 March 17,2021

Submission to Inquiry into Rural Health Services in Tasmania

I submit this response after the requested due date and apologise for its delay that is directly attributed to my workload as a rural General Practitioner.
I have inserted a preamble to provide the committee with the context of my submission, followed by address terms of reference regarding;
1.Health outcomes,
2.Availability and timeliness of health services;
3.Barriers to access
7.Referral to tertiary care
8.Telehealth services

Preamble
I am a 55 year old female Australian Rural General Practitioner. I have worked in rural health in Australia since 1986. Initially as a Registered Nurse, and then during and after obtaining my medical degree from 2001 in rural Central Queensland. I have worked as a medical officer in a Queensland indigenous community, a GP registrar then Fellow in rural Queensland, then relocated to my home state of Tasmania in 2014. I am a Fellow of the Royal Australian College of General Practitioners, Fellow of the Australian Rural General Practitioners and Fellow of the Australian College of Rural and Remote Medicine. I have been employed as a sole contractor to Glamorgan Spring Bay Council as a part-time GP since 2014. My duties include day to day General Practice at Bicheno, with on-call duties at May Shaw Health Centre, Swansea over some weekends to assist the incumbent General Practitioners. I am thus invested in Rural Health on the East Coast of Tasmania and familiar with access to health care in a rural setting.

1. **Health Outcomes.** AIHW states;
    1. On average, Australians living in rural and remote areas have shorter lives, higher levels of disease and injury and poorer access to and use of health services, compared with people living in metropolitan areas. Poorer health outcomes in rural and remote areas may be due to multiple factors including lifestyle differences and a level of disadvantage related to education and employment opportunities, as well as access to health services'.[1]
    2. I carry no statistics to apply this AIHW statement to my chosen location (rated MMM 6-Remote Communities). Anecdotally I regularly see patients who delay presentation for medical care and suffer consequences of ischaemic heart disease, advanced cancers, infection and mental health disorder. Patients present later and generally avoid travel to larger centres that are 159.7km (1h56m) or 178km (2h24m) to Launceston or Hobart respectively. Patients requiring lengthy care eg. chemotherapy or radiation therapy for cancer suffer <u>at least</u> more fatigue, social fragmentation and disruption and economic deprivation than metropolitan counterparts despite the patient travel scheme and volunteer organisations that assist with accommodation and travel. I observe patients who cease ongoing treatment due to these factors thus potentially hastening their demise.
2. **Availability and timeliness of health services AND**
3. **Barriers to access;**
    a. <u>Ambulance services;</u> 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.

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[1] https://www.aihw.gov.au/reports/rural-remote-australians/rural-remote-health/contents/summary

b. Primary care, allied health and GP services. As already outlined, primary care as provided by GP seeks to manage increasingly chronic and complex conditions with view to keeping patients healthy and out of hospital. The provision of Medicare assistance by way of Enhanced Primary Care(EPC) referral to Allied health providers(AHP) for these patients assists to a minor degree the financial burden of chronic disease.[2] That AHP's visit to the Bicheno location is attributed to rural funding, and support from the local Health Advisory Group chaired by Lyn Taylor. We enjoy a visiting private physiotherapist, podiatrist, optometrist, nurse footcare practitioners, massage therapist, mental health social worker, RFDS youth mental health and social worker. It is glaringly apparent that patients will attend local AHP's but not travel for the same care. Crucially, access to annual podiatry and optometry assessment for persons with diabetes on a local level has the potential to recognise early deterioration and risk of diabetes complications such as blindness and gangrene. Barriers for GP care includes funding for a Practice nurse (PN) that must recognise the irrefutable role of this health provider. Keeping cold-chain of vaccination, ordering and checking stock, coordination of care, chronic disease coordination, assisting minor surgery, wound care, triage in rural practice and other duties that enhance the flow of a General Practice are a number of tasks provided by the PN.
c. Non-GP specialist services; Swansea General Practice provides rooms for visiting specialists Dr David Dunbabin for geriatric and general medicine and cardiologist Dr Nathan Dwyer and an echocardiographer. St Helens have visiting urologist Dr Rob Jensen, and Charles St Cardiologist and echocardiographer. Palliative care specialists are available by telephone in addition to most other specialists on an ad hoc basis. Telemedicine is advertised by 'email SPAM' on a perpetual basis and not attractive to this GP. Barriers for access to non-GP specialist are willingness for specialists to travel and/or schedule patient appointments to suit patient travel time. Plain x-ray services are available at I-med, St Helens. Patients must travel to Hobart or Launceston for any other imaging. Blood and some other specimen collection is done by the respective General Practices. Some GP practices are funded by the private pathology service however East Coast Health is not. Blood collection by GP's impacts on provision of care that GP's are more suitably qualified for.
d. Hospital services at St Mary's and May Shaw HC, Swansea are determined by bed availability. GP's medically manage these patients. St Helens Hospital apparently employs a FACEM. Patients travel to St Helens via ambulance or privately. I have little awareness of St Helens health services .
e. Maternity and child health services(CHS). Antenatal outreach is provided by a visiting midwife at St Mary's HC. CHS visit intermittently. It is quite difficult to contact either service to discuss patient concerns. Pregnant patients attending the LGH for obstetric care may see the midwife at St Mary's. Royal Hobart Hospital has not equivalent as far as I am aware-this would be an excellent service for this fecund location. Women determine their preference for LGH or RHH depending on family location and familiarity.
f. Pain management services. This GP attends teleconferencing with RHH ECHO pain management thus an interest in this ubiquitous condition. Access to specialist pain services is prohibitive from waiting time and geographic location. Reluctant patients are thus further disinclined to seek or attend this service that is only available publicly in Hobart, and privately with a considerable wait time and cost for a usually lower socio-economic cohort.
g. Palliative care services. This GP is bewildered at the provision of funding to educate the community on palliative care when there is no follow through for clinical services. The thankfully infrequent occurrence of such conditions generally invokes a crisis despite an attempt to educate family, patients and health providers. Generally the GP advises the Community Nurses within 2+ weeks that a patient is approaching a terminal state. Referral to either the North or South Palliative care service results in a comprehensive letter after telephone consultation with the patient, and perhaps home aids. The patient and family is

[2] The EPC provides a total of a 5 Medicare assisted visits to Allied Health in a calendar year for patients meeting Medicare criteria. Ie 2 visits to podiatrist, 1 visit to dietician, 2 visits to physio.

generally left without support other than their GP. My last palliative experience entailed intensive home visits to assess the patient and family, initiation of opiate, anti-emetic medication then sedation over an ensuing 48 hours. The patient deceased in the very late evening thus this GP drove 40km round trip from home to attend to reassure and counsel the family and outline procedures from there. Whilst this GP was honoured to provide end of life care in this situation, had the GP been away (as has happened in the past), one wonders what would have occurred. I have nursed palliative patients in hospital and at home previously and I know the above would have been adeptly managed by an available and local home-nursing service.

j. Patient transport service. Many patients are not aware of financial assistance for transport or do not bother with the onerous process of gaining (some) reluctant specialist signatures, delivering to GP for completion and submitting the form. It seems a punitive process. I encourage patients to apply since it is a method of protesting the cost of rural health care. The community transport service Tasmania (CTST) is an excellent service that is staffed by volunteers. It is occasionally unavailable or requires considerable notice in advance for booking. It is not available for all patients. The State Ambulance Transport service is not available in any meaningful form on the East Coast having tried to utilise this instead of a paramedic for medical transport.

k. 'After hours' health care. The telephone deputising service 'GP Assist' offers GP's respite from being available 24 hours per day. It is and should be apparent that the GP is not a sustainable profession otherwise. Living in a small community makes one conspicuous thus 'down time' is highly valued. Dr Omenka and myself assisted Drs Byrne and Grove with weekend and occasional weeknight call over the past 6 years. *This GP shall continue to do this however I perceive the situation at May Shaw health centre will not sustain.*

l. Indigenous and CALD communities. A large Southeast Asian population exists in Bicheno and Freycinet Peninsula. The population generally is on work or temporary visa, and applying for permanent residency. They are required to have private health insurance as they have no Medicare. The provision of health care to these community members is difficult as they must navigate the Australian health system, pay full price for investigation and care thus many are reluctant to pursue investigation and further care in comparison to a Medicare recipient. In my experience this has resulted in patients seeking a less than optimal health pathway. Language barriers may be difficult however the TIS (translation interpreting service) is easy to use.

m. Other. Rural medicine is on the verge of crisis on the mid-south East Coast. Dr Winston Johnson, East Coast Health at Triabunna is of retirement age. Dr Pranesh Naidoo at Spring Bay Medical Centre has announced his retirement to take effect in April 2021. Drs Camilla Byrne and Andrew Grove at Swansea General Practice provide emergency after-hours care at May Shaw Health Centre in addition to Aged Care and Acute care on the premises. Bicheno has lost Dr Okafor Omenka full time GP due to schooling needs for his children. Bicheno is propping up services with locum GP's whilst advertising for a permanent full time replacement. I cover 6.5 days per fortnight with the 0.5 day at Coles Bay for local residents. It is evident that a succession plan is essential albeit currently futile as evidenced by 53 GP vacancies in Tasmania with 4 of these on the mid-south East coast of Tasmania at the above locations and St Mary's.[3] With an anecdotal increase in population as the economy shifts, in particular housing affordability, the crisis we face will escalate. Approximately 4 new patients per week are moving into the Bicheno area; a net gain. In addition, local government has approved the development 'Tempus' at Swansea. It is a staged retirement and residential facility with 140 independent living units, 30 assisted living units and 44 nursing home suites, including a dementia ward and will further increase demand for health services.[4] The architect assures adequate clinic rooms and facilities and expresses confidence filling required services, however fails to appreciate the dearth of health

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[3] https://www.hrplustas.com.au/job-search?keywords=

[4] [4] https://tempusvillage.com.au/unanimous-support-from-east-coast-council-for-rural-retirement-village/

practitioners. Whilst one applauds economic injection and development in rural socio-economically strained locations, one also appreciates that infrastructure including health care needs to follow.

7. **Referral to tertiary care:**
   a. Referral pathways are confusing. The Royal Hobart Hospital has a template for referral that is easy to navigate. The Launceston General Hospital does not. The changing consultant names often require one to re-address the referral thus administrative time consumes patient consultation time. The demarcation between Northern and Southern Tasmania is manipulated by either Tasmanian Health Service to evade patient care. I recently contacted Northern Community Occupational Therapy to ask for urgent assessment and assistance for an injured patient self caring in Bicheno with mobility difficulty who had been discharged home from hospital without ongoing community support. I was informed they would be contacted within 2 days; I received a letter informing me that the patient was not eligible for Northern services and should contact Southern OT. Thankfully I had arranged admission to the local hospital. There are other similar anecdotes with other Tasmanian Health Services.
   b. Out-of pocket expenses. Please refer to 2.b.;j.;l.;
   c. Wait times. My GP career provides adequate cynicism regarding the political massage of this dilemma. There will never exist sufficient budget for health thus one concedes patient wellbeing is the casualty. My most recent experience is observing the anxiety of patients who test positive for the National Bowel Cancer Screening program thus mandating a colonoscopy to investigate possible bowel cancer. My frustration are reminder letters from the NBCSP informing me the patient has not yet received a colonoscopy, and my response is repeated referring the patient to the public system if they have no private insurance and emailing the GP Liaison Officer to petition favour. Some patients self-fund a colonoscopy thus out of pocket costs of between $2000-3000.
   d. Health outcomes. I live in a small community thus de-identifying patients is a consideration. Anecdotes are all that I can provide. That said; a patient with delayed colonoscopy for NBCSP +ve test was finally diagnosed with inoperable bowel cancer late 2020. That patient is now deceased.
8. **Telehealth services.** Medicare's telemedicine item numbers during the COVID-19 shutdown was a lifesaver for patients, General Practice, allied health and medical specialists. Discussions with colleagues and weekly medical literature implores the Federal Minister for Health to sustain these item numbers. GP's agree that the telephone item number that recognises the previously unrewarded work of catch-up phone calls to patients at the day's end should continue.

In conclusion, I have addressed the relevant topics outlined in the terms of reference in the context of an experienced and committed rural general practitioner. The challenges of rural health are considerable and appear insurmountable, yet an opportunity for key health providers to advise those with legislative capacity to appreciate the availability, barriers and pathways that one navigates on behalf of and with patients is respected.

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