions in income. A less complicated and inflexible Medicare system would help.

As rural areas are likely to be of lower socioeconomic groups, the reliance on bulk billing further reduces income.

c. Wait-times.

AMA Tasmania does not have access to wait times data. However, what is on the public record through the Report on Government Services and the Health Department's Dashboard (https://healthstats.dhhs.tas.gov.au/healthsystem) shows that there is a problem that needs addressing.

We believe the Private Cardiology Service is servicing the North and North West of Tasmania has a six month wait for a new patient to be seen by a specialist.

Orthopaedic, ENT, Neurology, Cardiology, endoscopy, and colonoscopy all have unacceptable wait times and are certainly very poor compared to access and wait times on the mainland. See Report on Government Services 2021 and https://outpatients.tas.gov.au/clinicians/wait_times for data.

d. Health outcome impact of delays accessing care.

> *"FOBT positive – I refer – plus six months later still not done. I get letters from the National Screening program asking why they haven't had their colonoscopy? Yes, why?"*

Elderly patients wait years with pain for their hips and knees, and meanwhile, their mobility suffers and their health declines.

In NW Tasmania, palliative patients present late due to lack of access to medical imaging, GPs, and respiratory and other specialists. This delay is exacerbated by poor health literacy and overall poor health due to multi-morbidity. The outcomes are poorer for such patients in our community.[296]

According to the RACGP submission:

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.

[296] Australian Medical Association (Tas), 2021, *Submission #52*, pp. 10-12.

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.[297]

According to the Arthritis and Osteoporosis Tasmania submission:

Early diagnosis and access to specialty services is critical to avoid or limit irreversible joint damage, deformity and disability associated with some forms of arthritis. In addition, poorly managed arthritis and related musculoskeletal conditions contribute to the morbidity of conditions such as diabetes, cardiovascular disease and depression, and ongoing high use of health care resources. Patients with inflammatory arthritis require management and treatment of their rheumatological condition by a rheumatologist as they are often prescribed complex medications that can only be prescribed by a rheumatologist. As a consequence of the current lack of musculoskeletal health services, people with arthritis living in rural and remote Tasmanian communities:

- *experience long delays for Rheumatology specialist appointments; or simply give up waiting;*
- *are often referred inappropriately to surgical or neurology waiting lists;*
- *are not given the opportunity for early diagnosis and referral to improved pain pathways and self-management programs; and*
- *experience poorer health outcomes.*
- *The PBS mandates 6 monthly rheumatologist reviews in all patients receiving high cost complex medications, without which ongoing medication supply cannot be obtained. This patient population comprises 25% of rheumatology practice.*[298]

According to the Occupational Therapy Australia submission:

The referral system needs to be simple to understand, and access easy to obtain. One reform that could improve the accessibility and timeliness of occupational therapy services would be a single point of referral for occupational therapy in each region, streamed and triaged by skilled occupational therapists.

Older people experiencing mental health challenges, especially those living in rural and remote areas, encounter multiple issues when seeking well-timed access to the required services, as well as the time and duration limits imposed on service delivery. Early intervention is essential in the initial stages of ageing and decline, and can lead to significant cost reductions by keeping people out of hospital.

However, waiting times for services can be exceptionally long, particularly in rural communities. There should be increased access to health services for older Australians, particularly those which can be provided in the home rather than hospital.

[297] Royal Australian College of GP's, 2021, *Submission #65*, p. 6.
[298] Arthritis and Osteoporosis, 2021, *Submission #43*, p. 5.

There is a need for a shift in priorities and an investment in more occupational therapists in the public health system, to reduce wait lists and enable reasonable time to be spent with each client. With regard to waitlists, the website that provides outpatient waiting times only has a category for "Allied Health". OTA would like to see this sub-categorised, with waiting times for each allied health profession.

http://outpatients.tas.gov.au/clinicians/wait_times

There are occasions when older clients should be seen in their own home, and while OTA acknowledges that providing such services often means occupational therapists see a smaller caseload, this drawback is outweighed by the longer-term cost benefits, most notably the avoidance of hospital admissions.[299]

Minke Hoekstra and Myles Clarkson-Fletcher, Diabetes Tasmania on referral pathways:

Dr SEIDEL *-You mentioned this in your submission. You say your referral pathways have been available and have been available for years, but obviously are poorly defined. And then you say patients often have no idea how to navigate the health system to receive the care they need. So, some money's being invested in developing those pathways and then they still don't meet the need of the patients, and patients don't know what to do next.*

Ms HOEKSTRA *- For example, we were working with a PhD to review the diabetes health pathways, which is fantastic. We're identifying opportunities for us to better link, to get patients referred to us at multiple stages for newly diagnosed, ongoing, starting insulin, whatever we can do to refer them to us, but there's no equivalent pathway for people with diabetes. There's nothing they can refer to other than their local GP to say, "What happens, I've been diagnosed with diabetes. What happens?" There's the annual cycle of care. A comprehensive GP will tell them all of those things, but not everybody does. If people don't have the health literacy to look up reputable websites or to even take the initiative to contact us and find out, they can fall through. We've had referrals come through, for example, we coach patients who are then so complex that we'll ask the social worker to help them. The social worker spends so much of their time sending off referrals and then having to chase up, "Did you get the referral?" "No, I don't know where it went." "Okay." Follow it up again. Follow it up again. And linking back to the patient. So, there are gaps everywhere in terms of both the sharing of referrals and patient information, and also the navigation - how to navigate that. Especially for the individual.*

CHAIR *- … if it's a GP sending a referral or a nurse practitioner or a specialist sending someone to someone else, you expect that it's received and actioned, and you don't expect to spend half your life following up. So, what's the problem here? How is this happening, do we know?*

Ms HOEKSTRA *- I don't know, no. It's not across the board, but definitely for some organizations it's almost like the procedures and policies aren't in place to send back an automatic receipt of referral, a procedure to action it. That's my experience from what the social worker said.*

CHAIR *- Can we name some of these, so we know where we're looking?*

[299] OT Australia, 2021, *Submission #57*, p. 8.

Mr CLARKSON-FLETCHER *- There are two things. What our social worker has done is highlighted that there's fragmented care. For some person living in the north-west vs the north, what are the services available? That local knowledge isn't always available to everyone. In a system like Tasmania, there's probably an over-reliance on personality-driven care; some people who've been there for long enough who know. It's relationship-based care rather than using a pathway.*

CHAIR *- So it falls down with the use of locums, for example?*

Mr CLARKSON-FLETCHER *- Exactly. So, there's that issue. There's the issue of their being inundated. We referred someone recently to the hospital team for follow-up, but that referral sat there for a week and we had to chase it up. That's simply because their waitlists are so long, they're acting on getting someone to see them.*[300]

And further in relation to the COACH program, Ms Hoekstra noted:

Speaking from the perspective of the COACH Program, there are lots of worthwhile, especially smaller, community-led initiatives that come up, be it Strength to Strength exercise classes and that sort of thing. To keep track of them, and they disappear after a period of funding, is really, really hard. Our COACH Program for people with or at risk of diabetes has been running for 11 years. A few years ago we did a GP survey to see how many GPs knew about the program and it was at 50 percent. It takes a long time to establish the knowledge of particular services. Reliability of funding and longer-term funding for the right programs helps to create awareness and embed those programs into the health pathways.[301]

[300] Ms Minke Hoekstra, *Transcript of Evidence*, 20 August 2021, pp. 7-8.
[301] Ms Minke Hoekstra, *Transcript of Evidence*, 20 August 2021, p. 9.

TERM OF REFERENCE 8

AVAILABILITY, FUNCTIONALITY AND USE OF TELEHEALTH SERVICES

Dr Ross Lamplugh, Ochre Health, made the following comments in relation to telehealth facilities for rural GPs:

> ***CHAIR*** *- For remote and rural practices with telehealth, how important is having a good internet connection, good facilities like cameras on the ceiling over the examination bed and things like that?*
>
> ***Dr LAMPLUGH*** *- They are absolutely critical. As we go forward the problem with rural health is that every day that I work as a doctor I'm more likely to get sued than I was yesterday. The reason for that is there is a more litigious society emerging but it's also because medicine is getting more complicated every day. Even in my lifetime - the number of medications I'm expected to know and understand.*
>
> *When you go back to the good old days, when I wish I existed, with my little doctor's bag and five pills and a scalpel, I'd still be working clinically now if that was the case. If you're going to ask someone to work in Queenstown, now they must have really good access to help. That's one of the things I always say to the young ones who are hesitant to go out - the phone's your friend. That was in my day, you'd stabilise a patient, you needed to have really good initial emergency management skills but then the next thing I would do is ring someone who knew more than I did. For some reason not everyone is happy to do that, but when you've got cameras over the bed and someone able to look in, someone in the background talking to you -*
>
> ***CHAIR*** *- You can see it live.*
>
> ***Dr LAMPLUGH*** *- To see what you do. That's partly to give you assistance and it's partly to give you confidence. The number of times that Hamish and I were dealing with an emergency in Bourke and we would just ring the other one to say, can you just pop in, I know you're not on call, but can you pop in? Hamish would come in and I would be managing someone with an infarct or whatever it might have been and you'd say, this is the story and this is what I've done. Is there anything you can think of that I have missed? And he would say, no, that sounds fine. Okay. Off you go, back to the pub and I'll keep managing the patient but you manage them much more confidently. That's what some of this telehealth stuff can do. It can give you the confidence that you're not doing anything silly because you don't know what you've forgotten. You know if there's a problem.*[302]

Ms Adrienne Picone, TasCOSS:

> *Digital inclusion is an area that TasCOSS has quite a strong focus on more generally across our work, but specifically in health, because we know that increased use of digital technology will improve access and outcomes for many Tasmanians - but for many others, the shift to*

[302] Dr Ross Lamplugh, *Transcript of Evidence*, 17 May 2022, p. 21.

online or digital services will only exacerbate their exclusion. This, of course, is worse in rural areas with the challenge of connection, affordability, and digital skills being exacerbated.

A TasCOSS health literacy report produced in 2021 found that while digital technology could improve access to health care for many Tasmanians, for many others it was actually a barrier to getting care. That report found five areas of challenge -

- *cost of devices*
- *data access*
- *digital literacy skills and literacy skills*
- *being able to navigate services*
- *the user experience.*[303]

According to the Rural Doctors Association of Tasmania (RDAT) submission:

Telehealth services can be grouped in 2 areas. Primary care carrying our telehealth to patients to avoid the need to present at the medical centre. This is funded federally currently, and state government should campaign to continue the adequately remunerated Medicare item numbers, with caveats ensuring patients are seen by their regular doctor or practice. Telehealth also applies to non-GP specialist clinics from the major hospitals. This has been a significant success for rural patients to avoid the long stressful travel to the major hospital for outpatient clinics. RDAT would like to see this continue for rural patients and expand to allow video links which are better for both clinician and patient. The savings in travel costs and time for patients is key and means for some patients who struggle with the travel, and may cancel appointments, there is less likely to be a problem. In some practices support for a dedicated room to undertake videoconferencing would be helpful for those patients who do not have access to this type of technology. The room plus equipment that provides fast connection speeds would be useful.[304]

According to the Australian College of Rural and Remote Medicine (ACRRM):

ACRRM acknowledges that telehealth is an important component of rural generalist practice noting that it is not an acceptable 'replacement' for face-to-face services and instead should be viewed as a tool to support and strengthen in-person care. Telehealth can improve health outcomes by facilitating timely access to essential specialist services and advice. It can further extend the scope of practice of Rural Generalists to provide comprehensive care for patients in the local community in consultation with other specialists if required. There is particular value for both patients and practitioners in shared care arrangements which facilitate quality models of care involving the patient-end clinicians (Rural Generalists) and remote-end specialists/consultants. It can also improve the professional relationship and mutual respect between rural practitioners and their urban-based colleagues and promote communication and collaboration to achieve high quality patient care.

[303] Adrienne Picone, TasCOSS, *Transcript of Evidence*, 26 November 2021, p. 2.
[304] Rural Doctors Association of Tasmania, 2021, *Submission #30*, p. 11.

However there can be perverse outcomes to a reliance on telehealth. These include a decline in the provision of face-to-face visiting specialist services to rural communities and more importantly, a reduction in the levels of equipment, staffing and skills in rural facilities and services. Telehealth must only ever be regarded as a support, never a replacement for rural communities and their health workers. Any use or expansion of telehealth services must be done within a policy context that recognises that telehealth should complement rather than replace face-to-face care; support high quality continuity of care with the patient's usual GP or practice; and minimise the potential for telehealth services to undermine both the quality of care and overall sustainability of rural and remote practices and primary care services in particular.[305]

According to the AMA submission:

Availability, functionality and use of telehealth services.

"Telehealth has helped. I do a lot by phone now. Patients don't mind follow up with clinic or LGH specialists by phone once they are known. (It saves them a trip to Launceston, 100 km round trip and transport problems.) But we could do more if we had more doctors. I still only have the same number of hours in the day." AMA is working hard with the Australian Government nationally to ensure that some form of telehealth remains post-COVID.

While telehealth cannot and should not replace a physical examination or face-to-face consultation, it does have a role to play with some patient care and has been welcomed by many patients and practitioners alike. The THS has provided telehealth infrastructure and training for the Specialist Palliative Care teams for some time now. Palliative patients on the West Coast, King Island, can access telehealth consultations. GPs and primary health nurses in these areas can phone the palliative care team to discuss clients via telephone or videoconference calls.[306]

According to the RACS submission:

Another key priority for RACS over the past twelve months has been the integration of telehealth services into traditional models of health care delivery across Australia. The COVID-19 pandemic has resulted in rapid changes to medical practice, precipitating a rapid uptake of telehealth for consultations. RACS recently commissioned a rapid review to investigate the factors that either prohibit or encourage the implementation and use of telehealth, and to examine patient and provider perceptions of telehealth services.

In 2020 RACS also conducted two separate telehealth surveys which garnered more than six hundred responses by surgeons and more than eleven hundred responses by patients. The telehealth review combined with the data generated from the surveys, provide important evidence of the important role that telehealth will play in the future of Australia and Tasmania's health system. We also encourage that these findings be taken into consideration as part of this review and guide Tasmania's future telehealth strategy.[307]

[305] Australian College of Rural and Remote Medicine, 2021, *Submission #36*, pp. 3-4.
[306] Australian Medical Association (Tas), 2021, *Submission #52*, p. 12.
[307] Royal Australian College of Surgeons, 2021, *Submission #66*, p.2.

According to the Primary Health North Submission*:*

> *There is an increasing move towards digital medical records and the need for technology within health services such as telehealth consultations, medical equipment with wireless capability, requirement for capture of patient data at the bedside etc. Currently, no Primary Health North service inputs its records directly into Digital Medical Record (DMR) and 2 of its 8 district hospitals do not have wi-fi, with another 2 district hospitals having inadequate wi-fi with only a small area of the site covered wirelessly. Lack of wi-fi at rural facilities is a major barrier to use of telehealth at our sites* [and] *is also an additional stressor for staff given connectivity is an essential requirement for an increasing number of tasks and systems across our health service.*[308]

The CTST submission made the following statements regarding the availability, functionality and use of telehealth services:

> *We would like to note that, for many of our users, who are among the most socio-economically disadvantaged Tasmanians, digital technology is by and large not a help, but rather an extra hurdle they face in accessing health services. Many of the most disadvantaged do not have ready access to suitable technology for telehealth consultations and the like, nor the knowledge or ability to use equipment if they do have it. These are potentially the costliest patients in the health system, often having multiple or more complex problems than the "average". For these patients, access to services needs to be physical, face-to-face contact.*[309]

Dr Dennis Pashen, a General Practitioner located in Queenstown and former President of ACRRM, provided evidence regarding his experience with telehealth:

> *The problems I've seen with the facilities in towns within rural Tasmania, of which I have seen many, is under-equipment. The actual buildings are fine. There's no problem with that. But they are under-resourced with equipment and with the pharmacopoeia provided within those institutions. I've listed some of those in there and I don't want to repeat or go over it. I will leave that for you.*
>
> *The issue I would like to highlight within the facilities is there is a very cheap option for a state health department to develop a good telehealth service in Tasmania.*
>
> *Prior to coming down here I had been led to believe that Tasmania had a fairly strong telehealth program with a good infrastructure. I was somewhat dismayed when I landed in Tasmania and working in the rural community that there was, in fact, very little infrastructure in telehealth within the state.*
>
> *This isn't new information. This was a fairly longstanding resource provided to rural and remote communities throughout Australia. There are over 450 sites in rural Queensland, for example, as of the late 1990s, with telehealth facilities supporting their rural and remote health workers.*
>
> *The point I was making, particularly is the gap in emergency services within Tasmania Health Service. I could work, for example, in Doomadgee in the Gulf of Carpentaria or*

[308] Primary Health North, 2021, *Submission #13*, p. 16.
[309] CTST, 2021, *Submission #14*, p. 4.

Mornington Island that link directly to either the Flying Doctor Service or the emergency department in Mt Isa, Cairns, Townsville, or even Brisbane, to have advice from the emergency physicians there if I had a critical patient. They could actually watch what I was doing, advise me on what I was doing and support me as a clinician in that remote and often scary environment.

That actually doesn't cost a lot. I think the price when I last looked at it, which was some years ago, was about $16 000 to set up. I think it is somewhere over $25 000 to $30 000 but still that is a cheap price to have that kind of support available to your rural clinician. That includes the remote area nurses. It includes a number of other people who can access those resources.

At the moment it seems to me that telehealth in Tasmania is basically held for meetings. The private sector has embraced it because there is a Medicare remuneration but there is a fair resistance within the specialists in Tasmania to actually accessing from the public system to another public system.

For example, I had a patient in Scottsdale with a fractured subcapital humerus, which is the neck of the humerus. She was in a lot of pain. The orthopaedic people expected her to be ambulanced across to Burnie for them to cast their eyes on it. They already had the X-ray. They knew what it was. And they knew that there wouldn't have been anything they could have done with it. They would have cast their eyes on it then put her in an ambulance to go back to Scottsdale. Unnecessary travel, unnecessary pain and discomfort for the patient.

That could have been handled simply with a telehealth video conference link. The facilities were there in the Scottsdale hospital but there is a failure to engage on the part of the specialists within the public health service.

It is not a unique problem for Tasmania. When it's introduced everywhere, the same resistance from our specialist colleagues seems to exist.

That doesn't exist in the case of the haematologists and the renal physicians, I might add. They tend to support that because they have often very sick patients and telehealth seems to be a favourable opportunity for them to reduce the discomfort of their patients.[310]

According to the Women's Health Tasmania submission:

The Federal Government's move to broaden the Medicare Benefits Schedule around telehealth schedules in response to the pandemic was a positive move. Medical professionals report many positives of the growth in telehealth services during the COVID crisis. WHT's own telehealth services also took off in this period, as clients' confidence about this form of service delivery increased.

The increased access to telehealth services was particularly beneficial for rural patients as it gave patients more choice in the doctors they consult around services. It was a huge boon for people seeking services that their regular GP might not provide. It was particularly important for people seeking the medical termination of pregnancy and STI testing and treatment.

[310] Dr Dennis Pashen, *Transcript of Evidence*, 17 February 2022, pp. 22-3.

This was wound back in July, making it only possible to access Medicare funded telehealth with your regular GP or practice, and only if you have been an active patient with that practice within the last 12 months. This restricted access for women seeking sexual and reproductive health services. GPs practices in rural areas may not offer specialist sexual and reproductive health services. Few rural GPs have done the additional training required to deliver specific sexual and reproductive health services. Women may live in rural areas where the local GP is a conscientious objector to the provision of certain women's health services. The long term impact of policy decisions such as this is women seeking terminations being unable to access services in a timely way. Medical terminations, which are more affordable and can be administered in a woman's own home, are only available up to 9 weeks gestation. Women whose pregnancies are further advanced are forced into the hospital system to seek a surgical termination.[311]

According to the Huon Valley Council submission:

Limited Telehealth services are available to residents of the Valley, however are met with challenges. These challenges include

- *Low literacy levels which require patients to need support person to manage the technology.*
- *Lack of available specialists to utilise Telehealth within the public system.*
- *Limited room space within practices for Patients to utilise Telehealth.*
- *Unreliable internet connections for remote areas.*
- *There should be consideration into Staff available to support patients to connect and utilise the system.*
- *The rebate for telehealth consultations for both the general practitioners and specialist.*[312]

According to the Arthritis and Osteoporosis Tasmania submission:

Whilst it is understood that regional patients are reviewed utilising telehealth whenever feasible, the Australian Rheumatology Association recommends that initial appointments are conducted face to face due to the inherent examination limitations of Telehealth consultations. Good clinical practice is to physically assess a patient at least every 12 months.[313]

According to the Health Consumers Tasmania (HCT) submission:

During the past 15 months there has been a substantial increase in both the provision and use of telehealth services across Tasmania. This has allowed some clients to access services which were previously out-of-reach. The use of specific Medicare item numbers for these services has assisted in the streamlining of service provision. However, there are still specific barriers to access for a substantial number of Tasmania's rural population highlighted in kitchen table discussions carried out by Health Consumer Tasmania at the beginning of 2021. These include:

[311] Women's Health Tasmania, 2021, *Submission #22*, pp. 6-7.
[312] Huon Valley Council, 2021, *Submission# 19,* pp. 7-8.
[313] Arthritis and Osteoporosis Tasmania, 2021, *Submission #43*, p. 5.

- *a number of people had never heard of or did not know how to access telehealth services*
- *there were also a range of issues that complicated the use of GP Assist, Telehealth and on-line services.*

These limitations included:

- *The patchiness of internet coverage and speed*
- *The cost of internet coverage and associated hardware*
- *Age and physical limitations on learning new skills*
- *A growing disparity between those who were able to access afterhours medical help on-line and those who could not*
- *rural health consumers were concerned about the associated technological costs associated with being able to access telehealth services. These comprised the cost of suitable hardware and software but also the cost of maintaining a high-speed internet connection. For rural health consumers experiencing poverty this could create situations where they struggled to gain access to health treatment*
- *rural health consumers were also concerned that the increased use of telehealth services would result in a decreased access to on the ground services into the future thus exacerbating shortages of health services in rural areas*
- *rural health consumers showed concern for those in the community who struggled with literacy and in particular computer literacy. Rural health consumers have a lower-than average school leaving age and lower literacy levels than the rest of Tasmania. These issues combined with an aging population who may be slightly more reticent to use computers to transact business limit the usability of telehealth services in rural areas. On ground services need to be maintained to maintain health access in rural and remote areas.*[314]

According to the Occupational Therapy Australia (OTA) submission:

> *The Australian Government is to be commended for its timely amendments to the Medicare Benefits Schedule (MBS) that have allowed allied health professionals to deliver services via telehealth throughout the COVID-19 pandemic. This enabled the ongoing care of vulnerable Australians and ensured the short to medium term viability of many allied health practices. In the case of occupational therapy, it appears the majority of services can be effectively delivered via telehealth. OTA is currently participating in a university-led study of just how efficacious such services are. Until such evidence-based findings become available, however, OTA is largely guided by the anecdotal evidence of highly experienced members – which is remarkably consistent. Members report that telehealth is well received by most – but not all – clients. Most – but not all – services can be delivered by telehealth very effectively. OTA recognises the opportunities that technology presents for improved service delivery in rural, regional and remote areas. It should also be noted that e-mental health is an emerging area of practice for many occupational therapists and other mental health clinicians.*
>
> *While the growth of telehealth might alleviate the problem of remoteness, there are obviously occasions when the health practitioner must be physically present with the client. This is particularly true of occupational therapists, who sometimes need to work with the*

[314] Health Consumers Tasmania, 2021, *Submission #56*, p. 9.

client in the environment in which they are trying to function, such as their home, workplace or school. Occupational therapists and other health professionals face a number of barriers to providing telehealth services to clients in rural and remote areas. These include access to videoconferencing technology in an appropriate clinical space; slow Internet speeds; and ensuring that patients have completed necessary tests and scans prior to a telehealth appointment. Older people may also require assistance to become familiar with the technology used to provide telehealth services.

The success of telehealth often depends on how clinicians adapt their practice and/or modify their services to work in a telehealth environment. There are a number of positive aspects, including improved care coordination for clients and the convenience of not having to travel a considerable distance to access services. OTA members report that, as a result of telehealth consultations, they can now see more clients in a day – a significant consideration in the context of a developing occupational therapy workforce shortage. Greater funding for telehealth service provision at both a federal and state level would also address many of the current challenges and might, in the longer term, prove a cost saving to the health system.[315]

Primary Health Tasmania (PHT) referred to both digital health capacity and access to telehealth in its submission. With regard to digital health literacy the submission notes:

- *As is the case with many services, a contemporary and capable digital spine is critical. Tasmania's digital infrastructure is antiquated, compartmentalised, inwardly focussed and unfit for purpose. This leads to poor communication, an absence of timely data to inform service design, inefficient and costly handling challenges, errors in transposition and ultimately to greater likelihood of avoidable harm. In terms of rural impact, the further from the 'centre' a service is, the more prone to the impacts of poor data and communications the provider and consumer are likely to be.*

…

- *The lack of a 'joined up' health environment where health information and data can be shared significantly impacts the delivery of safe and high-quality care to rural and remote communities. Currently, the Tasmanian Health Service has a legacy IT system that has been developed in an ad hoc manner over many years using different platforms. As a result, hospitals cannot atomically* (sic) *store and share, or communicate patient information between hospital campuses nor with primary health providers, leading to many issues for both patients, their general practitioners and other community-based service providers.*
- *The root cause of this problem is the absence of a contemporary hospital patient management and health record infrastructure, integrated with state and national eHealth infrastructure. Such systems facilitate end to-end electronic communication with primary care referrers and allows general practices to access information about care received within the hospital by their patients.*
- *There are also other acute care patient management systems – for example Tas Ambulance – that have no ability to transfer a patient record to general practice –*

[315] Occupational Therapy Australia, 2021, *Submission #57*, p. 8-9.

platforms that do not integrate with the rest of the health system are a major impediment to communication and integration.

…

- *Unfortunately, some rural and remote areas that would benefit the most have the oldest infrastructure and the least connectivity – this should not be a deterrent for investing significantly in digital infrastructure and health technology but signals that other government partnerships and investment will be needed.*[316]

Regarding telehealth particularly, the Primary Health Tasmania submission notes:

- *Effective use of telehealth and remote service access is a major potential boon for rural and remote Tasmanians. Rural health facilities and practitioners have certainly made some valuable use of telehealth and growth in its application for clinical purposes has been pushed, but by and large use of telehealth facilities and infrastructure prior to COVID-19 in Tasmania has been predominantly for administrative purposes.*
- *Telehealth for primary and community health care is widely seen as a solution to address service access challenges, although historically it has also been seen as 'too complex to implement' or 'not compatible with patient expectations'. COVID-19, however, has been a driver for rapid telehealth establishment to help reduce the risk of community transmission and provide protection for patients and health care providers by negating the need for patients to present at a medical centre. Although positioned as a temporary measure, telehealth is currently supported with MBS items for out-of-hospital patients.*
- *COVID-19 has also provided the opportunity to learn what works and doesn't work when using telehealth – to date, the large majority of telehealth has been over the phone with video link not widely taken up. To ensure Tasmanians are supported by more flexible and accessible models of care, there must be a range of simple to use telehealth solutions are available within the hospital system, and in community public and private primary care. Telehealth options should be able to include (and switch between) voice and video and potentially allow patients to provide/share information from selected health apps where this information could be useful.*
- *Telehealth broadly has demonstrated its effectiveness in terms of contributing to service continuity, good health outcomes as well as cost efficiency. It has generally been embraced by communities and providers alike for the provision of many primary care and community services.*
- *In rural and remote areas telehealth supports rural patients and their providers to overcome barriers to accessing services. An excellent example is access to non-GP specialist clinics based in the major hospital. Using telehealth patients can avoid travelling for their outpatient care – in Tasmania travel can be long and uncomfortable due to geography, weather conditions and road conditions.*
- *There are barriers to the effective use of telehealth, particularly digital and health literacy capability which varies greatly across Tasmania's population. This will need to be addressed in any move to more widespread use of non 'face-to-face' clinical engagement. Disadvantaged, aged and poorly literate populations as well as those in rural and remote areas often lack the capacity, digital infrastructure and health literacy*

[316] Primary Health Tasmania, 2021, *Submission #64*, pp.11-12.

to engage remotely. Resolving this challenge will require ongoing investment through local government, technology providers, community organisations and health services.

- *Telehealth implementation in Tasmania requires ongoing efforts to ensure a coordinated, state-wide approach to embedding telehealth is progressed. This includes sorting the lack of fit-for-purpose equipment, dedicated rooms and access point in rural facilities.*[317]

PHT recommends the Government consider "*prioritising eReferral, shared record viewing, care planning, My Health Record and electronic prescribing as the key areas where a digital interface between hospital and other community-based care providers would improve the security, timeliness, quality and completeness of shared patient information and optimise continuous quality and health outcomes."*[318]

Psychologist Tim Sanderson called for the establishment of a virtual ward in the Royal Hobart Hospital:

> *I see such a ward as offering our rural community of the Huon Valley easier access to medical care and faster recovery times for a range of situations and conditions that are currently causing immense pressure on actual beds in the main Hobart hospital.*
>
> *This model recently established by a number of National Health Trusts in the UK, as a result of COVID19, has lead to significant benefits in patient care and hospital bed management, with patients being sent home with technology to allow them/carers to submit key health observations on a daily basis (as per nursing care on a physical ward) which is captured electronically via an App and made available for medical and nursing staff to be alerted should a patient need either readmission or another service.*
>
> *Contact with patients has been both by app and by phone depending on the NH trust. The ability for staff to manage the pressure of COVID19 patients appears to have been greatly enhanced…*
>
> *My further exploration of this model and pathway for patients brought up RPA in Sydney which now has a virtual ward. This is not a hospital which services a rural community, but from the point of view of the Huon Valley and other rural communities served by the RHH, the potential could provide access to hospital services and care without actually being 'in hospital.'*
>
> *…*
>
> *I am aware of the recent RHH attempts at establishing a 'hospital at home'; model of which I have had a disappointing experience. I was sent home, 'discharged' with IV medications to show up at a local clinic for a nurse to administer for me over five days. This included a weekend. The Sunday dose of antibiotics required me to attend the home of my GP for its administration.*
>
> *A far from satisfactory arrangement. This is not 'hospital at home' this was dereliction of care in my view. I managed to deal with it, and had to attend a clinic in Kingston not Huonville, with my Antibiotics hanging over the top of a door. It worked, but it was far from*

[317] Primary Health Tasmania, 2021, *Submission #64*, pp. 11-12.
[318] Primary Health Tasmania, 2021, *Submission #64*, p. 12.

satisfactory. 'Hospital at Home' - seems to me not well thought out, clearly not fully funded and seemingly in my view an attempt to cut corners and save money, whilst compromising patient care.

The model of RHH hospital beds at the local Aged Care facility has also proven problematic especially for those of us who are not aged - and I certainly have never fitted the criteria for access to one of those beds when I needed one in the past.

The model of a fully funded and staffed virtual ward with a NUM and roster of nursing staff and daily virtual 'ward rounds' with doctors promises better access to care, prevention of needing to be admitted to a hospital bed in the actual hospital and better circumstances for recovery by being in one's own home, yet still 'a patient' not yet discharged from hospital care until well enough.[319]

According to the Tasmanian Government submission:

Expanding the use of telehealth in the THS has been a key part of the strategy to reduce the need for patients to travel for services under the One Health System reforms. Telehealth has become an increasingly important part of Tasmania's model of delivering health care where clinically safe and appropriate.

Telehealth services enable people in rural communities to access vital health services closer to where they live (for example via tele or video conference). This has resulted in improved access to, and timeliness of, care for patients in rural and remote locations, in turn helping to reduce potentially avoidable hospital admissions, length of stay in hospital, readmissions and unnecessary presentations to emergency departments.

The Tasmanian Government has expanded the state's telehealth infrastructure and capacity in recent years, both as part of the One Health System reforms and through the Government's response to the COVID-19 pandemic (with a 1200 per cent increase in demand for telehealth services from January 2020 to May 2020). This has included significantly expanding appointment capacity across Tasmania with 20 virtual rooms expanded to accommodate up to 5 000 virtual appointment bookings. It is estimated that for the period from March 2020 to February 2021, this expansion of telehealth resulted in 793,400 kilometres (approximately 9 705 hours) of patient travel saved.

The expansion of public telehealth services, along with the extension of the Australian Government's MBS rebates for telehealth services, has supported improved provision of care in rural and remote areas. Telehealth services enable patients to connect from their local health service through to their medical specialist elsewhere in the state, reducing the need for patient travel through the provision of specialist services remotely to people in their local area.

Within the community care setting Tasmania Government telehealth services are used for a range of services including (but not limited to):

- *antenatal classes*
- *diabetes education*
- *community nursing assessment, care and review*

[319] Tim Sanderson, 2021, *Submission #61*, p. 1.

- *allied health therapies*
- *Child Health and Parenting Service*
- *Hospital in the Home, to support community palliative care.*

Ongoing use and expansion of telehealth and virtual healthcare has the potential to significantly improve patient care and patient experience of care for those people living in rural and remote communities, through increasing access to high quality, timely health care, closer to people's homes. This is a key focus of the next stage of the Tasmanian Government's health reform agenda …[320]

And further:

As noted above in Section 2, increased access to telehealth in the THS was a key part of the strategy to reduce the need for patients to travel for services under the One Health System reforms. Telehealth has become an increasingly important part of Tasmania's model of delivering health care where clinically safe and appropriate, enabling people to access vital health services closer to where they live, via use of both phone and video conference.

Current activity underway as part of the Telehealth Expansion Project to support improved access to acute, subacute and specialist health services for people living in rural and remote areas includes:

- *Implementation of Cardiac Rehabilitation Education via Telehealth for rural and remote patients.*
- *Provision of telehealth for outpatient appointments to the following specialities:*
    - *Renal*
    - *Neurology*
    - *Orthopaedics*
    - *Cardiology*
    - *Rehabilitation (including Tele-rehab)*
    - *Spinal Medicine*
    - *Surgery*
    - *Cardiothoracic*
    - *Vascular*
    - *Infectious Diseases*
    - *Rheumatology*
    - *Sexual Health*
    - *Respiratory*
    - *Endocrinology*
    - *Allied health*
- *Use of telehealth to provide persistent pain services to north and north west Tasmania.*
- *Upgrading clinical telehealth capability in district hospitals and CHCs.*
- *Implementing telehealth outpatient consultations for patients in their home environment.*[321]

The Tasmanian Government submission confirms that increased access to telehealth and the introduction of virtual care solutions is an initiative of the Our Healthcare Future reform program

[320] Tasmanian Government, 2021, *Submission #72*, pp. 17-18.
[321] Tasmanian Government, 2021, *Submission #72*, pp. 32-3.

which proposes three key areas for improvement: 'Better Community Care', 'Modernising Tasmania's Health System', and 'Planning for the Future'.[322]

> *The Tasmania* (sic) *Government has committed to the development and implementation of a Telehealth and Virtual Care Strategy for Tasmania that provides high quality patient care and integrates service delivery across acute, subacute, primary and community care.*
>
> *A statewide approach to telehealth and virtual healthcare that brings together and builds on existing Tasmanian and Australian Government telehealth initiatives (including gains made as part of the COVID-19 response), has the potential to significantly improve patient care and the patient experience and increase access to primary and community-based healthcare.*[323]

Furthermore, the Government's *Our Healthcare Future* strategy includes actions to:

> *Develop a Health ICT Plan 2020 - 2030 encompassing electronic medical records, a new patient information system, electronic tools for managing care for patients in appropriate settings, and the new Human Resource Information System.*
>
> *Partner with Primary Health Tasmania to improve patient care by enhancing the interface between specialist and primary healthcare through:*
>
> - *implementation of a single eReferral system between primary care and the Tasmanian Health Service*
> - *scoping the requirements to implement a secure web-based application to enable GPs to view key information about patients in the care held by the Tasmanian Health Service*
> - *a continued partnership-based focus on the development and implementation of jointly agreed clinician led Tasmanian health pathways.*[324]

[322] Tasmanian Government, 2021, *Submission #72*, p. 39.
[323] Tasmanian Government, 2021, *Submission #72*, p. 40.
[324] https://www.health.tas.gov.au/about/what-we-do/strategic-programs-and-initiatives/our-healthcare-future (accessed 30 August 2022).

TERM OF REFERENCE 9

ANY OTHER MATTERS INCIDENTAL THERETO

Integration of Services and Electronic Data

The Rural Doctors Association of Tasmania (RDAT) submission supports an improvement in integration across all parts of the health system and its key interfaces (e.g., primary health, mental health, disability services, aged care and acute care):

> *A key priority should be integration of mental health and alcohol & drug services. Unfortunately, substance use and mental health are two key comorbidities that interplay and require extensive outpatient (and sometimes inpatient) support and care. RDAT does not believe these two services are best delivered independent of each other.*[325]

Ray Bange OAM calls for a community integrated model of health care:

> *Community integrated healthcare*
>
> *A common theme in past reviews is to recognise the importance of healthcare that is close to the community and which ensures right care, right patient, and right time. These principles align with national policies that envisage the growth of integrated out-of-hospital care to cater for an aging population and increasing incidence of chronic conditions that is seen to be preventable, with the burden particularly acute in rural and remote areas.*
>
> *Most patient attendances by ATas are not acute cases demanding a 'lights and sirens' response and the objective of achieving an integrated healthcare system needs to go beyond the perception of ATas as a pre-hospital emergency care provider operating in a silo. Policymakers should embrace the concept of ATas as the principal public agency facilitating the role of paramedics in the provision of broader healthcare responses through the delivery of out-of-hospital care in diverse situations (whether in the field, a healthcare facility or at home) and under conditions at times of unscheduled emergency.*
>
> *This pattern of care and practice activities has been demonstrated by effective diversion and referral programs nationally and internationally. ECPs are increasingly becoming first line healthcare providers and the Australian Productivity Commission has recommended using ECPs to deliver efficient health care. Pilot projects funded by the former Health Workforce Australia have also shown the benefits of community and extended paramedic care. More recently the future of healthcare delivery is envisaged as having a greater emphasis on primary care with the release of the draft National Preventive Health Strategy. Achieving the goals of this strategy will require the engagement of all elements of the health workforce in integrated healthcare and embody optimal pathways of out-of-hospital care including community paramedics and ECPs holding prescribing rights.*
>
> *Among the transformational factors in delivering integrated healthcare will be the full implementation of electronic health records and access to patient data in out-of-hospital and clinic settings. Electronic data collection can be a powerful tool in monitoring patient*

[325] Rural Doctors Association of Tasmania, 2021, *Submission #30*, p. 11.

indicators for chronic care, for patient handover purposes, for research, systemic analysis and in areas of auditing and quality assurance.

For ambulance services, electronic health records should enable rapid retrieval of records and transmission of data while en-route to definitive facilities. Fully integrated electronic health holds the promise of facilitating clinical feedback to the paramedic, ATas, the patient's GP and/or specialist physician and other services, thus enabling a seamless delivery of care.[326]

The Rural Doctors Association of Tasmania calls for the digitisation of all specialist letters, emergency department presentations, investigations, discharge summaries, procedures and correspondence:

A 'one-stop-shop' electronic medical record should be prioritised. This would allow for a seamless entrance to the Tasmanian Health System through the emergency department, specialist outpatients or day surgery; continue through an inpatient admission including ordering and signing investigations and providing a clinical handover back to primary care with written communication. We need to replace the 10+ ICT systems that clinicians and ancillary staff need to navigate on a daily basis to provide patient care. Overwhelming feedback from primary health clinicians is that My Health Record is not very user friendly. It is currently limited to shared health summaries, THS discharge summaries (albeit in limited form with poor formatting and difficult navigation) and MBS data.

The THS could improve the formatting of electronic discharge summaries in their presentation on MyHR, include specialist letters/correspondence and all hospital investigations (including imaging). Giving GPs access to hospital digital records would help to make information available for ongoing care. The information currently available in the DMR is presented in a more user-friendly way than MyHR.

Other states, such as Queensland have an online portal that allows access to the hospital clinical records. Reports from primary health care providers in that state indicate that portal is limited in what clinicians can access. RDAT would recommend that if a similar model was adapted then Tasmanian GPs have available all of the DMR in the form of a web browser portal. Current remote interfaces with Citrix logins and remote desktop connections would not be acceptable. Timely communication and access to correspondence is the most important part of primary care's interaction with the Tasmanian Health Service and is often poor or non-existent.

The THS needs to invest heavily in e-Referral technology with the ability to easily find the services for the applicable medical conditions, minimum referral standards, e-acceptance of referral, indication of wait time or physical appointment time and then communication back to the General Practitioner electronically. With the increased number of presentations to district hospitals, especially with introduction of new mountain biking courses in rural areas; a continued investment in x-ray and ultrasound technology by the THS is needed to appropriately assess and manage patients in these rural emergency departments. The Royal Children's Hospital in Melbourne has developed a web portal and phone app that helps patients (and their parents) keep up to date with their healthcare interactions with the hospital. It provides reminders for appointments, recent test results/investigations, enables

[326] Ray Bange, 2021, *Submission #54*, p. 21.

electronic communication with hospital-based specialists and provides advice for common medical conditions.

The THS could invest in producing a similar application for the Tasmanian context, in parallel with a health professionals' web portal. Currently once a referral is written, it is printed and signed and then faxed to one of many numbers at the referral hospital. The Fax numbers change often and need to be checked on the Tas health directory before the fax is sent. The referrals are not acknowledged until a letter arrives in the post or the patient is informed, they have an appointment. Often correspondence is not received in a timely fashion about the outpatient appointment. Some consultation notes arrive to the GP practice by fax and then need to be scanned to the patient file.[327]

Ms Helen Thomas, Growth and Strategy Manager, King Island Council outlined the challenges experienced on King Island in relation to integration of services:

In many ways, King Island is a microcosm of Tasmania. We do not have different issues from the rest of the state. Access to specialists, interdepartmental communications, patient advocacy and mental healthcare are things we have heard just in the couple of hours we have been here in the room. It was definitely evident in the submissions we read that came through to the committee. Our small population and remote location mean those issues are exacerbated. On King Island, a specialist might be something as simple as a podiatrist, a dentist or a pathology appointment. It really is painful trying to access any of this. If you want anything more than a basic GP appointment or basic triage at the hospital, you are looking at either waiting for a visiting service provider or flying off island to access those services on mainland Tasmania.[328]

Pet ownership

According to the RSPCA submission:

There is unequivocal evidence that pet ownership has implications for the healthcare system and overall public expenditure. Companion animals offer a range of health-related benefits including improvement in overall health and psychological wellbeing, which is important given the increased life expectancy and the prevalence of chronic diseases in the general population.

These issues are especially evident when considering the specific health challenges facing rural communities.

Yet, to date, there has been little discussion of the role that companion animals can play in primary healthcare and health promotion, particularly in rural communities.[329]

In relation to recognition of the role of pets in delivery of health care services, the RSPCA submission continues:

Multi-purpose health care services that embrace the range of existing health care service providers and addresses the gaps in service provision are critical to improving health outcomes. Team-based care should also be paired with programs to educate consumers

[327] Rural Doctors Association of Tasmania, 2021, *Submission #30*, pp. 11-13.
[328] Helen Thomas, *Transcript of Evidence*, 2 November 2021, p. 72.
[329] RSPCA, 2021, *Submission #41*, p. 1.

about the various types of qualified practitioners who are available – and this should include specialist expertise in human/pet dynamics.

The subject of companion animals can be a catalyst for engaging patients in discussions about preventive health. Practitioners in team-based care environments are in an ideal position to understand the human-pet dynamic, and to encourage patients to interact with their pets to improve their own health and wellbeing.

Questions relating to companion animals could be asked during routine social history taking. The knowledge gained from this approach may facilitate more tailored patient management and personalised lifestyle recommendations. On that basis, it is important that traditional health care services engage with organisations with appropriate expertise in human/pet dynamics. This would include the RSPCA.

Upskilling the rural health care workforce

People working in the rural health sector require specific qualifications and skill sets in order to provide appropriate assistance and care. In many areas, integrated primary care models foster inter-professional working relationships, and staff are experienced at working in collaboration and in partnership.

However, for these models to be effective, there needs to be an expanded understanding of the role of existing occupations, the further development and deployment of emerging occupations such as the GP generalist, nurse practitioner, enhanced community nursing role, physician assistants, and the extended scope of paramedics, to name just a few.

Of course, in our view, this should also include those with appropriate skills in, and understanding of, the unique dynamics of human/animal relationships.

To achieve this, we believe there should be a specific focus ensuring these qualifications and skills needs are met or there is a real risk the needs of this critical workforce will be overlooked – and that means existing disadvantage in diverse rural communities will be exacerbated and perhaps even further entrenched.

…

The role of NGOs and volunteers in delivering improved rural health outcomes

There is clear evidence that supporting the development of social capital will deliver better health outcomes, particularly in rural areas.

Strong and direct links between government and NGOs and volunteers will strengthen social networks and community-centred approaches to health enable greater involvement by these groups and result in improved outcomes across a range of metrics.

While relationships and trust take time to nurture and build up, communities can (and do) come together in times of crisis. For example, a multi-stakeholder approach was utilised to great effect during the Dunalley fires in Tasmania in 2012 and, more recently, major disaster events such as the widespread bushfires last year across the mainland.

The relationships forged in these times stand communities in good stead and should be maintained so they are readily accessed when disasters loom – and to avert or mitigate possible future adverse outcomes.

More and more, policy changes implemented without a clear cost/benefit analysis and in the absence of any evidence-based impact assessment. These decisions often result in cost-shifting between levels of government and/or unrealistic expectations on what NGOs are able to deliver as part of their existing cause-based activities.

The state government's recently implemented Cat Management Act is one such example. While the regulations imposed under this Act are welcome, the outcomes are unfunded. Local government does not have the capacity to police or enforce the Act; and charitable NGOs such as the RSPCA are being expected to undertake a range of costly activities that are simply unsustainable without funding support. This is simply untenable.

Along with other NGOs, the RSPCA expects a commitment from government to:

- *A consultative approach that engages with the organisation on issues that are relevant to our field of expertise;*
- *Accountability and transparency in regulatory and administrative processes and, in particular, a commitment to undertaking credible regulatory impact statements when considering policy change; and*
- *Increased accessibility to forums and consultative processes to ensure meaningful and genuine engagement between government and our stakeholder groups.*[330]

Emerging Technology

The Swoop Aero submission describes how drone technology can improve access to healthcare commodities and pathology service by improving the connection between rural and urban areas. According to that submission:

We are ready to assist the Tasmanian Government in building a resilient and robust health supply chain; through innovation, technological ingenuity and aeromedical logistics

Transport of pathology samples

Swoop Aero has experience of transporting a range of different pathology samples, requiring cold chain conditions, differing levels of dangerous goods packaging, and with differing levels of urgency. We have transported infectious samples (dangerous goods) according to IATA dangerous goods requirements, including TB sputum sample, HIV viral load samples, cholera stool samples, and blood samples covering a range of different requirements.

Pharmaceuticals & vaccine distribution

Transport of vaccines under cold chain conditions is Swoop Aero's bread and butter. We also have extensive experience of transporting routine pharmaceuticals required by distant clinics, so that they can re-stock on-demand rather than holding expensive inventory of unnecessary goods. Emergency deliveries have also become a commonplace occurrence for the operations team, given the environments in which we operate, and the lack of any alternative method for transporting much-needed medical supplies.

Reducing human interaction in the supply chain

[330] RSPCA, 2021, *Submission #41*, pp. 7-9.

Our aviation safety procedures include cleaning and decontamination procedures, which work alongside the technology we have created to massively reduce the human interaction required with the aircraft, and ensure that the likelihood of transmission of any communicable disease is kept to a minimum. This is been essential in Africa.

Speed & safety of delivery in a crisis situation

Our aircraft travel at a standard speed of 115 km/h, reaching their destination in under 60 minutes every time. We track our aircraft at all times, and thus know exactly where the payload is at all times. Furthermore, we have rigid safety procedures that are in line with local regulatory and IATA guidelines, so that we know the cargo is safe and sound on its journey.[331]

[331] Swoop Aero, 2021, *Submission #49*, p. 3.

Appendix A: Definitions and Glossary (Health Roles and Services)

Health roles

Rural generalist

'medical practitioner who is trained to meet the specific current and future healthcare needs of Australian rural and remote communities, in a sustainable and cost-effective way, by providing both comprehensive general practice and emergency care and required components of other medical specialist care in hospital and community settings as part of a rural healthcare team.'[1] The current registered specialty for rural generalists is general practice.

Training/registration

Bachelor's degree – 4-6 years

Internship – 1 year

General registration

Residency and advanced specialised training – 4+ years

Royal Australian College of General Practitioners (RACGP) program, plus
Fellowship in Advanced Rural General Practice

or Australian College of Rural and Remote Medicine (ACCRM) program.

Specialist registration with the Medical Board of Australia.[2]

In Tasmania – The University of Tasmania (UTAS) offers a Bachelor of Medical Science and Doctor of Medicine.*

*from 2023, replacing the Bachelor of Medicine and Bachelor of Surgery

The federally funded Tasmanian Rural Generalist Pathway facilitates training for medical practitioners to meet the needs of rural and remote communities in Tasmania. Practitioners can enter the pathway at different points, depending on prior training.

Registered nurse

Nurse who is trained to 'assess, plan, and implement nursing care for patients in accordance with accepted nursing practice and standards in hospitals, aged care, and other health care facilities, and in the community. They administer medications, monitor responses to treatments and care plans, and promote good health through health education programs.'[3]

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[1] This definition was agreed by the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM) in January 2018 and is known as the *Collingrove Agreement.* National Rural Generalist Taskforce, *Advice to the National Rural Health Commissioner on the Development of the National Rural Generalist Pathway*, Office of the National Rural Health Commissioner, Cairns, December 2018, p. 5.

[2] Department of Health Tasmania (DoHT), *Health Workforce 2040 – Volume 3. Medicine*, publication date 13 December 2019, p. 37; DoHT, 'Tasmanian Rural Generalist Pathway at a glance', DoHT website, accessed 12 August 2022; Australian Government Department of Health (DoH), *National Medical Workforce Strategy 2021-2031*, DoH, Canberra, 2021 [publication date 15 March 2022], p. 46.

[3] DoHT, *Health Workforce 2040 – Volume 4. Nursing and midwifery,* 13 December 2019, p. 45.

Training/registration
Bachelor of Nursing, or Graduate Entry Masters in Nursing.

Registration with the Nursing and Midwifery Board of Australia.

In Tasmania – UTAS offers a Bachelor of Nursing, and postgraduate programs for nursing specialisations.

Nurse practitioner

Nurse who provides 'advanced and extended nursing care. Their role includes assessing and managing patients, prescribing medications, and treatments as authorised in relevant legislation and referring patients to other health care professionals.'

'Nurse Practitioner' is a registration endorsement, not a division of practice.'[4]

Training/registration
As per registered nurse, plus Master's degree or equivalent.

5,000 hours of experience at the clinical advanced nursing practice level within six years prior to application for endorsement.

Registration with the Nursing and Midwifery Board of Australia (general registration as a registered nurse plus endorsement as a nurse practitioner).

In Tasmania – Theoretical study takes place externally. Supervised clinical practice can occur in Tasmania.[5]

General practitioner

Medical practitioner who is 'the first point of contact for most personal health matters. They provide preventative medical care, investigate, diagnose, and manage conditions within a biopsychosocial model.

General practitioners provide ongoing and holistic care for individuals, their families, and the community more broadly. Amongst many tasks, they analyse test results, refer patients to other specialists, record information, prescribe and administer drugs and other treatment programs, notify government health bodies of specified diseases, and admit patients to hospital. General practitioners work in urban, regional, or rural settings.'[6]

Training/registration
Bachelor's degree – 4-6 years
Internship – 1 year
General registration
Residency and advanced specialised training – 3+ years.

Specialist registration with the Medical Board of Australia.

[4] Ibid, p. 46.
[5] Ibid.
[6] DOHT, *Health Workforce 2040 – Volume 3. Medicine*, op. cit., p. 37.

In Tasmania – UTAS offers a Bachelor of Medical Science and Doctor of Medicine.*

*from 2023, replacing the Bachelor of Medicine and Bachelor of Surgery

Non-GP specialist

Non-GP medical practitioner who has completed advanced education and clinical training in a specific medical field.

The Medical Board of Australia provides a list of specialties, fields of speciality practice and related specialist titles, as approved by the COAG Health Council and in force in each state and territory from 1 June 2018.

Specialities, other than general practice, are:

- Addiction medicine
- Anaesthesia
- Dermatology
- Emergency medicine
- Intensive care medicine
- Medical administration
- Obstetrics and gynaecology
- Occupational and environmental medicine
- Ophthalmology
- Paediatrics and child health
- Pain medicine
- Palliative medicine
- Pathology
- Physician (fields of specialty practice: cardiology, clinical genetics, clinical pharmacology, endocrinology, gastroenterology and hepatology, general medicine, geriatric medicine, haematology, immunology and allergy, infectious diseases, medical oncology, nephrology, neurology, nuclear medicine, respiratory and sleep medicine, rheumatology)
- Psychiatry
- Public health medicine
- Radiation oncology
- Radiology
- Rehabilitation medicine
- Sexual health medicine
- Sport and exercise medicine
- Surgery.[7]

Training/registration

Degree and training as per requirements for specialty.

Specialist registration with the Medical Board of Australia.

[7] Australian Institute of Health and Welfare (AIHW), 'topic summaries – glossary' in *Australia's health 2022*, AIHW, Canberra, release date 7 July 2022; Medical Board of Australia, *List of specialities, fields of speciality practice and related specialist titles*, 1 June 2018.

Health practitioner Under the Health Practitioner Regulation National Law, *health practitioner* means an individual who practises a health profession.

Health profession means the following professions:

- Aboriginal and Torres Strait Islander health practice
- Chinese medicine
- chiropractic
- dental (including the profession of a dentist, dental therapist, dental hygienist, dental prosthetist and oral health therapist)
- medical
- medical radiation practice
- midwifery
- nursing
- occupational therapy
- optometry
- osteopathy
- paramedicine
- pharmacy
- physiotherapy
- podiatry
- psychology.[8]

Training/registration

Degree/qualification and training as per requirements for profession.

Registration with the relevant National Board.

[8] *Health Practitioner Regulation National Law Act 2009* (Qld).

Allied health professional

'A health professional who is not a doctor, nurse, or dentist. Allied health professionals include (but are not limited to) Aboriginal and Torres Strait Islander health practitioners, chiropractors, occupational therapists, optometrists, osteopaths, pharmacists, physiotherapists, podiatrists, psychologists, sonographers, and speech pathologists.' [9] Allied health professionals provide specialised expertise in preventing, diagnosing and treating a range of conditions and illnesses, and often work within multidisciplinary health teams to support a patient's specific needs.

Note: There is no universally accepted definition of allied health, with different definitions used internationally and within Australia.

Generally, the Australian Government recognises allied health professions that meet the following:

- all practising professionals have a university level qualification of Australian Qualification Framework level 7 or higher in a recognised allied health field, that is accredited by their relevant national accreditation body
- a national professional organisation with clearly defined membership criteria
- clear national entry level competency standards and assessment processes
- autonomy of practice and
- a defined scope of practice.[10]

Training/registration

Degree/qualification as per requirements for profession.

Some allied health professions are regulated under the National Regulation and Accreditation Scheme (maintained by the Australian Health Practitioner Regulation Agency), and therefore require registration with the relevant National Board. Others are self-regulated, with accreditation managed by the relevant professional peak body.

In Tasmania – UTAS offers undergraduate and/or postgraduate courses in some allied health fields, including pharmacy, psychology, social work, physiotherapy, occupational therapy and speech pathology.

Paramedic

Health practitioner who provides 'emergency care to patients and transport to medical facilities. Their duties and tasks include:

- assessment of a patient's condition and provision of medical treatment and care
- resuscitating and stabilising patients if necessary

[9] AIHW, 'topic summaries – glossary', op. cit.

[10] Australian Government Department of Health and Aged Care (DoHAC), 'About allied health', DoHAC website, last updated 11 March 2022.

- using complex life support techniques, administer[ing] oxygen, drips, and medical drugs where required
- making decisions whether and how to move patients
- collaboration with other emergency services personnel.'[11]

Training/registration
Bachelor's degree (or equivalent as deemed by the Paramedicine Board).

Registration with the Paramedicine Board of Australia.

In Tasmania – UTAS offers a Bachelor of Paramedicine, Paramedicine Conversion Pathway (for practicing paramedics and military medics to upgrade existing qualifications), and postgraduate programs.

Extended care paramedic

Paramedic working within an ambulance service with 'an increased scope of practice that means they can treat a range of patients at home, without transporting them to an emergency department. Additional interventions include suturing, catheter replacement and distributing short-term antibiotics which will tide the patient over until they can see their GP. [Extended care paramedics] can also refer patients to other community based services.'[12]

Training/registration
As per paramedic, plus additional training.

In Tasmania – Short course training provided in-house by Ambulance Tasmania.

UTAS offers postgraduate programs in advanced paramedicine, which include an extended care paramedic specialisation.

Paramedic practitioner

Specialist paramedic with additional primary care skills, who is able to treat a wider range of health conditions. This role is the top tier of specialist paramedics. Paramedic practitioners are qualified to practice in a range of healthcare settings (not only ambulance services). [13]

Training/registration
As per paramedic, plus Master's degree.

Pharmacist

Health practitioner who is trained to 'compound and dispense pharmaceuticals and other drugs and medicines, conduct research on

[11] DoHT, *Health Workforce 2040 – Volume 2. Allied health,* 13 December 2019, p. 54.
[12] Department of Health and Human Services Tasmania, *Review of Ambulance Tasmania Clinical and Operational Services – Final report,* May 2017, p. 22.
[13] Australasian College of Paramedic Practitioners (ACPP), 'What is a Paramedic Practitioner?', ACPP website, accessed 18 August 2022.

production, storage, quality control and distribution of drugs and related supplies and advise patients and other health professionals on the selection, dosage, interactions, and side effects of pharmaceuticals. Pharmacists work with other health professionals to monitor the health and progress of patients and ensure medications are taken in a safe and effective manner.

Pharmacists have a legislated regulatory role in the manufacture, supply and distribution of drugs and poisons and work closely with other health professionals managing medication risk.'[14]

Training/registration

Bachelor of Pharmacy or Master of Pharmacy.

Registration with the Pharmacy Board of Australia.

In Tasmania – UTAS offers a Bachelor of Pharmacy with Honours, and postgraduate programs in clinical pharmacy.

[14] DoHT, *Health Workforce 2040 – Allied Health,* op. cit., p. 55.

Types of healthcare

Primary care 'The first contact a person has with the health system. It is often synonymous with general practice, however the sector covers a range of public, private and non-government health services and health service providers. These include nursing, midwifery, pharmacy, dentistry, Aboriginal health services and allied health. Primary care may be delivered in a range of settings, including aged care, disability care and the community.' [15] It covers care that is not related to a hospital visit, including health promotion, prevention, early intervention, treatment of acute conditions, and management of chronic conditions.[16]

Acute/tertiary care 'Care provided to patients admitted to hospital that is intended to cure illness, alleviate symptoms of illness or manage childbirth.'[17]

Hospital in the Home A service providing multidisciplinary care for hospital inpatients in their place of residence, which would otherwise be provided in hospital. Place of residence may be permanent or temporary (includes residential aged care facilities).

In Tasmania – Hospital in the Home is a joint initiative of the Community Rapid Response Service (ComRRS) and the state's major public hospitals. It may also be referred to as a 'virtual ward'.

Eligible patients can be admitted and transferred to Hospital in the Home from the emergency department, or transferred during a hospital admission. Patients must be referred by a medical consultant who identifies that the required care is suitable to be delivered in the home. [18]

Virtual Care Centre A centrally coordinated service that provides medical care from a different location to the patient, using technologies such as telephone, video conferencing, remote monitoring, and electronic medical records.[19]

Hospital service levels

Major hospitals

The Tasmanian Role Delineation Framework and Clinical Services Profile sets out the levels of service for Tasmania's four major acute hospitals. The levels are based on the degree of acuity of the patient.

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[15] AIHW, 'General practice, allied health and other primary care services' in *Australia's health 2022,* op. cit.
[16] AIHW, *Primary health care in Australia*, Cat. No. WEB 132, AIHW, Canberra, 2016, last updated 24 May 2016.
[17] AIHW, 'topic summaries – glossary', op. cit.
[18] Tasmanian Health Service, *Hospital in the Home: General information for health and community service providers*, fact sheet, April 2020 [publication date 13 December 2020].
[19] NSW Agency for Clinical Innovation (ACI), *Spotlight on virtual care: COVID-19 and remote monitoring - Illawarra Shoalhaven LHD, Southern New South Wales LHD, Sydney LHD and St Vincent's Health Network*, ACI, Sydney, June 2021.

The highest level(s) of service provided at each of the hospitals is set out below:

- The **Royal Hobart Hospital** is the major referral hub for the state, providing mainly **Level 6** type services for highly specialised treatment or very acute patients, as well as care for residents of southern Tasmania.
- The **Launceston General Hospital** provides mainly **Level 5** type services.
- The **North West Regional Hospital** provides **Level 4** and **Level 3** services.
- The **Mersey Community Hospital** provides **Level 4** and **Level 3** services. [20]

District hospitals

District hospitals provide some **Level 3** and **Level 2** services, as described in the Role Delineation Framework and Clinical Services Profile.

Under the *Rural Medical Practitioners (Tasmanian State Service) Agreement 2019*, district hospitals are classified as Tier 1, 2 or 3, as described below.

Tier 1

'A Tier 1 facility is a rural inpatient facility that has contracted a general practitioner who is credentialed in emergency treatment to be continuously contactable and able to attend the hospital within 15 minutes of being contacted.'[21]

Facilities

Midlands Multipurpose Health Centre (Oatlands)
May Shaw Health Centre (Swansea)
West Coast District Hospital (Queenstown)
King Island Hospital and Health Centre
Smithton District Hospital and Community Services
Flinders Island Multipurpose Centre
North Eastern Soldiers Memorial Hospital (Scottsdale)
St Helens District Hospital and Community Care Centre

Tier 2

'A Tier 2 facility is a rural inpatient facility that has contracted a general practitioner who has clinical privileges appropriate to the role of the facility and who is continuously contactable and able to attend the hospital within 30 minutes of being contacted. However, the doctor may be unavailable by prior arrangement with the hospital for an aggregate period not exceeding two hours in any 24-hour period.'[22]

Facilities

New Norfolk District Hospital
Huon Regional Care (Franklin)
Esperance Multipurpose Centre (Dover)

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[20] DoHT, *Tasmanian Role Delineation Framework and Clinical Services Profile*, version 4.0, 2018; Tasmanian Government Submission to the Legislative Council Sessional Committee: Government Administration A, *Inquiry into rural health services in Tasmania*, August 2021.
[21] DoHT, *Tasmania's District Hospitals Report* [unpublished], August 2020.
[22] Ibid.

Tasman Health and Community Service (Nubeena)
George Town District Hospital and Community Centre
Beaconsfield District Hospital
Deloraine District Hospital
Campbell Town Health and Community Service
St Marys Community Health Centre

Tier 3

'A Tier 3 facility is a non-inpatient facility (but may have 1 or 2 observation beds) that has contracted a community general practitioner who is contactable during agreed hours and who provides a continuously staffed telephone service when he/she is unavailable for any period exceeding two hours. The telephone service may include arrangements with other general practitioners in adjacent towns and/or statewide telephone triage services.'[23]

Facilities
Toosey Aged and Community Care (Longford)

[23] Ibid.

Appendix B: Pharmacist Scope of Practice (Australia and OECD comparators)

Table 1: Pharmacist Scope of Practice – Australia and OECD comparators

Domain of Competency	Task	*Enabled by legislative authority*					
		AUS	**CAN (AB)[1]**	**UK[2,3]**	**IRE[4]**	**USA[5]**	**NZ[6]**
Medication Supply and Dispensing	Assuring integrity of medicine supply through the application of Quality Use of Medicine (QUM) principles	✓	✓	✓	✓	✓	✓
	Generic and Biosimilar substitution where patient has provided consent	✓	✓	✓	✓	✓	✓
	Assuring the proper storage of medicines, including cold chain management	✓	✓	✓	✓	✓	✓
	Preparing and compounding of medicines as required	✓	✓	✓	✓	✓	✓
	Ensuring continued supply of previously prescribed chronic therapy medications	✓	✓	✓	✓	✓	✓
	Supplying medicines as required, safely and accurately, across the categorised scheduling						
	• Over-the-counter (Not Scheduled)	✓	✓	✓	✓	✓	✓
	• Pharmacy Medicine (Schedule 2)	✓					
	• Pharmacist Only Medicine (Schedule 3)	✓					
	• Prescription Only Medicine (Schedule 4)	✓					
	• Controlled Drug (Schedule 8)	✓	✓	✓	✓	✓	✓
	Providing appropriately tailored counselling, information and education to enable safe and efficacious medicines management	✓	✓	✓	✓	✓	✓
	Complex supply arrangements (e.g. clozapine)	✓	✓	✓	✓	✓	✓

Table Key: Enabled by legislative authority

✓ Enabled

✱ Partially Enabled

✗ Not enabled

[1] Pharmacists' Scope of Practice in Canada: https://www.pharmacists.ca/pharmacy-in-canada/scope-of-practice-canada/

[2] United Kingdom – Independent Pharmacist Prescriber. Who Can Prescribe What? Pharmaceutical Services Negotiating Committee. https://psnc.org.uk/dispensing-supply/receiving-a-prescription/who-can-prescribe-what/

[3] General Pharmaceutical Council – Guidance for Pharmacist Prescribers https://www.pharmacyregulation.org/sites/default/files/document/in-practice-guidance-for-pharmacist-prescribers-february-2020.pdf

[4] Medicinal Products (prescription and Control of Supply) (Amendment) Regulations 2020 http://www.irishstatutebook.ie/eli/2020/si/98/made/en/print?q=medicinal+products

[5] https://naspa.us/resource/statewide-protocols-for-pharmacist-prescribing/

[6] Medicines Regulation 1984 http://www.legislation.govt.nz/regulation/public/1984/0143/latest/whole.html

Table 1: Pharmacist Scope of Practice – Australia and OECD comparators

Domain of Competency	Task	*Enabled by legislative authority*					
		AUS	CAN (AB)[1]	UK[2,3]	IRE[4]	USA[5]	NZ[6]
Prescribing	• Over-the-counter (Not Scheduled)	✓					✓
	• Pharmacy Medicine (Schedule 2)	✓	✓	✓	✓	✓	✓
	• Pharmacist Only Medicine (Schedule 3)	✓					✓
	• Prescription Only Medicine (Schedule 4)	* [7]			✗	*	✗
	• Controlled Drug (Schedule 8)	✗	✗	✓	✗	*	✗
	Therapeutic adaptation – change/adapt drug dosage, formulation, regimen (based on determination of clinical need) across the categorised scheduling						
	• Over-the-counter (Not Scheduled)	✓					✓
	• Pharmacy Medicine (Schedule 2)	✓	✓	✓	✓	✓	✓
	• Pharmacist Only Medicine (Schedule 3)	✓					✓
	• Prescription Only Medicine (Schedule 4)	✗			✗	✗	✓
	• Controlled Drug (Schedule 8)	✗	✗	✓	✗	✗	✓
	Medication continuance/prescription renewal and supply for extended period across the categorised scheduling						
	• Over-the-counter (Not Scheduled)	✓					✓
	• Pharmacy Medicine (Schedule 2)	✓	✓	✓	✓	✓	✓
	• Pharmacist Only Medicine (Schedule 3)	✓					✓
	• Prescription Only Medicine (Schedule 4)	*[8]			*	*	✗
	• Controlled Drug (Schedule 8)	✗	✓	✓	✗	✗	✗
	Prescribing medication across the categorised scheduling						
	Collaborative prescribing						
	• Over-the-counter (Not Scheduled)	✓					✓
	• Pharmacy Medicine (Schedule 2)	✓	✓	✓	✓	✓	✓
	• Pharmacist Only Medicine (Schedule 3)	✓					✓

[7] Very limited circumstances, under Health (Drugs and Poisons) Regulation *Drug Therapy Protocol – Communicable Diseases Program* (during a declared public health emergency), requires a *Serious Shortage Substitution Notice* (SSSN) issued by the Therapeutic Goods Administration (TGA).
[8] Limited Circumstances: Limited to *National Health (Continued Dispensing Emergency Measures)* Determination 2020 (while in effect); Prior to 31 March 2020, limited to lipid-modifying agents and oral hormonal contraceptives in National Health (Continued Dispensing) Determination 2012; and specific State and Territory legislation.

Table 1: Pharmacist Scope of Practice – Australia and OECD comparators

Domain of Competency	Task	*Enabled by legislative authority*					
		AUS	CAN (AB)[1]	UK[2,3]	IRE[4]	USA[5]	NZ[6]
Prescribing	• Prescription Only Medicine (Schedule 4)	✗	✓	✓	*	*	✗
	• Controlled Drug (Schedule 8)	✗	✗	✓	✗	✗	✗
	Structured prescribing (protocol-driven prescribing)						
	• Over-the-counter (Not Scheduled)	✓					✓
	• Pharmacy Medicine (Schedule 2)	✓	✓	✓	✓	✓	✓
	• Pharmacist Only Medicine (Schedule 3)	✓					✓
	• Prescription Only Medicine (Schedule 4)	* [9]			✗	*	*
	• Controlled Drug (Schedule 8)	✗	✗	✓	✗	✗	✗
	Autonomous prescribing – initiate new prescription or drug therapy						
	• Over-the-counter (Not Scheduled)	✓					✓
	• Pharmacy Medicine (Schedule 2)	✓	✓	✓	✓	✓	✓
	• Pharmacist Only Medicine (Schedule 3)	✓					✓
	• Prescription Only Medicine (Schedule 4)	✗			✗	✗	✗
	• Controlled Drug (Schedule 8)	✗	✗	✓	✗	✗	✗
	Deprescribing medicines across the categorised scheduling						
	• Over-the-counter (Not Scheduled)	✓					✓
	• Pharmacy Medicine (Schedule 2)	✓	✓	✓	✓	✓	✓
	• Pharmacist Only Medicine (Schedule 3)	✓					✓
	• Prescription Only Medicine (Schedule 4)	✗			✗	✗	✗
	• Controlled Drug (Schedule 8)	✗	✗	✓	✗	✗	✗
	Assessing common conditions and providing appropriate management approaches (including pharmacological, non-pharmacological and referral) across the categorised scheduling						
	• Over-the-counter (Not Scheduled)	✓					✓
	• Pharmacy Medicine (Schedule 2)	✓			✓	✓	✓
	• Pharmacist Only Medicine (Schedule 3)	✓	✓	✓			✓

[9] In Queensland, in limited circumstances for the treatment of uncomplicated Urinary Tract Infection (UTI), under Health (Drugs and Poisons) Regulation 1996 *Drug Therapy Protocol – Pharmacist UTI Trial.*

Table 1: Pharmacist Scope of Practice – Australia and OECD comparators

Domain of Competency	Task	*Enabled by legislative authority*					
		AUS	**CAN (AB)[1]**	**UK[2,3]**	**IRE[4]**	**USA[5]**	**NZ[6]**
Prescribing	• Prescription Only Medicine (Schedule 4)	✱ [10]			✗	✱	✗
	• Controlled Drug (Schedule 8)	✗	✗	✓	✗	✗	✗
Review Medications	Monitor for response to treatment, including setting patient expectations for treatment efficacy and screening for potential sub or non-therapeutic outcomes	✓	✓	✓	✓	✓	✓
	Patient follow up and referral for further care when required (written and verbal)	✓	✓	✓	✓	✓	✓
	Medication adherence counselling	✓	✓	✓	✓	✓	✓
	Medication management review - assuring the proper prescribing of medications so that dose regimes and dosage forms are appropriate	✓	✓	✓	✓	✓	✓
Disease Management	Screening using questionnaire or device, educating and referring patients at risk where appropriate to relevant health professional	✓	✓	✓	✓	✓	✓
	Management of common conditions (wound and pain management, migraines, dental conditions, urinary tract infections, ear, nose and throat (ENT) infections) by recommending treatment (pharmacological and non-pharmacological), education, lifestyle interventions and advice	✓	✓	✓	✓	✓	✓
	Targeted health promotion campaigns, including general health checks	✓	✓	✓	✓	✓	✓
	Prevention programs – smoking cessation, obesity programs	✓	✓	✓	✓	✓	✓
	Delivering harm minimisation and public health initiatives (e.g Needle and Syringe Programs)	✓	✓	✓	✓	✓	✓
	Prevention strategies for chronic disease – smoking cessation, obesity programs	✓	✓	✓	✓	✓	✓
	Chronic Disease (such as diabetes, asthma, chronic obstructive pulmonary disease (COPD) - Ongoing monitoring, education, lifestyle interventions and advice)	✓	✓	✓	✓	✓	✓
	Chronic conditions where there is medicine adjustment needed e.g. INR testing	✓	✓	✓	✓	✓	✓

[10] In Queensland, in limited circumstances for the treatment of uncomplicated Urinary Tract Infection (UTI), under Health (Drugs and Poisons) Regulation 1996 *Drug Therapy Protocol – Pharmacist UTI Trial*

Table 1: Pharmacist Scope of Practice – Australia and OECD comparators

Domain of Competency	Task	*Enabled by legislative authority*					
		AUS	**CAN (AB)[1]**	**UK[2,3]**	**IRE[4]**	**USA[5]**	**NZ[6]**
Disease Management	Acute care - common conditions (wound and pain management (such as migraines), dental conditions, urinary tract infections, ear, nose and throat (ENT) infections), resulting from chronic conditions by recommending treatment (pharmacological and non-pharmacological), education, lifestyle interventions and advice	✓	✓	✓	✓	✓	✓
Medicine Administration	Travel medicine	* [11]	✓	✓	✓	✓	✗
	Administration of injectable medicines (vaccine)						
	• Over-the-counter (Not Scheduled)	n/a	✓	✓	✓	✓	n/a
	• Pharmacy Medicine (Schedule 2)	n/a					n/a
	• Pharmacist Only Medicine (Schedule 3)	n/a					n/a
	• Prescription Only Medicine (Schedule 4)	* [12]					*
	• Controlled Drug (Schedule 8)	n/a					n/a
	Administration of medicines (non-vaccine injectables, inhaled medications)						
	• Over-the-counter (Not Scheduled)	✗	✓	✓	✓	*	✓
	• Pharmacy Medicine (Schedule 2)	✗					✓
	• Pharmacist Only Medicine (Schedule 3) e.g. Vit B12	* [13]					*
	• Prescription Only Medicine (Schedule 4) e.g. denosumab	✗					✗
	• Controlled Drug (Schedule 8) e.g. buprenorphine	✗	✓	✓	✗	✗	✗
Laboratory Tests	Order and interpret laboratory tests (appropriate to pharmacist care)	* [14]	✓	✓	✗	✗	✗
	Point of care testing	✓	✓	✓	✓	✓	✓
	Diagnostic testing (such as pulmonary function testing, blood pressure testing)	✓	✓	✓	✓	✓	✓

[11] Limited to certain conditions approved under specific State and Territory legislation.
[12] Limited to certain conditions approved under specific State and Territory legislation.
[13] Limited to adrenaline of a strength 0.1% or less to a person who is 10 years or more, for the treatment of anaphylaxis, in certain States and Territories.
[14] Whilst pharmacists are not prohibited by legislation, there are administrative barriers which hinder an approved pathology practitioner from accepting the referral. https://www.legislation.gov.au/Details/F2018L00223