Rural Health Legislative Council Inquiry 2021.

A Patients Perspective.

I wish to make a submission to this inquiry as I am witnessing personally just how hard it is to get good timely patient care in rural Tasmania.

I live in Scottsdale having moved from Canberra in 2011 in retirement.

What drew us to this part of Tasmania was that Scottsdale appeared to have lots of services being the regional hub for north east Tasmania.
Close enough to Launceston that if we needed city services they were an hours drive away.

The town ticked lots of boxes, multiple doctors surgeries, and a hospital with 24 hour Accident and Emergency department., along with locally based ambulance services.

Since 2011, things have progressively gone downhill.
One long term doctor retired and closed his surgery so now there is only one doctors surgery in the town, run like so many rural GP clinics by Ochre Health .

Progressively long term resident doctors have left or retired from this practice and we have been left with a string of locum General Practitioners, here for a week or maybe a month then gone, rarely to be seen again.

Why does Ochre Health have such a high staff turnover with GP's not wanting a long term commitment? Are they horrible to work for?
Apparently St Helens, also an Ochre run practice, has the same issue of high staff turnover, so the town rumour mill is saying.

It is now taking up to 5 weeks to get an appointment with a doctor, and city people would not tolerate that, but in rural Tasmania, get used to it as the norm and better than 8 weeks.
By comparison, our Vets have shorter wait times of 1 to 2 days and are better equipped than our hospital, which is a damning indictment of rural health in this state.

Likewise the local hospital NESMH, a rump of its former self, now considered by health bureaucrats as a dumping ground for bed blockers from LGH and little else.

In the case of NESMH both my wife and I have been inpatients and the level of care and staff to patient ratio is better there than both LGH and St Vincent's.
Successive governments paid to build and over the years upgrade the hospital and its buildings, but would now like to close it if they could.
The government of the day pays to staff the place so the core infrastructure is already in place, but no longer valued in Hobart or Launceston.

The old local farmers tell me of the things it used to do, but not anymore.
Yes, I know there are litigation lawyers around every corner these days that were not there in 1970, but if you give these little hospitals with their attached A&E

departments the clinical resources and the doctors the training to perform limited treatment, then you free up the major hospitals for the difficult stuff for which they are resourced.
Every patient treated at NESMH is one more that LGH never sees.

In an effort to improve the situation, in 2018 I helped [redacted] a now retired GP from the practice to put together a submission to government for a bedside ultrasound equipment for NESMH and the staff training to go with it so the doctors that used it had the documented competencies for that equipment.

The idea being that with better diagnostic capability at NESMH then the greater ability to know what needed to go to LGH or (RHH if serious enough), and what could safely be treated locally, thereby freeing up resources at the major hospitals.

Also we still have the occasional emergency birth at NESMH from mothers that simply run out of time before getting to Launceston, and these days ultrasound is considered as a necessary tool for the process
The ultrasound was to be co funded with significant funds already raised by the hospital auxiliary.

The then minister sat on that submission for 12 months then just said a blanket "no".

The hospital auxiliary has since purchased a much simpler portable ultrasound device on the basis that some capability is better than no capability and if government won't help then it has to be a lesser machine based on the money to hand. .
Interested GP's have since used their own money for training but since none stay for more than a few weeks or have retired, so we have the capability but few doctors that are trained to use it.

We tried to help ourselves and got no help from government when we asked for a hand up, not just a hand out, it was rejected by government.
There are simply not enough votes here !!

Part of the issue is that those in health bureaucracy invariably come with an agenda that any money spent by government on resources or enhanced capability in rural services like NESMH but equally applicable to other rural health services around the state is taking health budget money that the two big hospitals should have got.

Rural health services are not valued in Hobart or Launceston and not viewed as an "assistant" to city health providers, but as a thief for funds they could have had..
They forget, every patient successfully treated in rural facilities is one the big hospitals may well not see.

Decisions on funding of rural services needs to be peer reviewed by clinicians and administrators not directly involved, so the proposal gets viewed on its merits not that it "steals" funding from city health facilities

Another potential solution on the horizon and of significant potential benefit to rural health in Tasmania is enhanced blood pathology screening, using drones to fly blood samples collected at NESMH (and equally applicable to other regional hospitals) to Launceston for testing.

Scottsdale will never justify a full blood pathology laboratory, nor should it, but this would give NESMH access to city based pathology in a time critical environment.

Swoop Aero (**https://swoop.aero/**) are currently working with civil aviation authorities for clearance to operate medical drones in the Launceston airport controlled airspace and are hopeful of approval to do so.

I had hoped to provide a rough order of magnitude costings to the committee of such a service but swoop.aero say they prefer to negotiate on a case by case basis.

The direct route from NESMH to LGH is just over 45 km and a drone of the proposed type would cover that distance in around 23 minutes versus in excess of 1 hour or more depending on traffic at the time.

That effectively would give timely blood testing capability to NESMH A&E another step in deciding who needs care in a big city hospital and who has a condition even if needing hospitalization that can be treated quite safely in Scottsdale.

Its implementation also means that the limited ambulance capacity in Scottsdale is reserved for the most urgent of cases, due to better diagnosis at the point of initial service.

Nice pipe dream, but from passed experience there is little point even asking for a feasibility study to be done.

No one in authority values rural hospitals any more, so to enhance their capability they perceive isn't worth doing.

Lets spend the money on a football stadium upgrade instead, that should make the votes roll in on election day..

I feel quite strongly about this subject and have mentioned my activism to Launceston plastic surgeon [redacted]
He has, through his own diligence, managed to start a plastic surgery training unit in both Launceston and Hobart hospitals because he believes in better regional health outcomes. We need capabilities in Tasmania, not just mainland Australia.
I mentioned to him about our continuous stream of locum GP's in Scottsdale.

Dr [redacted] is quite vocal on the reasons why GP's don't stay in rural GP practices, particularly the current Federal government policy of compulsory rural postings for junior doctors or those with overseas qualifications who wish to practice in Australia .

"It breeds nothing but resentment and you end up with doctors that don't want to be there, doing the minimum required to meet the government directive and leave as soon as they are able to, vowing never to return to rural practice".

He says there is a better way by "**incentives, not punishment**" for working in rural practice.
Many doctors are still carrying debt from HECs fees during their training at university.
Wiping those debts for doctors in rural practice is one option, another better option, that is applicable to doctors of all ages and levels of qualification is a favourable tax offset on their income for doctors in regional areas that struggle to attract doctors.

Scottsdale although designated as a rural health area does not appear on the ATO list of Remote Zones so even if this Tax Offset option was in effect, doctors working here would not qualify - another reason why Scottsdale would struggle to attract and keep doctors

Yes if implemented there would be a hit to tax revenue but that is offset if doctors are not being paid as locums but as normal local long term doctors.

With the right incentives you get people that want to be in regional areas, not because they are ordered there but because they want to be there.

A"carrot versus a stick" approach.

Another helpful suggestion is that during the recruitment process for GP training , apparently lots of the questions asked, favour, city-centric applicants, not those that come from rural areas and would like to return to their communities once qualified.

There are few votes in rural communities and governments both State and Federal know that.

This inquiry like so many beforehand is just government of all levels holding yet another inquiry as a good excuse to seem like they are doing something while actually using it as a reason to do nothing.

"Wait until the report is released then we will institute its recommendations".
Never happens and it rests on the shelf with all the other reports.

I am sorry if that appears too cynical, but I use decades of bush fire inquiries after every catastrophic event yet successive reports sit on shelves gathering dust.

I hope I am wrong in this case.

Yours respectfully,

John. W. (Bill) Tomlinson Dated: 11/3/2021

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