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RDAT Submission to the *Our Healthcare Future Immediate Actions and Consultation Paper*

Our Healthcare Future
Health Planning
Department of Health
GPO Box 125
Hobart Tasmania 7001
Sent via email: ourhealthcarefuture@health.tas.gov.au

11th of February 2021

To whom it may concern,

Thank you for the opportunity to provide a submission to the above-mentioned Consultation Paper. The Rural Doctors Association of Tasmania (RDAT) is the peak rural body for doctors working in rural and remote Tasmania and represents the views and aspirations of rural doctors. We aim to promote career pathways in rural practice, and support services provided by rural doctors in Tasmania. We support rural communities through advocacy and sustaining health services in rural Tasmania.

Please find enclosed our submission that aims to provide RDAT's ideas, concerns and future expectations of our Healthcare Future.

Any enquiries can be sent to office@rdaa.com.au.

Yours sincerely,

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Reform Initiative 1

Consultation questions:

1. How can we target better our current investment as well as future investments in health to ensure a sustainable and balanced mix of services is delivered across the whole of the health system to provide right care in the right place at the right time?

The consultation paper has a heavy focus on preventing avoidable hospital admissions. 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 from the State Government.

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.

2. How can we shift the focus from hospital based care to better community care in the community?

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 renumeration of Rural Generalists will provide a workforce to the highest areas of need in Tasmania to provide comprehensive Primary Care and undertake preventative healthcare.

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3. How can we facilitate increased access to primary healthcare, in particular:

a. after-hours and on weekends.

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.

b. in rural and regional areas.

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.

c. for low-income and vulnerable clients.

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 as 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.

d. for extended treatment options (e.g. urgent care or non-emergency care)?

GPs need to be supported with nursing and allied health staff to deliver care afterhours as urgent or non-emergency care.

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4. The UCC Feasibility Report 2019 identifies UCCs as a feasible service model for Tasmania. Are there other barriers and opportunities for implementing a model of urgent care in Tasmania not identified by the study?

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 incorrectly selected the healthcare facility for their ailment will be able to be transferred and managed in the correct location in a timely manner.

5. How can we make better use of telehealth, so people can receive care closer to home, and what are the barriers preventing utilisation of telehealth?

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 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 hospital. 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 appointment, 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.

6. How can we make better use of our District Hospitals to enable maximum utilisation of beds in these facilities as a step-down from public hospitals and a step-up from the community to improve patient flow in acute hospitals and care in the community?

District hospitals need to be adequately resourced and staffed to ensure maximum utilisation. The District hospitals cannot 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 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 is also essential. This supports robust emergency care, inpatient care and rehabilitation.

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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.

7. How can we improve integration across all parts of our health system and its key interfaces (e.g. primary health, mental health, disability services, aged care and acute care)? What should be our priorities for integration?

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.

8. How can we strengthen the interface between hospital services and aged care to improve community healthcare for older Tasmanians?

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. They GP is likely to be the best source of information and well placed to assist 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, any advanced care directives and plan transition of are back to the 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 ensure that continuity of care does not lead to any adverse clinical events.

9. How can we make the best use of co-located private hospitals to avoid public hospital presentations and admissions (by privately insured patients)?

If a clinical condition can be appropriately managed in a co-located private hospital, without producing unnecessary delay and an appropriate consultant can be sourced to provide the care then this would be acceptable to RDAT. These patients should be identified in the emergency department and transferred appropriately.

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1*0. How can we build health literacy, self-management and preventative health approaches into the day-to-day practices of our health services across the whole of the health system?*

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 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.

11. How can we better incorporate preventative health and health literacy initiatives into current and future care, across the range of settings, including acute, community, primary and private?

See comments above – using as many community-based organisations and the formal education system is advised.

12. How do we provide clear pathways into our health system so that patients are accessing the most appropriate care for them?

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).

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Reform Initiative 2

Consultation questions:

1. How can we best target our digital investment to improve the timely sharing of patient information across key health interfaces?

All specialist letters, emergency department presentations, investigations, discharge summaries, procedures and correspondence should be made available to primary care.

2. What digitisation opportunities should be prioritised in a Health ICT Plan 2020- 2030 and why?

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.

3. What information should be prioritised for addition to the My Health Record to assist clinicians in treating patients across various health settings (e.g. GP rooms, Hospital in the Home, Hospital, Specialist Outpatients)?

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.

4. What are the opportunities to develop a digital interface between hospitals and other care providers (such as GPs, aged care and the private system) to improve the timely sharing of patient information?

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

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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.

5. What information would help to improve your experience as a patient or consumer interacting with public hospital or health services in Tasmania?

6. What technology would be best to help you to deliver improved patient outcomes?

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 eReferral 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 deprtments.

7. How can we use technology to empower patients with their own self-care?

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 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.

8. What is the key paper or manual administrative process that would provide the most benefit to digitise/bring online?

Writing an electronic referral, printing it, signing it, faxing it and hearing nothing about the acceptance of the referral and then not receiving correspondence after the patient has had an outpatient appointment (or if you do it arrives by fax and needs to be scanned into the medical record!)

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Reform Initiative 3a

Consultation questions:

1. What are the major priorities that should be considered in the development of a 20 year infrastructure strategy?

As touched on previously, an increase in rural trauma from tourist-based adventure activities has seen a considerable increase in the demand for rural emergency services. The THS need to ensure that these facilities are capable of adequately assessing and managing these patients. Robust pre-hospital care and retrieval services need to wrap around rural sites to provide support for the critically unwell.

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.

2. How should the Government ensure we achieve the right balance of infrastructure investment across the range of care settings including acute, subacute and care delivered in the community?

3. How do we ensure current facilities continue to be invested in appropriately so they continue to be fit-for-purpose?

4. What are the key factors that should be considered in the development of modern health facilities in a community setting – e.g. location, proximity to other community services?

5. How do we integrate our capital investment planning with the private sector to help complement and/or supplement the public system?

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Reform Initiative 3b

Consultation questions:

1. How should the Health Workforce 2040 strategy be further refined to guide and inform the development of a strong and sustainable professional workforce that is aligned to meeting the future health needs of Tasmanians?

Ensuring medical, nursing, and allied health staff are trained to provide care in rural settings. 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 a Rural Generalist Allied Health Professionals to ensure good allied health provision of care to rural communities should also be carried out in Tasmania

2. How do we work with the private sector, as well as other levels of government, to ensure our combined workforce serves the future needs of our community?

3. What steps can be taken to improve the State's ability to attract and retain health professionals in regional areas, particularly the North West?

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.

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.

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4. What innovations or changes are needed to our health workforce to more closely align our professional health teams with the future needs of Tasmanians?

Rural areas are struggling to staff practices and district hospitals with medical nursing and allied health staff.
Training staff with the skills they need to work in these areas is key to retention. Rural Generalist Training in both medical and allied health areas has been shown to assist in recruiting and retaining staff to these areas.

5. How do we support health professionals to work to their full scope of practice?

In the Mersey Community Hospital example, adequate training as a Rural Generalist in emergency, anaesthetics, obstetrics, palliative care, adult internal medicine and mental will allow these doctors to work to a full scope of practice and provide a range of outpatient and inpatient services in both a public health system and private capacity.

There needs to be a provision of industrial agreements allowing work to the full scope with indemnity provided for the extended skills used.

6. How do we support Tasmanians to access the education and training they need to be part of the State's future workforce?

Tasmanians need to be encouraged to attend secondary school education and barriers that prevent pre-tertiary education and the transition to University needs to be addressed for lower socioeconomic and rural areas. The University of Tasmania is support early years medicine and nursing training in multiple centres in Tasmania, rather than centralised in Hobart. The Department of Health need to work constructively with the University of Tasmania to address the workforce needs of Tasmania.

Reform Initiative 3c

Consultation questions:

No comments made.