Tasmanian Chronic Disease Prevention Alliance

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Public Health Association Australia

One State, One Health System, Better Outcomes: Delivering Safe and Sustainable Clinical Services Rebuilding Tasmania's Health System Green Paper

Submission from
the Tasmanian Chronic Disease Prevention Alliance and
the Public Health Association of Australia (Tasmanian branch)

The Tasmanian Chronic Disease Prevention Alliance (TCDPA) is a group of seven non–government organisations which have expertise in the area of chronic disease prevention and management. All member organisations share a mission to reduce the death and suffering from chronic disease in Tasmania.

The Alliance commenced operating in 2002 and is comprised of the following member organisations:

- Heart Foundation (Tasmania)
- Cancer Council Tasmania
- Diabetes Tasmania
- National Stroke Foundation (Tasmania)
- Arthritis and Osteoporosis Tasmania
- Asthma Foundation of Tasmania
- Kidney Health Australia (Tasmania)

The Public Health Association of Australia Incorporated (PHAA) is recognised as the principal non-government organisation for public health in Australia and works to promote the health and well-being of all Australians. The Association seeks better population health outcomes based on prevention, the social determinants of health and equity principles.

20 February 2015

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Preamble

Members of the Tasmanian Chronic Disease Prevention Alliance (TCDPA) and the Public Health Association of Australia (PHAA) Tasmanian branch, welcome the opportunity to provide this submission. The *One State, One Health System, Better Outcomes: Delivering Safe and Sustainable Clinical Services – Rebuilding Tasmania's Health System* reform (Green Paper) provides many opportunities to examine Tasmania's health system, determine what is working well, ensure these areas continue to work well, determine where improvements can be made, and provide adequate resourcing to make these improvements happen.

The Green Paper highlights that there is definitely room for improvement in terms of providing quality care that is efficient or sustainable. The TCDPA and PHAA certainly support the need for improvement in this sector, and there is no better time to do it than during the transition from three Tasmanian Health Organisations (THOs) to a single Tasmanian Health Service (THS).

However, one of our key concerns regarding this reform process is its principal focus on the acute and clinical setting.

In the foreword from the Health Minister in the Green Paper, the Minister refers to the Green Paper and subsequent White Paper as only "one part of the puzzle". Other "key elements of health reform" are listed – yet preventative health is not mentioned.

Whilst we have many dedicated and highly skilled clinicians, nurses and allied health professionals employed in these expensive hospitals that many believe is the "health system", the cost of running this has come at the expense of investment in the "front end" of our health system. Indeed for many years we have seen primary care service systematically eroded to cover acute care funding, and preventive health has played second-cousin to our hospitals. Continuing to just focus on the hospital system to deal with ill-health will not stem the tide of growing chronic disease conditions, however in the Tasmanian Budget 2014-15, it appears that the government is continuing to do just that; with funding for prevention decreasing from just 2.6% of the total health budget in 2014-15 to just 1.7% in 2017-18.

The TCDPA and PHAA understand that there will be an announcement in relation to the government's pre election commitment *A Plan to build a Healthy Tasmania* to address the development and delivery of action on preventative health.

A key issue is how *A Healthy Tasmania* will intersect with the reform being undertaken through the *One State, One Health System, Better Outcomes* process. Our response to the Green Paper is provided in the context of this vacuum.

Unfortunately, a fundamental omission of the Green Paper is that it fails to set out, or provide any context about the continuum of care from prevention to primary health care in the community to acute and sub-acute sectors and secondary prevention. Our view is that intersections along the continuum are interdependent and all strategies should be linked to a whole of system road map that is clearly articulated in every part of the chain.

Unfortunately, in the absence of this road map, there is structural deficiency in the Green Paper that may continue to reinforce a siloed approach to planning.

A further deficiency in the Green Paper structure is its failure to take into account an integrated approach to commissioning across Commonwealth and State funding sources and the for profit and not for profit sectors. There is a strong risk that focussing DHHS commissioning primarily on the THS without integrating primary health care and in joined-up arrangements with other funding sources both within and outside, DHHS will miss the greatest opportunity of the reform process – integration across the continuum of care.

In addition, the TCDPA and PHAA would like to highlight that there is much that could be learnt from the submissions (not publicly available) and witness transcripts provided to the 2013 Joint Select Committee on Preventative Health that could inform the reform process. Whilst we welcome and fully support the establishment of a new Joint Select Committee on Preventative Health (since the previous one was prorogued prior to it reporting), we are concerned that the timing of this new Committee being able to report its findings, and the timing of the coinciding (but not-aligned) reform agenda, will result yet again in siloed-decision making. Many of the witness transcripts include many of the principles enunciated in this preamble.

In addition to the feedback and concerns raised in this preamble, the TCDPA and PHAA provide the following in our submission:

- feedback in relation to the consultation questions of the Green paper relevant to the TCDPA and PHAA
- feedback in relation to the supplementary papers, and
- further feedback in relation to the Green Paper, on specific issues relevant to individual member organisations of this combined submission (at Appendix 1).

Recommendations

1. **That the Tasmanian Government request the Australian Government to continue to fund the work that the soon-to-be defunded Tasmania Medicare Local has been undertaking under the Tasmanian Health Assistance Package (THAP), so that the valuable work that is underway, particularly with regard to health risk factors and social determinants of health, streamlined care pathways, improved care coordination, and the development and implementation of Tasmanian health pathways, is able to continue.**

2. **That the Government determines how the findings from both the previously established and the newly established Joint Select Committee on Preventative Health can feed into *A Healthy Tasmania*.**

3. **That the Government ensures that chronic disease management programs are available in the community care system, not just for those with existing chronic disease, but also for those deemed to be at high risk of developing disease.**

4. **That the Government ensures adequate funding for commissioning services is provided to both Government and non-Government for and not-for profit community health care providers as part of any shift in the balance of health care provision from hospital to the community through the *One State, One Health System, Better Outcomes* reform process.**

5. **That the Government, in consultation with the community and health sector (potentially through the yet to be announced *A Healthy Tasmania* process), develop a range of health indicators, set health targets based on these indicators, and commit to regularly monitoring and reporting against these indicators.**

Recommendations drawn from Appendix 1

6. **That there is improved and consistent uptake of the *NVDPA Guidelines on the Assessment and Management of Absolute Cardiovascular Disease Risk* in the primary care setting.**

7. **That there is improved and consistent data collection relating to cardiac rehabilitation, starting with a commitment to ensure hospitals are able to collect and report data against the Safety and Quality Commission's recently released Acute Coronary Syndrome Clinical Care Standard.**

8. **That there is a review of heart failure management services in Tasmania, in order to determine where improvements can be made.**

9. **That the Government reviews the current definition of potentially avoidable admissions as part of the development of the White Paper.**

10. **Diabetes Tasmania calls for the recommendations from the soon-to-be-released National Diabetes Strategy to be incorporated into the A Healthy Tasmania strategy.**

11. That the Department of Health and Human Services works with the Asthma Foundation of Tasmania to determine how the recommendations from the soon-to-be-released National Asthma Strategy can be implemented in Tasmania.

TCDPA and PHAA feedback regarding relevant consultation questions in the Green Paper

Is the Tasmanian health system all it should be, or should we be open to change in order to improve outcomes for all Tasmanians regardless of where they live?

The TCDPA and PHAA actively lobbied for and support the decision to move from the current three THO structure to a single Tasmanian Health Service; however the transition must be undertaken fully in the true sense of a single service, if it is to enable whole of system change.

Strong leadership and cultural change as outlined in the *Commission on Delivery of Health Services in Tasmania* report will be a pre-requisite to ensuring that the parochial THO boundaries and associated budget-bidding processes do not endure past a sensible transition period. Provision of health services; whether they are primary, acute or sub-acute must be planned at the statewide level, with the funding being provided for the commissioning and delivery of services to the right people, at the right time, in the right place.

As the Green Paper rightly highlights, there is a need to determine how to more effectively, efficiently and safely deliver health services. The TCDPA and the PHAA will not provide specific comment regarding the appropriateness or otherwise of the Draft Role Delineation Framework, other than to state that at a surface level, this appears to be an appropriate framework to seek feedback on, and to note that a number of TCDPA members are represented on a number of the Clinical Advisory Groups and have had an opportunity to provide input through this mechanism.

It will also be imperative for the Tasmanian Government to be fully across, and directly providing input into the Australian Government's Reform of the Federation White Paper (particularly in this instance to the *Roles and Responsibilities in Health* issues paper, but also the issues papers on *Housing and Homelessness* and *Education*), as this will have far reaching implications for health service funding and delivery in Tasmania, as well as the health of Tasmanians generally.

From a preventative health and social determinants of health perspective, the TCDPA and PHAA supports the need for Tasmanians to be able to have equitable access to health services in Tasmania, regardless of where they live, or the other social determinants that shape their circumstances.

If it improves the quality and safety of care, do you agree we should limit the number of sites at which some services are provided?

The TCDPA sand PHAA supports the notion of ensuring that services are provided by skilled and competent service providers working within their scope of practice. Obviously the more cases a service and its staff is exposed to, the more likely that service is able to appropriately deal with similar subsequent cases. This is advantageous from a safety and quality perspective. From a cost perspective, there are also advantages to limiting the number of sites at which some services are provided, as better economies of scale can be achieved in terms of clinical throughput, medical equipment supply ordering/purchasing etc.

If it improves the quality and safety of care, what should we consider in deciding where a service is located and what support needs to be considered to ensure patients have equitable access?

Pages 16 and 17 of the Green Paper provide a good overview of the considerations which would need to be thought through in determining how best to provide access to better care.

Accommodation and transport are obviously the key considerations from a patient and family/carer perspective if travel is required to physically attend a service which is of some distance away. The Green Paper identifies that there will be a need to address this in the reform process. We are aware that the Tasmanian Council of Social Services (TasCOSS) has undertaken significant work around transport in the community, and have provided specific feedback regarding this issue in their own submission to this consultation process, which we support.

However, as highlighted in the Green Paper, there is an opportunity to better utilise Telehealth services. Where appropriate, in some circumstances the need for specialists from within Tasmania or from interstate physically being in attendance at a service, may be reduced if Telehealth facilities were better utilised. This is not to say that face-to-face patient and specialist meetings are not important or required in many circumstances. However, a review of where Telehealth services can be used more frequently, where appropriate, should be undertaken.

How do we promote and maintain safe primary and community care to consumers and communities such that they seek out these services rather than attend Emergency Departments when their conditions are more advanced?

As stated previously in this submission, it will be imperative for the Tasmanian Government to be fully across, and directly providing input into the Australian Government's Reform of the Federation White Paper in relation to the *Roles and Responsibilities in Health* issues paper.

Secondly, there are significant opportunities for the new Primary Health Network (PHN), once established to improve early detection of people at high risk of disease and reducing avoidable hospital admissions. This is particularly important following the introduction of activity based funding, with shared acute and sub-acute care costs between federal and state/territory governments.

In order to promote and maintain safe primary and community care to Tasmanians, these services need to be resourced appropriately, both financially, and through appropriately trained, skilled staff. The Green Paper rightly points out that "there have been increasing costs and investment in the acute care system, but there has not been equivalent investment in primary and community care" (p. 20). This must be addressed.

The submission from TasCOSS for this consultation raises some serious concerns around the already resource-stretched community sector and the significant funding cuts that they are experiencing. Members of the TCDPA and the PHAA share these concerns.

The Tasmanian Government and its Health Department also needs to ensure that it works collaboratively with the yet-to-be-established new PHN to ensure that the patient journey is smoother, and that the fragmentation between primary, acute and sub-acute care is removed. The work that the current Tasmania Medicare Local has been undertaking with care pathways and care coordination needs to continue, to be undertaken ideally by the yet to be established PHN.

Recommendation 1:
That the Tasmanian Government request the Australian Government to continue to fund the work that the soon-to-be defunded Tasmania Medicare Local has been undertaking under the Tasmanian Health Assistance Package (THAP), so that the valuable work that is underway, particularly with regard to health risk factors and social determinants of health, streamlined care pathways, improved care coordination, and the development and implementation of Tasmanian health pathways, is able to continue.

Finally, the TCDPA and the PHAA have serious concerns about the potential effect that the Australian Government's proposed Medicare co-payment will have on the health of Tasmanians, and on attendance at emergency departments. If a co-payment, such as the various co-payments proposed by the Australian Government is implemented, resulting adverse health outcomes due to delays in seeking treatment, as well as the potential increased burden on emergency departments will be need to be monitored and remedied.

How do we determine which services to focus on to expand the role of primary and community care?

One only has to look at our risk factor indicators to realise that we need primary and community care to be resourced to provide health promotion, disease prevention and management programs.

	% of people with hypertension	% of people with high total cholesterol	% of people obese	% of people smoke	% of people who are insufficiently active for health
TAS	**40.9 (ranked 1)**	**39.4 (ranked 1)**	**27.8 (ranked 4)**	**21.7 (ranked 2)**	**59.5 (ranked 4)**
SA	33.8	35.0	29.7	18.2	61.2
NSW	31.8	32.3	26.4	16.1	55.1
ACT	29.2	31.6	25.1	14.2	50.5
QLD	29.9	30.8	30.4	19.4	59.9
VIC	32.1	33.2	25.7	18.3	56.6
WA	30.4	34.7	28.1	19.4	55.4
NT	23.7	29.8	27.2	25.1	62.8
Australia	31.6	32.8	27.5	18.0	57.0

We also believe that there is a need to engage with communities in order to better understand their needs and expectations. We call on the Tasmanian Government to, as recommended at recommendation 45 of the *Commission on Delivery of Health Services in Tasmania* report, establish "a comprehensive statewide community engagement and

capacity building strategy be developed and implemented as a matter of priority. This strategy should seek to increase health literacy, health system awareness and advocacy skills". This strategy should inform the needs of the DHHS, THS and PHN in one comprehensive approach.

What public-private partnerships should we explore for the delivery of health services in Tasmania?

The Tasmanian Government already has the ability to further examine potential public-private partnerships, or in some cases, directly commission, not just from the public sector through its budgeting processes, but also from the private sector. Commissioning is strategic purchasing, whereby scarce resources are allocated on the basis of identified health needs, with ongoing monitoring and evaluation of outcomes. Through commissioning health services strategically – whether it be commissioning from the public or the private sector – the Tasmanian Government has the ability to improve health outcomes through targeted improvements in service integration, providing access to better health care, and through improving the continuity of care for patients.

TCDPA and PHAA feedback regarding the supplementary papers

Supplement No. 1 – Sustainability and the Tasmanian Health System
The Supplement No. 1 paper on Sustainability and the Tasmanian Health System states that "a sustainable health system is one that is designed to meet the health and health care needs of individuals and the population (from health promotion and disease prevention to restoring health and supporting end of life)". However, as stated previously, the Green Paper is solely focussed on clinical services. In the absence of any detail as to what the strategy for *A Healthy Tasmania* might entail, it is impossible to determine whether the *One State, One Health System, Better Outcomes* reform program will deliver a sustainable health system, if a key component of the health system – that is, the prevention of ill-health component of the health system – is not included in the whole of health system reform.

The TCDPA and PHAA, as members of the Health in All Policies Collaboration provided a submission to the previously established Joint Select Committee on Preventative Health in 2013. We also appeared as witnesses to that Committee. It is obviously unfortunate that the previous Committee was unable to report on its findings prior to it being prorogued given the numerous submissions and representations made to it that would ideally have fed into the health reform process. It is pleasing that the Joint Select Committee on Preventative Health has been "re-established", however, with the time required for the new Committee to receive new submissions and evidence, the findings of the Committee will now not be released until the 18 August 2015 - well after the White Paper has been released. It is also unclear how the findings of the Committee can feed into the development/planning for *A Healthy Tasmania*.

Recommendation 2:
That the Government determines how the findings from both the previously established and the newly established Joint Select Committee on Preventative Health can feed into *A Healthy Tasmania*.

Supplement No. 2 – Tasmania's Health Workforce
The Supplement No. 2 paper on Tasmania's Health Workforce states that "…the health sector needs to refocus on wellness, prevention and primary health care if it is to be sustainable in the future", however it fails to articulate how it will achieve this.

In order to provide services where they are needed we need to break down the silos that have continued to exist within the three THO structure. Health service employees may need to become employees of the Tasmanian Health Service – that is, the entire health service, rather than be an employee of a specific site within it. For example (but not limited to this example), in order to deliver cardiac services statewide, a cardiologist may need to be employed at more than one site e.g. might be predominantly based at the Royal Hobart Hospital, but through a pre-determined roster, also deliver services at the North West Regional Hospital (NWRH). Our health system cannot support, nor is it necessarily clinically safe to have specialist services at all sites. We can however, improve the coverage of the services that are deemed to be required, through better utilising the staff that we have. This may at first seem challenging to those who haven't

been required to work at different sites before, but this is a common practice in other States and Territories.

Supplement No. 3 paper - Building a Stronger Community Care System

In Supplement No. 3 paper - Building a Stronger Community Care System, it states that "solutions to the pressure created by increasing demand do not just lie with the clinical redesign of hospital services. They also lie in exploring community based alternatives to hospital care where it is safe and appropriate to do so". The TCDPA and PHAA would agree with this notion, and agree that there are many services that, if provided in the community, could well mean that acute hospitalisations may be avoided.

The section on Health Care in the Community talks about delivering chronic disease management programs in the community in order to keep people out of hospital.

It has been said, that the only difference between those at high risk of chronic disease, and those with a diagnosis of chronic disease, is an acute event – therefore, reducing the risk of those at high risk, should also be an aim of primary health care activities.

Recommendation 3:
That the Government ensures that chronic disease management programs are available in the community care system, not just for those with existing chronic disease, but also for those deemed to be at high risk of disease.

Recommendation 4:
That the Government ensures adequate funding for commissioning services is provided to both Government and non-Government for and not-for profit community health care providers as part of any shift in the balance of health care provision from hospital to the community through the *One State, One Health System, Better Outcomes* reform process.

There are a number of issues not addressed in the overview in Supplement No. 3, which relate specifically to cardiovascular disease. These are identified in the Heart Foundation's additional comments in Appendix 1 of this submission.

Supplement No. 4 – Emergency Care

The TCDPA and PHAA have nothing further to add than what has been discussed in the broader Green Paper discussion, other than to add that the findings from the reports of the Royal Hobart, Launceston General, Mersey Community and North West Regional Hospital emergency departments (undertaken by the University of Tasmania and Healthcare Reform Consulting as part of the Clinical Redesign project), must be analysed, and then translated into planning and implementation of improvement processes, rather than remain reports that sit on shelves.

Supplement No. 5 – Elective Surgery

Whilst it is acknowledged that improvements to the elective surgery needs to be one of the foci for reform, increased volumes of elective surgery being undertaken by our public hospitals is not an indicator to measure the health of Tasmania's population.

A decrease in elective surgery waiting times is not a key indicator to determine whether Tasmanians are the healthiest population in Australia by 2025.

In consultation with the community and the health sector, the Government needs to develop a set of performance indicators and health surveillance measures which will provide an indication of the health of Tasmania's population. Among other indicators, these would include smoking rates, overweight and obesity levels, levels of physical activity, fruit and vegetable intake, to name just a few. Targets for improvement should also be set. There then needs to be a commitment, as well as capacity to collect/analyse and monitor these data regularly in order for Tasmanians to have an open and transparent picture of our health and wellbeing status, as well as improvements or otherwise against the baseline measures.

Recommendation 5:
That the Government, in consultation with the community and health sector (potentially through the yet to be announced *A Healthy Tasmania* process), develop a range of health indicators, set health targets based on these indicators, and commit to regularly monitoring and reporting against these indicators.

Appendix 1

Additional responses from individual member organisations of this combined submission

Specific issues identified by the Heart Foundation in relation to the Green Paper consultation

Where are the gaps?

From a prevention perspective

In order to avoid much of the chronic disease burden that presents at our hospitals, a coordinated approach to preventing it in the first place, where possible, is needed. A way to do this in relation to cardiovascular diseases is to determine out of those who do not yet have overt disease, who is at increased absolute risk. This would involve those over the age of 45 (or 35 for Aboriginal and Torres Strait Islander peoples) having an integrated health check, which will determine their risk of heart disease, stroke, kidney disease and diabetes. Those deemed to be at moderate to high risk of developing disease can then be supported to manage this through lifestyle modification, and where indicated, with medication. The National Vascular Disease Prevention Alliance (NVDPA) (comprised of Diabetes Australia, the National Heart Foundation of Australia, Kidney Health Australia and the National Stroke Foundation) released *Guidelines for the assessment of absolute cardiovascular disease* risk in March 2009. Building on this work the NVDPA released the *Guidelines for the Management of Absolute Cardiovascular Disease Risk* in May 2012. The guidelines were approved by the National Health and Medical Research Council (NHMRC) and provide recommendations for the management of CVD risk in the primary prevention setting.

The uptake of these guidelines in primary care has been ad-hoc. We continue to advocate that these guidelines be consistently adopted in primary care, with community health care settings (not just private general practice) having a major role to play in providing this preventative health service in their communities.

Recommendation 6:
That there is improved and consistent uptake of the *NVDPA Guidelines on the Assessment and Management of Absolute Cardiovascular Disease Risk* in the primary care setting.

From a sub-acute / secondary prevention perspective

Again, in order to prevent many avoidable hospital admissions, not only do we need to reduce the risk of developing disease, but we also need to better manage those with chronic disease. Of all hospital admissions for heart attack, more than one-third (34%) are repeat events. Many patients are readmitted to hospital who have not attended or completed cardiac rehabilitation. It means they miss out on the care they need after their heart attack to maximise their chance of avoiding a future cardiac event. Disturbingly, studies show the biggest barrier to patients not attending or completing cardiac rehabilitation is lack of referral to a cardiac program.

Face-to-face cardiac rehabilitation programs are currently only available in the public health system, and only available in Hobart, Launceston, Burnie and Latrobe. The rehabilitation services in Hobart and Launceston are provided full-time, and those in Latrobe and Burnie are part time.

Whilst there are some very diligent cardiac rehabilitation practitioners employed within the public health system that do good work for those lucky enough to be referred to, and

then those lucky enough to be able to attend these cardiac rehabilitation programs, these services are stretched.

Considerable scope exists for the expansion of cardiac rehabilitation in Tasmania. Any expansion would depend on a variety of health-care professionals undergoing training. Many professionals, such as nurses in regional hospitals and community health centres, would be perfectly placed - if supported and trained in rehabilitation and the ongoing management of cardiac patients, to offer cardiac rehabilitation in their communities. Expanded capacity would enable rehabilitation programs to be offered to patients who are at high risk of developing cardiac disease, and could also be offered on an outreach basis, perhaps supporting cardiologists and general physicians who conduct outreach clinics.

There is a major issue relating to inability to collect and collate data regarding cardiac rehabilitation referral, attendance and completion in Tasmania. Each site collects varying levels of information, however it is not consistent, can not be collated at a State level, and therefore the true picture of cardiac rehabilitation referrals, attendance and completion is unknown. This is a key area for service improvement.

Recommendation 7:
That there is improved and consistent data collection relating to cardiac rehabilitation, starting with a commitment to ensure hospitals are able to collect and report data against the Safety and Quality Commission's recently released Acute Coronary Syndrome Clinical Care Standard.

Similarly, there is a need to improve the management of people with heart failure. Despite significant advances in the management of this condition, prevalence remains high, outcomes are poor and financial and emotional costs are high. Indicators suggest case detection and diagnosis is poor, care is inconsistent and disconnected, and hospital admissions are frequent.

The Heart Foundation has identified core principles and action-based recommendations required to drive a systematic approach to heart failure care in Australia. This approach should be underpinned by implementation of a chronic heart failure care model, access to meaningful data, workforce planning and research. Within each theme, principles have been identified that strengthen all systems-based policy strategies to facilitate optimal chronic heart failure care. There is opportunity for significant positive change with limited investment.

Recommendation 8:
That there is a review of heart failure management services in Tasmania, in order to determine where improvements can be made.

What additional areas should we be considering for interstate partnerships in order to improve service within Tasmania?
The Heart Foundation would look to the Cardiac Clinical Advisory Group (of which we are a member) to provide this advice, however there may be a need to determine whether we should seek to establish an interstate partnership to improve services to adults with congenital heart disease. We understand that paediatrics/children receive support from interstate health services and believe that this specific area of expertise should continue

to be provided in that way. However there is a growing number of adults with congenital heart disease that are no longer managed through the interstate system, that are likely to benefit from a service provided through partnership in Tasmania.

What services, despite comparatively low volumes, should we continue or invest in in Tasmania, and what interstate supports may be required to maintain them?
The Heart Foundation again looks to the Cardiac Clinical Advisory Group for this advice, as they are able to access and analyse the data. The Heart Foundation supports the view of the Cardiac Clinical Advisory Group that cardiothoracic surgery should continue to be provided in Tasmania. The current cardiothoracic unit at the Royal Hobart Hospital has consistently produced excellent surgical results, and from July 2008 to December 2013 had a Zero % 30 day mortality for all isolated coronary artery bypass graft procedures (primary, redo, elective and urgent included). Cardiothoracic services need to be supported (through addressing the existing identified barriers) and not further eroded, to ensure that we can continue to provide a service that is safe, and can achieve the levels of service provision and throughput that it was able to provide a number of years ago.

Supplement No. 3 paper - Building a Stronger Community Care System
There are a number of issues not addressed in the overview in Supplement No. 3, which relate specifically to cardiovascular disease.

Firstly, the data presented regarding avoidable hospital admissions is perhaps only the tip of the iceberg. We understand that the definition widely used by governments is based on the *Atlas of Avoidable Hospitalisations in Australia*, developed by the University of Adelaide in 2007.

The definition is based on admissions that result from ambulatory-care sensitive conditions, which appears to exclude heart attack and stroke while including cardiovascular conditions such as heart failure, angina, rheumatic heart disease and hypertension.

Given that a very high proportion of heart attacks and strokes occur in those who have already suffered these events, or are at a measureable high risk of an event, it seems inappropriate to exclude them from any definition of potentially preventable hospitalisations.

Of concern to us is the use of this definition in the National Healthcare Agreement (PI 22- Selected potentially preventable hospitalisations, 2012).

It seems illogical to exclude heart attack and stroke on the basis that they are not considered to be “admissions to hospital that could have potentially been prevented through the provision of appropriate non-hospital health services”.

This is especially true given that many heart attacks and strokes are repeat events, many first time events occur in people who are at known high risk of these events, and that there is an effective method of identifying people at high absolute risk.

We are concerned that the definition could give rise to distorted decision making, with insufficient emphasis given to the need to reduce avoidable heart attack and stroke

admissions; and especially as it may be curbing action on policies and strategies that could make significant inroads on avoidable admissions, such as improved access and completion rates for cardiac rehabilitation, support for integrated health checks and on-going management in primary care, and a national cardiac procedures register.

One study published in the New Zealand Medical Journal in 2006, found that cardiovascular conditions were responsible for 47% of potentially avoidable hospitalisations at Christchurch Hospital.

We understand that there has been discussion at the relevant inter-government committee about the current definition and that there is support for a revision of the definition.

Recommendation 9:
That the Government reviews the current definition of potentially avoidable admissions as part of the development of the White Paper.

Specific Issues identified by Diabetes Tasmania in relation to the Green Paper consultation

Diabetes Tasmania strongly supports the comments and recommendations of the Heart Foundation at Recommendation 6 in regard to need to ensure consistent adoption in the primary care setting of The National Vascular Disease Prevention Alliance (NVDPA) *Guidelines for the Management of Absolute Cardiovascular Disease Risk*.

Identifying those in our communities at high risk of developing chronic diseases such as diabetes and cardiovascular disease is paramount but we must ensure that there is appropriate access to evidence based lifestyle modification programs for people to participate in once they have been identified at high risk. Currently this is not the case in Tasmania and needs to be addressed.

Programs may be delivered by a number of means including face to face and telephone and should integrated into local communities. Diabetes Tasmania detailed a comprehensive approach to the implementation of evidence based lifestyle modification programs, focussed on diabetes, in its submission to the Joint Select Committee on Preventative Health.

In referencing the Joint Select Committee on Preventative Health it again highlights the issues previously raised in this combined TCDPA/PHAA response to the Green Paper about the importance of ensuring that the findings of the Joint Select Committee can be linked into *A Healthy Tasmania.*

Diabetes Tasmania reiterates it's support for Recommendation 2 of this submission.

In 2013 the federal government committed to developing a National Diabetes Strategy. The strategy will inform how existing health spending can be better targeted to address diabetes prevention and management. The final report is due to be released in the next few months and it will be important that recommendations be incorporated into *A Healthy Tasmania.*

Recommendation 10:
Diabetes Tasmania calls for the recommendations from the soon-to-be-released National Diabetes Strategy to be incorporated into the *A Healthy Tasmania* strategy.

Specific issues identified by the Asthma Foundation of Tasmania in relation to the Green Paper consultation

Context

As a community-based not-for-profit that concentrates on delivering the daily needs of the end-consumer, we do not have the resources to conduct the analysis required to answer the questions in the Green Paper with any certainty. That said, we would like to offer the following observations from our fifty year corporate memory of working with people with asthma, and their caregivers – comprising both professionals and family members.

Adherence

When it comes to asthma, ensuring hospitals are not over-taxed by preventable emergencies or admissions, and our community is not burdened with avoidable deaths, the answer to these problems can be summed up in one word “Adherence”.

Dissimilar to many chronic diseases that require a patient to make substantial changes to their life in order to control or prevent its recurrence, reducing the impact of asthma on the patient and upon our health system is most often achieved by a simple regime of medication and minor life-style modifications. Other preventive measures will likely assist, such as eating an improved diet or exercising, but the mainstay is the use of medication, usually inhaled through a mechanical device.

Unfortunately, up to 90 per cent of patients with inhalers do not use their device properly. Many have poor knowledge of asthma and many also have poor self-management skills. Furthermore, with around 30% of asthma patients having their prescription for a preventer filled only once it appears they neither understand how their medication works, nor do they understand its potential benefits.[1]

With post-diagnosis or post-acute-incident education of the patient these issues can be overcome. But here is the problem. Analysis of the Foundation's own data tells us that many patients are either not receiving this education or have misinterpreted what they have been told by their carers.[2]

Best practice

While we have stated that adherence is the key, the patient must be given the appropriate advice to adhere to. According to the Australian Care Track[3] study, only 38% of asthma-related consultations in general practice accorded with current best practice evidence.

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[1] Australian Centre for Asthma Monitoring 2011. Asthma in Australia 2011. AIHW Asthma Series no. 4. Cat. no. ACM 22. Canberra: AIHW.

2 Blackhall M PK e al. Patient demographics, disease severity and compliance of individuals seeking advice from the Asthma Foundation of Tasmania. Respirology, TSANZ & ANZSRS Annual Scientific Meetings, Canberra, ACT. 2012;17(Suppl 1).

[3] Runciman WB et al CareTrack: assessing the appropriateness of health care delivery in Australia, Medical Journal of Australia 2012; 197 (2): 100-105

As we have already mentioned, offering a systemic solution goes beyond what an organisation such as ours can achieve. However, in broad terms we would suggest that in restructuring our health system the Department looks at defining a more regimented series of interventions that will lead to adherence – over and above the incentives offered by Cycle of Care and the guidance offered by Health Pathways -that can be reported on to ensure the patient receives a seamless experience and appropriate assistance, not just between hospital and community care but when transitioning back and forth between various carers in the community.

The National Asthma Strategy is currently being finalised and will shortly be released. It is anticipated that this will provide further evidence and guidance to improve asthma management.

Recommendation 11:
That the Department of Health and Human Services works with the Asthma Foundation of Tasmania to determine how the recommendations from the soon-to-be-released National Asthma Strategy can be implemented in Tasmania.

"Although the diseases that kill attract much of the public's attention, musculoskeletal conditions are the major cause of morbidity through the world, having a substantial influence on health and quality of life, and inflicting an enormous burden of cost on health systems."

Dr Gro Harlem Bruntland, Director-General of the WHO, January 2009.

Specific issues identified by the Arthritis & Osteoporosis Tasmania in relation to the Green Paper consultation

Is the Tasmanian health system all it should be, or should we be open to change in order to improve outcomes for all Tasmanians regardless of where they live?

Essentially no, the Tasmanian health system is not all it should be, and yes, we should be open to change in order to improve outcomes for all Tasmanians regardless of where they live.

- There is too strong a focus on the 'hospital' and the acute care sector, whereas the majority of gains to be made are in the primary and community care sectors. The balance of care provision needs to be shifted from hospitals to the community.
- More equitable and timely access to multidisciplinary care for people with severe or inflammatory arthritis is essential to avoid the tsunami of health care costs associated with poorly managed arthritis and musculoskeletal conditions.
- Best practice care for people with arthritis slows disease progression and reduces pain and immobility caused by arthritis and helps to preserve independence and quality of life. At present we have limited service, inequity of access, delays in diagnosis and treatment, limited access to multi-disciplinary care, and fragmentation of care.
- It is essential that we have a stronger focus on health promotion and primary prevention. Up to 70% of osteoarthritis is preventable by reducing overweight and obesity, and preventing joint injuries, while smoking is a major risk factor for developing rheumatoid arthritis. Working with, and better resourcing organisations such as Arthritis & Osteoporosis Tasmania that deliver existing health promotion and primary prevention programs, would provide a cost effective means of enhancing arthritis prevention and management.
- A more systematic and integrated approach to supporting patient education at the primary and secondary care levels is urgently required, recognising the low level of health literacy in Tasmania.

Key Elements of Care

- Early diagnosis and appropriate intervention to prevent or delay disease progression and reduce future disability. In Juvenile Idiopathic Arthritis (JIA), up to 41% of children in some areas experience delays of more than 6 months from symptom onset to diagnosis. The window of opportunity is within 12 weeks of onset and that is critical and can alter the course of the condition, prevent or delay joint damage and increases the chance of disease remission. Currently in Tasmania we have no dedicated Paediatric Rheumatologists.
- Multidisciplinary team care is consistently recommended in local and international guidelines and standards of care for people with most forms of arthritis but this is not happening effectively in Tasmania.

- Access to an appropriately skilled multidisciplinary team, core members of which should include a rheumatologist, a rheumatologist nurse, a physiotherapist, an occupational therapist, a psychologist and a social worker, is essential to the delivery of care for people with Rheumatoid Arthritis (RA), JIA, and other forms of inflammatory arthritis, as well as more complex and advanced cases of Osteoarthritis.
- Hydrotherapy services are an important evidence-based intervention for people with arthritis and musculoskeletal conditions. There is currently only one purpose built hydrotherapy pool in Hobart providing clinical rehabilitation services for public hospital patients, and this is an ageing facility that cannot depended upon for much longer. Arthritis Tasmania utilises this facility to provide community warm water exercise programs for over 250 people each week, and even without this service being widely advertised we are currently unable to meet demand. Both public and community based warm water exercise and hydrotherapy services are in jeopardy and severely time limited without the development of new purpose built facilities.

Workforce Capacity Building

- In view of prevalence and impact, the question needs to be asked is 1FTE Rheumatologist in the public health system sufficient? I think not.
- There is a need to address shortages and mal-distribution in the rheumatology workforces to improve access to specialist diagnosis and care for people with arthritis, especially those with inflammatory arthritis. This is particularly important as rheumatologists are the only medical practitioners that can prescribe biologic disease-modifying anti-rheumatic drugs (bDMARDS) which are used to treat inflammatory forms of arthritis such as RA and JIA.
- Specialist nurses in rheumatology have been found to improve patient outcomes and reduce costs in both primary and specialist care. In Tasmania, we have one rheumatology nurse position (RHH) that is currently funded on a time limited basis through a mish-mash of goodwill and pharmaceutical funding. This arrangement will shortly cease leaving a significant gap. This is a prime example of a cost effective solution to a pathway that connects hospital and community care.
- Shortfall in confidence and skills in the management of arthritis among allied health workers.

Every Tasmanian is entitled to a service designed and delivered based on disease incidence, prevalence and impact on their quality of life, the One State, One Health System, Better Outcomes reform package presents the Tasmanian Government with an opportunity to deliver a health system that is safe, efficient, timely and responsive to the needs of Tasmanians.

For further information

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