

Primary Health Services Plan

Issues Paper

Department of Health and Human Services, Tasmania

Table of contents

Glossary of Terms/Acronyms	2
Foreword	3
The development of the Primary Health Services Plan	4
The purpose of this issues paper	5
How to respond to this issues paper	6
Opportunities to contribute to the Primary Health Services Plan	7
Relationship to other planning processes	8
Questions posed in this issues paper	9
Tasmania's Primary Health Services	10
The Case for Change	13
Tasmania's Changing Community	13
Primary Health Issues in Tasmania	16
The Way Forward	21
Planning Services to Optimise Quality and Sustainability	21
1. Principles	21
2. State-wide Service Model	22
3. Communication and Collaboration between Service Providers	28
Other factors influencing Service System Sustainability	31
Conclusion and next steps	34
Appendix 1: State Primary Health Services	35

Glossary of Terms/Acronyms

Acute Care	Care needs and treatment driven by the patient's medical diagnosis.
ALOS	Average length of stay: the average number of days that a patient was in the hospital
CHC	Community Health Centre
DH	District Hospital
GP	General Practitioner
HACC	Home and Community Care a joint Australian Government and State funded program
MPC	Multi Purpose Centre
MPS	Multi Purpose Service
Non-Acute Care	Care provided for a person with an impairment, disability or handicap and for whom the primary treatment goal is maintenance of a patient's current health and functional status.
NC	Nursing Centre
OBD	Occupied bed days: the total number of days in which hospital beds were being used by patients
Rehabilitation	Care provided for a person with an impairment, disability or handicap and for whom the primary treatment goal is improvement in functional status.
Separations	The total number of patients who were discharged, transferred out or died in a hospital
Subacute Care	Care needs and treatment that are driven primarily by the patient's functional status, not the underlying medical diagnosis. The goal of treatment is functional improvement.

Foreword

The Tasmanian Government is committed to working in partnership with the community to improve the health and wellbeing of Tasmanians. The Department of Health and Human Services is leading the development of a Primary Health Services Plan that will determine how our primary health services should be organised to provide high quality care for all Tasmanians on a sustainable basis into the future. A Clinical Services Plan is also being developed for our major public hospitals. Both plans will help shape our health care system for the future.

'Health and wellbeing' means more than the absence of disease. In healthy communities people feel welcome, safe and secure. Health promotion and illness prevention are prominent activities and healthy lifestyles are encouraged through individuals' participation in community activities, the creation of safe public spaces and the availability of a range of opportunities to participate in activities that prevent illness and promote good health.

A strong, sustainable public health care system that supports healthy lifestyles and provides access to high quality health services is essential to support the health and wellbeing of the Tasmanian community. Our primary health services need to work cooperatively with other community-based services and our public hospitals to provide integrated, quality care in the most appropriate service locations, close to where people live.

Even more than other Australian communities, the Tasmanian community is ageing and the prevalence of chronic disease is increasing. The costs of health care are also increasing well above general inflation. An international shortage of health care professionals means that communities, particularly those which are smaller or non-metropolitan, are facing great challenges attracting and retaining health care professionals. We need to design our health care system carefully to ensure that quality care is accessible to all Tasmanians on a fair and equitable basis.

We have a strong foundation on which we can build, but there is a clear imperative to change and to position our health care system to meet future demands and challenges. I encourage all those with an interest in our health care system to read this paper and contribute to the development of the Primary Health Services Plan by responding to the issues it raises.

Dr Martyn Forrest

Secretary, Department of Health and Human Services

The development of the Primary Health Services Plan

The Department of Health and Human Services Tasmania is leading the development of a Primary Health Services Plan that will determine how our primary health services should be organised to provide high quality care for all Tasmanians on a sustainable basis into the future.

On December 5 2006, Minister Giddings launched a discussion paper: *A Primary Health Strategy for Tasmania* and urged all Tasmanians to have their say on the future of the State's primary health care services.¹

As primary health services are provided by a range of community based health services, General Practitioners (GPs) and other service providers, the development of a Primary Health Services Plan has already involved talking to many of the individuals and organisations who make up the primary care workforce.

The 65 submissions received in response to the discussion paper, and the outcomes of local consultations and workshop discussions have been collated and analysed, and used in the development of this paper. These results, and additional submissions received in response to this issues paper, will be taken into account as the Primary Health Services Plan is finalised.

The ongoing work of the Primary Health Services Plan project team has been subject to a Quality Review process that has been undertaken by Professor Judith Dwyer, of Flinders University, one of Australia's recognised experts on health system design and primary health care. Dr Felicity Jefferies, CEO of the Western Australian College of Rural and Remote Medicine and Mr Kim Snowball, a Western Australian rural health policy expert and service manager, both well known for their expertise in rural health, have also worked with the Primary Health Services Plan project team and stakeholders to inform the development of the service model.

Both the Primary Health Services Plan and the Clinical Services Plan are being informed by demand projection data commissioned by the Department for use in both Plans and in joint research and planning on interface issues across the primary and acute systems.

¹ Department of Health and Human Services (2006) *A Primary Health Strategy for Tasmania, Discussion Paper*, DHHS: Hobart http://www.dhhs.tas.gov.au/agency/chs/documents/Primary_Health_Strategy.pdf.

The purpose of this issues paper

This discussion paper builds on the broad strategic directions that were released for comment in the discussion paper: *A Primary Health Strategy for Tasmania* and proposes a framework and key components of the future primary health service system in Tasmania. It reflects the major themes that have arisen during the first round of consultations.

The Department invites comments on the issues raised in this issues paper from all individuals and organisations who have an interest in Tasmania's health care system.

How to respond to this issues paper

There is no set format and submissions do not need to be formal documents, although generally they should be written and where possible they should be in electronic format.

You are invited to consider and respond to the specific questions raised in this issues paper and other matters of interest to do with primary health services in Tasmania.

Submissions should be marked '*Response to Primary Health Services Plan Discussion Paper No 2*' and be sent to:

Post: Primary Health Services Plan
Project Manager
Tasmanian Department of Health and Human Services
GPO Box 125
HOBART TAS 7001

Email: elizabeth.shannon@dhhs.tas.gov.au

Submissions should be lodged by 16 April 2007. The receipt of your submission will be acknowledged.

It is not intended to publish submissions, but a list of individuals and organisations that respond to this discussion paper may be published. You should note clearly on your submission if you do not wish to be identified in any public document, in which case your submission will be attributed anonymously. Contents of submissions will not be published in an identifying manner without specific consent.

Opportunities to contribute to the Primary Health Services Plan

The publication of this issues paper is part of a broader consultation that the Department is undertaking with health care professionals, consumers, organisations involved in educating and supporting the health workforce, researchers and community-based organisations. The input received from this consultation has been used in the development of this issues paper. Consultation will continue as the Primary Health Services Plan is developed.

Following the release of this paper, the views of stakeholders on the service model and its application at the local level will be sought. A second round of consultations with local communities will occur throughout March and April 2007 and in this process more information about what this model could mean for each local service will be discussed.

Relationship to other planning processes

The Primary Health Services Plan is being developed in conjunction with the development of a Clinical Services Plan. Together, these plans will provide an overall plan for an integrated, sustainable, quality public health care system for all Tasmanians.

The Primary Health Services Plan will also be informed by plans and developments for the primary care component of care in diabetes, mental health, oral health, children's services, and drug and alcohol services.

Questions posed in this issues paper

The questions raised in this issues paper are listed below. Please feel free to respond to some or all of the questions or to other issues raised in this paper. We seek your comment on:

Question 1 (page 24)

The principles proposed as a basis for the Primary Health Services Plan. Are they comprehensive and appropriate? Do they define an appropriate balance between access to health care services and service safety, effectiveness and efficiency? Should any additional principles be considered?

Question 2 (page 28)

Whether the services are grouped appropriately within the three tier model?

Question 3 (page 35)

*The proposed structures for communication and collaboration between service providers.
Will clinical networks provide the right links between primary health care and other types of care?
Will Primary Care Partnerships strengthen the relationship between General Practice and Community Health Services?*

Question 4 (page 38)

Whether there are other important types of infrastructure support that should be addressed in this plan?

Tasmania's Primary Health Services

Primary health care is defined by the World Health Organization as:

"...essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain... It is the first level of contact of individuals, the family and the community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process."²

Primary health services range from simple episodic care where an individual may only consult with a General Practitioner (GP) and have a prescription filled at a pharmacy to complex and long term management of chronic conditions such as diabetes that involve services from across the sector.

Responsibility for delivering primary health services in Australia lies with all tiers of Government, with the private sector, and with community sector organizations. Funding responsibility for primary medical services mainly rests with the Australian Government, although State Governments, local communities and individuals are contributing increasing amounts to pay for these services.

The Australian Government contributes significantly to primary care in Tasmania, through a range of programs, including funding general practice service delivery (through access to the Medicare Benefits Schedule) and support.³ The Australian Government also supports the operation of 'General Practice Tasmania'.⁴

The development of a collaborative approach with other funders or providers, in particular the Australian Government, will be a key success factor in the development of the Primary Health Services Plan.

The Tasmanian Government provides Community Health Services such as community health centres, rural health services, community nursing and allied health services. Some of these are delivered in collaboration with the Australian Government through joint funded programs e.g. Home and Community Care or Multi Purpose Services.

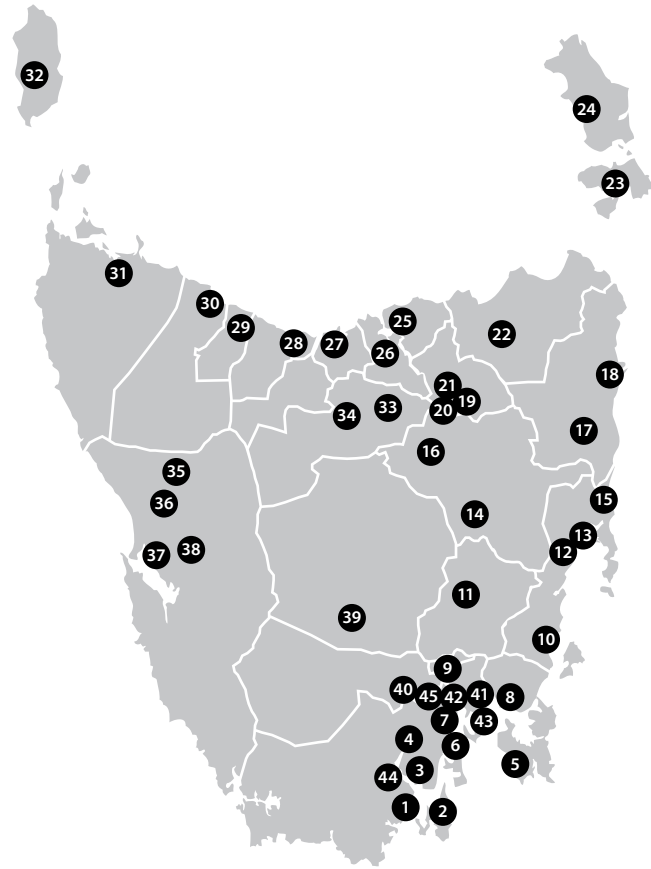
Tasmania's primary health care services are distributed widely across the state. Figure 1 shows the location of the Department's primary health services in over 40 communities. Appendix 1 provides further information about Tasmanian primary health services.

2 World Health Organization (2002) *Primary Health Care Review Project Region Specific Report*. Regional Office for the Western Pacific: Manila, Philippines.

3 This includes an expanded model of general practice that involves practice nurses, GPs and other services through the More Allied Health Services (MAHS) program and mental health services through the Better Outcomes in Mental Health program. More information on the Australian Department of Health and Ageing may be found at <http://www.aodgp.gov.au/internet/wcms/publishing.nsf/Content/Home>

4 The General Practice Tasmania network supports contemporary general practice in Tasmania by linking GPs with each other, by supporting all members of the general practice team and, increasingly, by enabling, supporting and/or closely liaising with allied health professionals as part of the primary care team. More information on the General Practice Tasmania network may be found at <http://www.gptasmania.com.au/>

Figure 1 DHHS Primary Health Services by Local Government Area

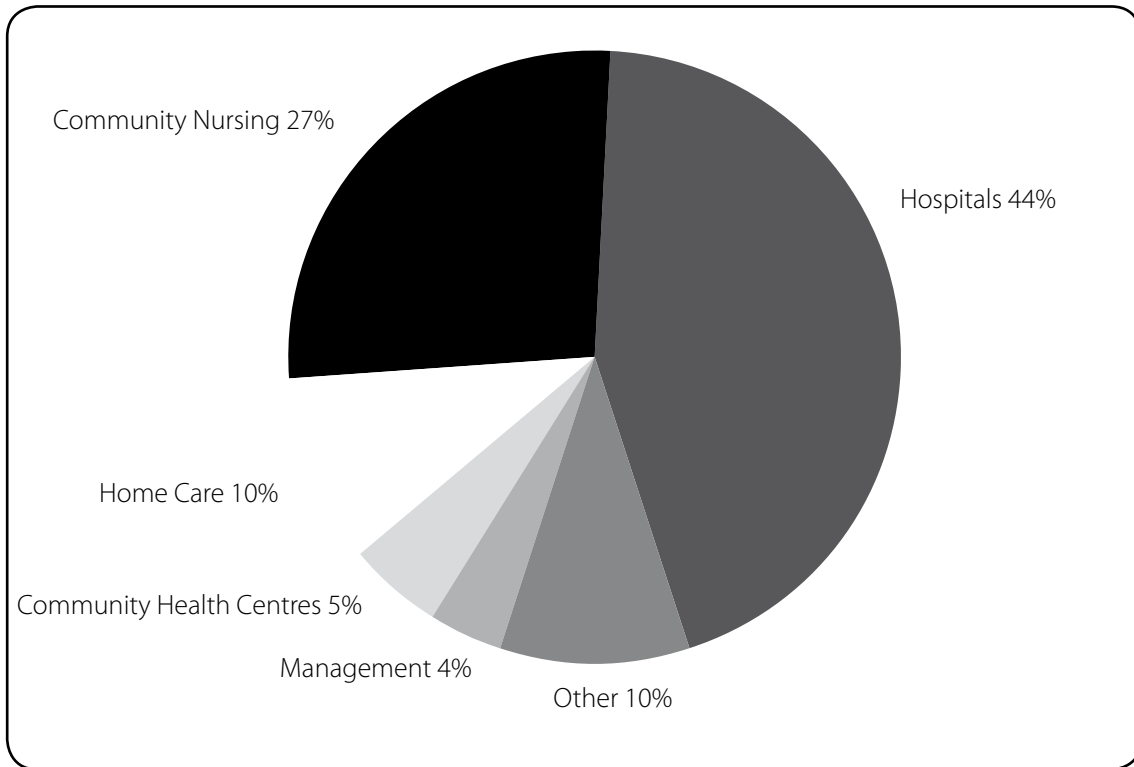


- | | |
|---|---|
| 1 Esperance MPC | 23 Cape Barren Island Nursing Centre |
| 2 Bruny Island CHC | 24 Flinders Island MPC |
| 3 Cygnet CHC | 25 George Town DH |
| 4 Huon CHC | 26 Beaconsfield MPS |
| 5 Tasman MPS (Nubeena) | 27 Devonport CHC |
| 6 Kingston CHC | 28 Ulverstone CHC |
| 7 Repatriation Centre | 29 Parkside CHC & Burnie CHC |
| 8 Sorell CHC | 30 Wynyard CHC |
| 9 Bridgewater CHC (Brighton) | 31 Smithton DH |
| 10 Spring Bay CHC (Triabunna) | 32 King Island Hospital & Health Centre MPC |
| 11 Midlands MPC (Oatlands) | 33 Westbury CHC |
| 12 May Shaw NC | 34 Deloraine DH |
| 13 Swansea CHC | 35 HealthWest Rosebery CH |
| 14 Campbell Town MPS | 36 Zeehan CNRHSCS |
| 15 Bicheno Nursing Centre | 37 West Coast DH (Queenstown) |
| 16 Toosey Inc. (Longford) | 38 Strahan CNC |
| 17 St Marys HC | 39 Ouse DH |
| 18 St Helens DH | 40 New Norfolk DH |
| 19 John L Grove CHC | 41 Risdon Vale CHC |
| 20 Kings Meadows CHC | 42 Clarence CHC |
| 21 Ravenswood CHC | 43 Clarence Plains CHC (Rokeby) |
| 22 North-East Soldiers Memorial Hospital (Scottsdale) | 44 Huon Eldercare Inc. (Franklin) |
| | 45 Glenorchy CHC |

The Department's primary health program has received considerable increases in funding over the last five years. Its overall budget has increased from \$73.2 million in 2001-02, to \$98.0 million in 2005-06.

As shown in Figure 2, the distribution of funds within primary health has been largely directed to rural hospitals and community nursing, with a significantly lower investment in allied health and home care services.

Figure 2 DHHS Primary Health Budget 2005-06 by Care Type



The Case for Change

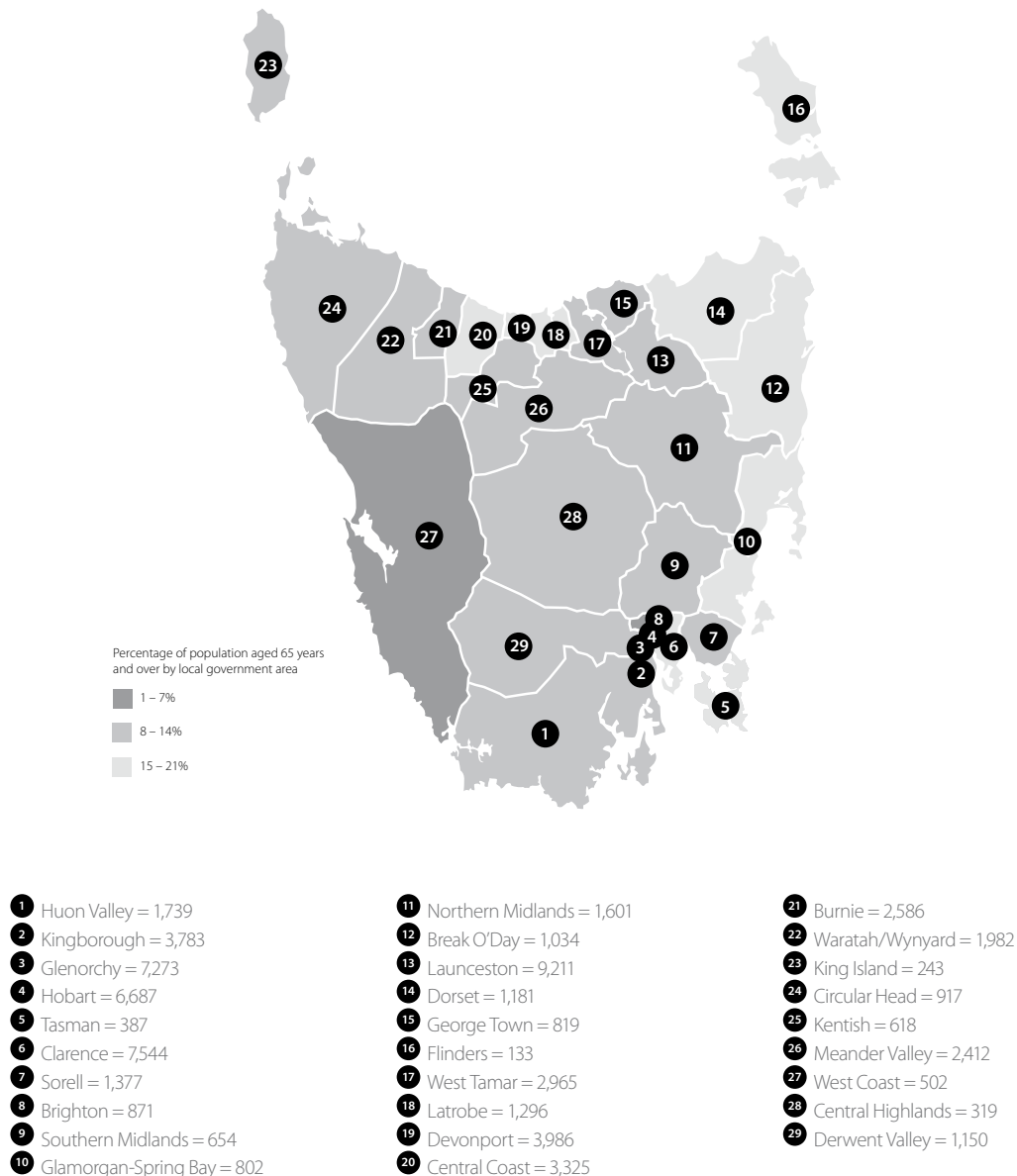
Tasmania's Changing Community

The make up of our community is changing and health services in Tasmania need to take account of these changes in order to continue to provide services that meet the community's needs.

Demographic changes

As a consequence of increased life expectancy and (to a lesser extent) reduced fertility rates, the age profile of the population is changing.⁵ In June 2006, Tasmania had the second highest proportion of any Australian state or territory of people aged 65 years or more.⁶ Figure 3 shows the uneven distribution of the older population across the state. This uneven distribution is likely to increase as more Tasmanians move into retirement.

Figure 3 Population Aged 65 and Over by Local Government Area (2003)

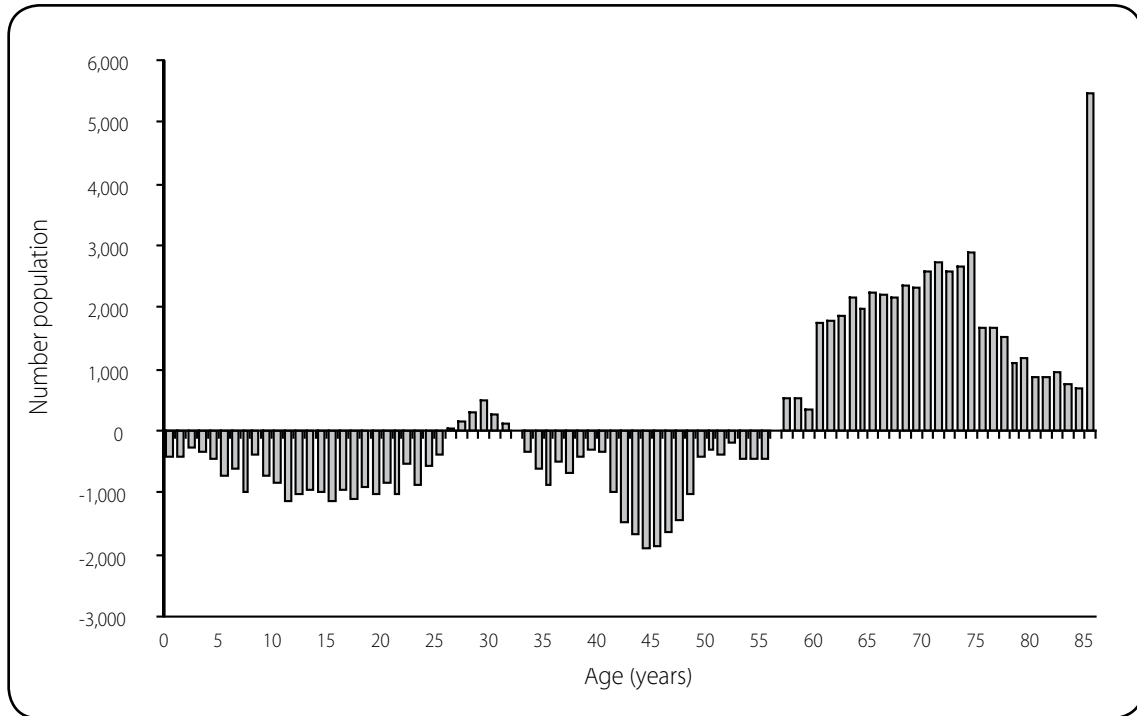


5 Productivity Commission (2005) *Economic Implications of an Ageing Australia*, Research Report, Canberra.

6 Australian Bureau of Statistics (2006) *Australian Demographic Statistics*, catalogue number 3201.0.

In addition, the Tasmanian population is ageing at a more rapid rate than other States and Territories. Figure 4 below shows the projected change by age group between 2006 and 2021.⁷ While the population is predicted to increase by about 3% overall, almost all growth occurs in the older age groups, with a decrease in the size of almost all younger age groups.

Figure 4 Projected Change by Age in the Tasmanian Population, 2006 to 2021



Source: ABS Population Projections Australia 2002-2101 Cat No. 3222.0. Cited in *Tasmania's Population 2003 An information paper on recent trends and State Government policies* Department of Treasury and Finance, 2003, ISBN 0 7246 5092 X

These changes have important implications for the health care system. Older people have a greater need for health services and their needs are more likely to be related to chronic diseases.⁸

Health status of the Tasmanian community

Tasmanians, on average, have lower life expectancies and higher mortality rates than the national average:

- Between 2002-2004, the average life expectancy at birth of Tasmanian males was 76.7 years and Tasmanian females 81.8 years. This is below the Australian average of 78.1 years for males and 83 years for females;⁹
- The age standardised mortality rate for 2005 in Tasmania is 6.9 per 1,000 population; higher than the national average of 6.0 per 1,000 population;¹⁰

7 Australian Bureau of Statistics (2006) *Population Projections Australia, 2004-2101*, catalogue number 3222.0.

8 Productivity Commission (2005) *Economic Implications of an Ageing Australia*, Research Report, Canberra.

9 Australian Institute of Health and Welfare (2006) *Australia's Health 2006*, AIHW cat. no. AUS 73. AIHW: Canberra.

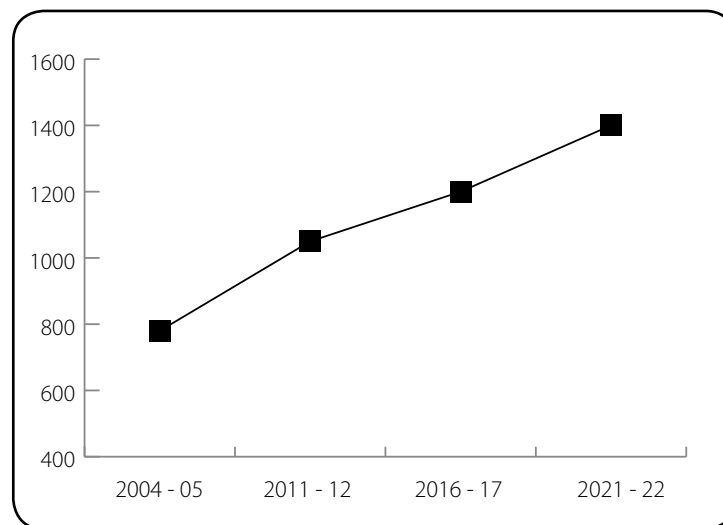
10 Australian Bureau of Statistics (2006) *Deaths, Australia, 2005*, catalogue number 3302.0.

Compared with the national average, Tasmania has:

- A higher proportion of the population who report a long term health condition (79.0% compared with 76.7%);
- A higher proportion of the population aged 18 years and above who smoke (25.4% compared with 23.2%);
- A higher proportion of the population who are obese (17.1% compared with 16.6%);
- A lower proportion of the population consuming the national recommended fruit and vegetable intake;
- Smoking-related mortality rates are significantly higher than the national average.¹¹

In 2004-05, Tasmania had one of the highest rates of hospital separations¹² due to diabetes (after Western Australia and the Northern Territory) at 10.72 separations per 1,000 population, compared with the national average of 9.77 per 1,000 population.¹³ Demand projections indicate that there will be significant increases in the need for both inpatient and community based services through the next several decades. As shown in Figure 5, preliminary projections show that the number of separations for diabetes (DRG-K60) will grow by almost 100 per cent in Tasmania by 2021-22.

Figure 5 Projected Hospital Separations for Diabetes, 2004-05 to 2021-22



More effort in areas such as health promotion, illness prevention and chronic disease management will be required to ensure the best possible health and wellbeing for Tasmania's population.

11 Australian Bureau of Statistics (2006) *National Health Survey, 2004-05*, catalogue number 4364.0.

12 Hospital 'separations' are the total number of patients who were discharged, transferred out or died.

13 Australian Institute of Health and Welfare (2006) *Australian Hospital Statistics 2004-05*, AIHW cat. no. HSE 41. AIHA: Canberra.

Primary Health Issues in Tasmania

The benefits of a strong primary health care system are well documented. There is international evidence that countries with a well developed primary care system have healthier populations and reduced health care costs.¹⁴ In particular:

...Much of the success relies on a well integrated system that is adaptive and flexible and has the capacity to respond to changing needs and emerging models of care.¹⁵

Closer to home, the 2004 report, *The Tasmanian Hospital System: Reforms for the 21st Century* stressed that effective primary health care interventions can contribute to containing the demand for hospital specialist services.¹⁶

In Australia and internationally there is significant concern at the long-term sustainability of health systems. National spending on health care is rising rapidly, doubling in the past thirty years. However, costs in health continue to rise well above general inflation. Without change and refocussing, our health system will be unsustainable in the future.

While maintaining the current service model, Tasmania is already experiencing significant difficulties in the viability of some of its smaller services. Future workforce changes are likely to reduce our capacity to maintain these services into the future. Our primary health care services, as they are currently structured and funded, are not able to provide the range of services now needed especially the prevention, early detection and community based management of chronic disease.

There is an urgent need to address these issues in a systematic and considered way if Tasmania is to have a health system that is sustainable and able to meet the current and changing needs of its community.

Resource allocation is not well matched to current and future needs

The pattern of funding in any area tends to be based on 'history and geography', reflecting past decisions and the relative activism or problems of services in local areas. While allied health, palliative care and health promotion only accounted for 15% of total primary health service funding in 2005-06, allocations to rural hospitals and community nursing services made up more than 70%.

It is recognised that that these latter services are highly valued by the community and that the health professionals who work within them are committed to providing good services within the current service model. However, this investment disparity does not reflect contemporary service delivery practice in which there is an increased emphasis on community based care rather than inpatient care and on new ways of delivering services in the community. Workforce changes, advances in technology and clinical advances have meant that there is a need to re-examine how we use these important professional resources in order to best meet the needs of the community now and in the future.

In addition, an examination of the performance of these areas raises concerns as to their sustainability and effectiveness.

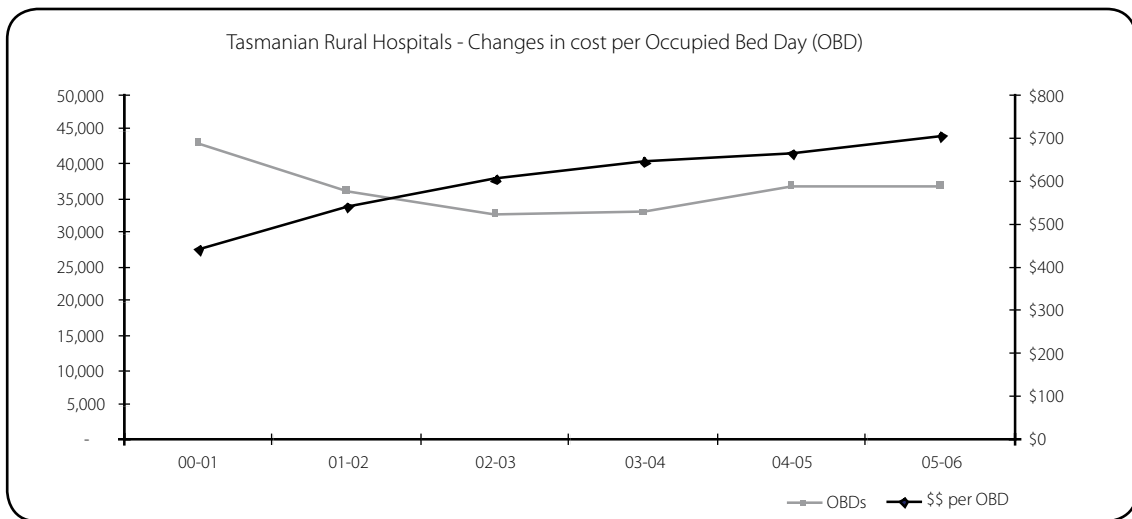
14 J McDonald & L Hare (2004) *Literature Review: The Contribution of Primary and Community Health Services*, The Centre for Health Equity, Training, Research and Evaluation, Centre for Primary Health Care and Equity: University of New South Wales, p 3.

15 Ibid. p 4.

16 Expert Advisory Group (2004) *The Tasmanian Hospital System: Reforms for the 21st Century: Report of the expert advisory group review into key issues for public and private hospital services in Tasmania*, Printing Authority of Tasmania: Hobart. <http://dhhs.tas.gov.au/agency/publications/documents/2004-06-Richardson-Report-v2.pdf>

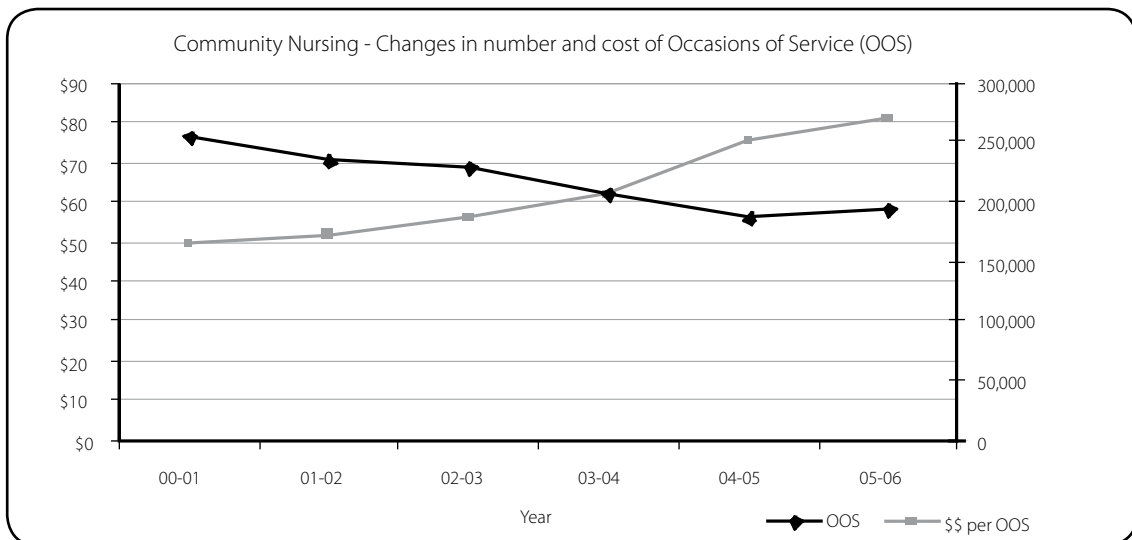
Figures 6 and 7 illustrate recent trends in these services. In just the last five years, the actual expenditure associated with rural hospitals has increased by 31% to \$38.3 million. In the same period, the average occupancy of rural hospitals has dropped from 78% to 64%. This reflects changing clinical practice as well as difficulties in maintaining adequate staffing levels. This low patient throughput, coupled with high turnover of staff, create the potential for serious clinical safety issues. Recruitment difficulties in general practice exacerbate these risks.

Figure 6 Activity, Cost per Occupied Bed Day, 2000-01 to 2005-06



The number of occasions of service provided by Departmental community nursing services has decreased over the last 5 years (from 254,590 to 194,417). During the same time, the budget for this service has increased by 21% (unadjusted) to \$14.7 million. There could be a number of potential reasons for the decline in activity, including different data collection methodologies. A recent analysis of data from community nursing does not show increasing complexity of care.

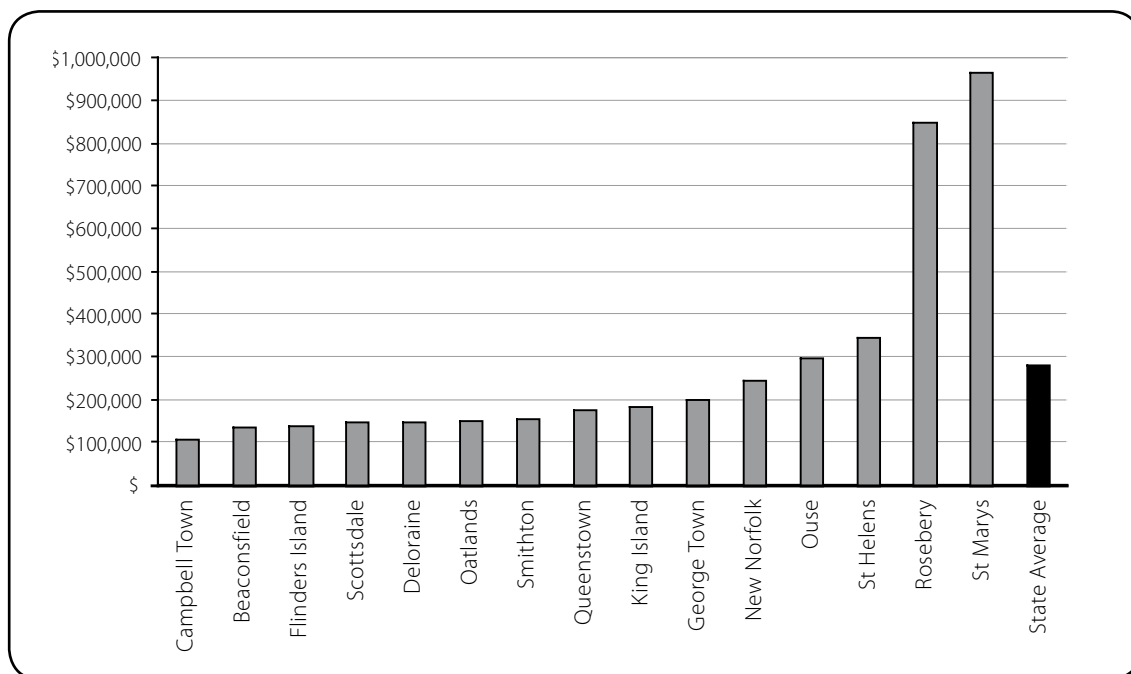
Figure 7 Activity, Cost per Community Nursing Occasion of Service, 2000-01 to 2005-06



Further work is required to understand the downward trend in the number of services provided by community nurses in the face of an ageing population and an increase in chronic disease. There may be opportunities to better utilise this valuable resource.

While costs in rural hospitals are high due to the small size of most of the facilities and the associated high fixed costs, there is also wide variation in the annual cost of an occupied bed across Tasmania's rural sites. This is illustrated in Figure 8 below.

Figure 8 Annual Cost per Occupied Bed, 2005-06



Those sites with the highest costs are those that are affected by:

- the small size of the unit (it now costs a minimum of \$1.5 million to run any stand alone rural inpatient facility)
- low levels of occupancy
- severe staff shortages, resulting in a reliance on high cost locum staffing.

By investing in these historical patterns of service delivery, we are losing the opportunity to provide other community health services that more closely meet the current needs of the Tasmanian community.

For example, Tasmania is not investing in diabetes education and care,¹⁷ rehabilitation¹⁸, preventive strategies, mental health, or alcohol and drug services at the same level as other jurisdictions. This limits our capacity to discharge hospital patients who have ongoing care needs.

17 Tasmanian General Practice Divisions (2004) *Tasmanian Type 2 Diabetes Care Pathway Project Draft Report on Service Gaps Relative to the Pathway*.

18 P Milne & K Eagar (2007) *Draft - Rehabilitation Services in Tasmania: current situation and future plans*, Centre for Health Service Development: University of Wollongong.

The challenge of chronic disease

Chronic diseases such as heart disease, stroke, cancer, emphysema, depression, dementia, diabetes, asthma and arthritis create significant health problems in all developed countries. In Australia, chronic disease is a major cause of premature death¹⁹ and costs approximately 70% of the total health expenditure that can be allocated to disease²⁰.

Chronic disease management increasingly relies on care in the community, with patients being supported to understand their condition, manage it actively with professional support and seek assistance at an early stage if their health deteriorates, before hospital admission is necessary.

The *Clinical Services Plan Issues Paper* notes that most modern health care systems have increased the range of non-admitted and community based services, reserving hospital beds for those who require specialist care that cannot be provided in other settings.²¹ Tasmania is yet to address this challenge.

Workforce

Tasmania shares with the rest of the country major issues which must be addressed if the potential gains of primary health care system reform are to be realised. These include ageing of the health workforce, strong competition for the available workforce nationally and internationally, uneven distribution of the health workforce, with a concentration in urban areas and shortages in rural and regional communities and changing expectations in relation to work/family/leisure commitments.

Nationally, there is an average of 1 GP to every 1,000 persons in the population.²² While Tasmania is not disadvantaged on average, GP numbers in 22 of the 29 local government areas fall below the national average.²³ Under these circumstances, the impact of retirements and other departures from the workforce is highly significant.

The average age of Tasmanian GPs during GP Census week 2006 was 49.7 years. About one third of the workforce was aged over 55 years, one third was between 45-54 years and one third was less than 45 years of age.²⁴ The situation is similar in relation to nursing. In 2006, 44% of the current Primary Health Services nursing workforce was aged 51 or over.²⁵ If the Department's community and rural nurses retire at the current average age, within 10 years a quarter of the current workforce will need to be replaced.

New technologies enable different approaches to care

Developments in health technology provide opportunities for different care arrangements for patients, especially improved ability to monitor markers of chronic disease, the use of remote monitoring capacities and the transmission of information across distance. National development of an electronic health record system will also improve communication between all health care providers, particularly for patients with chronic and complex conditions.

There are significant opportunities to maximise the use of technologies such as Telehealth, which enables health care professionals in one area to consult with other professionals or patients in another location, and to transfer of diagnostic information between service providers. Videoconferencing can reduce the professional isolation of individual staff and small teams in rural areas.

19 C. Mathers, E. Vos, C. Stevenson, S. Begg (1999) *The burden of disease and injury in Australia*. AIHW Cat. No. PHE 17. AIHW: Canberra.

20 AIHW (2006) *Chronic diseases and associated risk factors in Australia, 2006*. Commonwealth of Australia, Canberra.

21 Department of Health and Human Services (2007) *Clinical Services Plan Issues Paper*, DHHS: Tasmania. p 27.

22 Based on the Australian Institute of Health and Welfare (2006) *Medical Labour Force*, AIHW cat. no. HWL 39 and Australian Bureau of Statistics (2006) *Updated Population Projections: 2004 to 2101, Australia*, catalogue number 3222.0.

23 Based on Tasmanian General Practice Divisions (2006) *Census of Tasmanian General Practitioners, 2006 Results*, TGPD: Hobart and Australian Bureau of Statistics (2005) *National Regional Profile, 1999 to 2003*, catalogue number 1379.0.55.001.

24 Tasmanian General Practice Divisions (2006) *Census of Tasmanian General Practitioners, 2006 Results*, TGPD: Hobart, pp 4-5.

25 Based on extracted DHHS Human Resource Data.

Safety and quality are important concerns

The safety and quality of health care is of concern to communities around the world. Factors which contribute to clinical risk have been identified and as a result systems have been improved to provide safer, high quality care. Within community based health services there is much to be done to improve the systems that ensure safety and quality. Workforce and resourcing challenges increase the difficulty of the task.

The need to integrate services

Because there are a number of service providers and different funding programs, the primary health care system contains unnecessary duplication and can be difficult to navigate for a person in the community requiring care. The primary health care system would be strengthened with improved integration.

The Way Forward

Planning Services to Optimise Quality and Sustainability

The objective of the Primary Health Services Plan is that Tasmania will have a sustainable primary health care system that provides reliable access to safe care, with a balance of health promotion, illness and injury prevention, early detection and treatment services and that the primary care system will work with other health and human services to support the health and wellbeing of the Tasmanian community.

1. Principles

To meet the objective of designing a primary health system that can better meet the changing needs of the Tasmanian community, the Primary Health Services Plan will be based on the following principles:

1. The services provided by Tasmania's primary health services should be:
 - Client focussed.
 - Appropriate to the community's needs.
 - Accessible as close as possible to where people live provided they can be provided safely, effectively and at an acceptable cost.
 - Integrated with the other elements of the health services.
 - Focused on health promotion and illness prevention.
2. Where services cannot be delivered safely, effectively and at an acceptable cost from within local communities, access to services should be facilitated through service coordination, the provision of outreach services from an external base, the use of technology, transport assistance and other appropriate community support.

Many primary care services can be provided from within local communities (i.e. at the local government authority level). This can be feasible if:

- there is sufficient patient throughput to provide a service of appropriate quality and safety;
- it is possible to support a professional workforce of the size necessary to provide reliable cover and a service of appropriate quality and safety;
- it is an effective use of resources given consideration of the health needs of the community.

Question 1

Please comment on the principles proposed as a basis for the Primary Health Services Plan. Are they comprehensive and appropriate? Do they define an appropriate balance between access to health care services and service safety, effectiveness and efficiency? Should any additional principles be considered?

2. State-wide Service Model

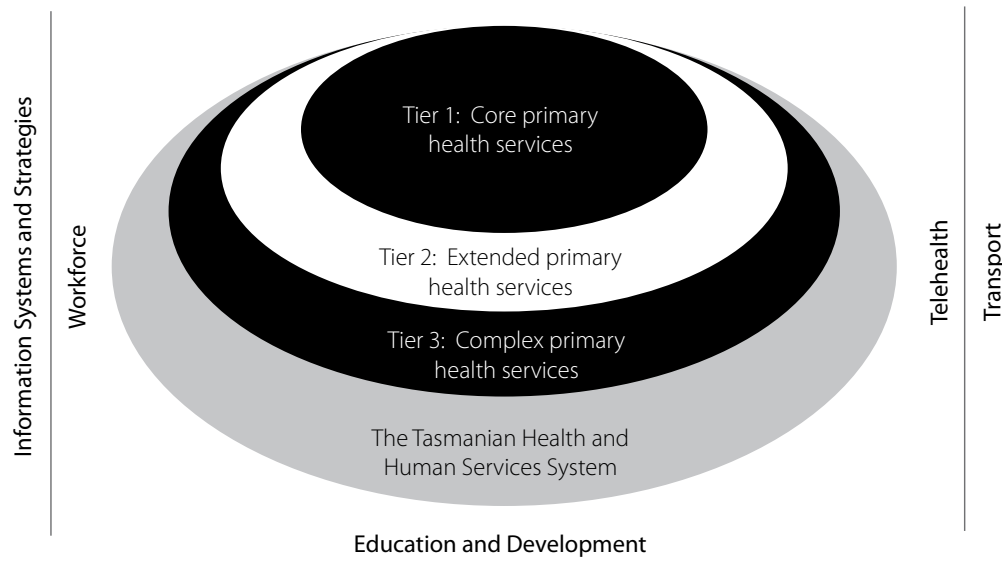
A state-wide service model will be established that sets clear expectations about what services will be available where, enables us to improve the match between service distribution and population need, provides the minimum requirements for a safe and effective service and provides a level of certainty for both communities and staff. While the model will be state-wide, implementation will adapt to local circumstances and encourage innovation.

This service model is based on a commitment to the role of community health facilities as a key resource for their community, acting as an access and referral point for community health services, intrinsically linked to other parts of the health care system, including GPs, hospitals, aged care facilities, NGO community support services and community mental health services and developing close links with the community, engaging them in the planning and development of services.

Community health services operate within a social view of health whereby improvements in health and wellbeing are achieved by directing efforts towards addressing the social and environmental determinants of health; They foster an integrated approach to service delivery through the operation of multidisciplinary teams and seek to respond to individual, group and community needs through a wide range of services, activities and approaches, adapted to the needs of their local communities.

The model also supports the development of strong links between primary health services by enabling the exchange of staff and the development of joint programs, including integrated health promotion to improve population health outcomes at the local level.

Implementation of this model will enable the redirection of resources to services that match the community's current health care needs, such as chronic disease, including diabetes, mental health, alcohol and drug or rehabilitation services.

Figure 9 A Model for Primary Health Services²⁶

The proposed service model uses a 3-tiered framework for services. The distribution of service types within the tiers reflect the complexity of service provision, the extent that other services need to be involved or other support provided for safe and reliable practice and the service's geographic coverage.

Tier One: Core community health services that are provided by non specialist staff within a local community.

Tier One includes the following: in-home and centre based community aged care; clinic based community nursing and domiciliary nursing services; day centres, child and family health services; health coaching and advice concerning healthy lifestyle and primary prevention activities; access to some visiting services including primary allied health services; capacity to treat minor injury; blood diagnostic and collecting services; referral to GP services.

Tier Two: Extended primary care services are based on interdisciplinary community health teams and are able to respond to more complex care needs, especially those that require coordination of services and more specialised workforce skills. There would be a greater focus on chronic disease. Services could also include residential aged care or rural inpatient services. Services would be located across Tasmania according to the factors outlined above and many would be responsible for service provision across more than one local neighbourhood.

In addition to Tier 1 services, Tier 2 services may include: General Practitioners, either within the facility or locally; subacute inpatient services, e.g. step down from acute health services; on site imprest system for inpatients; low and high care residential care; respite and interim care for older persons; minor surgical procedures under local anaesthetic in a procedures room; palliative care; slow stream rehabilitation; specialist community nursing e.g. cancer nurses; chronic disease management; general diabetes education; allied health services; primary mental health or alcohol and drug services; youth health services; women's health; post natal care and limited antenatal services.

Tier Three: Complex primary care services cover the full range of primary health services relevant to the needs of a broader catchment area and may have a more acute focus that requires considerable support and active involvement from more specialised providers, often within a shared care model. This could include integrated services operating across the acute hospital and community care interface.

In addition to Tier 1 and 2 services, the following could be provided according to need: complex palliative care; hospital in the home (contracted with acute hospitals); rural non specialist obstetrics for normal (low risk) patients; inpatient and outpatient rehabilitation; minor surgery for low risk patients; general anaesthetics for low risk patients; alcohol and drug services; oral health services; visiting specialist mental health care; dietetics; specialist diabetes education; continence service; medical oncology; support for patients under the care of a larger renal unit; more extensive health promotion and prevention programs.

The state-wide service model will be applied to all Departmental primary health services, through a careful process of assessment of existing capacity and planning for the future.²⁷

DHHS Primary Health services will be placed within the model will be in line with the principles outlined above and will include consideration of context and future needs, specifically:

- Population trends and levels of community need,
- Distance from other services,
- Sustainability considerations such as cost and workforce availability.

²⁷ A tool for assessing existing capacity (the Service Capability Framework) has already been trialled and will be used as part of the development of the Primary Health Services Plan. The framework is based on the NSW 'Guide to the Role Delineation of Health Services' which is also used in determining the roles of the Tasmanian acute health services. (NSW Health (2002) *Guide to the Role Delineation of Health Services* (Third Edition) State-wide Services Development Branch: Sydney.

In any of the Primary Health regional areas there is likely to be one or more Tier three facilities. These could be a rural hospital providing more acute inpatient services or there could be a high level urban primary health centre acting as an integrated care centre, both supported by the major hospital of the area. There would also be a number of Tier two facilities, representing lower level services focussing mainly on aged care or sub acute inpatient care and/or providing an outreach service to other smaller communities. There may also be a number of Tier one health centres in smaller communities.

Question 2

Are services grouped appropriately within the 3-tier model?

2.1 Rural Health Centres

All Rural Health Centres will be maintained. Most will undergo some form of role change, as a result of the application of the state-wide model. The precise shape of these changes will not be known until the assessment process against the model outlined above has been completed. During the consultation period, senior Department staff will engage with each rural health centre in discussions about the assessment, the future growth path, and the potential implications for their services.

There is likely to be an increased focus on the prevention and management of chronic disease, the local delivery of components of specialised primary health care, and the development of closer linkages with general practice and the broader health system. There may be some changes in bed usage where safety and sustainability cannot be assured. These issues will also be discussed in community and stakeholder consultations.

2.2 Emergency Response

Rural Health Centres need to respond effectively to medical emergencies and it is proposed to strengthen this capacity within a state-wide emergency system. Local capacity is often limited by workforce shortages, reliance on locum staff and difficulties in accessing training. A strategy to address these issues will be developed with the Acute Health Services as part of the Clinical Services Plan. This will include a range of initiatives to improve service coordination, emergency response and support from major hospitals in managing emergencies.

All rural health centres which currently have an emergency response role will continue to have the appropriate facilities to enable on-site care of minor injuries as well as where necessary stabilisation and transfer of those patients who are seriously unwell or injured.

The emergency response role of each Rural Health Centre will be defined. It will be based on factors such as level of community need, isolation/distance from a major centre and availability of ambulance/paramedic services. The workforce and facility requirements for a site to operate as a designated higher level response service will also be identified using the Service Capability Framework and support will be provided where appropriate in line with its requirements.

Examples of initiatives that could be implemented to support emergency response include:

- Examining ways to enhance access to retrieval services for rural sites, for example having a single contact point for service providers that can take responsibility for all aspects of transport and arrange clinical advice and support and bed allocation.
- Joint clinical review across Acute Health and Primary Health to review shared cases.
- Improved training for rural service providers in conjunction with major hospitals.
- Improved Telehealth facilities in emergency treatment areas in rural facilities, with direct connection to an acute Department of Emergency Medicine.

2.3 Urban Primary Health Centres

It is intended that under the state-wide services model, major community health centres will be further developed as Primary Health Centres offering a broad range of primary health care, with collocated outpatient and day patient services currently provided in acute hospitals.

They will become inter-professional centres of excellence in the community, consolidating allied health and nursing resources and acting as a base for outreach of specialised services into rural areas. Close relations with general practice will be established through a range of methods including co-location where feasible.

Detailed planning is currently underway to develop this model, in consultation with acute services and General Practice. It is intended that there will be one Primary Health Centre in each of the major centres except Hobart, where there could be several.

These arrangements will enable more effective early detection of chronic disease and provide a coordinated response to follow up and treatment, in line with national chronic disease directions.

Examples of services that could be provided through Primary Health Centres include:

- Community health services including oral health services.
- Aged care and rehabilitation services (non-inpatient)
- Mental health services
- Specialist outpatient, renal dialysis and chemotherapy
- Collocated GP, diagnostic and other private providers
- Collocated child health and children's services.

2.4 Prevention, Early Intervention, Self-Management

Support for sustainable health promoting, injury and illness-preventing programs will be an essential component of primary health care.

Each health centre will have a role in working with key stakeholders and the local community to design and implement programs to support healthy life conditions and choices, and address local causes of illness and injury. The Department's Population Health unit will advise on evidence based processes and program options to ensure effective programs.

Local innovation is required to respond to local conditions and find new ways to work with patients who have long-term needs for care at the primary level. Primary care providers will be supported to adopt a systems based approach to working with people with chronic disease and to develop new approaches and skills, such as health coaching, to better support individuals in the self management of chronic disease.

Examples of prevention, early intervention and self-management activities include:

- An expansion of the range of approaches to chronic disease that are currently used including group work programs (e.g. Stanford Chronic Disease Management Programs) and individual health coaching.
- An expansion of the number of Health Promotion Coordinators throughout the state
- A reappraisal of elements of the health system that people with risk factors for chronic conditions encounter, including establishing a coordinated approach and referral mechanisms to community based programs that can support them in the management of their risk factors or their existing chronic condition.

3. Communication and collaboration between service providers

The plan will also provide the basis for specifying linkages and methods of support between primary care providers and other parts of the health and human services system.

3.1 Clinical Networks

It is proposed that state-wide clinical networks be developed, with the goal of strengthening the links between local service delivery and the secondary and acute sectors. Joint protocols for clinical management will reduce inefficiencies and duplicated effort within the current system. Networks will systematise the provision of clinical support between local and central services, identifying what each can do to support the other so that care can be provided safely at different sites. Networking makes possible the coordination of care across the continuum from community to acute, with benefits in improved safety, and increased support for rural service providers. The networks will also provide the mechanism to improve the general practice/hospital interface and for support to be provided from the major hospitals to rural GPs.

The aim will be more effective provision of services through principles of cooperation and integration between service providers and collaboration across health service and institutional boundaries.

3.2 Acute Primary Interface

Primary health care services can contribute significantly to the broader sustainability of the health services by assisting to manage demand on the acute hospital system. While traditionally primary care services have provided post acute episodic and chronic care and the rural hospitals have acted as step down facilities, more can be done to enhance this role.

Examples of initiatives that could be implemented to strengthen the linkages between hospitals and community include:

- The extension of dialysis and chemotherapy services to some community-based sites.
- Facilitating the introduction of more after hours GP clinics
- The role of Community Nursing in post acute care can be strengthened with the development of specialist nurses able to provide higher level care in the community e.g. cancer nurses, Hospital in the Home.
- The further development of outreach services from the major hospitals to rural areas, as has already occurred in pre and post natal services on the West Coast.
- The concept of Community Health services having an “in-reach” role into the major hospitals has already been established within Palliative Care.

3.3 Primary Care – Interface with secondary services

Secondary services are those specialised areas that are not centred on acute hospitals, such as Mental Health, Oral Health and Alcohol and Drug Services. Most people who access secondary services also access care through primary health providers. Some will be able to be maintained solely or partly at the primary health level if there is sufficient support to the primary health provider. National and international practice is placing increased emphasis on the role of the primary health care sector in responding to and addressing a range of mental health and alcohol and drug issues.

Examples of cooperation between Primary Health and Secondary services

- Mental Health Services will develop and implement Group Programs including delivery in primary care settings.
- Mental Health Services will develop an early intervention and mental health promotion education toolkit for use in secondary and tertiary educational institutions that will provide information about Mental Health Services and primary care providers.
- Funding of a GP liaison officer by Mental Health Services to progress partnership initiatives.
- Continued development of a Shared Care Pharmacotherapy model.
- Work with General Practice to improve early identification and management of alcohol and benzodiazepine withdrawal.
- Continued development of tobacco cessation services.

3.4 Primary Health Partnerships: working with General Practice and the community sector

The Primary Health Services Plan will identify methods of fostering partnerships at the local level, that bring together the Australian Government, local government, non-government organisations, general practice and Departmental service providers.

It is proposed that Primary Health Partnerships will be developed, linking all primary service providers within defined areas. This concept is intended to foster greater coordination of services within each area, to develop clinical links between local services in order to enhance the quality and safety of services, to support workforce sustainability and to achieve greater efficiency in the use of resources. This emphasis on the local area will enable greater involvement of the community in health service planning and improvement.

3.5 General Practice

General practice plays a significant role in providing services, information and referral to people who need primary care, and is critical to effective health promotion and early intervention. GPs and practice nurses have a central role in service coordination and ongoing community based treatment and support. Greater collaboration between GPs and the broader primary health sector could produce many benefits for consumers, GPs, and other primary health care providers.

In some settings, general practice could be funded by DHHS to allocate allied health services and other necessary support to GP practices and their patients. The method of using the funds could be tailored to local circumstances. In this case, general practice would be accountable to the Department for equitable use of these resources according to the intended purposes.

Examples of initiatives that could be implemented to strengthen support for General Practice include:

- A consistent Departmental policy concerning the availability of support arrangements for GPs.
- Closer links between rural GPs and acute hospitals, especially for training and support.
- Demonstration of alternative methods of achieving better integration between state health services and general practice.
- Co-location of general practice and state health services where this is possible and would benefit service arrangements. Many sites already provide accommodation for rural GPs. These arrangements will be formalised and expanded over time to support sustainability of general practice.

3.6 Community Sector

Non government organisations provide a wide range of community support services as well as traditional primary health care services such as community nursing. The national review of community care services, 'The Way Forward', identifies potential improvements such as simpler means of accessing the community care system, better linkages between services and more effective client assessment processes (to reduce the number of times eligibility and need must be determined).²⁸ This national work will provide guidance on how to improve collaboration between service providers and integration of services across the sector.

Examples of initiatives to support the non-government sector include:

- A project to trial mechanisms for simpler access to community care services.
- Clarification of the relative roles of the State and the non government sector in the provision of Home and Community Care services.

3.7 Local Government

Local government is already a significant contributor to primary health services especially in rural areas, particularly in public health and community recovery. In recent years local government bodies have become more involved in the provision of services, and in some cases provide considerable support to GP recruitment. In addition, local government involvement in programs for healthy lifestyles along with the provision of infrastructure and activities that support greater health and wellbeing in their communities will be essential if Tasmania is to address its long standing health status deficits.

Examples of initiatives that could be implemented with local government include:

- Strengthening the primary care aspects of the Tasmanian Local Government Partnership arrangements
- Expansion of local government partnerships in health promotion.

Question 3

Please comment on the proposed structures for communication and collaboration between service providers. Will clinical networks provide the right links between primary care and other types of care? Will Primary Care Partnerships strengthen the relationship between General Practice and Community Health Services?

Other factors influencing Service System Sustainability

Workforce

There is a need to develop a work force strategy to ensure the continued availability of a competent skilled workforce.

Workforce planning will need to consider the roles, knowledge and skills and the staff training and development that will be required in future. While many primary health practitioners are well qualified and experienced, ongoing effort will be required to maintain and strengthen the skill base of the workforce to deliver services in accordance with the proposed model.

Examples of initiatives that could be implemented to address workforce challenges include:

- Increased support through GP Workforce to aid in the recruitment of General Practitioners to Tasmania
- Working with General Practice to explore opportunities with the Australian Government for other health professionals to access to Medicare benefits in order to provide greater sustainability of primary health services.
- Developing programs and protocols whereby staff in the major hospitals provide support and training to rural workforce.
- Examining the roles of the existing community health workforce in the context of the new service model to achieve a better match with service requirements.
- Further development of Nurse Practitioners
- Consideration of new workforce models to meet the new service requirements e.g. generic health degrees that will equip health providers to undertake lifestyle counselling and support in relation to chronic disease.
- Consideration of retention strategies that can assist existing health professionals to stay in the workforce.

Education and Training

As noted in the *Clinical Services Plan Issues Paper* these are core elements of Tasmania's health care system. There is a well-established relationship between the University of Tasmania and the public health care system. Both the University and the DHHS have continued to explore new ways of working in order to meet the challenges associated with a changing workforce and the introduction of new models of care.

For example, as more acute care moves into community-based settings, it will be important to ensure the continuation of adequate undergraduate and postgraduate clinical training opportunities.

Examples of initiatives that could be implemented to address education and training challenges include:

- Working with the University of Tasmania to examine the feasibility of a Primary Health Clinical Education Centre at the Clarence Community Health Centre providing inter-professional learning experience for medical, nursing and allied health staff in a community based setting
- Strengthening the Partners in Health agreement with the University of Tasmania in order to further develop primary health research in this state and specifically to undertake research and evaluation of the outcomes of trials established as part of the implementation of the Primary Health Services Plan.
- Within that context, to explore the potential to expand allied health tertiary education within Tasmania.

Infrastructure

Future infrastructure planning and design will maximise flexibility of use, and development will be matched to population changes and migration patterns. A Department Infrastructure Investment Strategy will be developed to underpin both the Clinical Services Plan and the Primary Health Services Plan.

The availability of transport services in the local community and between communities will be a critical factor in the capacity of this service model to meet the needs of individuals and communities.

Example of an initiative to address infrastructure challenges includes:

- A joint project between Department of Infrastructure Energy and Resources and DHHS to strengthen community access to non emergency transport at the local level. This will examine the feasibility of establishing regional community transport networks that will provide transport for people attending health care where public transport is not available.

Information Strategy

Underpinning the integration of services will need to be the development of an information integration strategy (including information systems, information management, information technology and telecommunication). As noted in the *Clinical Services Plan Issues Paper*²⁹ information technology offers the potential to improve service quality, deliver services closer to local populations and manage workforce shortages.

Examples of initiatives that could be implemented to address information challenges could include:

- Development of additional Telehealth and other ICT facilities to support state-wide rural and remote medical emergencies and assist with the co-ordination of pandemic responses.
- Development of support for co-ordinating cross-jurisdictional care for our aging population living in rural and remote communities.
- Extending the existing reach of the Telehealth Tasmania Network and operational infrastructure to enable new connectivity for additional rural communities where Telehealth services have been identified as a local priority.
- Improving state-wide information systems within an integrated information framework.

This will also enable remote access to services and information using Internet communications and Telehealth. This is occurring through the development of DHHS whole of Agency planning and will take into account the information integration issues of other service providers.

Question 4

Are there other important types of infrastructure support that should be addressed in this plan?

Conclusion and next steps

Tasmania's challenge is to create a health care system that is better able to meet the current and future needs of its community. The Primary Health Services planning process provides us with an opportunity to achieve this.

The Department is eager to engage stakeholders in the Primary Health Services Plan and you are encouraged to comment on the principles and service directions raised in this Issues Paper. There will also be opportunities to discuss the implications of these proposals at a range of meetings in local communities across the state in March and April 2007.

Once this consultation period is completed, an analysis of all the information will lead to the development of a Primary Health Services Plan. This will address future directions for primary health services on a state-wide basis as well as identifying changes that will occur at a local level over the next five years. The plan will be completed in mid-2007.

In addition to the consultations occurring as the plan is developed, there will be opportunities for further discussion with communities and other stakeholders throughout the implementation process.

Appendix 1:

State Primary Health Services

Primary health services in Tasmania include those funded by the State Government through DHHS as well as those funded through the Australian Government.

The Structure of State Primary Health Services

The Department's Primary Health service has recently been structured as three geographic areas, aligned geographically to the three major hospitals in Southern Tasmania, Northern Tasmania and the North West. There is a further clustering of services at a district level, largely represented by one or more local government areas. Current Primary Health Coordination areas are:

Fawkner: Derwent Valley, Central Highlands, Southern Midlands, Glenorchy and Brighton

Wellington: Kingborough, Huon Valley,

Rumney: Clarence, Sorell, Tasman, Spring Bay/Glamorgan

North Esk: Break O'Day, Dorset, Flinders Is, Northern Midlands, Georgetown

South Esk: Launceston, West Tamar, Meander

Cradle Coast: Latrobe, Kentish, Devonport, Central Coast, Burnie, Waratah/Wynyard

Circular Head & King Island

West Coast

Primary Health within the Department includes community nursing, home care, and a range of allied health services provided through a number of community health centres across Tasmania. It also includes small rural health facilities which provide inpatient care, some aged care and also act as a base for community health and domiciliary services.

Tasmania has 160 rural health inpatient beds provided through 20 inpatient facilities. These are listed in Table 1. There are 4 stand-alone facilities under 11 beds, and all are under 50 beds. Fourteen facilities also have aged care facilities, and in these cases, most have very small numbers of inpatient beds (between 2 and 4). The small size of the facilities is a significant adverse factor affecting the cost structure of the Primary Health Services in Tasmania.

Table 1 DHHS Rural Inpatient Facilities

Location	Inpatient (Acute) Beds	Residential Aged Care Beds	2005-6 Total Beds
Beaconsfield	4	18	22
Campbell Town	6	20	26
Deloraine	20	0	20
Flinders Island	4	9	13
George Town	15	0	15
Health West - Rosebery	7	0	7
Health West - Queenstown	10	16	26
King Island	6	14	20
Midlands - Oatlands	4	19	23
New Norfolk	12	0	12
North East Soldiers Memorial Hospital Scottsdale	20	29	49
Ouse	4	6	10
Smithton	16	22	38
St Helens	10	0	10
St Mary's	8	0	8
Total	146	153	299

The Department also funds inpatient beds at the following sites:

- Swansea (May Shaw Nursing Centre): two beds, Nubeena (Tasman Multi Purpose Service): two beds
- Dover (Esperance Multi Purpose Centre): two beds
- Huon: six beds
- Longford (Toosey): two beds

The usage of these small rural hospitals is decreasing. This can be seen by looking at three key indicators for hospital activity across the state. Separations, the average length of stay and the overall occupied bed days give some indication of how busy a hospital is. Looking only at the small rural hospitals around Tasmania, these three indicators show an overall downward trend in hospital activity.

Over the last eight years, separations have decreased from 5,335 (in 1998-99) to 5052 (in 2005-6). The average length of stay has also decreased from 8.35 to 7.29 days during that time. The number of occupied bed days has also dropped, from 44,533 (in 1998-99) to 36,813 (in 2005-6).

That means that the average occupancy of rural hospitals has dropped from 78% to 64%. In just the last five years, the actual expenditure associated with this service has increased by 31% to \$38.3 million.

The patient profile for the rural health facilities shows significant variation across the sites. State-wide, in 2005-06 the average age of patients being treated in rural health facilities was 60, however 50% of separations were over 65 and they accounted for 77% of occupied bed days. The average age at various sites reflects their different roles. Sites with a more acute focus tend to have significantly lower average age and average length of stay compared to sites that have a non acute, more respite type role. For example one site had an average age of 52 and an average length of stay of 4 days, while another had an average age of 77 and an average length of stay of 19 days.

On a state-wide basis, by far the majority of patients were admitted from their local area through their General Practitioner (75%). However 22% were transferred from another hospital. The majority of patients are from the immediate local area of the rural facility.

There are also 23 community based health centres with no inpatient facilities.

Community Health Centres

Clarence, Clarence Plains, Risdon Vale, Kingston, Bridgewater, Glenorchy, New Norfolk, Sorell, Huonville, Cygnet, Kings Meadows, Ravenswood, Westbury, Burnie, Ulverstone, Devonport, Wynyard, Triabunna, Swansea, Bruny Island, Cape Barren Island, Strahan, Zeehan

Community health services are also provided from larger service centres in Hobart (Repatriation Centre), Launceston (John L Grove, Allambie) and Burnie (Parkside).

More specialised services are provided at the area level, e.g. community rehabilitation, aged care assessment and palliative care services. Youth Health is soon to be incorporated within the Department's Primary Health service.

Partnerships in Primary Health

The Home and Community Care (HACC) Program (jointly funded by Australian and State Governments) provides a proportion of the community nursing, other home care services and allied health services across Tasmania. While the program is restricted to services required by the frail aged and younger people with a disability, Departmental community nursing and allied health services also receive funding from the state to provide services to a broader range of community members, particularly those requiring post acute care. HACC Services are delivered by both Government and non government providers. Community transport is provided through the HACC program for those who are eligible. There are a range of other service providers who contribute to community transport at the local level.

The total estimated number of hours of HACC support has increased from 943,079 in 2001-2002 to 1,213,292 in 2005-06 (+28.6%), with the major expansion occurring in the non government sector. The funding available for this program from both the Australian Government and the Tasmanian Government has increased from \$27.563 million in 2001-2002 to \$38,481 million in 2005-06 (+39.6% unadjusted). Adjusting for indexation, the real growth in funding over this period was 25.2%. Tasmania invests high levels of HACC funding in government managed community nursing services.

Residential aged care is an important partner to the primary health system. It is funded directly by the Australian Government and generally provided through the non government sector. However in rural areas where there are no viable alternative providers State Government takes on a service provision role, as part of rural health facilities, Multi Purpose Centres or Services. The State Government also has historical funding agreements with a small number of Local Authorities which results in the State subsidising the aged care services that they provide.

General practice is a key component of primary health and while most GP practices are separate private enterprises, largely funded through the Australian Government Medicare Benefits Schedule, in rural areas many have contractual relationships for inpatient hospital care with the Department through the Rural Medical Practitioners Agreement. In some areas where specific local conditions have initiated it, there are broader contractual arrangements with private GP providers. General practices in Clarence and Risdon Vale community health centres in Hobart are the only ones managed by the Department of Health and Human Services.

The Achievements of State Primary Health Services

The Tasmanian primary health care system has many strengths and much valuable work has been undertaken thus providing strong foundations on which to build. Examples from within DHHS include:

- The development of Health West (rural health services in Tasmania's West Coast) as an alternative geographic model for integrated service delivery.
- The development of Multi Purpose Centres and Multi Purpose Services across the state to improve integration of care in small rural locations.
- Improvements in quality and safety processes within the Department's Aged Rural and Community Health services.
- Full accreditation of residential age care services within rural health centres.
- The move to consistent practice across the state as a result of the clinical leadership.
- Implementation of the new model of service delivery for Palliative Care.
- Implementation of Australian Government funded Program of Experience in the Palliative Approach which has enabled primary health providers to access professional development activities in Palliative Care and have short term placements with the Palliative Care Service.

Notes

Notes

