The following is a response collated by the Health Promotion Consultants / Coordinators, Tasmanian Health Service, primarily Michelle Towle (THS-NW), Rebecca Essex (THS-S), Hayley Tristram (THS-N) and Jenelle Wells (THS-NW).

Reform Initiative 1 – Consultation questions:

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

Health promotion and disease prevention presently take up a tiny fraction of the health budget, yet when appropriately funded, they create a solid foundation for a stable health system.

This takes courage, however. When prevention works, nothing happens.
People go on living their healthy, happy lives.

Why invest in health promotion?
$1 invested in health promotion saves $5 in health spending.
Committing at least 6% of the health budget to health promotion / disease prevention would bring us in line with other countries such as New Zealand, Canada and Finland.
At present our rate nationally is around 40c for every $100 spent on health.

Many preventative health interventions are cost effective. They focus on keeping people well and preventing expensive illnesses that cost individuals, communities, and governments economically and psycho-socially.*

*References available on request

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

It's frustrating to hear hospital staff being described as the 'front line' when surely our front line of health care should be the primary prevention efforts: healthy eating, physical activity, remaining a non-smoker, low or no use of alcohol, community connections, mental and sexual wellbeing. Creating healthy environments where people live, work and play. Immunisation.
This is about building a fence at the top of the cliff, so people don't need an ambulance at the bottom of the valley.

Not forgetting secondary prevention: screening for cancer, high blood pressure, diabetes, kidney disease, and many more – so we catch people early.

Tertiary prevention tries to soften the blow of already established illness, with cardiac rehab programs, support groups, screening for complications (eg of diabetes), chronic disease self management programs.

We already know that works to in other countries. We need rigorously designed and evaluated research, so we can work out how this works best in Tasmania. We need to know that the strategies

and processes for implementing such a shift are evidence based and are those that best support improved health outcomes as well as improved cost effectiveness.*

*References available on request

10. 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?

We already have a workforce skilled in health literacy, self-management and preventative health approaches: the Health Promotion Consultants / Coordinators and the Public Health Services Health Improvement team. Their combined FTE is tiny, however, compared with the number of staff in the THS / Department of Health / Department of Communities and the time required to change practice in these areas.

Health literacy training (face to face) for THS staff exists and covers:

- Communicating clearly and checking understanding (with Teachback)
- Writing Clearly: Health Literacy
- Wayfinding and the Health Literacy environment.

These are delivered by the Health Promotion Consultants / Coordinators.
In other parts of Australia, Teachback is mandatory training for all (new) health staff.
An excellent online module on Teachback is also available.

Very cost-effective evidence-based self management programs are coordinated by the Health Promotion Consultants / Coordinators: the Chronic Disease Self Management Program (called Get the Most out of Life in Tasmania) and the Chronic Pain Self Management Program. With more staff support, these could be ramped up and delivered more often in the community.

There is also scope (but currently little capacity) for the Health Promotion Consultants to engage staff in providing more self-management support to patients.

There is expertise amongst the Health Promotion Consultants / Coordinators and the Public Health Services Health Improvement team across the spectrum of preventative health and health promotion approaches. What is required is the courage to fund them in such a way that the interventions can be more effective at a greater scale.

To truly disperse this way of working across the system, in addition to the specialised team that exists, champions in each site / service could have part of their work time allocated to Working in Health Promoting Ways. They could run training and quality improvement activities on a particular focus (like health literacy) whilst supported by the Health Promotion teams.

We would also need changes to information systems to prompt and record preventive care, and work with community partners to engage a range of disciplines, including practice nurses, and develop of effective linkages with services in the local community*. Implemented well and across the whole health system, values based care models* may support this change.
*References available on request

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?

Value and allow time for staff to engage
There is little current incentive for staff to engage in prevention initiatives in busy clinical environments with competing demands. Staff tell us that management focus more on making sure they are completing paperwork.

Clearly staff time spent on health promotion and disease prevention would need to be accounted for and valued: in SoDs, PDAs, and daily workflow paperwork.

We need more initiatives and processes that highlight how this preventive work is valued. A current initiative is Inspiring Health Promotion: Our Stories.

We can all be Health Connectors
The Right Place initiative holds promise for helping all our staff connect patients with other services and programs in their community. This is already effective in several Tasmanian communities and could be used more widely. A 'Health Connector' role could facilitate and share this approach through our communities.

Ultimately, tap into the expertise that already exists within the health service and fund it so the efforts can be multiplied. This is essential given the rise of chronic conditions.

Have courage
Note that there will be no dramatic headlines to accompany this change: "Less people turned up at the Emergency Department this week"; "Lots of people looked after themselves and each other in their home communities" – it doesn't make the news. We seek incremental positive change.

Look at root causes
Perhaps it's also time to look at some of the root causes that have resulted in the current ballooning of the health budget. Until root causes of poor health outcomes in Tasmania are addressed and / or mitigated the Tasmanian Government will continue to face increasing health costs.

Evidence is now growing that Adverse Childhood Experiences (ACE) are significantly associated with risk behaviours and poor health outcomes (both physical and mental) in adulthood.

Recent studies have found that an increased ACE score has been associated with an increased risk of drinking, chronic disease, depression and PTSD in adulthood [1]

Increased ACE scores also appear to have "a strong graded relationship to the risk of drug initiation from early adolescence into adulthood ……. drug use for 4 successive birth cohorts dating back to

[1] Chang, X., Jiang, X., Mkandarwire, T., & Shen, M. (2019). Associations between adverse childhood experiences and health outcomes in adults aged 18-59 years. *PloS one*, *14*(2), e0211850. https://doi.org/10.1371/journal.pone.0211850

1900 suggests that the effects of adverse childhood experiences transcend secular changes such as increased availability of drugs, social attitudes toward drugs, and recent massive expenditures and public information campaigns to prevent drug use."[2]

A study conducted in 2019 and published in The Lancet looked at the risk factors for and causes of ill health that are attributable to one or multiple types of ACE and the associated financial cost to the health system in Europe and America.

This study found that "ACEs were attributed to about 30% of cases of anxiety and 40% of cases of depression in north America and more than a quarter of both conditions in Europe. Costs of cardiovascular disease attributable to ACEs were substantially higher than for most other causes of ill health because of higher DALYs [Disability Adjusted Life Years] for this condition. Total annual costs attributable to ACEs were estimated to be US$581 billion in Europe and $748 billion in north America. More than 75% of these costs arose in individuals with two or more ACEs."[3]

The same study suggested that "a 10% reduction in ACE prevalence could equate to annual savings of 3 million DALYs or $105 billion. Programmes to prevent ACEs and moderate their effects are available. Rebalancing expenditure towards ensuring safe and nurturing childhoods would be economically beneficial and relieve pressures on health-care systems"[3]

As such, early life remains the most important social determinant of health – setting the scene for each Tasmanian child's future.

[2] Shanta R. Dube, Vincent J. Felitti, Maxia Dong, Daniel P. Chapman, Wayne H. Giles and Robert F. Anda: Childhood Abuse, Neglect and Household Dysfunction and the Risk of Illicit Drug Use: The Adverse Childhood Experiences Study, Paediatrics, March 2003, 111 (3) 564-572.

[3] Prof Mark A bellis, DSc, Prof Karen Hughes, PhD, Kat Ford, PhD, Kat Ford, PhD, Gabriela Ramos Rodriguez, MRes, Dinesh Sethi, MD, Jonathon Passmore, MPH, (2019). Life course health consequences and associated annual costs of adverse childhood experiences across Europe and North America: a systemic review and meta-analysis. *The Lancet,* DOI:https://doi.org/10.1016/S2468-2667(19)30145-8

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

Two suggestions:

1. Local Wellbeing Health Connectors – to build health system literacy in the community, and
2. Implement and boost the action from the Tasmanian Health Literacy Plan 2019-2024 to build a health literate environment within our health settings.

Health Connectors

Health promotion within a community development context draws upon existing community strengths to build stronger, more sustainable communities for the future.[4]

There is support globally for locally-based strategies that build on the skills of individuals, the power of local networks, and the support of local institutions. The use of Local Wellbeing Health Connectors models are proving to be effective in Ireland, England, Melbourne, Hawkesbury NSW, Plenty Valley Victoria, and Tasmania.

The Tasmanian Anticipatory Care project (2020): Action Learning to Improve Health in Tasmanian Communities, examined local community based approaches to understand what models of anticipatory care could prevent and reduce the impact of chronic conditions.

The project researchers UTas and the Sax Institute recognised that health is shaped by the social, economic, and psychological experiences people have. UTas (2019) in their reported findings recommended that decentralised, flexible and locally driven models of health care should be funded[5]. These local models would empower community led responses that build connections between organisations and localised preventative health responses. Community Connectors based in local communities is a key recommendation put forward.

Health Connectors work on making it easier for individuals and communities to access, understand and use health information. Health Connectors have also been shown to be an effective strategy in improving access to health services, particularly for those people who find accessing services more difficult (Wallace et al, 2020).[6]

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[3] Harris M. The Interface Between Primary Health Care and Population Health: Challenges and Opportunities for Prevention. Public Health Res Pract (2016).

[4] Sibbald, Bonnie & McDonald, Ruth & Roland, Martin. (2007). Shifting care from hospitals to the community: A review of the evidence on quality and efficiency. Journal of health services research & policy. 12. 110-7.

[6] Wallace, C; Farmer, J; White, C; & McCosker, A; (2020); Collaboration with community connectors to improve primary care access for hardly reached people: a case comparison of rural Ireland and Australia; *BMC Health Service Research; 20:172;* https://doi.org/10.1186/s12913-020-4984-2

Health Literacy Plan
Implementing the priorities of the Tasmanian Health Literacy Plan 2019-2024 will:

- Improve health literacy awareness across the community.
- Increase health literate organisations that can respond to individual and community health literacy needs.
- Develop a health literate workforce across Tasmania with the knowledge and skills to make best practice routine.
- Create partnerships to improve health outcomes together.

Reform Initiative 2 –
Consultation questions:

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

With regards health information online, there is scope for increased education of the community about how to find reliable information. Resources already exist for this, and initiatives could be shared with the community through neighbourhood houses etc.

Using telehealth where practical and possible saves people time and money, and allows appointments to go ahead even if they are anxious or feeling too unwell to go out.

We have started offering the self management programs (Get the Most out of Life and the Persistent Pain Self Management Program) online in 2020, which allows access for remote areas and people who have difficulties with travel.

Reform Initiative 3a – Consultation questions:

1. What are the major priorities that should be considered in the development of a 20 year infrastructure strategy to ensure the right care is provided in the right place and at the right time?

Look to the community for answers. See also an excellent example from the Education Department with regard to their Child and Family Centres - true grass roots community development and community engagement for years before the first brick is laid. Our community health centres should be similarly constructed and managed - including some community management and should be located where they are most needed and accessible eg in the North, Rocherlea, Northern Suburbs.

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?

There's an even broader question and that is for true prevention we need investment in infrastructure outside health, on things that impact on health. Health begins where people live, work, play, learn - the determinants of health. We need to consider green spaces, bike lanes, clean air, clean water, social housing, transport and many more. So we need to collaborate and coordinate infrastructure across sectors to improve the health of vulnerable populations and reduce health disparities. A Health in All Policies approach could help here, and work has begun on that in Tasmania.

3. How do we ensure current facilities continue to be invested in appropriately so they continue to be fit-for-purpose, including during the COVID-19 pandemic?

Make sure to include community, consumer and staff voices in planning new facilities or renovating old ones. Simulation has been used successfully in the NW with staff to ensure new facilities are fit for purpose, however, this could be used consistently whenever changes are planned.

Ask the people who will use it, both staff and potential patients.

Consider Trauma Informed Practices when designing new places – knowing people will get better outcomes from their care if they are able to have a sense of safety when visiting our services. Further support for the Safe in Our Care Network could assist with this.

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

A number of principles for re-imagining community healthcare have been documented by Kings Fund and reproduced by Monash Health, page 5 [8] - locate services where they are needed and build them around the established need of the local community. Consult with, and engage the local community *long term* as codevelopers of health before a brick is laid. Use an assets based model.

Consider ease of access by public transport and active transport – so people need not be always reliant on cars in an increasingly resource-constrained world.

8 Garrubba M & Melder A. 2019. Re-imagining Community Healthcare Services. Centre for Clinical Effectiveness, Monash Health, Melbourne, Australia.

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?

Given the growing evidence-based research confirming the impact of adverse childhood experiences upon adult health perhaps it's time to build a culture of Trauma-informed care (TIC) within our hospital care and service system.

TIC is a patient-centred approach to healthcare that calls on health professionals to provide care in a way that prevents re-traumatization of patients and staff.

TIC is applied universally regardless of trauma disclosure. Grounded in an understanding of the impact of trauma on patients and the workforce, TIC is conceptualized as a lens through which policy and practice are reviewed and revised to ensure settings and services are safe and welcoming for both patients and staff.

There is no mention of climate change in the Health Workforce 2040 strategy – yet this is the greatest global health threat facing the world this century – and we are not immune to its effects here in Tasmania.
We can have a modern view of primary health care AND work towards the sustainable development goals.
A vision for primary health care in the 21st century: towards universal health coverage and the Sustainable Development Goals. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2018

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

Allocate time for networking and interacting with each other.
A single source of funding for THS and medicare funded care would make a difference.

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?

Staff wellbeing programs, properly funded, will pay for themselves through productivity and improved recruitment and retention. Look to Tasmania Police for a model.

Survey the staff who come here – what attracted you? For locum and agency staff, ask them – what was good and not so good? These people are a wealth of knowledge as they work all over the place. Their short term contract can be 'testing the waters' to see if they want to settle down here. Act on the feedback.

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?

A focus on prevention (primary, secondary and tertiary), health promotion, health literacy, and self-management support.

Conversations early – with everyone – about end-of-life and resuscitation so we aren't making these decisions for people without having the conversation first.

The growing scientific knowledge base that links childhood stress and trauma with disruptions of the developing nervous, cardiovascular, immune, and metabolic systems, and the evidence that these disruptions can lead to lifelong impairments in learning, behaviour, and both physical and mental health, should be fully incorporated into the training of all current and future doctors in Tasmania. [7]

Our health workforce need to be prepared for the health impacts of climate change. "Climate change is the greatest global health threat facing the world in the 21st century, but it is also the greatest opportunity to redefine the social and environmental determinants of health." (The Lancet)

There is much that we can to reduce our impacts – work has already started with the GreenHealth Tas - Sustainability at Work module on THEO for THS staff. More can be done at policy level to reduce our climate change impact.

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

In terms of health promotion and disease prevention, value that work. Through allocating time or acknowledgement or work flow changes.

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

In terms of health promotion, disease prevention, health literacy and self-management support, value that training for staff (and students) and backfill people so they can attend. Or pay for them to attend out of work hours. So often we have people who book into workshops but can't come at the last minute because it's busy on the ward.

It is also essential to acknowledge that we need future workers to be prepared for the impacts of climate change, and for them to be part of mitigation as well as adaptation. There are many actions that support health and wellbeing **and** reduce our impact on the global climate: active transport and the facilities to make this safe; good public transport

[7] Shonkoff JP, Garner AA, American Academy of Paediatrics Committee on Psychosocial Aspects of Child and Family Health. Toxic stress, brain development, and the early childhood foundations of lifelong health. Pediatrics. 2011,

infrastructure; eating more fresh, local food; building community resilience, wellbeing and self-management of chronic conditions.

Reform Initiative 3c – Consultation questions:

2. How can we better engage meaningfully and effectively with consumers and other key stakeholders in health service planning, delivery and quality improvement?

Keep improving on the work we have done already with CCEC – to ensure they are more representative of the population.
Link with Health Consumers Tasmania and draw on their expertise.
Find other ways to engage with consumers who aren't comfortable coming to a meeting with a group.
It is important to engage patients, their families and our communities in designing effective approaches to address psychological trauma and ensure that individuals with lived experience support the design and implementation of trauma-informed policies in health service planning, delivery and quality improvement.

3. How can we strengthen and optimise consumer engagement and participation at all levels of healthcare including:
a. Personal: participation and engagement in a person's own care

Build staff skills in self-management support.
Give staff the opportunity, in work time, to attend chronic disease or chronic pain self management programs to simultaneously improve their personal health outcomes, and give them tools to use when supporting the self-management of patients.

5. How can we improve opportunities for consumers to feed back on their healthcare including following discharge from care?

Trial post-discharge phone calls.[6,7] This can serve a dual purpose - feedback and picking up on potential issues that may result in avoidable rehospitalisation.

6 Dorothy M. Mwachiro, Jacqueline Baron-Lee, Frederick R. Kates; Impact of Post-Discharge Follow-Up Calls on 30-Day Hospital Readmissions in Neurosurgery. *Global Journal on Quality and Safety in Healthcare* 1 May 2019; 2 (2): 46–52

7. Ebony Lewis, Sarah Samperi, Christopher Boyd-Skinner, Telephone follow-up calls for older patients after hospital discharge, *Age and Ageing*, Volume 46, Issue 4, July 2017, Pages 544–546,

6. How do we strengthen education and training for health professionals and health policy makers and planners in relation to the importance of consumer engagement and participation across all levels of healthcare?

Staff will attend education and training re the importance of consumer engagement and participation across all levels of healthcare if it's a directive they need to follow - it needs to be non-optional. Most staff desire to do the right thing, but competing priorities means the "musts" come first, always. This needs to be a "must" too.

7. What format would be best to engage our future health leaders?

Use online platforms at least some of the time. Future health leaders may be hiding in our rural and remote areas, and you won't find them if face to face meetings are always in Hobart.