Inquiry into Rural Health Services

Submission from Cindy Hollings

Director Allied Health Services THS North

These comments are made in reference to the Northern region only, publicly funded services in rural locations & district hospitals.

2b: 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 eg 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

3: Barriers to access to allied health services:

- Very few services are available locally at rural sites- this is mainly due to lack of positions available, but also due to inability to recruit for specific professions (Occupational Therapy) for many reasons including professional isolation, governance lines being non-profession specific, and expectations of the service not matching current evidence based practice.
- Lack of knowledge or understanding about the role, scope and benefits of allied health in the general community and potentially also in the professional community
- Generally relies on referral by other healthcare workers who also may not be conversant with access / referral/ eligibility if service providers are not on hand to discuss patient's needs
- many allied health actively 'pull' patients who fit criteria for service rather than passively waiting for referral
- Generally inpatients at rural sites would often be classed as low priority presentations who may also not be seen f in hospital at LGH- ie they might not be missing any more than the equivalent Launceston patient. This does not make it acceptable
- The above varies depending on profession required- eg Physiotherapy services approx. 90 % of patient beds, Occupational Therapy receives referrals for approximately 70%, where-as needs for services such as Podiatry or Psychology are far less common.
- Transport to regional centres such as Launceston is cited as a barrier, costs, and limits those who are unable to sit in a vehicle for up to 3 hours each way

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

4: planning systems, projections and outcome measures

- This is obviously a very complex area which I am unable to comment on, except for the large number of rural inpatient facilities in the north which do not seem to be fully utilised due to funding constraints not allowing full operational utilisation.
- Money appears to be invested into bricks and mortar rather than staff and services; this is a political issue, not a health service issue in my opinion.
- It would make better sense on the face of it to have fewer, larger rural inpatient facilities for economies of scale, or changes in service to meet local community health needs.
- Tasmania's health outcomes are poor, but the health system is not responsible for the majority of this- social determinants etc
- Health services appear to be geared towards aged care and support of GP practices. Unclear how this relates to service planning for population health needs but needs for Allied Health are not solely determined by medical diagnosis or GP referral alone.

5: Staffing of community health & hospital

- These are run on a bed and nursing staffing model
- Allied health is under-represented in the staffing mix in Tasmania as a whole but especially in regional area (1 & 2)

7: Referral to tertiary care

- Experience referring to state wide services in Hobart is not always positive, with inequitable access to people from other region
- Anecdotal issues with access to and adequacy of PTAS- eg patients stranded in Melbourne, unable to catch bus due to health issues or provision of unusable taxi dockets due to PTAS rigidity of application of rules

8: availability, functionality of telehealth

- COVID has demonstrated that a lot of allied health interventions can be provided via alternative means to face to face.
- The low numbers of allied health positions per capita, and issues of recruitment and retention impact on ability to provide these services*
- Established FTE for general services has had little increase insufficient FTE to meet current local high priority/urgent demand
- Services such as telehealth require admin support and person support at the receiving end for technical trouble shooting and patient assistance

Summary:

Current services, structures and staffing models are not evidently affecting the morbidity and mortality of rural and regional Tasmanians, evidenced by data on health issues and outcomes.

Tasmania has the lowest utilisation of rehabilitation services, very low levels of non-admitted patient care; and has almost 5% below the national average of AH staff employed in public hospitals. Tasmanian population has high levels of pain, osteoporosis, back problems, diabetes, stomach and colon cancer mortality, high blood pressure, and kidney disease when compared to the other states and territories.

These stats, plus the rural nature of the population, as well as weighting to take into consideration the underlying issues driving poor health such as socioeconomic, education, employment, smoking etc suggests Tasmania should have greater than the national average in employed Allied Health staff to provide restorative or maintenance services to enable patients to enjoy evidenced economically viable quality of life years associated with AHS care.

Changes to achieve these outcomes will require significant service redesign and community engagement.

References:

1 Department of Health Tasmania December 2020 Health Workforce 2040 Allied Health *IN DRAFT*

2 Goddard, M March 2021Demand Supply Value A report on allied health services in Tasmania