ANZSPM

The Australian & New Zealand Society of Palliative Medicine Inc. ABN 54 931 717 498

Sessional Committee Government Administration A Sub-Committee
TAS Legislative Council
Parliament House, HOBART TAS 7000

17 March 2021

Dear Sub-Committee,

ANZSPM Submission to the Rural Health Services Inquiry

The Australian and New Zealand Society of Palliative Medicine (ANZSPM) appreciates the opportunity to provide the attached submission to the Sessional Committee Government Administration A Sub-Committee regarding its *Rural Health Services Inquiry*.

ANZSPM is the specialty medical society that represents medical practitioners who provide care for people with a life limiting illness in Australia and New Zealand. We aim to improve health outcomes by working with and influencing the system and community around the person with a life-limiting illness. ANZSPM facilitates professional development, support, and advocacy for its members across Australia and New Zealand to promote best practice in palliative medicine.

Any inquiries in relation to this submission can be directed to:
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We would be happy to meet with members of the Sub-Committee to provide further information in support of this Inquiry.

Yours sincerely,

A/Prof Leeroy William
President

Janice Besch
Chief Executive Officer

ANZSPM Submission:

TAS Rural Health Services Inquiry

March 2021

Table of Contents

1. Introduction

1.1 This submission is made by the Australian and New Zealand Society of Palliative Medicine (ANZSPM), the specialty medical society for medical practitioners who provide care for people with a life-limiting illness in Australia and New Zealand. ANZSPM represents practitioners of palliative medicine across Australia and New Zealand.

1.2 ANZSPM appreciates the opportunity to make this submission to the Legislative Council Sessional Committee Government Administration A Sub-Committee (the Sub-Committee) with respect to its *Rural Health Services Inquiry* (the Inquiry).

1.3 In this submission, we firstly provide background information on ANZSPM, then comment on the Inquiry's terms of reference, in particular with respect to end-of-life and palliative care.

1.4 We would welcome the opportunity to meet with the Sub-Committee to provide additional information that may be of assistance with the Inquiry.

2. Executive Summary

2.1 The rural population is aging at a faster rate than the metropolitan population, which contributes to a higher total disease burden rate. Rural and remote patients are more likely to face barriers in accessing general practitioners (GPs) and specialists, and lower attendance rates including lower participation in health screenings may also be leading to poorer health outcomes in these areas. In terms of the provision of palliative and end-of-life care, these trends can increase the burden on under-resourced residential aged care and palliative care services in rural and remote areas.

4.1 Tasmania is divided into three regions and serviced by three different health and specialist care services. Of the three regions, the North West has the highest proportion of those living outside urban areas (70%), followed by the Northern Region (45%) and the Southern Region (45%).[1] The provision of palliative care across these rural areas 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 (SPCS) support GPs in the provision of palliative care, but do not have the workforce to lead the care of the majority of patients. These varied combinations of health professionals and services create disparities in access and quality of health services for rural and remote patients. It also means that it is difficult to determine exactly who delivers palliative care in rural and remote Tasmania.

4.2 In areas without specialist palliative care services, access and quality of palliative care is often determined by the interest, knowledge, initiative, and capacity of GPs. While it is clear that more specialists are needed in these areas, there still remains no substantial incentives for staff specialists to move to and work in rural and remote settings. There are also several other challenges to achieving greater specialist input. The spread-out topography of Tasmania, the small population in each location, and the small numbers of trained palliative care specialists mean that rural palliative patients may always rely more on generalist support compared to the urban population. For this reason, a model which encourages experienced generalist trained

[1] Australian Bureau of Statistics 2020, *3218.0 - Regional Population Growth, Australia, 2018-19*, https://www.abs.gov.au/statistics/people/population/regional-population/2018-19

general practitioners to develop relationships with staff specialists who can provide ongoing support, training and joint visits would do more to improve palliative care long-term.

2.2 There are some positive features to palliative care provision in rural and remote settings when compared to metropolitan areas. Local hospitals and local health professionals offer a sense of familiarity and community for many patients. However, this sense of community and continuity of care is being threatened with the loss of older GPs, many of whom are being replaced with "fly-in/fly-out" doctors.

3. About ANZSPM

3.1 ANZSPM is a not-for-profit specialist medical society for medical practitioners who provide care for people with a life-limiting illness. ANZSPM aims to improve health outcomes by working with and influencing the system and community around the person with a life-limiting illness.

3.2 ANZSPM facilitates professional development, support, and advocacy for its members across Australia and New Zealand to promote best practice in palliative medicine.

3.3 ANZSPM promotes the discipline and practice of Palliative Medicine in order to improve the quality of care for patients with palliative diagnoses and support their families.

3.4 ANZSPM is overseen by a Council of members, which includes representation from Australia and New Zealand and also from the Royal Australasian College of Physicians' Australasian Chapter of Palliative Medicine. ANZSPM's day-to-day operations are managed by a small team of staff based in Canberra ACT.

3.5 Our members include palliative medicine specialists, doctors training in the specialty of Palliative Medicine, General Practitioners and doctors who are specialists in other disciplines with an interest in palliative medicine such as oncologists, haematologists, intensivists, psychiatrists and geriatricians. ANZSPM currently has 541 members, including 18 members based in Tasmania.

4. ANZSPM Comments on the Terms of Reference

4.3 We address in this part each of the terms of reference, insofar as it is relevant to ANZSPM's role as the peak body representing practitioners of palliative medicine in Australia and New Zealand.

(1) Health outcomes, including comparative health outcomes

4.4 The rural population is aging at a faster rate than the metropolitan population due to young people moving to cities and older people moving to rural and remote areas post-retirement. The requirement for palliative care in any particular area reflects the burden of disease of the population. In 2015, the total disease burden rate in remote and very remote areas was 1.4 times higher than in major cities.[2]

[2] Australian Institute of Health and Welfare 2019. Rural & remote health. Cat. no. PHE 255. Canberra: AIHW. Viewed 21 December 2020 2020, https://www.aihw.gov.au/reports/rural-remote-australians/rural-remote-health

4.5 In 2016, people in remote areas were more likely to report barriers to accessing GPs and specialists.[3] These barriers may contribute to lower participation rates in health screening and higher rates of potentially avoidable deaths. In 2015-2017, life expectancy for both males and females decreased as remoteness increased.[4] These demographic trends can increase the burden on under-resourced residential aged care and palliative care services in rural and remote areas.

4.6 Infants, children, and adolescents are similarly affected to adults in rural and remote settings, and improving palliative care services and support in these areas will similarly improve the situation of this population.

4.7 Tasmania is faced with an aging population with increasing prevalence of age-related chronic conditions such as cancer, organ failure, and dementia.[5] These are all conditions which may require palliative care. It is estimated that 1 in 4 of the Tasmanian population will be over the age of 65 years in coming decades.[6] In addition, the rurality of the population leads to shortened lives and higher levels of illness and disease risk factors than those in major cities.

4.8 The North West Health District, with a population of 111,954, has the highest percentage of people living outside urban areas.[7] This district has an older, poorer population with poor health literacy, high levels of chronic disease and cancer, and poor health outcomes including mortality due to cancers and heart disease. 20% of the North West population are aged over 65 years.[8] The primary determinants of health remain poor.[9]

4.9 A health outcome for patients living in rural Tasmania includes that of a 'good death' or 'safe death'. This could describe a death in the home (including residential aged care), in a regional or district palliative care bed (hospice), in a regional or district public hospital, or in a regional private hospital.

4.10 Dying in one's preferred place of death has been used as a quality marker, with an in-hospital death often seen as a poor outcome. While rural and remote residents may initially indicate that home is their preferred place of death, this is often unachievable for those living out of town. Unlike large metropolitan tertiary hospitals however, the local rural hospital is often seen as a safe and familiar place, and providing that residents die within their community, a hospital death is often not seen as a 'bad' outcome.

4.11 The view of rural hospitals as safe, familiar places unfortunately may change as older GPs are replaced with "fly-in/fly-out" GPs. The Inquiry needs to be careful in determining how they will measure the quality of palliative care in rural, regional, and remote areas. Place of death is not the only outcome measure and is also not necessarily a reliable outcome measure.

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[3] Australian Institute of Health and Welfare 2019, *Rural & remote health. Cat. no. PHE 255*, Viewed 21 December 2020, https://www.aihw.gov.au/reports/rural-remote-australians/rural-remote-health

[4] Ibid.

[5] COTA Tasmania 2013, *Facing the future: A Baseline Profile on Older Tasmanians*, Viewed 9 March 2021, http://www.dpac.tas.gov.au/__data/assets/pdf_file/0015/214323/Facing_the_Future_-_A_Baseline_Profile_on_Older_Tasmanians.pdf

[6] Ibid.

[7] Australian Bureau of Statistics 2020, *3218.0 - Regional Population Growth, Australia, 2018-19*, https://www.abs.gov.au/statistics/people/population/regional-population/2018-19

[8] Australian Bureau of Statistics 2015, *3235.0 - Population by Age and Sex, Regions of Australia, 2015,* https://www.abs.gov.au/ausstats/abs@.nsf/Previousproducts/3235.0Main%20Features402015?opendocument&tabname=Summary&prodno=3235.0&issue=2015&num=&view=

[9] Primary Health Tasmania 2015, "Community Health Checks", Viewed 9 March 2021, https://www.primaryhealthtas.com.au/resources/community-health-profiles/

(2) & (3) Availability and timeliness of health services, and barriers of access to:

a. Ambulance services

4.12 ANZSPM does not have any comment on this term of reference.

b. Primary care, allied health and general practice services

4.13 The Australian Institute of Health and Welfare (AIHW) data indicate that people living in remote and very remote areas generally have poorer access to health services, including medical imaging, than people in regional areas and major cities.[10] They may need to travel longer distances to access health services. They also may have poorer health literacy and educational levels, which can also become barriers to service access.

4.14 Patients in rural and remote settings will generally have reduced access to GPs, nurses, palliative care beds, home equipment, and allied health professionals such as counsellors and psychologists. GPs and private specialists are not provided reimbursement for travel related to home visits, which makes such consultations far less accessible for rural and remote patients.

4.15 Barriers to GP involvement in palliative care and support for palliative patients in rural and regional Tasmania include time, workload capacity, lack of timely relevant information from hospital and specialists, lack of confidence in palliative care skills, lack of community backup, and poor Medicare remuneration.

4.16 Reliable Wi-Fi is essential for both health care professionals and patients. Poor internet access can therefore become a further barrier to access and quality of services.

4.17 In North West Tasmania, the two largest population centres of Devonport and Burnie have experienced GP shortages for the past few years, making it difficult for patients to access a GP for routine care. Most GP clinics have 'closed books' and patients often travel to other towns to find a GP. This situation is repeated across the other health regions in both Hobart and Launceston.

4.18 One positive feature of traditional rural and remote general practice has been the 'cradle to the grave' relationships established often over generations, with continuity of care across rooms, hospitals, home, and residential aged care. However, the loss of older GPs through retirement, worsening GP shortages, and an increase in "fly-in/fly-out" doctors may be having a negative impact on continuity and cause a loss of trust in the local hospital.

4.19 There are many clinicians (specialists and non-specialists) that are continuing to live and work in the same community. Whilst this is often seen as a privilege by clinicians, there is also a need to acknowledge the emotional burden of caring for their community, acquaintances, colleagues, friends and sometimes even family. Everyone working in this area needs to consider how best to manage the ongoing demands of the job and the need for professional development and self-care.

[10] Australian Institute of Health and Welfare 2019, *Rural & remote health. Cat. no. PHE 255*, Viewed 21 December 2020, https://www.aihw.gov.au/reports/rural-remote-australians/rural-remote-health

c. Non-GP specialist medical services

4.20 The North West Health Service district has no respiratory physician, leading to delays in diagnosis of lung diseases including lung cancer.

4.21 Please refer to *(f) Pain management services* for ANZSPM's comments on pain specialists.

d. Hospital services

4.22 Please refer to *(g) Palliative care services* for ANZSPM's comments on hospital services in relation to palliative care.

e. Maternity, maternal and child health services

4.23 ANZSPM does not have any comment on this term of reference, other than to underscore the importance of paediatric palliative care in the population.

f. Pain management services

4.24 There is one Chronic Pain Service in Hobart. In rural areas, pain management is provided by GPs and allied health services locally. The North and North West do not have pain specialists, which means that palliative care specialists are often requested to provide pain advice and to support GPs in this area. There is limited access across the whole of Tasmania for coeliac plexus nerve blocks, which can greatly assist in management of pain in pancreatic and gastric cancers. Access to spinal nerve blocks is only available in Hobart, and hence increased suffering may occur for people in other communities where such intervention is unavailable.

4.25 The Tasmanian HealthPathways has completed a review of its pain management pathways, including reviews on medication in pain management (particularly opioid medications) and multidisciplinary approaches to complex pain.

g. Palliative care services

4.26 Community palliative care in rural Tasmania is traditionally provided by general practitioners and community nurses, with input from SPCS based in the larger urban areas of Hobart, Launceston, Devonport, and Burnie. Palliative care in residential aged care facilities is delivered by the facility's staff, with input from GPs and some involvement with palliative care specialists. The SPCS support GPs in the provision of palliative care but do not have the workforce to lead the care of the majority of patients.

4.27 The model of palliative care provision that has been used in Tasmania since 2008 is based upon a model of care in which those with the greatest need receive specialist input and the majority of palliative care patients receive generalist input (see Appendix). This has worked to some extent, however those that miss out will be those in rural areas and other marginalised populations.

4.28 Patients often prefer to have their own GP provide palliative care at home. Barriers to GPs providing palliative care include time, workload capacity, lack of timely relevant information from hospital and specialists, lack of confidence in palliative care skills, lack of community backup, and poor Medicare remuneration.[11] Medicare remuneration does not cover the time for consultations and distances that may need to be travelled to visit patients at home. In situations where both the GP and patient lack the capacity to travel, GPs must also provide prescriptions and other documents without Medicare renumeration. Some general practitioners will not conduct home visits and others will visit patients only within 5km of their clinic.

4.29 The availability of specialist palliative care varies by region, and is summarised in the following table:

Specialist Palliative Care Services by region

North West Region	North Region	South Region
Population: 111 954 • No Hospice • 1 FTE Palliative Medicine Consultants • 0.5 FTE Registrar (co-funded academic post) • No hospital consultation Community Clinical Nurse Consultants	Population: 145 033 • Hospice (4-7 beds) • 2 FTE Palliative Medicine Consultants • 0.5 FTE Hospice Registrar (shared with LGH medical staff) • Community Clinical Nurse Consultants	Population: 271 214 • Hospice (10 beds) • 1 FTE Hospice Consultant • 1 0.8 FTE and 1 0.6 FTE Community Only Consultants • 2 0.6 FTE Hospital Consultants • 1 Oncologist working in community palliative care • 1 FTE Hospital Registrar • 1 FTE Registrar in the community • 1 FTE hospice Resident Medical Officer • 1.8 FTE hospital Clinical Nurse Consultants • Community Clinical Nurse Consultants

4.30 In North West Tasmania, many patients are from low socio-economic backgrounds with poor social determinants of health, and there is a high prevalence of complex comorbidities. Without a hospice in this region, palliative care services must make community visits to palliative patients, which is more time-consuming than working from a central hospice. By comparison, hospital patients in the Southern region are seen every workday for treatment optimisation and assistance with streamlining of discharge planning.

4.31 The North West Tasmania SPCS medical staffing is well below the national benchmark of Palliative Care Australia. Palliative Care Australia recommends 2.0 FTE palliative medicine

[11] Herrmann, A., Carey, M. L., Zucca, A. C., Boyd, L. A. P., & Roberts, B. J. (2019). Australian GPs' perceptions of barriers and enablers to best practice palliative care: a qualitative study. BMC Palliative Care, 18(1), 1–14; Sanderson, C., & Tieman, J. (2010). CareSearch - online palliative care information for GPs. *Australian family physician*, 39(5), 341–343.

specialists and 1.0 FTE registrar per 100,000 population.[12] ANZSPM offers a note of caution in applying this recommendation to rural areas, due to the additional time needed for travel between patients and also due to the generally older, sicker populations of these areas. It is also noted that this modelling is based on traditional referral patterns with 80-90% of referrals coming from Cancer Services. The SPCS receive at least 40% of referrals from non-malignant diseases including motor neurone disease and terminal organ failure.

4.32 Palliative Care Australia recognises that there are no formal benchmarks for palliative care staffing profiles.[13] Palliative care services are expected to have access to the full complement of Allied Health practitioners including social workers, physiotherapists, occupational therapists, music and art therapists, pastoral care workers, bereavement counsellors and other health professionals who can address patient needs. Rural palliative patients have limited access to many Allied Health practitioners. In North West Tasmania for example, there is only one social worker with the North West Specialist Palliative Care Service, resulting in limited bereavement support in remote areas.

4.33 Allied Health practitioners play an essential role in meeting the needs of people living with a life limiting illness, their family, and carers. This support can include:

- Providing support to manage physical symptoms including medication, nutrition, communication, and mobility
- Assisting people to maintain function and independence, including through the provision of equipment for home care
- Providing a wide range of psychological and social support, pastoral care, and bereavement support
- Providing therapies that focus on improving the quality of life of people, families, and carers, and providing/sharing education with people with life limiting illness

4.34 The limited availability of Allied Health professionals can create significant problems for palliative patients in rural Tasmania. For example, a recent referral to private and public occupational therapy for a palliative care client in Ulverstone led to the referrer being advised of a 3-month wait. Occupational therapists are particularly important for palliative patients who have a goal of dying at home.

4.35 In rural and remote areas, provision of 24/7 on-call palliative care is challenging. Where available, palliative care nurses are either supported by local specialists (who are often sole practitioners), local non-specialists, or remote clinicians via an afterhours number. Remote clinicians do not know the patient and often lack an understanding of the local supports available.

4.36 Rural patients and carers in Tasmania are supported after-hours by GP Assist, which is staffed by a registered nurse and a GP. They provide telephone support from 1800 until 0745 Monday to Friday and 24-hours on weekends and public holidays. GP Assist is not currently able to provide specialist palliative care expertise, and the service cannot provide prescriptions for schedule 8 medicines. Palliative care staff specialists support community and hospital doctors in the South and North West. Northern Palliative Care staff specialists support the Northern community and hospital doctors.

4.37 After-hours services are limited, particularly for patients in rural areas. It is not always possible to have enough GPs on-call every night with so few in the area. Travelling at night in rural areas

[12] Palliative Care Australia 2018, *Palliative Care Service Development Guidelines*, Viewed 9 March 2021, https://palliativecare.org.au/wp-content/uploads/dlm_uploads/2018/02/PalliativeCare-Service-Delivery-2018_web2.pdf
[13] Ibid.

can also be dangerous, especially if the area is not known to the person driving. For staff safety there should be 2 people in a vehicle, as is being trialled by the Community Rapid Response Nursing Teams in the North and South. Even if travel costs were reimbursed, GPs are also unlikely to be available at night (or even in the day) to travel many kilometres to outliers.

4.38 The quality of primary palliative medicine in rural and remote Tasmania largely depends on the knowledge, experience, and interest of individual GPs. The number and distribution of GPs who have a special interest in palliative care is not known. Those who work in the area need to have skills and knowledge in palliative care and be provided with the clinical information from hospital specialists to enable palliative care to be delivered. The group of practitioners who is delivering this level of care is aging and being replaced by "fly-in/fly-out" doctors, which will reduce continuity of care in these areas.

4.39 There are no data available from the Royal Australian College of Physicians (RACP) of the number and location of GPs who have completed the RACP Palliative Medicine Diploma. The RACGP and Australian College of Rural and Remote Medicine (ACRRM) advanced skills training pathways enable Rural Generalists to develop an advanced skill, which may include palliative care. The location of those GPs with this palliative care advanced skill set is also not published, and it is hoped that the RACGP and ACRRM will contribute to the Inquiry to provide more information.

4.40 While it is clear that more specialist palliative care input is needed in rural areas, there are several challenges to achieving this. The spread-out topography of Tasmania, the small population in each location, and the small numbers of trained palliative care specialists mean that rural palliative patients may always rely more on generalist support compared to the urban population. For this reason, a model which encourages experienced generalist trained general practitioners to develop relationships with staff specialists who are able to provide ongoing support, training and joint visits would do more to improve palliative care long-term. Each service also needs to have more than one staff specialist working in the community to cover both the acute palliative care needs of the rest of the community and the time taken out to cater for rural and remote visits.

4.41 The significant overlap of end-of-life care with aged care and geriatric medicine can also not be underestimated. There is a strong case for the appointment of an academic palliative care (possibly oncology trained) specialist who is also a trained geriatric physician, to progress ways in which these areas can be synthesized in non-dementia settings to improve end-of-life care. Likewise, for the appointment of one or more academically dual-trained GPs and palliative care specialists (or geriatric physicians) with an interest in end-of-life care, and its outcome assessment, in rural Tasmania.

4.42 There is likely to be a need for more staff in rural end-of-life care until such time as a critical staffing mass is achieved, to diminish the huge levels of specialist and GP fatigue that can develop in the face of an aging rural population with increasing health expectations.

h. Pharmacy services

4.43 Rural pharmacy services are essential for the provision of palliative care in these areas. In the North West, the Specialist Palliative Care Service Nurse Educator has contacted each community pharmacy, and this contact and education has encouraged most pharmacies to stock essential medications for palliative patients at end of life. The hospital pharmacy at Latrobe has also commenced home deliveries to palliative care clients.

4.44 After-hours pharmacy services are unfortunately limited. In Launceston for example, there has been no community pharmacy available after-hours on weekends until very recently. This situation has been exacerbated by the added restrictions on opioid prescribing by the federal Department of Health.

i. Dental services

4.45 ANZSPM does not have any comment on this term of reference.

j. Patient transport services

4.46 ANZSPM does not have any comment on this term of reference.

k. 'After hours' health care

4.47 The SPCS South in Hobart provides an after-hours service for Hospital doctors and GPs in the South and North West. The SPCS North provides this service in that district.

4.48 Rural patients and carers in Tasmania are supported after-hours by GP Assist, which is staffed by a registered nurse and a GP. They provide telephone support from 1800 until 0745 Monday to Friday and 24-hours on weekends and public holidays. This is phone support only.

l. Indigenous and culturally and linguistically diverse (CALD) communities

4.49 The cultural needs of Aboriginal patients and their families need to be considered by those providing palliative care and bereavement care services. These considerations can include providing care on country, supporting dying on country, involving Aboriginal Liaison Officers, and facilitating Sorry Business and Smoking Ceremonies. It is important that palliative care services in rural locations have the ability to fulfil these cultural wishes.

4.50 Nationally, around 10% of palliative care patients have a preferred language other than English. In rural communities, recent increases in refugees and migrants have changed language demographics. Non-English-speaking patients often rely on family or community members to act as interpreters, which raises issues of confidentiality and privacy. Telephone interpreters are not always available, which creates further access issues for these patients.

m. Other.

4.51 The recent passing of voluntary assisted dying legislation by Tasmania's House of Assembly could be generative of new community needs and urgent new strains on the health system. ANZSPM supports the urgent need for equitable access to high-quality generalist and specialist palliative care services across all States and Territories. Tasmania is no exception and ANZSPM

commends to the inquiry our Position Statement on Euthanasia and Physician-Assisted Suicide[14].

(4) Planning systems, projections and outcomes measures used to determine provision of community health and hospital services

4.52 ANZSPM is not in a position to contribute to this term of reference but considers the analysis to be an important one for policy and planning purposes.

(5) Staffing of community health and hospital services

4.53 In relation to palliative medicine in rural and remote communities, it is not clear who is providing palliative medicine, or what qualifications they possess. Whilst this knowledge about staffing likely exists at the local level, having access to this information at a health systems level is needed to facilitate effective workforce planning.

4.54 The national quota for 2.0 FTE palliative medicine specialists/100,000 population may need to be higher in rural and remote areas, due to the additional time needed for travel between patients and also due to the generally older, sicker populations of these areas.

(6) Capital and recurrent health expenditure

4.55 ANZSPM is not in a position to contribute to this term of reference but considers the analysis to be an important one for policy and planning purposes. Palliative Care Tasmania may be able to provide this information in relation to palliative care.

(7) Referral to tertiary care including:

a. Adequacy of referral pathways

4.56 The Tasmanian Health Service website has referral pathways for clinicians and patients.[15]

4.57 The Tasmania HealthPathways has links to palliative care services and is a repository of information for clinicians.[16] The Tasmanian Health Service Formulary also has helpful information about palliative medications.[17]

[14] See: https://www.anzspm.org.au/c/anzspm?a=sendfile&ft=p&fid=1491523669&sid=
[15] Department of Health Tasmania, "Palliative Care", viewed 9 March 2021, https://www.dhhs.tas.gov.au/palliativecare
[16] Primary Health Tasmania 2020, "Palliative Care", viewed 9 March 2021, https://www.primaryhealthtas.com.au/for-health-professionals/programs/palliative-care/
[17] Department of Health Tasmania. "Tasmanian Palliative Care Formulary", viewed 9 March 2021, https://palliativecareformulary.tas.gov.au/SpecialtyFormulary/3

b. Out-of-pocket expenses

4.58 Palliative patients living in the North and North West can access a PET scan as part of their oncology tests at Launceston with an out-of-pocket expense of $700. Patients can access the same test in Hobart with no out-of-pocket expense, however travel and accommodation costs are only partially covered, and they often need to be accompanied by a family member.

c. Wait-times

4.59 The Private Cardiology Service servicing the North and North West of Tasmania has a six month wait for a new patient to be seen by a specialist.

d. Health outcome impact of delays accessing care

4.60 ANZSPM does not have any comment on this term of reference.

(8) Availability, functionality and use of telehealth services

4.61 Telehealth is generally being used more widely both to provide specialist support, and to assist with efficiency and timeliness of review. Reliable internet is not always available, and not all residents have the technological literacy to utilise videoconferencing. Telephone consultations are not always satisfactory in terms of patient experience. Reliable Wi-Fi is essential for both health care professionals and patients. Poor internet access can therefore become a further barrier to access and quality of services, and this has become particularly apparent during COVID-19.

4.62 For palliative patients in Tasmania, the Tasmanian Health Service provides telehealth infrastructure and training for the Specialist Palliative Care teams. Palliative patients on the West Coast and King Island can access telehealth consultations. GPs and primary health nurses in these areas can also phone the palliative care team to discuss clients via telephone or videoconference calls.

(9) Any other matters incidental thereto.

4.63 ANZSPM does not have any comment on this term of reference.

5. Conclusion

5.1 We commend the Sub-Committee for considering the important issues around health outcomes and access to hospital services in rural Tasmania.

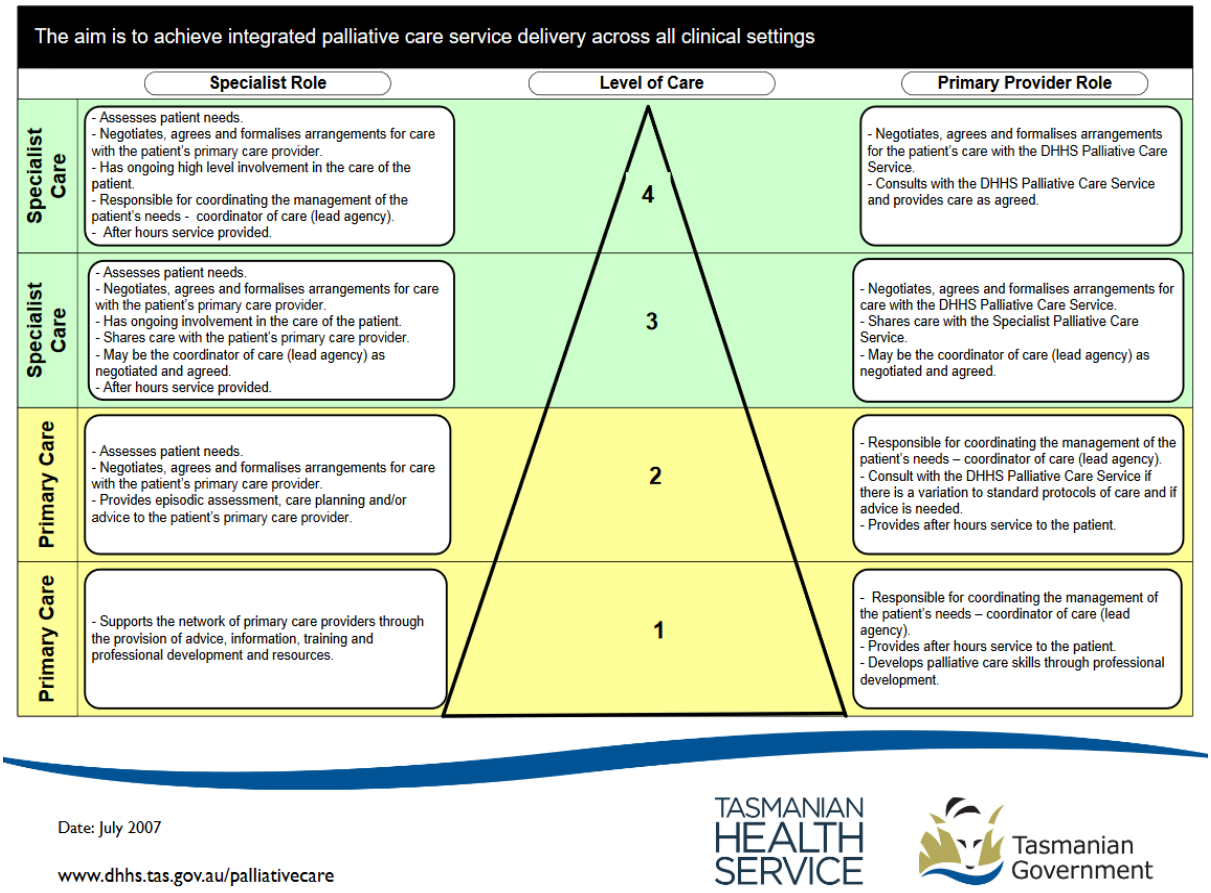
5.2 This Inquiry presents an important opportunity to facilitate greater quality and consistency in the delivery of palliative care services across rural Tasmania.

5.3 An ongoing challenge is that rural settings are faced with higher palliative care needs that must be met in an environment where the provision of quality and accessible services require more resources than are often available.

5.4 The current state of palliative care across Tasmania is varied. Some patients in these areas benefit from dedicated specialist services, while others rely on a combination of generalists and other health professionals for their palliative care needs. More data about how palliative care is provided and variation of patient experience will be essential for understanding the true state of palliative care in these areas.

5.5 ANZSPM supports a stronger focus on these issues in palliative care within rural and remote settings, and thanks the Sub-Committee for contributing to this process.

Appendix



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