## Table of contents

List of figures and tables 3

1. **Summary of actions** 5
   1.1 The primary health approach 5
   1.2 Health planning principles 5
   1.3 Service delivery model 5
   1.4 The prevention and management of chronic conditions 6
   1.5 General practice 7
   1.6 Rural health centres 7
   1.7 Communication and collaboration between service providers 8
   1.8 Strengthening community participation in primary health 8
   1.9 The health workforce 8
   1.10 Quality and safety initiatives 9
   1.11 Education and training 9
   1.12 Community transport 10

2. **Introduction and background** 11
   2.1 Background 12

3. **What is primary health care?** 13
   3.1 Definition of primary health care 13

4. **Tasmanian Primary Health Services** 14
   4.1 Policy and planning framework 14
   4.2 Primary Health Services managed or funded by the Department 16
   4.3 General practice 20
   4.4 Home and Community Care services (HACC) 21
   4.5 Key related services 21
   4.6 Other private primary health care providers 23
   4.7 Community and consumer involvement in primary health 23
   4.8 The primary health activity profile 24
   4.9 Workforce profile 31
   4.10 Transport 34

5. **Assessment of future health care needs** 36
   5.1 Tasmania’s changing community 36
   5.2 Hospital use and projected demand 41

6. **Implications of delivery profile/future service demand** 43
   6.1 The importance of Primary Health Services 43
   6.2 Issues arising from current service delivery profile and expected future demand 43
List of figures and tables

Table 1 Department operated rural inpatient facilities 18
Table 2 Department funded rural inpatient beds 19
Table 3 Australian Government-funded Regional Health Services 22
Table 4 Top 10 Youth Health Services delivered in 2005-06 26
Table 5 Per cent of GP services bulk-billed by Federal Electorate 27
Figure 1 Home and Community Care services by type of service delivered 2004-05 28
Table 6 HACC services: Number of clients assisted by age group 28
Table 7 HACC services: Number of clients by selected service type 29
Table 8 HACC services: Units of service delivery by service type 29
Table 9 Aged care places, ACAT region, June 2006 30
Table 10 GP numbers and Full-Time Equivalents per 1000 population Tasmania 2006 31
Table 11 Primary Health Nurses (Headcount by age group and award/stream) 2007 32
Table 12 Primary Health allied health employees by age group, 2007 33
Figure 2 Primary Health allied health employee by profession, 2007 33
Figure 3 Population aged 65 and over by LGA (2003) 36
Figure 4 Projected change by age in the Tasmanian population, 2006 to 2021 37
Figure 5 Projected change (%) in resident population by LGA 2006 to 2021 37
Table 13 Socio-economic Index of Disadvantage, State and Territory, 2001 39
Figure 6 Socio-economic Index of Disadvantage, Tasmanian LGAs, 2001 39
Figure 7 Projected hospital separations for diabetes, 2004-05 to 2021-22 40
Table 14 Health risk factors, Tasmania and Australia, various years 40
Table 15 Projected demand for outpatient services by LGA 42
Figure 8 Primary Health Services by LGA 44
Figure 9 Activity, cost per occupied bedday, 2000-01 to 2005-06 45
Figure 10 Activity, annual cost per occupied bed, 2000-01 to 2005-06 46
Figure 11 Activity, cost, community nursing occasion of service, 2000-01 to 2005-06 47
Figure 12 Comprehensive model of prevention and management of chronic conditions 58
Figure 13 Primary Health Services areas 73
Figure 14 Rumney 74
Table 16 Departmental services: Clarence municipal area 75
Table 17 Departmental services: Glamorgan Spring Bay municipal area 76
Table 18 Departmental services: Sorell municipal area 78
Table 19 Departmental services: Tasman municipal area 79
Figure 15 Wellington 80
Table 20 Departmental services: Hobart municipal area 81
1. Summary of actions

1.1 The primary health approach
A primary health approach will be promoted throughout the network of primary health services to
guide day-to-day practice and to better meet the needs of Tasmania. Key elements of the primary
health care approach include:
• a focus on health and wellbeing, not just illness;
• a population perspective on health, not only for individuals;
• a multi-disciplinary team approach to care;
• a partnership approach in which a range of groups and organisations need to work together on
improving health;
• a focus on actual health needs, such as chronic disease, rather than service needs; and
• fostering individuals’ control over their health and participation in health decision making.

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.

There will be an expansion of the number of Health Promotion Coordinators by four positions throughout
the state, and integration of health promotion approaches across the primary health workforce.

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

1. The services provided by Tasmania’s primary health services should be:
• accessible as close as possible to where people live as long as they can be provided safely,
effectively and at an acceptable cost;
• appropriate to the community’s needs;
• client- and family-focused;
• integrated with the other elements of the health service system;
• designed for sustainability;
• focused on health promotion, illness prevention and early intervention; and
• delivered in a culturally appropriate manner.

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.

1.3 Service delivery model
A tiered service delivery model establishing an integrated network of primary health services
across Tasmania has been applied to all services delivered by the Department of Health and
Human Services (the Department). Tiers 1-3 represent primary health service sites and have been
developed considering current and future needs, specifically:
• population trends and levels of community need;
• distance from other services; and
• sustainability considerations such as cost and workforce availability.

**Tier 1** sites provide core primary health and community care services within a local community. They reflect the increasing emphasis on community-based and home-based care and the provision of these services through an integrated team approach.

**Tier 2** sites operate rural inpatient services (subacute beds) in addition to their primary health and community care services.

**Tier 3** sites provide extended primary health services with significant outreach across the network and a stronger representation of acute services, including integrated care centres developed in association with the Acute Health Services.

Primary health services will also be provided within Tier 4 integrated care centres in a hospital setting and would be of a more complex nature.

The state-wide model set out in this Plan will be applied to existing service sites:

- **Tier 1** – Sites that provide core primary health services: Bridgewater, Bruny Is, Burnie (Jones St), Cape Barren Island, Cygnet, Huonville, Kings Meadows, Ouse, Ravenswood, Risdon Vale, Rokeby, Rosebery, Sorell, Strahan, Swansea, Spring Bay (Triabunna), Ulverstone, Westbury, Wynyard and Zeehan.

- **Tier 2** – Rural sites that provide both Tier 1 level services and inpatient services: Beaconsfield, Campbell Town, Deloraine, Dover (Esperance MPC), Flinders Island, Franklin (Eldercare), George Town, King Island, New Norfolk, Nubeena (Tasman MPS), Oatlands, Queenstown, Scottsdale, Smithton, St Helens, and Swansea (May Shaw Nursing Centre).

- **Tier 3** – Sites that provide extended primary health services with significant outreach across the network and incorporating over time a stronger representation of acute services: Burnie (Parkside); Devonport; Launceston (developing into a Tier 4 integrated care centre over time), Glenorchy, Kingston (upgraded over time from its current Tier 1 status), Clarence and Hobart (Repatriation Centre).

### 1.4 The prevention and management of chronic conditions

Community-based health services will be changed and expanded over time to better respond to the changing needs of the Tasmanian population. Service change will be implemented to enable:

- greater capacity to treat diabetes and other chronic diseases at the primary health level;
- greater access to home-based services such as post-acute care and specialised community nursing;
- more emphasis on health promotion;
- working with young people, through collaborative partnerships, to adopt healthy lifestyles;
- development of new models to expand rehabilitation services in the community;
- increased access to mental health and alcohol and drug programs in rural areas; and
- an expansion of the approaches to chronic disease self-management.

Each health centre is to 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.

---

1 For comment on St Marys and Longford, see Rural Health Centres, 1.6.
I.5 General practice

A new relationship between general practice and the Department of Health and Human Services will be established that better supports the sustainability of the sector and provides additional capacity to respond to the challenges of chronic disease:

- the Department will work with general practice representatives to progress general practice provision of state-funded community health services;
- a demonstration site in Launceston will be developed and operational within one year;
- a consistent Departmental policy concerning the availability of support arrangements for general practice will be developed in collaboration with general practice organisations;
- closer links will be developed between rural General Practitioners and acute hospitals, especially for training and support;
- co-location of general practice and state health services will occur where this is possible and would benefit service arrangements;
- funding demonstration sites, in both urban and rural communities, of new chronic disease/community and population health initiatives using a team approach incorporating community health and general practice; and
- following the evaluation of demonstration sites, as benefits are proven and resources become available, it is envisioned that these initiatives will become established elements of Tasmania’s primary health service system.

I.6 Rural health centres

A changed and expanded role for rural health centres will be implemented to ensure these services better meet the needs of the Tasmanian population and their local communities. This will include:

- greater access to home-based services such as post-acute care;
- increased day respite services;
- more health promotion and management of chronic disease;
- increased access to community nursing; and
- increased access to visiting services such as allied health or mental health services.

In applying the health planning principles to rural health sites within Tasmania, it is clear that some are not meeting the criteria established to demonstrate sustainability. It is not possible for them to deliver the current service to their community in a way that is safe, effective and at an acceptable cost. Nor will it be possible to continue to provide these services in the future when workforce issues worsen. Consultation has occurred with the communities of St Marys, Ouse and Rosebery in relation to this issue. Work is now occurring to develop models of service that will better meet their needs on a more sustainable basis. Ouse and Rosebery will be developed as Tier 1 sites in the short term.

The recruitment of a General Practitioner remains very difficult within the current service model at the St Marys Community Health Centre and maintaining it at a Tier 2 level is not sustainable in the long term. The Department has recently received a submission which raises the potential for a new approach to the delivery of services in the Break O’Day municipality. This requires further investigation and extensive consultation with the communities of St Marys and St Helens before a firm direction can be established. This proposal may provide significant improvement in health services for the whole municipality and deserves further consideration.

The two beds at Longford are exclusively utilised for aged care and discussions will occur with the management of the nursing home as to their appropriate future use.
Monitoring services against standards of quality, safety and sustainability is an ongoing process and, as the needs of the community change, and as health workforce issues arise, the roles of rural health centres may need to change. Changes in inpatient services will include:

- planned overnight non-medical respite as required (Rosebery and Ouse); and
- increase in inpatient beds in two sites (New Norfolk, and over time in Swansea).

All rural health centres which require 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.

1.7 Communication and collaboration between service providers

Improved communication and collaboration between service providers will be a priority:

- through the establishment of Clinical Networks across the acute, primary and other services, especially in relation to emergency medicine, aged care, rehabilitation and obstetrics;
- through the development of cross-program integrated care centres, to extend dialysis and chemotherapy services to some community-based sites, facilitate the introduction of more after-hours general practice clinics and work together to develop processes to deliver more specialised care in the community;
- through a redefinition of the role of Community Nursing in order to provide more acute level care in the community, for example cancer nurses, Hospital in the Home arrangements;
- through the development of Community Health “in-reach” services into the major hospitals;
- through the development of consultation, liaison and outreach services from Alcohol and Drug Services and Mental Health Services to primary health centres;
- through the development of Home and Community Care services which prevent or delay decline and promote client independence (with a percentage of the funding allocation attributed specifically to rural and remote areas); and
- through the development of Primary Health Partnerships at the local level incorporating both local service providers from general practice, non-government organisations and State and Local Government as well as community representation.

1.8 Strengthening community participation in primary health

In addition to existing processes, the following priority actions will be taken to strengthen community participation in primary health:

- the development of Departmental community and consumer engagement policies and processes;
- strengthening community and consumer engagement through engagement with community representatives, local government and community organisations in local Primary Health Partnerships; and
- the development of regional consumer engagement processes involving Primary Health and Acute Health services that will provide an opportunity for community representatives to be involved in the implementation of the Tasmanian Health Plan, along with service providers, local government and other stakeholders.

1.9 The health workforce

The new health service models arising from the planning process generate a specific set of health workforce issues that require an overarching health workforce plan. This will include a long-term strategy to link Tasmania’s workforce needs to health care education and training and research. Priority actions include:
• increased support, through General Practice Workforce Tasmania, to aid in the recruitment of general practitioners to Tasmania;

• implementation of Nurse Practitioners working in rural health teams in 2008;

• consideration of new workforce models to meet the new service requirements eg generic health degrees that will equip health providers to undertake lifestyle counselling and support in relation to chronic disease, increased utilisation of therapy assistants, direct care providers; expanded scope of practice for rural paramedics; and

• consideration of retention strategies that can assist existing health professionals to stay in the workforce.

1.10 Quality and safety initiatives
In addition to existing processes, the following priority actions will be taken to address service quality and patient safety issues:

• The results of the clinical role delineation (Capability Framework) assessment will be applied to rural inpatient sites. In the event that services do not have appropriate access to clinical support services, an appropriately skilled and available workforce, equipment, suitable facilities and appropriate capacity to maintain clinical standards, alternative arrangements for delivery of services will be considered.

• The clinical role delineation process will be extended to Community Health Centres.

• External accreditation of broader primary health care services will be established to underpin the quality agenda, and to ensure the community can have confidence in its services. This will augment the well-established accreditation system for general practice and residential aged care.

• All Community Health sites will be subject to a quality auditing system.

1.11 Education and training
The Department of Health and Human Services will work with the University of Tasmania and other educational providers to provide sustainable health workforce training and development, including a commitment to vocational, undergraduate and postgraduate student placements in primary health care and multi-disciplinary settings. Actions include:

• strengthening the Partners in Health agreement with the University in order to further develop primary health research and education in this state;

• undertaking research and evaluation of the outcomes of demonstration sites established as part of the implementation of the Primary Health Services Plan;

• exploring the potential to expand allied health tertiary education within Tasmania including consideration of addressing priority workforce issues such as access to physiotherapy, nutrition, dietetics;

• further development of a degree course for Environmental Health Officers in Tasmania;

• working with the University 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. General practice services to the community will continue under this arrangement;

• working with the University to examine the feasibility of developing the Launceston General Hospital precinct as an enhanced primary/secondary Education Centre providing interprofessional learning for health professional students;

• developing all Rural Health Centres as Rural Health Teaching sites; and

• increased workplace clinical psychology training across the Department.
1.12 Community transport

Access to community transport will be improved.

The Department of Health and Human Services will commence a project to establish community transport networks that will better coordinate and improve transport options for people attending health care services where public transport either is not available or is inappropriate. To advance the project, the following actions will be undertaken immediately:

- provision of additional funding to assist in meeting the needs of people who are transport disadvantaged but outside the Home and Community Care target group to access transport for non-urgent health-related needs; and
- engagement of a project manager to maintain linkages with the Department of Infrastructure, Energy and Resources, map existing resources, develop a working model and project plan and undertake the necessary liaison with the community sector and local communities to engage them in the process.

The Home and Community Care program will continue to expand the community transport resources in line with the established needs of its target population.
2. Introduction and background

The Tasmanian health system is under intense pressure and must initiate a health reform program as a matter of urgency.

The proposed reform program described in this paper has been the subject of wide consultation with health organisations, and the community and has been informed by external experts and consultants.

The impetus for reform comes from a number of quarters simultaneously. At the base is an increasingly ageing population coupled with an epidemic of chronic disease. This epidemic will continue to worsen while the health risk factors for chronic disease in the community remain high. In other words Tasmanians are in the midst of a chronic disease epidemic that must be dealt with now and we must also deal with the causes if we are to stem the tide in the future.

At the same time there are escalating costs in our hospitals, problems in recruitment and retention of health professionals and a clear mismatch between current services and the changing needs of the community. This means Tasmania has a system that is unsustainable and not able to respond to the challenges it faces.

The proposed reforms describe a way forward to address each of these challenges:

• Strengthening the primary health care system to better respond to the chronic disease epidemic. These services will focus on reducing the level of risk in the community and provide the means for early identification and intervention in chronic disease. This approach will also provide the means to support people to better manage their chronic condition in the community.

• Working with our acute health services, specifically the major hospitals, to assist them to better respond to clinical demands coming from an ageing population and a heavy chronic disease burden. These reforms centre on achieving efficiencies, improved integration and clarifying roles and responsibilities. Many services currently offered by major hospitals can be provided in other community settings and the reforms describe how that can be achieved.

• The financial status of the health system has meant that the reforms must be balanced and timed to ensure they are affordable, although it is recognised that implementation will require investment into critical change management issues.

• The reforms have been designed within the parameters of well established health planning principles. While they will require some changes to some services, these, in their current form, are the least sustainable of our services.

While other States and Territories are experiencing similar issues, Tasmania’s health is deteriorating at a rate worse than other States. In response, this reform program represents the first time that a jurisdiction has responded in a comprehensive and state-wide way covering both hospital and community programs and services. We have strong support from health leaders across the State for the implementation of these reforms. All understand that the current system must change and we are committed to the changes.

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.
2.1 Background

On 5 December 2006, Lara Giddings MHA, Minister for Health and Human Services, 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. Within three months, 72 responses had been received from a broad range of individuals, as well as professional and community organisations. These responses, and the outcomes of local consultations and workshop discussions, were collated and analysed, and used in the development of an Issues Paper, launched by Minister Giddings on 27 March 2007. A further 74 responses to the Issues Paper, and further local consultations, have informed the Primary Health Services Plan. Appendix 1 provides details on the development of this Plan.

The initial work of the Primary Health Services Plan project team has been subject to a Quality Review process 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, Chief Executive Officer (CEO) of the Western Australian Centre 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 and final Plan. Appendix 2 summarises the results of this consultation process.

Both the Primary Health Services Plan and the Clinical Services Plan are being informed by an acute (hospital) services demand projection project commissioned by the Department of Health and Human Services for use in both Plans and in joint research and planning on interface issues across the primary and acute systems.

---


3. What is primary health care?

3.1 Definition of primary health care

Every time Tasmanians visit their General Practitioner (GP), or have a prescription filled at a pharmacy, or consult with a community nurse or health care worker, they are accessing primary health care.

**Primary health care** is defined by the World Health Organisation 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.\(^4\)

Responsibility for delivering primary health services in Australia lies with all tiers of Government, with the private sector, and with community sector organisations. 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 health services in Tasmania, through a range of programs, including funding general practice service delivery (through access to the Medicare Benefits Schedule) and support.\(^5\) The Australian Government also supports the operation of “General Practice Tasmania”.\(^6\)

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 primary health approach is characterised by:

- Area-based planning for the health care needs of local communities stemming from a population health approach to health care planning.
- Considering the needs of all the population within a given area, not just those accessing health services.
- A social model of health ensuring health and wellbeing is improved by addressing social and environmental determinants of health, in tandem with biological and medical factors.
- The health care system working collaboratively with other sectors to address the social and environmental factors that inhibit wellbeing.\(^7\)

---


\(^5\) 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.aodg.gov.au/internet/wcms/publishing.nsf/Content/home](http://www.aodg.gov.au/internet/wcms/publishing.nsf/Content/home).

\(^6\) 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 health service team. More information on the General Practice Tasmania network may be found at [http://www.gotasmania.com.au/](http://www.gotasmania.com.au/).

4. Tasmanian Primary Health Services

4.1 Policy and planning framework

As a result of consultations concerning the development of a Primary Health Strategy for Tasmania, eight key areas for action have been identified. These are:

1. Service coordination: Service coordination strategies will place consumers and communities at the central focus of service delivery.

2. Quality and safety: Primary health care services will meet appropriate standards of quality and safety.

3. Partnerships: Strengthening partnerships with the Australian Government, Local Government, the University of Tasmania, general practice, the non-government sector, and private providers will deliver better primary health care services critical to future system sustainability.

4. Promoting health, wellbeing and resilience; illness and injury prevention; early intervention: Promoting health, resilience and wellbeing, and enabling people and communities to increase capacity to manage their own health will represent a major change in the approach to primary health care services in Tasmania.

5. Continuum of chronic disease prevention and management: A primary health care system will encompass both treatment services to individuals and services to improve both individual and community wellbeing, recognising these as complementary, not competing, services.

6. Workforce development: Workforce development is integral to the major changes facing primary health care services, and to ongoing workforce sustainability. A more flexible approach to vocational, undergraduate and postgraduate training, new job structures and ongoing commitment to training and skill enhancement by the Department, University of Tasmania, the Vocational Education and Training sector and service providers, will be key elements for a sustainable future workforce. Partnerships between the Tasmanian and Australian Governments must be expanded and enhanced to create further opportunities the development of the state’s workforce education.

7. Planning and funding service delivery models that are accessible, flexible, equitable and sustainable: The Primary Health Services Plan will provide the blueprint for service delivery for the next five years, addressing the distribution of services across Tasmania, taking into account demographic and health status considerations.

8. Developing facilities and other infrastructure that support contemporary service models: There is a strong agreement that physical infrastructure can best support the optimal provision of services to the community through flexibility of design and alignment to an integrated service model and that the availability of transport services in the local community and between communities is a critical factor in our capacity to meet the health needs of Tasmanians.

4.1.1 Links with other planning processes

The Department has developed a strategic framework for health service delivery in Tasmania – the Tasmanian Health Plan.

The Tasmanian Health Plan is an overarching document which sets the future direction for a high-quality, sustainable, responsive, and integrated health system to meet the future needs of the Tasmanian community.
The Tasmanian Health Plan is supported by:

- The Primary Health Services Plan (this document); and
- The Clinical Services Plan.

Appendix 3 details a range of policies and planning processes that have been undertaken at national or state-wide level prior to the development of this Plan. Other current planning processes are listed below.

**Clinical Services Plan**

The Department has developed a Clinical Services Plan to define the roles, services, and strategic directions for Tasmania’s three major public acute hospitals – the Royal Hobart Hospital, Launceston General Hospital, and the North West Regional Hospital (Burnie and Mersey campuses) – to the year 2021. The Acute Clinical Services Plan also provides the foundation for strategic facility planning and management in this area.

**Aged and Rehabilitation Services Plan (Draft)**

The Department has commissioned the development of a strategic plan for Aged and Rehabilitation Services in Tasmania. This plan assessed the existing provision of rehabilitation services in Tasmania (identifying current gaps in service delivery), reviewed models of best practice, and included recommendations for the future delivery of aged and rehabilitation services in Tasmania, including the implications of future service delivery.

**Strategic framework for State-wide Cancer Services (Draft)**

This framework is being developed by the Department and clinicians across Tasmania’s health system. This framework promotes the development of a cohesive, integrated, state-wide approach to cancer control that draws on the best available evidence, builds on national and international experience of success and seeks to enable services to equal or exceed international benchmarks of effectiveness. The framework will underpin the future development of a Tasmanian Cancer Plan which will identify planning priorities and objectives for cancer services in the short, medium and longer term.

**Review of Alcohol, Tobacco and Other Drug Treatment Services in Tasmania**

The Department of Health and Human Services is currently undertaking a review of alcohol, tobacco and other drug treatment services in Tasmania. It is anticipated that the review will provide clarity around the range, scale and capacity of existing services provided in Tasmania and a comprehensive, cohesive plan for future policy and service development including a framework for the development of the sector in order to achieve the principles and objectives of the Tasmanian Drug Strategy 2005-2009.

**Tasmania’s Diabetes Action Plan**

The Tasmanian Government has developed a diabetes action plan aligned to the Council of Australian Government (COAG) policy directions for diabetes reform. The plan sets out clear goals for the reduction of the incidence of diabetes within the state. The three major policy directions are as follows:

- primary prevention to target the known modifiable lifestyle risk factors associated with Type 2 diabetes;
- early detection and intervention for Type 2 diabetes; and
- improved integrated care and self-management for those recently diagnosed, or with established Type 2 diabetes.

These directions have been taken into account in the development of the Primary Health Services Plan.
4.2 Primary Health Services managed or funded by the Department

4.2.1 Departmental structure

Within the Department of Health and Human Services, the Community Health Services Group is responsible for primary health, along with other non-acute health and community support services. Details on related Community Health Services programs are set out in Appendix 4.

Primary Health Services provides a broad range of services through a number of community health centres across Tasmania. This section of the Department also includes small rural health facilities which provide inpatient care and some aged care, and act as a base for community health and domiciliary services. This grouping also reflects a focus on the needs of people in rural and remote communities.

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, each containing a number of Local Government Areas. These have been developed to provide a network of services around Tasmania that balances accessibility with sustainability, providing the economies of scale associated with larger groupings of services.

As part of this planning process there has been an alteration to the structure in the North West to achieve better linkages and integration.

The Department’s Primary Health Coordination areas are:

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

**Wellington:** Hobart, Kingborough and Huon Valley,

**Rumney:** Clarence, Sorell, Tasman and Glamorgan Spring Bay

**North Esk:** Break O’Day, Dorset, Flinders Is, Northern Midlands and George Town

**South Esk:** Launceston, West Tamar and Meander

**Mersey:** Latrobe, Kentish, Devonport and Central Coast

**Hellyer:** Burnie, Circular Head, King Island, Waratah-Wynyard and West Coast

The Department’s Primary Health Coordination areas are illustrated in Figure 12 on p 73.

The Primary Health Coordinators will be a key resource in the implementation of the Primary Health Services Plan. They will be responsible for:

- encouraging, mentoring and supporting the site/service managers/team leaders in providing existing services effectively and efficiently;
- managing key change initiatives and responding to significant service issues arising within a designated cluster of municipal areas (e.g. workforce);
- leading service quality improvement review and service development;
- working with local councils and other stakeholders to identify service gaps and priorities, and working to address identified gaps (including working with rural GPs to promote sustainable services).

4.2.2 Community Health Centres

There are 23 community-based health centres in Tasmania. These offer a range of services for local residents depending on their individual health care needs.
Community Health Centres do not offer inpatient services. Many Community Health Centres provide accommodation and meeting space for visiting services from other regions, including services provided by hospital, housing, disability, and family and child health services.¹

The services offered vary between Community Health Centres, depending on the needs of the local area, but may include counselling and support services, health promotion activities and medical, nursing, and allied health assistance.

**Support services**
Support services may include:

- alcohol and drug programs
- counselling
- Day Care Centre programs
- home help, home maintenance and personal care
- housing services
- rehabilitation programs
- transport
- volunteer assistance.

**Health promotion**

- health education
- health promotion.

**Medical, nursing and allied health**
A range of medical, nursing and allied health services may include:

- community nursing
- family and child health services
- general practice medical services
- mental health services
- oral health services
- post-acute care assistance
- social work, occupational therapy, physiotherapy, podiatry and speech therapy
- youth health services.

**Community Health Centres are located in:**
Bridgewater, Bruny Island, Burnie, Cape Barren Island, Clarence, Clarence Plains, Cygnet, Devonport, Glenorchy, Huonville, Kings Meadows, Kingston, New Norfolk, Ravenswood, Risdon Vale, Sorell, Strahan, Swansea, Spring Bay (Triabunna), Ulverstone, Westbury, Wynyard, Zeehan

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

---

¹ Family and Child Health is a primary health service delivered through Human Services (which is also responsible for the Child Protection Services, Adoption and Information Service, Family Violence Counselling and Support Service, and Sexual Assault and Support Service).
4.2.3 Rural inpatient facilities

Tasmania has 158 rural health inpatient beds provided through 20 inpatient facilities: 144 beds (15 facilities) run by the Department and 14 inpatient beds (five facilities) funded by the Department and run by other organisations. There are four stand-alone facilities with under 11 beds, and all have under 50 beds. Fourteen facilities also have aged care facilities, and in these cases, most have very small numbers of inpatient beds (between two and eight). As discussed in Section 8 of this Plan, there are a range of issues associated with the sustainability of the current service delivery profile illustrated in Table 1 below.

Table 1 Department operated rural inpatient facilities

<table>
<thead>
<tr>
<th>Name/Location</th>
<th>Inpatient (subacute) beds</th>
<th>Residential aged care beds</th>
<th>2005-6 total beds</th>
<th>Other services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beaconsfield District Health Service (Multi Purpose Service)</td>
<td>4</td>
<td>18</td>
<td>22</td>
<td>Respite, palliative and post-natal care. Community and visiting services and support groups.</td>
</tr>
<tr>
<td>Campbell Town Health and Community Service (Multi Purpose Service)</td>
<td>6</td>
<td>20</td>
<td>26</td>
<td>Day centres, information, advocacy, home visiting, social support, recreation, referral, co-ordination, podiatry, equipment hire and provision of rooms for general practice.</td>
</tr>
<tr>
<td>Deloraine Hospital</td>
<td>20</td>
<td>0</td>
<td>20</td>
<td>Coordinate a broad range of community and allied health services within Meander Valley.</td>
</tr>
<tr>
<td>Flinders Island Multi Purpose Centre</td>
<td>4</td>
<td>9</td>
<td>13</td>
<td>Coordinate a broad range of community, visiting services and support services, and provision of rooms for general practice.</td>
</tr>
<tr>
<td>George Town District Hospital &amp; Community Health Centre</td>
<td>15</td>
<td>0</td>
<td>15</td>
<td>Visiting services. Base for community nursing, home help/personal care and home maintenance.</td>
</tr>
<tr>
<td>Health West – Rosebery Hospital</td>
<td>7</td>
<td>0</td>
<td>7</td>
<td>Visiting diabetic clinic, needle exchange. Coordinate community nursing and other support programs, and provision of rooms for general practice.</td>
</tr>
<tr>
<td>Health West – West Coast District Hospital, Queenstown</td>
<td>10</td>
<td>16</td>
<td>26</td>
<td>Visiting radiology, diabetic clinic, physiotherapy, podiatry. Community nursing, home help/personal care and home maintenance, and provision of rooms for general practice.</td>
</tr>
<tr>
<td>King Island Hospital and Health Centre</td>
<td>6</td>
<td>14</td>
<td>20</td>
<td>Coordinate community services, visiting service and community nursing, child health, dental, antenatal, and alcohol and drug services, and provision of rooms for general practice.</td>
</tr>
<tr>
<td>Midlands Multi Purpose Health Centre – Oatlands</td>
<td>4</td>
<td>19</td>
<td>23</td>
<td>Coordinate delivery of community and visiting services including community nursing, child health, disability and diabetic education services, and provision of rooms for general practice.</td>
</tr>
<tr>
<td>New Norfolk District Hospital</td>
<td>10</td>
<td>0</td>
<td>10</td>
<td>Radiology, physiotherapy, podiatry, community health, mental health, child health and visiting consultants.</td>
</tr>
<tr>
<td>North East Soldiers Memorial Hospital Scottsdale</td>
<td>20</td>
<td>29</td>
<td>49</td>
<td>Radiology, physiotherapy, visiting services to Scottsdale and communities. Provision of community nursing and home help/personal care.</td>
</tr>
</tbody>
</table>

9 Under the terms of the Multi Purpose Agreements, funds can be used flexibly according to community need.
10 A full list of services provided at each facility is contained in Chapter 8.
### Regional primary health services

A range of services are provided across the primary health areas on a regional basis. The Primary Health Area managers work across these larger areas to develop integrated services both within the Department and across the broader health sector.

#### Palliative Care Service

The Palliative Care Service is a specialist service within Primary Health. The specialist, interdisciplinary consultancy team provides consultancy, support, advice and care to people living with a life-limiting illness, their families and carers. Specialist palliative care clinicians work within a consultancy framework across the whole health sector to support primary health service providers in urban and rural areas in the provision of quality palliative care.

---

11 Under the terms of the Multi Purpose Agreements, funds can be used flexibly according to community need.
The Palliative Care Service has three specialist community teams based in Hobart, Launceston and Burnie, with outreach to rural areas. It has dedicated inpatient facilities for palliative care patients in Hobart and Launceston and an in-reach service into the State’s teaching hospitals.

Care and support may be provided directly to individuals and families, or collaboratively with primary health service providers through consultancy, support, advice and information. The Service utilises a service delivery model that recognises that many patients will receive primary palliative care without having any contact with the Specialist Service and makes a clear distinction between consultation-liaison, shared care and services provided directly by the Specialist Service. The Specialist Service supports palliative care service provision across all levels.

**Youth Health Services**
Youth Health Services offer young people aged 12-24 years a flexible and confidential service including information, education, support, referral, and counselling on issues such as:
- drugs and alcohol (including needle availability program)
- sexual health
- GP consultations
- specialist counselling
- pregnancy testing
- referral services
- anything that affects the health and wellbeing of young people.

Options are available for working one to one or in groups depending on the young person’s personal choice. Services are provided by three regional teams based in Hobart, Launceston and Burnie.

**Other specific services**
Some specific primary health services may be provided at a Community Health Centre, rural inpatient facility or as a visiting service across an entire region. These include:
- Aged Care Assessment Team (ACAT)
- Community Equipment Scheme
- Community Options Service
- Community Rehabilitation Services
- Community Therapy Services (Physiotherapy, Speech Pathology, Occupational Therapy and Podiatry)
- Continence Service
- Health Promotion Activities.

### 4.3 General practice
General practice is a key component of primary health. In May 2006, there were 541 GPs in Tasmania or 1.1 GPs for every 1,000 people. There are a number of issues around the supply of GPs in Tasmania. Approximately 50 per cent of Tasmanian GPs practice in cities of more than 100,000 people, and another 25 per cent practice in rural areas with a population of less than 10,000 people, and the rest are spread between these two extremes.\(^2\)

Most GP practices are separate private enterprises, largely funded through the Australian Government Medicare Benefits Schedule (MBS) although this is often supplemented by an individual “gap” payment from patients. In rural areas, many GPs 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.

This results in about 50 per cent of the total rural general practice workforce receiving some funding support or incentives from the Department. The general practices in the Clarence and Risdon Vale Community Health Centres are the only ones managed by the Department.

The Divisions of General Practice network has been established to work with practices on programs and services intended to build general practice capacity, improve clinical skills and assist collaboration between GPs and other service providers. Divisions are independent general practice oriented organisations with highly developed networks.

4.4 Home and Community Care services (HACC)

The Home and Community Care Program (jointly funded by the Australian and State Government) provides a comprehensive range of community-based services to frail older people, younger people with a disability and carers of these groups. The overall objective of the HACC Program is to enhance the independence of people in the target population and to avoid their premature admission to inappropriate care settings.

In Tasmania the program funds around 60 non-government organisations, as well as business units within the Department, to provide such services as community nursing, allied health, centre day care, domestic assistance, personal care and community transport.

It should be noted that Departmental community nursing and allied health services also receive additional State Government funding to provide services to a broader range of community members than the HACC-eligible population, particularly those requiring post acute care. Similarly there are a range of other service providers who contribute to community transport at a local level.

HACC services provide essential support to the ageing population.

4.5 Key related services

4.5.1 Working with the Australian Government, local government, and non-government organisations

In addition to the contribution made by the Department and general practice, the primary health system in Tasmania comprises a dynamic mix of government, non-government and private services. While this can lead to a diverse and multi-faceted approach to primary health, it can also lead to service duplication and fragmentation. This can make it difficult for consumers to find the service they need, unless services and information are well coordinated at the local level.

The Australian Government Rural Primary Health Program funds a number of programs specifically designed to improve the health and well being of rural communities. These include the Regional Health Services, More Allied Health Services, and the Medical Specialist Outreach Program which have delivered other primary health projects to help support the delivery of primary health care in small rural communities. These programs are present in over a dozen rural communities around Tasmania.
The scope and extent of Regional Health Services are outlined in Table 3 below. This program is essential to the delivery of primary health services in Tasmania.

### Table 3 Australian Government-funded Regional Health Services

<table>
<thead>
<tr>
<th>Regional Health Service</th>
<th>Auspice</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Break O’Day Regional Health Service</td>
<td>Break O’Day Health Resource Association</td>
<td>Social Worker; Podiatry, Palliative Care, Youth Worker, Health Promotion</td>
</tr>
<tr>
<td>Bruny Island Regional Health Service</td>
<td>Department of Health and Human Services</td>
<td>Physiotherapy, Podiatry, Social Work, Occupational Therapy, Dietetics, Speech Pathology, Health Promotion Coordinator, Community Transport</td>
</tr>
<tr>
<td>Central Highlands Regional Health Service</td>
<td>Department of Health and Human Services</td>
<td>Youth Worker; Social Worker, Podiatry, Mental Health, Health Promotion</td>
</tr>
<tr>
<td>Circular Head Regional Health Service</td>
<td>Circular Head Rural Health Services Inc</td>
<td>Youth Work, Social Work, Mental Health, Podiatry, Health Promotion</td>
</tr>
<tr>
<td>Dorset Regional Health Service</td>
<td>Dorset Council</td>
<td>Social Worker; Youth Worker, Mental Health</td>
</tr>
<tr>
<td>Flinders Island R</td>
<td>Department of Health and Human Services</td>
<td>Podiatry</td>
</tr>
<tr>
<td>George Town Regional Health Service</td>
<td>George Town Health and Welfare Committee Inc</td>
<td>Mental Health, Youth Health, Social Work, Health Promotion</td>
</tr>
<tr>
<td>Glamorgan Spring Bay Regional Health Service</td>
<td>Glamorgan Spring Bay Council</td>
<td>Social Worker; Psychologist, Youth Worker</td>
</tr>
<tr>
<td>Huon Valley Regional Health Service</td>
<td>Huon Valley Council</td>
<td>Youth Health, Seniors Health, Rural Health and nutrition</td>
</tr>
<tr>
<td>Kentish Regional Health Service</td>
<td>Tandara Lodge Community Care Inc</td>
<td>Mental Health, Podiatry, Physiotherapy, OT, Youth Worker, Health Promotion</td>
</tr>
<tr>
<td>King Island Regional Health Service</td>
<td>King Island Council</td>
<td>Psychologist, Youth Worker, Health Prevention Projects</td>
</tr>
<tr>
<td>Meander Valley Regional Health Service</td>
<td>Department of Health and Human Services</td>
<td>Community Mental Health Worker, Social Worker, Youth Worker</td>
</tr>
<tr>
<td>Southern Midlands Regional Health Service</td>
<td>Department of Health and Human Services</td>
<td>Social Work, Podiatry, Physiotherapy</td>
</tr>
<tr>
<td>Tasman Regional Health Service</td>
<td>Tasman Council</td>
<td>Youth Worker, Social Worker</td>
</tr>
<tr>
<td>West Coast Regional Health Service</td>
<td>Department of Health and Human Services</td>
<td>Social Work, Youth Worker, Chronic Disease Self Mgt Worker</td>
</tr>
</tbody>
</table>

Source: Australian Department of Health and Ageing

As is evident from the above table, many non-government organisations actively provide primary health services in Tasmania. These organisations play a vital role in the primary health system in providing direct services and health promotion and education activities, and in complementing the work of government services. Non-government organisations often operate on relatively small budgets and also contribute extra funds to the primary health system through their own fund-raising efforts. The HACC services described earlier form a major part of this sector.

Residential aged care is an important partner to the primary health system. It is funded directly by the Australian Government (and individuals within residential aged care) 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 and non-government organisations which results in the State subsidising the aged care services that they provide.
Community Aged Care Packages and Extended Care in the Home packages are also funded by the Australian Government, and provide an integrated package of services which aim to support people to stay at home rather than enter residential care. These are also delivered by a range of providers, many in the non-government sector.

4.5.2 Working with the major acute public hospitals
While the Acute Health Services Group is responsible for the delivery of high-quality hospital and ambulance services within Tasmania, coordination between acute and primary health services is essential to a well-functioning health system. Most acute public hospital services are provided from the Royal Hobart Hospital, Launceston General Hospital, and the North West Regional Hospital (Burnie and Mersey Campuses).

An efficient, effective acute health service relies on support from a strong primary, community, and aged care service system. Effective primary health interventions can reduce the demand for the hospital specialist services, while early discharge and the optimal use of expensive hospital facilities depends upon the capacity of the primary health care system to provide care in a non-acute setting. Cooperation between the two sectors is essential for the delivery of a comprehensive health service to all Tasmanians.

4.5.3 Working with the Tasmanian Ambulance Service
The Acute Health Services Group is largely responsible for the Tasmanian Ambulance Service. The Tasmanian Ambulance Service provides emergency ambulance care, rescue and transport services and a non-emergency patient transport service through a network of 47 stations state-wide, providing road, rotary and fixed-wing transport.

Tasmania has a wide dispersal of highly qualified paramedics throughout urban and rural areas. Paramedics are supported by 450 volunteer officers who work alongside paramedics in 14 locations, as well as from 23 wholly volunteer stations. Three ambulance stations are operated by Primary Health Services: the Oatlands, Scottsdale and Queenstown sites.

Many of the communities with small volunteer stations are also serviced by others within the local area. For example, a paramedic at Zeehan provides a service across the whole West Coast. An effective road retrieval service is critical to the provision of safe and reliable health care in rural areas.

Emergency transports, urgent transports and non-urgent transports may be required whether the treatment is provided in a hospital, primary health service provider or in the patient’s home but are of particular importance for rural and regional areas of the state. The link between the Tasmanian Ambulance Service and rural health centres must be strong in order to ensure that medical emergencies are dealt with in a timely and appropriate manner.

4.6 Other private primary health care providers
There are a wide range of private primary health care providers in Tasmania, including pharmacists, physiotherapists, other allied health professionals, complementary medical providers such as acupuncturists, massage therapists, and others. The private sector provides a valuable resource of Tasmanian primary health care services.

4.7 Community and consumer involvement in primary health
Within the Department, the process of community and consumer participation is generally organised around particular sites, programs and communities. Five rural inpatient facilities (three Multi Purpose Services and two Multi Purpose Centres) have formal community and consumer committees as part of their governance structure. Others have a close relationship with community organisations in their municipal area.
Over the last 12 months, one of the aims of the Strengthening Community Health trial sites (organised through the Community Health Centres in Spring Bay/Triabunna, Kings Meadows and Jones St/Burnie) has been to strengthen community engagement in local services where this does not already exist.

The Department is seeking to establish an improved ability to engage communities and consumers in a more comprehensive way through this planning process. The proposed primary health care partnerships are a means of achieving good connections with the community to jointly address these issues.

4.8 The primary health activity profile

4.8.1 Community health centre activity

The diverse range of activities provided through the community health centres are delivered through a range of service programs. Core services include community nursing and community care (home care, personal care, home maintenance and home linen). Services are expanding, however, as Community Health Centres take on new roles with prevention and management of chronic disease, as described below.

**Case study**

The Chronic Condition Self-Management Program at Deloraine/Westbury is designed to help people with chronic health conditions learn healthier ways to live. The course, *Living a Healthy Life with Chronic Conditions*, is fun as well as practical, and builds confidence in coping with the everyday challenges of living with a chronic condition. Participants learn new information and tools that can assist them in maintaining a more active, fulfilling life by focusing on building skills, sharing experiences and support.

Many people who have chronic conditions experience symptoms such as fatigue, loss of energy, pain, breathing difficulties, sleeping problems, depression, and anxiety about the future. Some of these challenges can be managed on a daily basis to reduce the impact of the condition on the person’s life. This course contains practical suggestions to help overcome everyday obstacles so people can get more out of life.

The six-week course attracts up to 12 people of all ages and is currently facilitated by local Community Health Social Workers from Deloraine and Westbury. Referrals are generated from individual counselling sessions, local GPs, Allied Health Services and the local Day Centres. To date two courses have been offered and a third is starting soon.

All courses are evaluated prior to, and after the course to measure any changes participants may experience. Participants tend to enter the course frustrated and unsupported in managing their particular condition. They often have a lack of knowledge how to access information, a fear of challenging decisions of the health service providers and a lack of resources. With the introduction of self-management principles participants begin to approach their health and well-being in a more proactive manner. Feedback has been overwhelming, with participants expressing the course content as a catalyst for change in their lives enabling them to move from a sense of hopelessness to a sense of control over many aspects of their lives.

Observations have included a change in the language and perceptions of people living with chronic conditions: for example, in one group the first meeting was ‘problem saturated’ with a sense of hopelessness from participants, and by the third week the responses had noticeably changed from hopelessness to courage, strength and a sense of power and control over many aspects of their lives. This has been a rewarding experience for facilitators in being able to offer an intervention that can promote healthy living choices in a fun and supportive environment.
Community nursing
The number of occasions of service provided by Departmental community nursing services has decreased over the last five years (from 254,590 to 194,417).

A “snapshot” was undertaken of Community Nursing Services provided across the larger urban centres during the month of February 2007. The audit indicated that:

• there was significant variation across the state in relation to service characteristics and procedures;
• services were predominantly delivered to older clients in the HACC-eligible target group;
• the majority of clients could be characterised as low dependency, in which care was anticipated to be required for some length of time;
• the majority of referrals were sourced from hospitals and GPs;
• the majority of interventions included home and personal care checks, coordination, medication management, personal care, wound care;
• the Community Nursing Service was in general more expensive than the costings applicable under the Department of Veterans Affairs funding model; and
• the major workforce utilised was registered nurses working as community nurses with comparatively little use of other staff such as personal care assistants and enrolled nurses.

Community care
Data on community care services (eg personal care, home help and home maintenance) is not generally aggregated on a state-wide level but retrospective analysis of the 2004-05 data indicates that over 5,000 clients were supported with 177,000 occasions of service over that twelve months.

4.8.2 Rural inpatient activity
The usage of Tasmania’s small rural inpatient facilities is decreasing. This is a result of changes in both clinical practice and workforce, which has seen increasing concentration of more specialised care in the major hospitals and increasing care of patients in the community, aimed at allowing them to remain in their own homes. The extent of this trend is measured by three key indicators for inpatient activity across the state. Separations, the average length of stay and the overall occupied beddays give some indication of how busy an inpatient facility is. These three indicators show an overall downward trend in the activity levels of rural inpatient facilities over the last eight years, between 1998-99 and 2005-06:

• the number of separations have decreased from 5,335 to 5,052;
• the average length of stay has decreased from 8.35 days to 7.29 days;
• the number of occupied beddays have decreased from 44,533 to 36,813.

This means that the overall average occupancy of rural inpatient facilities has dropped from 78% to 64%.

In 2005-06, on a state-wide basis, the great majority of patients were admitted to a rural inpatient facility through their GP (75%). However 22% were transferred from another hospital, usually one of the major acute facilities. The majority of patients are from the immediate local area of the rural facility.

The average age of patients being treated in rural inpatient facilities was 60 years; however 50% of separations were over 65 years of age and this group accounted for 77% of occupied beddays. The great majority of patients (73%) were discharged to their own home following their stay in the rural inpatient facility.
4.8.3 Regional primary health service activity

The community palliative care service in 2005-06 had a total of 1,104 new referrals, 952 admissions and 816 deaths and provided 3,769 out-of-hours services. Forty-three per cent (1,623) of out-of-hours services were spent providing direct services to clients and 57% (2,146) were spent providing indirect services (providing advice and support to other service providers). An average of 421 clients were accessing the service each month.

The Youth Health Service provided more than 2,720 occasions of service at Youth Health Centres in 2005-06. Of these approximately 58% were provided in the South, 23% in the North and 19% in the North West. Table 4 shows the most frequent types of services delivered during that time. Suicide prevention, while not listed below, is another important service provided.

Table 4 Top 10 Youth Health Services delivered in 2005-06

<table>
<thead>
<tr>
<th>Type of service</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and fitness</td>
<td>11%</td>
</tr>
<tr>
<td>Alcohol and other drugs</td>
<td>10%</td>
</tr>
<tr>
<td>Emotional</td>
<td>9%</td>
</tr>
<tr>
<td>Information sessions</td>
<td>9%</td>
</tr>
<tr>
<td>Adolescent pregnancy/parenting</td>
<td>7%</td>
</tr>
<tr>
<td>Contraception</td>
<td>6%</td>
</tr>
<tr>
<td>Relationships</td>
<td>6%</td>
</tr>
<tr>
<td>Social</td>
<td>5%</td>
</tr>
<tr>
<td>Behaviour</td>
<td>4%</td>
</tr>
<tr>
<td>Minor ailments</td>
<td>4%</td>
</tr>
</tbody>
</table>

Source: Department of Health and Human Services

The Aged Care Assessment Team provided 4,888 assessments in 2005-06. The State-wide Continence Service provided 6,862 occasions of service. Community Podiatry provided 18,031 occasions of service.

4.8.4 General Practice activity

General Practice in Tasmania is the accessible first point of entry into the health system. GPs have regular contact with a large percentage of the Tasmania population and as such GPs are often the first point of contact to the broader health care system. Patients look to GPs for referral to appropriate services including allied health services, hospitals, specialists and other providers. GPs’ knowledge base is vital in accessing care for their patients.

In addition to providing access to Medicare, the Australian Government has attempted to improve the quality of general practice care through a range of incentive programs. These include:

• Practice Incentive Payments for after hours care, practice nurse subsidies, rural subsidies, quality prescribing, cervical screening, immunisation and IM/IT incentives; and
• Service Incentive Payments to support the management of chronic disease (particularly asthma, diabetes, and mental health).

Tasmanian residents used an average of 10.9 Medicare services per capita in 2005-06. This is below the average number of Medicare services per capita across Australia which was 12 in 2005-06.13

Table 5 shows Medicare reportage of bulk-billing\(^ {14}\) in Tasmania, grouped by Federal Electorate\(^ {15}\) (excluding practice nurse items). The proportion of Medicare services in Tasmania which are bulk-billed has increased, from 58.6% in 2000-01 to 65.5% in 2005-06. At the national level, the proportion of Medicare services bulk-billed in 2000-01 and 2005-06 has remained stagnant. However, the proportion of Medicare services in Tasmania which were bulk-billed in 2005-06 is below the national average of 71.7%\(^ {16}\).

Table 5 Percentage of GP services bulk-billed by Federal Electorate

<table>
<thead>
<tr>
<th>Electorate</th>
<th>% bulk-billed 2004</th>
<th>% bulk-billed 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bass</td>
<td>51.2%</td>
<td>57.8%</td>
</tr>
<tr>
<td>Braddon</td>
<td>63.2%</td>
<td>74.1%</td>
</tr>
<tr>
<td>Denison</td>
<td>55.9%</td>
<td>65.7%</td>
</tr>
<tr>
<td>Franklin</td>
<td>58.3%</td>
<td>65.0%</td>
</tr>
<tr>
<td>Lyons</td>
<td>71.5%</td>
<td>76.1%</td>
</tr>
</tbody>
</table>

Source: Medicare Australia

The Department’s general practices surgeries in the Clarence and Risdon Vale Community Health Centres bulk-bill health care card holders. While these centres will be included in the percentages above, absolute numbers for the 2006 calendar year were:

- Clarence Medical Centre – 18,181 patients bulk-billed;
- Risdon Vale Medical Centre – 7,763 patients bulk-billed.

Practice Nurses are increasingly becoming an important member of the primary health care team. The Practice Nurse Incentive provided by the Australian Government has resulted in 90% of eligible practices in the North and North West, and over 70% of practices in the South, employing one or more practice nurses. There are currently over 200 practice nurses employed across the state undertaking work on behalf of GPs in areas such as wound care, cervical screening and health assessments.

### 4.8.5 Home and Community Care activity

**Home and Community Care services**

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%), in response to an increase in real growth funding of 25.9%\(^ {17}\).

The Department provides a range of documentation for consumers and service providers on various aspects of the HACC Program on the Departmental website\(^ {18}\). An overview of HACC service types can be seen in Figure 1 on the following page.

---

\(^{14}\) ‘Bulk-billing’ is the practice of providing general practice services for the cost of the Medicare rebate alone, without any out-of-pocket expenses for the patient.

\(^{15}\) The coverage of Federal Electoral boundaries are: Denison covers central Hobart, Franklin the Hobart Eastern shore and the populated areas of Southern Tasmania; Bass covers Launceston and the North East coast, Braddon Burnie, Devonport and the North West coast. Lyons covers everything else in between. Source: Australia Votes – ABC News http://www.abc.net.au/elections/federal/2004/guide/state_tas.htm


\(^{17}\) 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%.

The most frequently utilised HACC service types are centre day care (respite), domestic assistance, personal care and nursing.

Data on the HACC Program is reported through the HACC minimum data set. There are a number of caveats on the data relating to quality and completeness. According to estimates from the Australian Bureau of Statistics 2005-06 there are currently more than 52,000 Tasmanians in the HACC target group.

Table 6 shows that 78% of clients are aged 65 years or over, with 42% of clients over 80 years of age.

Table 6 HACC services: Number of clients assisted by age group

<table>
<thead>
<tr>
<th>Age group</th>
<th>2003-04</th>
<th>2004-05</th>
<th>2005-06</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-49</td>
<td>2,409</td>
<td>2,856</td>
<td>2,748</td>
</tr>
<tr>
<td>50-64</td>
<td>2,973</td>
<td>2,982</td>
<td>3,939</td>
</tr>
<tr>
<td>65-80</td>
<td>7,667</td>
<td>7,830</td>
<td>11,016</td>
</tr>
<tr>
<td>80+</td>
<td>8,390</td>
<td>8,977</td>
<td>12,899</td>
</tr>
<tr>
<td>Total</td>
<td>21,439</td>
<td>22,645</td>
<td>30,602</td>
</tr>
</tbody>
</table>

Table 7 below shows that domestic assistance (‘home help’) was provided to 22% of all HACC clients. Almost 20% of HACC clients received nursing services, while 13% received transport services.
Table 7 HACC services: Number of clients by selected service type

<table>
<thead>
<tr>
<th>Service type</th>
<th>2003-04</th>
<th>2004-05</th>
<th>2005-06</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allied Health</td>
<td>2,750</td>
<td>3,568</td>
<td>3,423</td>
</tr>
<tr>
<td>Centre Day Care and Respite</td>
<td>1,746</td>
<td>1,796</td>
<td>2,002</td>
</tr>
<tr>
<td>Meals</td>
<td>4,176</td>
<td>4,291</td>
<td>4,498</td>
</tr>
<tr>
<td>Domestic Assistance</td>
<td>7,096</td>
<td>7,111</td>
<td>9,083</td>
</tr>
<tr>
<td>Home Maintenance</td>
<td>2,650</td>
<td>2,452</td>
<td>3,114</td>
</tr>
<tr>
<td>Nursing</td>
<td>7,241</td>
<td>6,879</td>
<td>7,770</td>
</tr>
<tr>
<td>Personal Care</td>
<td>2,268</td>
<td>2,579</td>
<td>2,917</td>
</tr>
<tr>
<td>Social Support</td>
<td>2,397</td>
<td>2,428</td>
<td>2,499</td>
</tr>
<tr>
<td>Transport</td>
<td>4,468</td>
<td>4,937</td>
<td>5,220</td>
</tr>
</tbody>
</table>

* An individual client may access more than one service type.


Table 8 below shows an increase in the delivery of HACC services over the last three years.19

Table 8 HACC services: Units of service delivery by service type

<table>
<thead>
<tr>
<th>Region: Total combined</th>
<th>2003-04</th>
<th>2004-05</th>
<th>2005-06</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allied health – Centre</td>
<td>Hours: 4,605</td>
<td>211,657</td>
<td>4,665</td>
</tr>
<tr>
<td>Allied health – Home</td>
<td>Hours: 34,480</td>
<td>1,311,592</td>
<td>34,480</td>
</tr>
<tr>
<td>Centre day care</td>
<td>Hours: 229,670</td>
<td>2,631,110</td>
<td>266,945</td>
</tr>
<tr>
<td>Domestic Assistance</td>
<td>Hours: 213,500</td>
<td>2,571,105</td>
<td>230,642</td>
</tr>
<tr>
<td>Home Maintenance</td>
<td>Hours: 50,193</td>
<td>1,349,844</td>
<td>55,685</td>
</tr>
<tr>
<td>Meals – Centre</td>
<td>Meals: 51,820</td>
<td>266,154</td>
<td>52,670</td>
</tr>
<tr>
<td>Meals – Home</td>
<td>Meals: 353,321</td>
<td>1,128,818</td>
<td>356,731</td>
</tr>
<tr>
<td>Nursing care – Centre</td>
<td>Hours: 590</td>
<td>29,871</td>
<td>3,410</td>
</tr>
<tr>
<td>Nursing care – Home</td>
<td>Hours: 127,150</td>
<td>6,177,074</td>
<td>129,785</td>
</tr>
<tr>
<td>Personal care</td>
<td>Hours: 123,200</td>
<td>4,367,800</td>
<td>143,800</td>
</tr>
<tr>
<td>Respite</td>
<td>Hours: 99,480</td>
<td>1,575,976</td>
<td>99,130</td>
</tr>
<tr>
<td>Social support</td>
<td>Hours: 92,480</td>
<td>1,301,374</td>
<td>89,328</td>
</tr>
<tr>
<td>Transport</td>
<td>Trips: 223,030</td>
<td>1,254,404</td>
<td>224,936</td>
</tr>
<tr>
<td><strong>Total outputs</strong></td>
<td><strong>1,603,519</strong></td>
<td><strong>26,876,779</strong></td>
<td><strong>1,692,207</strong></td>
</tr>
</tbody>
</table>


In the 2006-07 HACC Growth Funding round, additional recurrent funding has been provided to a number of HACC organisations to expand provision of domestic assistance and personal care. The providers funded have a presence across each of their respective regions. West Coast Health Centre has received funding to expand the existing Day Centre.

19 Given the unreliability of the HACC minimum data set, due to missing or inadequately stated data, output data has been sourced from HACC Annual Business Reports. The HACC program is undertaking two concurrent projects to improve the data collection and quality; these are implementation of a State HACC Data Repository and a HACC Data Quality Improvement Project.
4.8.6 Activity within key related services

Aged care

The Australian Government’s Residential Aged Care Program is allocated in proportion to the number of people aged 70 years or older. The current benchmarks for the provision of residential and community care places per 1,000 population aged 70 years and above are 40 high-care residential places, 48 low-care residential places, and 20 community aged care places.

Tasmania has 107.8 residential and aged care places per 1,000 population aged 70 years and above. This is above the number for most States and Territories, but is below the Australian Government’s benchmark rate. Table 9 shows the number of places and the number of Community Aged Care Packages (CACPs), and Extended Aged Care in the Home (EACH) packages per region.

<table>
<thead>
<tr>
<th>ACAT Region</th>
<th>High RAC</th>
<th>Low RAC</th>
<th>Total RACS</th>
<th>CACPs</th>
<th>EACH</th>
<th>EACH Dementia</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>South</td>
<td>1,055</td>
<td>1,124</td>
<td>2,179</td>
<td>453</td>
<td>32</td>
<td>0</td>
<td>2,664</td>
</tr>
<tr>
<td>North</td>
<td>673</td>
<td>552</td>
<td>1,225</td>
<td>259</td>
<td>23</td>
<td>10</td>
<td>1,517</td>
</tr>
<tr>
<td>North West</td>
<td>490</td>
<td>459</td>
<td>949</td>
<td>213</td>
<td>0</td>
<td>5</td>
<td>1,167</td>
</tr>
<tr>
<td>Total</td>
<td>2,218</td>
<td>2,135</td>
<td>4,353</td>
<td>925</td>
<td>55</td>
<td>15</td>
<td>5,348</td>
</tr>
</tbody>
</table>

Source: Department of Health and Ageing, Aged Care Stocktake of Places, June 2006

The actual number of available beds is less than that stated above as aged care places are counted by the Australian Government as soon as they move into the planning stage. It is not until they become operational that they are able to provide benefit to Tasmanians requiring aged care.

In rural areas where there are no viable alternative providers the State Government takes on a service provision role. Departmental rural aged care beds, as provided in Multi Purpose Services and Centres, and other rural facilities currently contain 148 residential aged care beds. In 2005-06, they provided 51,426 occupied beddays, resulting in an occupancy rate of 95% across the state.

Relative utilisation of acute care services by rural patients

Patients from rural/remote areas made up 14.5% of the total population and approximately 13% of all public and private hospital inpatient separations by Tasmanians, in 2004-05. That is 22,769 separations and 81,883 beddays from a total of 173,966 separations and 581,096 beddays.

Patients from rural/remote areas appear to be more dependent on public hospital inpatient services than those from urban/adjacent urban areas, who are more likely to use private hospitals in addition to public hospitals. This trend is more pronounced in relation to children’s use of hospital services. Patients from rural/remote areas made up 12% of all major public hospital outpatient presentations in 2005. They had a lower relative utilisation of these services than did patients from urban/adjacent areas.

Tasmanian Ambulance Service: Rural activity

The Tasmanian Ambulance Service responded to 61,774 cases in 2005-06. Caseload by station varies significantly across the state. At the top end of the scale, Launceston responded to over 10,500 cases in 2005-06. Other sites responded to less than 10 cases. Capacity to respond to medical emergencies depends on the staffing level and composition.

---

20 This is based on a breakdown of LGAs which classifies the following as rural and/or remote: Break O’Day, Central Highlands, Circular Head, Dorset, Flinders Island, George Town, Glamorgan Spring Bay, Huon Valley, Kentish, King Island, Southern Midlands, Tasman and West Coast. It is recognised that other municipal areas may have rural components but they are largely urban or adjacent to an urban area.

21 This total only accounts for persons giving an address in Tasmania as their usual residence and so excludes most interstate and overseas hospital patients.
4.9 Workforce profile

4.9.1 Medical

Nationally, there is an average of one 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. Table 10 shows both GP numbers and full-time equivalents (FTEs) per 1,000 population.

Table 10 GP numbers and full-time equivalents (FTE) per 1000 population Tasmania 2006

<table>
<thead>
<tr>
<th>LGA</th>
<th>GP number per 1000 population</th>
<th>GP FTE per 1000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Break O’Day</td>
<td>0.8</td>
<td>0.6</td>
</tr>
<tr>
<td>Dorset</td>
<td>0.8</td>
<td>0.8</td>
</tr>
<tr>
<td>Flinders</td>
<td>1.1</td>
<td>0.9</td>
</tr>
<tr>
<td>George Town</td>
<td>1.3</td>
<td>0.9</td>
</tr>
<tr>
<td>Launceston</td>
<td>1.1</td>
<td>0.8</td>
</tr>
<tr>
<td>Meander Valley</td>
<td>0.4</td>
<td>0.3</td>
</tr>
<tr>
<td>Northern Midlands</td>
<td>0.8</td>
<td>0.4</td>
</tr>
<tr>
<td>West Tamar</td>
<td>0.8</td>
<td>0.6</td>
</tr>
<tr>
<td><strong>Total North</strong></td>
<td><strong>0.9</strong></td>
<td><strong>0.7</strong></td>
</tr>
<tr>
<td>Burnie</td>
<td>0.8</td>
<td>0.5</td>
</tr>
<tr>
<td>Central Coast</td>
<td>0.9</td>
<td>0.6</td>
</tr>
<tr>
<td>Circular Head</td>
<td>0.7</td>
<td>0.5</td>
</tr>
<tr>
<td>Devonport</td>
<td>0.9</td>
<td>0.6</td>
</tr>
<tr>
<td>Kentish</td>
<td>0.7</td>
<td>0.4</td>
</tr>
<tr>
<td>King Island</td>
<td>0.6</td>
<td>0.6</td>
</tr>
<tr>
<td>Latrobe</td>
<td>1.5</td>
<td>0.9</td>
</tr>
<tr>
<td>Waratah-Wynyard</td>
<td>0.8</td>
<td>0.6</td>
</tr>
<tr>
<td>West Coast</td>
<td>1.0</td>
<td>0.6</td>
</tr>
<tr>
<td><strong>Total North West</strong></td>
<td><strong>0.9</strong></td>
<td><strong>0.6</strong></td>
</tr>
<tr>
<td>Brighton</td>
<td>0.5</td>
<td>0.4</td>
</tr>
<tr>
<td>Central Highlands</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Clarence</td>
<td>1.1</td>
<td>0.7</td>
</tr>
<tr>
<td>Derwent Valley</td>
<td>0.7</td>
<td>0.5</td>
</tr>
<tr>
<td>Glamorgan Spring Bay</td>
<td>1.0</td>
<td>0.4</td>
</tr>
<tr>
<td>Glenorchy</td>
<td>1.3</td>
<td>0.8</td>
</tr>
<tr>
<td>Hobart</td>
<td>2.2</td>
<td>1.4</td>
</tr>
<tr>
<td>Huon Valley</td>
<td>1.2</td>
<td>0.7</td>
</tr>
<tr>
<td>Kingborough</td>
<td>1.1</td>
<td>0.7</td>
</tr>
<tr>
<td>Sorell</td>
<td>1.0</td>
<td>0.6</td>
</tr>
<tr>
<td>Southern Midlands</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>Tasman</td>
<td>0.9</td>
<td>0.5</td>
</tr>
<tr>
<td><strong>Total South</strong></td>
<td><strong>1.3</strong></td>
<td><strong>0.8</strong></td>
</tr>
<tr>
<td><strong>Tasmania</strong></td>
<td><strong>1.1</strong></td>
<td><strong>0.7</strong></td>
</tr>
</tbody>
</table>


For a variety of reasons many GPs are reducing the number of hours they work per week and this means that the full-term equivalent for available general practice is less than the numbers of individuals practising. In May 2006 there were 531 GPs (headcount) working in Tasmania, or a full-time equivalent load of 351.7 GPs.

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 and 54 years and one-third was less than 45 years of age.24

4.9.2 Nursing

As shown in Table 11 below, in April 2007, 44% of the current Primary Health Services nursing workforce was aged 51 years or over and 77% of the total workforce were between 40 and 60 years of age. The Departmental Primary Health nursing workforce is predominantly female (95%). In April 2007, 66% of this workforce were employed on a permanent basis, 31% were employed as casuals, and 3% employed on a fixed-term basis. Nurses made up over 40% of departmental Primary Health full-time equivalent staff (485.5 in total).

Table 11 Primary Health Nurses (Headcount by age group and award/stream) 2007

<table>
<thead>
<tr>
<th>Nursing award</th>
<th>Age group in years</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>16 to 30</td>
<td>31 to 40</td>
</tr>
<tr>
<td>Nursing – Clinical Nurse Specialist</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Nursing – Community Family Child Health Nurse</td>
<td>8</td>
<td>38</td>
</tr>
<tr>
<td>Nursing – Enrolled Nurse</td>
<td>4</td>
<td>22</td>
</tr>
<tr>
<td>Nursing – Registered Nurse Level 1</td>
<td>23</td>
<td>27</td>
</tr>
<tr>
<td>Nursing – Registered Nurse Level 2</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Nursing – Registered Nurse Level 3</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Nursing – Registered Nurse Level 4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Nursing – Registered Nurse Level 5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total number of nurses</td>
<td>36</td>
<td>94</td>
</tr>
</tbody>
</table>

Per cent

|                | 5%     | 12%    | 39%    | 38%    | 6%     | 100%   |

Source: DHHS Human Resources Empower System

4.9.3 Allied health

There are 181 staff (123.5 full-time equivalent) allied health professionals employed within the Department’s Primary Health business unit, making up approximately 10% of all Primary Health employees across a broad range of disciplines.25

Information on some of these professional groups in Tasmania can be found in the 2001 Australian Bureau of Statistics reports cited by the Services for Australian Rural and Remote Allied Health.26 These reports suggest that with 2% of the national population residing in Tasmania and 2% of the national allied health professional workforce residing in this state, Tasmania is not facing an overall disadvantage.

Distribution within the state is, however, uneven. Outer regional and remote regions of Tasmania contain 36% of the population but only 24% of the allied health workforce. Some professional groups, eg orthotics and prosthetics, are based entirely in the larger population centres, such as Hobart. The allied health workforce in Tasmania grew by 5% between 1996 and 2001. The very small professions such as orthoptics, orthotics and audiology, however, showed significant decline. In addition, there

25 Allied Health professionals include the following: Dental Therapy, Dietetics and Nutrition, Occupational Therapy, Orthotics/Prosthetics, Pharmacy, Physiotherapy, Podiatry, Psychology, Social Work and Speech Pathology.
are currently acute shortages in some key allied health professions. Nutritionists, dieticians, exercise physiologists and speech pathologists are examples.

The 2003 Workforce Status Report noted a median age of 42 years for allied health professionals in Tasmania. Within the whole Department, the average age of allied health professionals is somewhat lower, as shown in Table 12 below.

Table 12 Primary Health allied health employees by age group, 2007

<table>
<thead>
<tr>
<th>Profession</th>
<th>Age group (years)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>16 to 30</td>
<td>31 to 40</td>
</tr>
<tr>
<td>Dietician</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Generic</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Generic – AHP</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Generic – Social Welfare Prof</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Diagnostic Radiographer</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Orhotist</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>Podiatrist</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Psychologist</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Social Worker</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Speech Pathologist</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total number of Allied Health</strong></td>
<td>32</td>
<td>42</td>
</tr>
</tbody>
</table>

Percent of Total 18% 23% 26% 27% 6% 1% 100%

Source: DHHS human Resources Empower System

Figure 2 below shows that Social Workers, Physiotherapists and Occupational Therapists make up the majority of the allied health professionals employed within the Departmental Primary Health unit. “Generic” positions make up another 13% of all allied health professions within Primary Health – this refers to a wide range of individual positions that cannot be aggregated into any one category.

Figure 2 Primary Health allied health employee by profession, 2007

4.9.4 Other health service staff

Therapy assistants, home care workers and other health services providers provide a vital supporting role to the three main health profession groupings. Health promotion workers and others focusing on healthy lifestyle development are also found in this category, both within the Department and in the many non-government organisations that focus on various aspects of health promotion, early intervention and chronic disease self-management.

In April 2007, the Department’s Primary Health unit employed 370 staff in various support roles. Of these, 58% provided home help and personal care. Another 35% acted as aides and assistants to allied health and other health service providers. Therapists (eg diversional therapists) made up the final major category within this group of health service providers (5%).

At this time, 53% of these staff were employed on a permanent basis, 20% were casuals and 7% were on fixed-term appointments. Employment status was not recorded for another 20% of this group.

In 2005-06, the Assistant Practitioners Project commenced an examination of rural workforce challenges and strategies to increase the supply of therapy assistants within the Department employed in a range of allied health areas, under remote supervision.

This is an area of ongoing interest, as new service models are developed, calling for new types of health service providers to action them.

Change is already occurring in the workforce, with new practitioners coming on line and established professions doing new types of work.

4.10 Transport

Due to the dispersed nature of the Tasmanian population, many clients access health and human services some distance away from their local area. Broadly speaking, the provision of transport is a personal responsibility, however a range of transport services is available to people who are transport disadvantaged either because of socio-economic circumstances or because health and disability preclude use of their own, or public, transport.

Public transport services are generally not planned with the needs of minority or disadvantaged groups in mind and traditionally have a radial configuration of networks to facilitate mass transfer of people to work, school and central business districts.

Transport assistance services

Within Tasmania the principal sources of assistance to transport disadvantaged people is undertaken by:

• The Department of Infrastructure Energy and Resources, which holds responsibility for the transport regulatory environment, contracting, and the provision of core regular passenger transport services, including school buses. It also administers the Transport Access Scheme.

• The Department of Health and Human Services which holds responsibility for:
  – the provision of ambulance services;
  – the provision of patient travel between inpatient settings;
  – the Patient Travel Assistance Scheme; and
  – HACC funded community transport.

• The Department of Education, which provides a subsidy to assist disabled school children.

• The Department of Veterans Affairs, which provides transport assistance to veterans with medical specialist needs.

• Non-government organisations providing transport for their community or client group.
• Family, friends, Local Government and unincorporated local transport groups, all of which provide transport assistance to the transport disadvantaged.

**Transport assistance within Acute Health Services**

Acute Health Services operates the Tasmanian Ambulance Service, Patient Transport (between inpatient settings) and the Patient Travel Assistance Scheme (PTAS) which helps to ensure equity of access for Tasmanian residents to specialist medical services.

The PTAS scheme is targeted toward Tasmanians who have to travel to access medical services, and face high travel costs in accessing these services. The Department contributes to the cost of patient travel and accommodation, and to the cost of travel and accommodation for an escort that might be required for the effective treatment of patients. The number of PTAS services has increased by 5% between 2001-02 and 2005-06.

**HACC Community Transport**

HACC-funded community transport refers to assistance with transportation for HACC eligible clients either directly (a ride in a vehicle provided or driven by an agency worker or volunteer) or indirectly (by taxi voucher, subsidy, or brokerage). In 2005-06, HACC Community Transport delivered 255,786 trips to HACC clients.

Between 1 July 2002 and 1 July 2006 recurrent HACC funding specifically targeted to community transport has increased by 66.8%. In addition one-off funding of $708,000 has been provided over the same period for new and replacement vehicles.

However, the provision of community transport remains reliant on the contribution of volunteers and this can often cause difficulties in supply as the pool from which this valuable resource is drawn diminishes.

The recent survey of HACC-funded community transport[^28] found that the main reason for the clients accessing HACC funded community transport was for transport to and from centre day care/shopping/outings (67%), with non-emergency medical trips totalling 25%.

This activity appears to be in keeping with the needs of the client group. The average age of clients utilising HACC transport is 71 years, with 38% of all transport being provided to persons over 80 years. Usage was fairly evenly split between individual transport and group transport. For trip duration the major utilisation was on short trips up to 30 minutes (42%), and for trips longer than two hours (31%).

**2005 rural community transport audit**

In 2005 the Department of Infrastructure, Energy and Resources commissioned consultants to undertake an audit and review into rural community transport. The consultants undertook a survey of clients’ transport utilisation in rural areas using a combination of telephone and mail-out survey.

The survey showed that 8% of rural households had required some form of transport assistance in the last five years, most needing transport assistance for less than three months. About 3-4% of households in rural areas have persons that require transport assistance at any time[^29].

**Issues**

The key points to be noted about transport is that it remains a gap for rural and regional areas and the services that are being provided are, in some cases, operating in isolation from each other and are, therefore, less effective than they could otherwise be.

[^29]: Department of Infrastructure, Energy and Resources (2005) *Rural Community Transport Audit and Review (Draft Final Report)*.
5. Assessment of future health care needs

5.1 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.

5.1.1 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. In June 2006, Tasmania had the second-highest proportion of any Australian state or territory of people aged 65 years or more. 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 LGA (2003)

Source: ABS 2003, National Regional Profile.

The Tasmanian population is also 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. 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**

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.

In addition to the change in the age structure of the population, it is projected that there will be an overall change in the distribution of the population across the state. Figure 5 illustrates the projected change in the resident population by LGA over the next 15 years.

**Figure 5 Projected change (%) in resident population by LGA 2006 and 2021**


Cultural diversity
At the 2001 Census, the majority of people in Tasmania were Australian-born (84.9% or 386,036 people). Tasmania recorded the highest proportion of people born in Australia, above the Australian proportion of 72.6%.

The largest overseas-born groups comprised people born in the United Kingdom (4.7% or 21,306 people), New Zealand (0.8% or 3,590 people), the Netherlands (0.5% or 2,483 people), Germany (0.4% or 1,908 people), and Italy (0.2% or 1,127 people).

Tasmania also recorded the highest proportion of people who speak English only at home (92.6% or 421,034 people), above the Australian proportion of 80%.

However, there are a large number of overseas-born groups represented in Tasmania by a small number of people. The top five countries of origin of settlers to Tasmania in 2004-05 were Sudan, the United Kingdom, New Zealand, Sierra Leone and the Philippines. In 2005-06, individuals and families from Fiji, Egypt, Thailand, China, Korea, India, Brazil, Ethiopia and South Africa also settled in Tasmania. This broad diversity, yet small numbers, creates difficulties in providing the appropriate level of services in a culturally appropriate way.

Settlers with multicultural backgrounds arrive via three pathways: family reunion, skilled migration or as humanitarian refugees. Many new arrivals need additional support for their health and wellbeing needs. Tasmania continues to settle the highest proportion of refugees in comparison to other States. In 2004-05, almost 32% of our settlers were refugees compared to the national proportion of around 10%.

Indigenous population
The Indigenous population of Tasmania was estimated at 15,773 persons in 2001, and represents 3.5% of the total Tasmanian population. This is the second highest proportion of any state or territory (second only to the Northern Territory) and is above the proportion of the Indigenous population across Australia at 2.2%.

The majority of the Indigenous population is located in the South (47.9%), followed by the North West (31.9%) and the North (20.1%).

The main Indigenous populations in Tasmanian are located in Launceston, Glenorchy, Clarence, Huon Valley and the Central Coast.

5.1.2 Socio-economic status
The Australian Bureau of Statistics (ABS) produces the Socio-Economic Indexes for Areas, which provides a method for determining the level of social and economic wellbeing of Australian communities.

The index below is the Index of Disadvantage, which focuses on low income earners, relatively lower educational attainment and high unemployment.

The baseline for the Index of Disadvantage is 1,000. A score above 1,000 indicates an area of socio-economic advantage, and a score below 1,000 indicates an area of disadvantage. The further the deviation away from 1,000, the greater the level of advantage or disadvantage.

Table 13 shows that Tasmania (969.7) has a greater level of disadvantage than the national average, and is above the Northern Territory only.

Table 13 Socio-economic Index of Disadvantage, State and Territory, 2001

<table>
<thead>
<tr>
<th>State/Territory</th>
<th>Disadvantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>1000.5</td>
</tr>
<tr>
<td>Victoria</td>
<td>1014.6</td>
</tr>
<tr>
<td>Queensland</td>
<td>991.5</td>
</tr>
<tr>
<td>South Australia</td>
<td>995.2</td>
</tr>
<tr>
<td>Western Australia</td>
<td>1003.6</td>
</tr>
<tr>
<td>Tasmania</td>
<td>969.7</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>952.3</td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>1078.7</td>
</tr>
</tbody>
</table>

Source: Australian Bureau of Statistics, Census of Population and Housing: Socio-Economic Indexes for Areas 2001, catalogue number 2033.655.001

Figure 6 shows the Index of Disadvantage by LGA.

5.1.3 Health status changes

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

- Between 2002 and 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.36
- 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.37

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;
• Significantly higher smoking-related mortality rates than the national average. In 2004-05, Tasmania had one of the highest rates of hospital separations 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. 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 7, preliminary projections show that the number of separations for diabetes will grow by almost 100% in Tasmania by 2021-22.

Figure 7 Projected hospital separations for diabetes, 2004-05 to 2021-22

Table 14 below compares Tasmania’s health risk factors to the rest of Australia. The information should be interpreted with caution, as results are self-reported and are not adjusted for jurisdictional age structures.

Table 14 Health risk factors, Tasmania and Australia, various years

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Indicator</th>
<th>Tasmania</th>
<th>Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaccination</td>
<td>% – Children 12-15 months</td>
<td>94.0</td>
<td>91.2</td>
</tr>
<tr>
<td></td>
<td>% – Children 24-27 months</td>
<td>94.5</td>
<td>92.4</td>
</tr>
<tr>
<td></td>
<td>% – Children 72-75 months</td>
<td>89.3</td>
<td>88.0</td>
</tr>
<tr>
<td>Smoking</td>
<td>% of 18 years + who are current daily/occasional smokers</td>
<td>24.5</td>
<td>23.2</td>
</tr>
<tr>
<td>Nutrition</td>
<td>% of 18 years + eating less than 5 serves vegetables</td>
<td>79.4</td>
<td>85.7</td>
</tr>
<tr>
<td></td>
<td>% of 18 years + eating less than 2 serves fruit</td>
<td>46.3</td>
<td>46</td>
</tr>
<tr>
<td>Alcohol consumption</td>
<td>% of 18 years + at risk of long-term alcohol-related harm</td>
<td>11.4</td>
<td>13.5</td>
</tr>
<tr>
<td>Physical activity</td>
<td>% of 18 years + classified as sedentary</td>
<td>34.1</td>
<td>34.0</td>
</tr>
<tr>
<td>Overweight/Obesity (BMI)</td>
<td>% of 18 years + classified as overweight</td>
<td>31.8</td>
<td>32.7</td>
</tr>
<tr>
<td></td>
<td>% of 18 years + classified as obese</td>
<td>17.1</td>
<td>16.6</td>
</tr>
</tbody>
</table>

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.

39 Hospital ‘separations’ are the total number of patients who were discharged, transferred out or died.
5.2 Hospital use and projected demand

5.2.1 Current use and projected demand for inpatient services

Projected resident demand for acute inpatient services

The Clinical Services Plan notes that the demand for acute inpatient services is projected to increase by 50% between 2004-05 and 2021-22, with higher growth in the public sector, and a significantly higher growth in day only separations. The proportion of separations in the public sector is projected to increase from 65.7% in 2004-05 to 67.7% in 2021-22.

Resident (ie Tasmanian) demand is projected to increase by 39% for beddays between 2004-05 and 2021-22. The proportion of beddays in the public sector is projected to increase from 68.8% in 2004-05 to 70% in 2021-22.

5.2.2 Ambulatory care-sensitive conditions

Ambulatory care-sensitive conditions are:

...certain conditions for which hospitalisation is considered potentially avoidable through preventive care and early disease management, usually delivered in a primary care setting, for example by a general medical practitioner, or at a community health centre. They can be used as an indicator to assess the adequacy, efficiency and quality of primary health care within the broader health system and may assist as a tool to monitor need; as a performance indicator of variations in access to, or the quality of, primary care; or in allocating limited resources among communities.41

A 2007 report (of 2001-02 data) shows Tasmania as having the highest rate of avoidable hospital admission in Australia (with 10.7%, compared to the national average of 8.7%).

Avoidable hospitalisation for diabetes complication rates in Tasmania were the second highest in Australia (1,246.8 per 100,000 population).42

The second-highest rate of avoidable hospitalisations in Tasmania was for Chronic Obstructive Pulmonary disease, with 293.4 per 100,000 population. Angina, congestive heart failure, dehydration and gastroenteritis, dental conditions, convulsions and epilepsy, ear nose and throat infections, and asthma were also significant causes of avoidable hospitalisation.43

It may be argued that this is old data and no longer relevant but the most recent national data (2004-05) shows that, compared to the rest of Australia, Tasmania continues to have the highest hospitalisation for diabetes complications, significantly worse than the national average.44

It is clear that considerable work is required to improve Tasmania’s capacity to deliver care outside the acute hospital system.

5.2.3 Current use and projected demand for outpatient services

This section of the Plan looks at the projected demand for outpatient care, based on an analysis of the three major public hospitals’ outpatient data. This information is included in the Primary Health Services Plan because it is anticipated that outpatient care will increasingly be delivered in settings outside the major public hospitals.

The Clinical Services Plan presents several models of projected outpatient services. The first model is based on demographic change only, and forecasts an overall increase of 9.9% in demand over the next 15 years. The second model is based on population demographics and historical service trends and forecasts an overall increase of 13.7% during that time.

42, 43 Ibid. p 22.
It is noted that the scope of change will depend on a significant range of policy options. While this provides a broad indication of future service demand, the streams of service type are of more assistance in developing future services. While these projections reflect the likely increasing demand on the major acute hospitals for outpatient appointments, some of these functions could be undertaken within local communities, as part of strengthening the post-acute role of the Department’s primary health services.

As noted in Table 15 below, all municipal areas are projected to require an increase in the type of outpatient services delivered by allied health professionals. This data from Acute Health Services aligns with the results of the Primary Health Service Capability Framework, which identified access to allied health as a consistent gap across all Primary Health service sites.45

### Table 15 Projected demand for outpatient services by LGA

<table>
<thead>
<tr>
<th>Place of residence</th>
<th>Allied clinical</th>
<th>Medical</th>
<th>Obstetrics/Gynaecology</th>
<th>Paediatric</th>
<th>Surgical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Break O’Day</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brighton</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burnie</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central Coast</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central Highlands</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Circular Head</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clarence</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Derwent Valley</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Devonport</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dorset</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Flinders Island</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>George Town</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glamorgan Spring Bay</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glenorchy</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hobart</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Huon Valley</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kentish</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>King Island</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Kingborough</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Latrobe</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Launceston</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Meander Valley</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Northern Midlands</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Sorell</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Southern Midlands</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tasman</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Waratah-Wynyard</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Coast</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>West Tamar</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

* Changes in service models in Circular Head and the West Coast have led to an increase in the demand for antenatal and post-natal care.

Source: Hardes data

Further work will be undertaken between the Department’s Community Health and Acute Health Services Groups to develop models of care to meet the projected levels and types of need in this area.

45. A tool for assessing existing capacity (the Service Capability Framework) has been 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.
6. Implications of delivery profile/future service demand

6.1 The importance of Primary Health Services

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

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.

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. The small size of the facilities is a significant adverse factor affecting the cost structure of primary health services in Tasmania.

Without change and refocusing, 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.

6.2 Issues arising from current service delivery profile and expected future demand

The *Primary Health Services Plan Issues Paper* set out to stimulate discussion within the community by outlining the issues arising from the current service delivery profile, and from expected future demand.

6.2.1 Population distribution and service spread

Tasmania has a relatively small and disaggregated population. Figure 8 shows the spread of primary health services by Local Government Areas (LGAs) but does not indicate the small number of people covered by some of these municipal areas.

- There are six LGAs with a population of less than 5,000. These are Flinders Island (897), King Island (1,570), Tasman (2,180), Central Highlands (2,294), Glamorgan Spring Bay (4,296) and the West Coast (4,946).
- There are eight LGAs with a population of more than 5,000 but less than 10,000. These are Southern Midlands (5,736), Kentish (5,784), Break O’Day (6,194), George Town (6,679), Dorset (7,120), Circular Head (8,099), Latrobe (8,769), and the Derwent Valley (9,517).


• There are nine LGAs with a population of more than 10,000 but less than 25,000. These are Sorell (11,454), Northern Midlands (12,167), Waratah-Wynyard (13,318), Brighton (13,819), Huon Valley (14,567), Meander Valley (17,300), Burnie (19,217), Central Coast (20,914), and the West Tamar (21,237).

• There are four LGAs with a population of more than 25,000 but less than 50,000. These are Devonport (25,266), Kingborough (31,530), Glenorchy (44,615) and Hobart (48,794).

• There are only two LGAs with a population of more than 50,000. These are Clarence (50,257) and Launceston (65,021).

The disaggregated and highly rural nature of the Tasmanian population means that there are significant issues in providing viable and sustainable health services across such a large number of small communities. Services are often quite small, with difficulty in achieving a critical mass in clinical volume and in economies of scale. The spread of services is illustrated in Figure 8.

Figure 8 Primary Health Services by LGA
6.2.2 Resource allocation is not well matched to current and future needs

The pattern of funding in any area is based on “history and geography” rather than on a planned distribution of resources either through a population-based funding process or by determining service priorities reflecting the changing needs of the community.

In 2005-06, within the Department’s primary health services, funding allocations to community nursing services made up 27% of the total, while rural hospitals took up 44% of all funds. At the same time, allied health, palliative care and health promotion only accounted for 15%.

It is recognised that existing services are highly valued by the community and that the health professionals who work within them are committed to providing good service within the current service model. However, this investment pattern 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 existing services raises concerns as to their sustainability and effectiveness. This process has identified considerable variation in the costs and patterns of delivery of particular health services. This raises questions about the effectiveness of some health services. While some of the observed variation will be related to the unique characteristics of services and communities, such variation also suggests that more attention to how resources are utilized in providing health care would result in larger health gains for the same level of expenditure.

Rural inpatient facilities

Although there has been a general decline in the three key indicators of rural inpatient activity (separations, length of stay and occupied beddays), the actual expenditure associated with this service has increased by 31% to $38.3 million in the last five years. Figure 9 illustrates these trends by plotting the number of occupied beddays against the cost per occupied bedday.

Figure 9 Activity, cost per occupied bedday, 2000-01 to 2005-06

This reflects changing clinical practice as well as difficulties in maintaining adequate staffing levels. This low patient throughput, coupled with a high turnover of staff in some sites, creates the potential for serious clinical safety issues. Recruitment difficulties in general practice exacerbate these risks.
While costs in rural inpatient facilities 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 10 below.

**Figure 10 Activity, 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 24-hour/7-day-a-week rural inpatient facility)
- low levels of occupancy
- severe staff shortages, resulting in a reliance on high-cost locum staffing.

This means that in some sites, the annual cost of an occupied bed is the same as that of an intensive care bed in a major acute care hospital. This has a significant opportunity cost for the health system as a whole. It would be possible to provide a wide range of community-based services, or a number of additional lower cost beds elsewhere, if these resources were utilised in a different manner.

The patient profile for the rural health facilities shows significant variation across the sites. 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 four days, while another had an average age of 77 and an average length of stay of 19 days. Several of these sites provide non-acute or low-acuity care in a service model that is not reflective of contemporary practice and has little impact on the health outcomes of the Tasmanian population.

Notwithstanding the increased demand for inpatient care across the acute care sector that is likely to arise as a result of the ageing population, this increased demand is not reflected across smaller rural sites due to changes in clinical practice and a reduction in the rural population.
Community health centre services

Although there has been a general decline in the number of occasions of service provided by departmental community nursing, funding for this service has increased by 21% (unadjusted) to $14.7 million over the last five years. Figure 11 illustrates these trends by plotting the number of occasions of service against the cost of each occasion of service during this time.

Figure 11 Activity cost, community nursing occasion of service, 2000-01 to 2005-06

Source: Department of Health and Human Services, 2006.

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. Anecdotal evidence suggests that there is some overlap between departmental community nursing, HACC-funded community nursing and practice nurses operating within general practice surgeries.

The role of community nursing needs to be examined in relation to the future health needs of Tasmanians and a process must be established to determine how to get the best health outcomes from the effective use of this valuable professional resource.

Impacts on future primary health service capacity

By investing in these historical patterns of service delivery, Tasmania is 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, rehabilitation, 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. Service gaps and unmet demand also exist particularly for access in rural communities to allied health professionals and community transport.

6.2.3 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 death and costs approximately 70% of the total health expenditure that can be allocated to disease.

Compared to the rest of Australia, Tasmania has the second-highest death rate for cancers overall, the second-highest death rate for circulatory diseases, the second-highest incidence of respiratory cancers, and the second-highest rates for accidents and intentional self-harm.\(^5^3\)

Tasmania’s age – standardised death rate for diabetes mellitus has more than doubled over the last 10 years. (This is otherwise known as Type 2 diabetes and is strongly related to lifestyle factors such as obesity, poor nutrition and lack of exercise as well as occurring more frequently in the older population.) It is the second-highest of all states and territories. Tasmania also has the highest number of new cases of Type 1 Diabetes (the type of diabetes that is usually present from childhood rather than occurring in older people).

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.\(^5^4\) Tasmania is yet to address this challenge.

It is clear that what is required is a “social view” of health that looks at a person’s activity and lifestyle, to prevent chronic disease before it develops further in the Tasmanian population.

### 6.2.4 Workforce challenges

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.

The 2006 state-wide GP survey confirmed that there is significant workforce pressure on Tasmania’s general practitioners. The older GPs in Tasmania are generally those who are working longer hours. As they retire, they are replaced by younger GPs, many of whom choose to work part-time. To maintain GP workforce capacity, every GP who leaves would have to be replaced with more than one new GP.

With regard to the nursing profession, if the Department’s community and rural nurses retire at the current average age, within ten years a quarter of the current workforce will need to be replaced.

Tasmania is yet to move to utilisation of nurse practitioners despite a long-standing process to establish this workforce. The project is at the stage of establishing this concept in various settings. The nurse practitioner model must move forward in order to gain the benefits of this new model of health service provider.

The workforce issues in Tasmania, especially in the disaggregated rural health sector, limit the opportunity to attract health professional students or to trial new types of professionals due to limited supervision opportunities and a scarcity of clinical placements.

While therapy assistants, direct care workers and other health services providers have limitations to their scope of practice, if adequately trained, supervised and resourced they could provide much more assistance than is currently the case. This approach may provide opportunities for increased local employment.

Health workforce education is key to the development of these new models.

---


6.2.5 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 the transfer of diagnostic information between service providers. Video conferencing can reduce the professional isolation of individual staff and small teams in rural areas.

Overcoming established ways of practising by health care providers may require education and incentives in order to gain the full benefit of Telehealth and the like. One current difficulty in this process is that the Australian Government Medical Benefits Schedule does not make payments to clinicians for most Telehealth consultations.

6.2.6 New ways of delivering services mean more out-of-hospital activity

The Clinical Services Plan notes that many new approaches to care have been implemented in different health care systems, for example:

• “Hospital in the Home” and “Hospital in the Nursing Home” where people who otherwise would require hospital care receive treatment in their homes;
• Post-Acute Care, where people who are discharged from hospital but require ongoing short term care receive that care in their homes;
• out-of-hospital preparation for surgery, so that patients can be admitted safely to hospital on the day of surgery rather than in advance;
• day-only surgery centres, where patients who do not require overnight admission can have their surgery performed safely and efficiently and where patients do not have to endure cancellations of surgery because of unexpected emergency cases; and
• chronic disease management, where patients are 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.

These are all methods of service delivery that could be delivered in people’s home and their communities. This will increase the level of accessibility of these services for clients but will increase the pressure on primary health services.

6.2.7 Safety and quality are important concerns

The safety and quality of health care is of concern to communities around the world. The Department’s Primary Health Service applies continuous quality improvement practices and principles to ensure the safety and satisfaction of consumers and increase the knowledge, skills and accountability of all staff with regard to the standards of their work and that of the service generally. Administrative systems that are either in place or being developed to support staff with this aim include pro-active risk management processes such as:

• agency and service-specific policy and procedures;
• employment of external review organisations;
• collection, analysis and strategic use of key performance and clinical data;
• credentialling and defining the scope of clinical practice for clinicians (includes conviction checks and routine review every five years); and
• incident and complaint management (which includes in-depth review of the serious incidents with resultant system change).

Factors which contribute to clinical risk have been identified and as a result systems have been improved to provide safer, high-quality care. Further work needs to be done on complaint management and with accreditation of services, including those with subacute beds, as this external, objective review process ensures maintenance of service standards.

Current workforce and resourcing challenges increase the difficulty of the task and the need to be vigilant in this area. The recent Service Capability Framework self-assessment undertaken by rural inpatient facilities indicated that, in some areas, there are significant gaps in the available clinical support required to enable these services to be delivered safely and effectively. Access to allied health professionals (in most sites) and access to the nursing and GP workforce (in some sites) were raised as significant concerns. This raises questions about the safety and sustainability of the current model of inpatient services in rural Tasmania.

6.2.8 The need to integrate and coordinate primary health services

Because there are a number of service providers and different funding programs, the primary health care system can be difficult to navigate for a person in the community requiring care. The primary health care system would be strengthened by changes that bring with them an improved integration of services.

This would also work to contain unnecessary duplication, often caused by inadequate communication or transfer of clinical information between service providers. Assessment processes, for example, can still be performed multiple times by different service providers or professionals, leading to waste of resources and difficulties for the client. The primary health care system would be improved by greater coordination between these health professionals.

6.2.9 Coordination with acute health services

Moving between primary and acute health services can also present difficulties for health consumers. Patients are not easily transferred between rural inpatient sites and major acute hospitals – they may be referred to inpatient care by their GP, then admitted to the rural inpatient site, discharged, and re-admitted at another site. This involves multiple assessments, leading to frustration on the part of patients and health providers. On the other hand, acute hospitals also report difficulties due to inadequate information exchange at the time of admission.

GPs are not the only “gatekeepers” to the acute sector, as patients can self-admit to hospital Departments of Emergency Medicine. Sometimes the patient would be more appropriately treated by their GP or other primary health service providers but the funding conditions associated with the Australian Health Care Agreement (between Tasmania and the Australian Government) mean that they cannot be referred back to the primary health service system.

In the case of emergency retrievals – where patients need ambulance transport to a major hospital – GPs, rural inpatient sites, ambulance services and major hospitals need to be clear about the protocols for working together, in order to provide an efficient service.

The discharge process, from acute care to primary health services, is also varied. The primary health service system can be very confusing to staff within acute hospitals and information about where to transfer their patient may be lacking. Appropriate technology, protocols and an established cooperative relationship are required if the transfer from an episode of acute care to the ongoing care of the patients in a community setting is to proceed smoothly.
7. Directions and actions

7.1 The primary health approach

Primary health care means essential health care based on practical, scientifically sound, culturally appropriate and socially acceptable methods. It is universally accessible to people in their communities, involves community participation, is integral to, and a central function of, the country’s health system, and is the first level of contact with the health system.\(^{55}\)

It should be provided by a suitably trained workforce supported by integrated referral systems and in a way that gives priority to those in most need. It endeavours to maximise community and individual self-reliance and participation and involves collaboration with other sectors. It includes health promotion, illness prevention and early intervention, as well as advocacy and community development.\(^{56}\)

Primary Health Services in Tasmania combine a population-based approach based on the social model of health with clinical care aimed at providing the best outcomes for individuals and communities. This approach encourages community capacity building in order to promote health and wellbeing of the communities.

7.2 Health planning principles

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 health service system will work with other health and human services to support the health and wellbeing of the Tasmanian community.

---


2. Health planning 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. Tasmania’s primary health services should be:
   • accessible as close as possible to where people live as long as they can be provided safely, effectively and at an acceptable cost;
   • appropriate to the community’s needs;
   • client and family-focused;
   • designed for sustainability;
   • integrated with the other elements of the health service system;
   • focused on health promotion, illness prevention and early intervention; and
   • delivered in a culturally appropriate manner.

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.

Accessibility

Many primary health services can be provided from within local communities (ie 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; and
• it is an effective use of resources given consideration of the health needs of the community.

Acceptable cost

The question of “what is acceptable cost?” came up in both the written submissions to the Issues Paper and in the consultation meetings held around the state. This concept is based on the understanding that public resources for health services will never be unlimited and that responsible budgetary management requires Government to make transparent and evidence-based decisions on priorities. Both Government and the community aim to achieve the best possible value for public expenditure, so that the greatest community benefit can be achieved and some services, because of their remoteness or special local factors, inevitably will cost more than equivalent services delivered in other locations.

Responsible planning, however, requires that an assessment is made of whether significant additional costs incurred to provide services in particular settings are justified by a corresponding health benefit. A decision about whether a service cost is acceptable, therefore, involves an assessment of the financial cost of providing the service, the benefit individuals and the community derive from the service, whether alternative services are available and the cost to individuals and the community of accessing those alternative services.

Sustainable services

Designing services for sustainability is a central concept in this Plan. Services designed for sustainability:

• have sufficient patient volume to support and maintain the competence of health care professionals;
• support a staffing infrastructure that can withstand temporary shortages without excessive cost or operational burden;
• have quality equipment and facilities;
• have appropriate access to necessary clinical and non-clinical support services;
• have costs that are reasonable and manageable over time, in the context of competing demands for limited resources; and
• have transparent and predictable funding allocations.

If services are not designed for sustainability, there may be:

• safety and quality consequences, because providers have to modify other services at short notice and without adequate planning to cover service gaps; or there are delays in accessing equivalent services; or recruitment and/or training compromises are made in an effort to address workforce shortages;
• cost consequences, because short-term solutions to support unsustainable services almost invariably generate excessive costs;
• poor continuity and integration of care; and
• reduced community confidence in the health care system.

Very high costs, together with safety and quality concerns, often are indicators that services are unsustainable.

7.3 Service delivery model

A state-wide service model will be applied to set clear directions about what services will be available where, to improve the match between service distribution and population need, to provide the minimum requirements for a safe and effective service and provide 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.

Implementation of this model will see the development of an integrated network of primary health services across Tasmania enabling larger centres to support smaller communities in the provision of sustainable services that are safe and reliable.

There will be increasing collaboration between primary and acute health services through the development of new facilities and models of care that enable the delivery of quality care in ambulatory and short-stay settings.

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, other primary health providers, hospitals, aged care facilities, non-government organisations, 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 direction 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.

Within this framework, the proposed service model uses a three-tiered framework for services.

Following feedback from stakeholders after the distribution of the Primary Health Services Plan
Issues Paper; the tiers have been simplified to better reflect the service network and to provide an appropriate emphasis on core primary health activities.

In order to meet the challenges facing the health system there is an urgent requirement to expand the role for community health centres beyond a one-stop shop for department and non-government health and community services.

Under the Primary Health Services Plan, Community Health Centres will become the focal point of Primary Health Networks, that will actively engage individuals, communities, service providers and key stakeholders in addressing the problems of the increase in chronic disease and Tasmania’s relatively poor health status.

Key components of the plan to expand the role of community health centres include:

• Development of a Community Health Centre Framework for all ‘Tier 1’ centres;
• Improved governance and management arrangements for community health centres;
• Development of a common and consistent approach to service planning and community engagement for community health centres;
• The implementation of a state-wide Primary Health Care training package for new ‘Tier 1’ rural health centres (to be conducted by health promotion coordinators); and
• Memorandum of Understanding with the Acute Health Services, Human Services and Community Health Services Groups in relation to the delivery of integrated services within community health centres.

This model articulates with and is the foundation for the tiered model of integrated care centres that will be central to the ongoing collaboration between the primary and acute care sectors.

Integrated care centres: Traditionally, settings for the delivery of health care have been determined largely by their sources of funding. State-funded health services have been provided mainly through State-owned facilities which often have been established in relative isolation from Commonwealth- or privately-funded health care providers such as GPs, private hospitals, private community nursing services and private allied health services.

There has been increasing recognition of the urgent need to integrate services to reduce gaps and duplication and ensure client access is unimpeded by funding or organisational boundaries.

Integrated care centres are facilities which:

• accommodate a range of health services that provide efficient, integrated care regardless of who funds, owns or provides each element of the services;
• operate under a philosophy which is less interventional and oriented towards care in the community rather than institutional care; and
• provide greater certainty of access for clients because they focus on non-emergency services including a broad range of non-admitted primary, secondary and tertiary services, short-stay elective services and specialised subacute services.

Integrated care centres may be stand-alone facilities; collocated with acute hospitals; or incorporated within acute hospitals.

Tier 1 sites provide core primary health and community care services within a local community. They reflect the increasing emphasis on community-based and home-based care and the provision of these services through an integrated team approach. These services may include some smaller single-practitioner service sites but it is expected that over time these will be incorporated into larger, more sustainable service teams. Services may be provided by the Department or in partnership with others, especially general practice or non-government organisations. Some of these services will be available locally and others provided through visiting services or other outreach mechanisms. Underpinning the activities provided from Tier 1 facilities will be a commitment to the broad primary health approach
which integrates effective treatment to the individual with wellness promoting activities at a population and individual level.

**Tier 1** sites will provide a range of the following services dependent on local community need and priorities. Each site may not provide all of these services from within their local resources; some may be provided as visiting services from elsewhere. However they represent a core set of services that we seek to make available in some form to every community:

- primary prevention and community development;
- private general practice, either located within the facility or available to the local community from a separate location;
- in-home and centre-based community care;
- clinic-based community nursing and domiciliary nursing services;
- specialist community nursing eg cancer nurses;
- chronic disease management such as general diabetes education;
- health coaching and advice concerning healthy lifestyle;
- allied health services;
- other services such as primary mental health or alcohol and drug services;
- youth health services; women's health; post-natal care and antenatal services provided by midwives and GPs;
- centre-based respite;
- child and family health services;
- capacity to treat minor injury; referral;
- primary palliative care;
- palliative care in the home; and
- referral to other more specialised service.

**Tier 2** sites operate rural inpatient services (subacute beds) in addition to their primary health and community care services. Services are located across Tasmania according to community need and service sustainability and many will be responsible for inpatient service provision across more than one local neighbourhood.

There will be an ongoing necessity to monitor the sustainability and role of these sites, especially in light of the development of alternative models of care in the community, workforce pressures, safety and quality issues, the development of other step-down, rehabilitation and aged care inpatient services and the establishment of integrated care centres.

While this tier also includes facilities that offer residential aged care, this is not a mandatory requirement of the tier and over time it is expected that the increasing development of the residential and community aged care industry will reduce the need for State Government involvement in the provision of aged care, except in small and isolated communities where such services would otherwise not be sustainable.

**Tier 2** sites may include:

- subacute inpatient services in a rural setting, eg step down from acute health services;
- rural midwife and GP obstetrics for low-risk patients in accordance with established departmental guidelines;
- low- and high-care residential care;
- inpatient palliative care;
- overnight respite and care waiting placement for older persons;
• minor surgical procedures under local anaesthetic in a procedures room; and
• slow stream rehabilitation.

Tier 1 services are also provided at all Tier 2 sites.

Tier 3 sites provide extended primary health services with significant outreach across the network and a stronger representation of acute services. Tier 3 services include 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 will be a greater focus on chronic disease. These 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.

Tier 3 sites may include integrated services operating across the acute hospital and community care interface. In the context of the urban-based integrated care centres they may include inpatient aged care and rehabilitation services.

In Tier 3 sites, in addition to Tier 1 services, the following could be provided according to need:
• specialised palliative care;
• hospital in the home (contracted with acute hospitals);
• inpatient and outpatient rehabilitation;
• aged care assessment;
• alcohol and drug services;
• oral health services;
• specialist mental health care;
• dietetics;
• specialist diabetes education;
• continence service;
• medical oncology;
• satellite renal dialysis services;
• same-day surgery; and
• more extensive health promotion and prevention programs.

Tier 4 services are not normally provided under the primary health services model, but are part of the acute care services model. Tier 4 is health care provided on a same-day basis that must be delivered in a hospital setting, requiring inpatient back-up in order to be safely and effectively delivered. Sites delivering Tier 4 care would generally be planned in metropolitan or large regional areas. Services at this tier include radiotherapy and day surgery or procedures involving a high degree of clinical risk (eg stents, angiograms or some laparoscopic surgical procedures). Most outpatient services that are required immediately pre- and post-admission would also be provided at Tier 4. Primary health services will also be provided within Tier 4 integrated care centres in a hospital setting and would be of a more complex nature.

There are further tiers that are related to acute health services and outlined in the Clinical Services Plan. The state-wide service model has been applied to all Departmental primary health and acute services, through a careful process of assessment of existing capacity and planning for the future.

Applying the model
The tiered service delivery model has been applied to all services delivered by the Department of Health and Human Services. Tiers 1-3 represent primary health service sites and have been developed considering current and future needs, specifically:
• population trends and levels of community need;
• distance from other services; and
• sustainability considerations such as cost and workforce availability.

In any of the Primary Health regional areas there will be one or more Tier 3 facilities providing more specialised services to the broader community and support and services across the network of community health centres. There would also be a number of Tier 2 facilities, representing rural inpatient services. All service centres will perform a Tier 1 role, undertaking the core primary health services of community-based care and promotion of wellness within their local communities. Clients can access services across all tiers although some may not be available in their local community. Some may require referral to a larger centre and may need to travel in order to gain access.

3. Service delivery model

A tiered service delivery model establishing an integrated network of primary health services across Tasmania will be applied to all services delivered by the Department of Health and Human Services. Tiers 1-3 represent primary health service sites and have been developed considering current and future needs, specifically:

• population trends and levels of community need;
• distance from other services; and
• sustainability considerations such as cost and workforce availability.

Tier One sites provide core primary health and community care services within a local community. They reflect the increasing emphasis on community-based and home-based care and the provision of these services through an integrated team approach.

Tier Two sites operate rural inpatient services (subacute beds) in addition to their primary health and community care services.

Tier Three sites provide extended primary health services with significant outreach across the network and incorporating over time a stronger representation of acute services including Integrated Care Centres developed in association with the Acute Health Services.

Primary health services will also be provided within Tier Four Integrated Care Centres in a hospital setting and would be of a more complex nature.

The state-wide model set out in this Plan will be applied to existing service sites:

**Tier One – Sites that provide core primary health services:** Bridgewater; Bruny Is, Burnie (Jones St), Cape Barren Island, Cygnet, Huonville, Kings Meadows, Ouse, Ravenswood, Risdon Vale, Rokeby, Rosebery, Sorell, Strahan, Swansea, Spring Bay (Triabunna), Ulverstone, Westbury, Wynyard and Zeehan.

**Tier Two – Rural sites that provide both Tier one level services and inpatient services:** Beaconsfield, Campbell Town, Deloraine, Dover (Esperance MPC), Flinders Island, Franklin (Eldercare), George Town, King Island, New Norfolk, Nubeena (Tasman MPS), Oatlands, Queenstown, Scottsdale, Smithton, St Helens, and Swansea (May Shaw Nursing Centre).

**Tier Three – Sites that provide extended primary health services with significant outreach across the network and incorporating over time a stronger representation of acute services:** Burnie (Parkside); Devonport; Launceston (developing into a Tier Four site Integrated Care Centre over time), Glenorchy, Kingston (upgraded over time from its current Tier 1 status), Clarence and Hobart (Repatriation Centre).

58 For comment on St Marys and Longford, see Rural Health Centres, 7.6.
7.4 The prevention and management of chronic conditions

In order to address the burgeoning chronic disease epidemic, the health system needs to enhance and expand its efforts in health promotion and illness and injury prevention. Health promotion is the process of enabling people to increase control over, and to improve, their health and wellbeing. It refocuses the emphasis from illness prevention and treatment to health as a positive concept that emphasises social and personal resources, as well as physical capacities. The overarching aim of health promotion is to improve overall health and wellbeing and reduce health inequalities across the population.

Early intervention aims to reduce progression of a disease or chronic condition through early detection, usually by screening, and by then providing early treatment.

Disease management seeks to improve function and includes minimisation of the impact of established disease, and prevention or delay of complications and through effective management and rehabilitation.

Self management is an approach that puts the person at the centre of their own health care. It involves the development or reinforcement of the skills and resources that a person needs to maximise their quality of life across the continuum of prevention and care. It empowers the individual to undertake risk reduction, informed decision making, care planning, medication management and working with health care providers to attain the best possible care, and to effectively negotiate the often complex health system. It requires a partnership between health workers and the person with the chronic condition, and is part of an integrated health care system. It is recognised that for some people self management is not possible, or is not a choice they wish to make. Below is a model of the continuum of prevention and management of chronic conditions that outlines the levels of prevention.

Adapted from National Public Health Partnership 2001 Background Paper: Preventing Chronic Disease: A Strategic Framework, Australian Government, Canberra.
Opportunities for expansion of this approach

There are opportunities for enhancing health promotion effort at the local level, by focusing on improving collaboration and integration across local government, private practitioners and non-government/community organisations within clearly defined geographical boundaries.

This could be facilitated through developing programs in local areas, using a “menu” of evidence-based strategies and with a greater emphasis on evaluating program outcomes. These will recognise that there are different levels of need, and different capacity to develop and implement programs across communities.

The Australian Better Health Initiative is a joint Australian, State and Territory Governments initiative providing both State and Commonwealth funding for new programs in health promotion and care integration. New programs include a national social marketing campaign focusing initially on physical activity and nutrition; a new Population Health Planning and Evaluation position to build capacity in health promotion program evaluation; new Community Nutrition positions across the State to work with a range of service providers and community groups and build nutrition skills across the workforce; and four new positions in Chronic Disease Prevention and Management.

Strong support exists from clinicians for increasing the focus on health promotion and illness and injury prevention. This recognises that we need to take measures to stem the increasing demand, and that people need skills and environments that support healthy choices.

There is capacity in some areas of the workforce, such as dental therapy, community nursing, and practice nursing, to reorient their roles to encompass health promotion/self-management approaches, and training and support will be provided to ensure this occurs.

There are opportunities to integrate learnings from the national and international research and practice to build the evidence base for health promotion and self-management.

Support for sustainable health promoting, injury and illness-preventing programs will be an essential component of primary health care. The Department’s Population Health unit will advise on evidence-based processes and program options to ensure effective programs.

The following actions will be taken to increase prevention, early intervention and self-management activities throughout Tasmania:

- each health centre to 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;
- an expansion of the range of approaches to chronic disease that are currently used including group work programs (eg Stanford Chronic Disease Management Programs) and individual approaches (eg health coaching), supported by systems, infrastructure and training;
- an expansion of the number of Health Promotion Coordinators throughout the state, and integration of health promotion approaches across the primary health workforce;
- the improvement of e-health infrastructure and support to complement services such as assessment and health coaching for a range of chronic conditions;
- increasing effort in cessation of tobacco smoking specifically targeting those most at risk, such as young women, Aboriginal people or those with mental illness;
- identifying population groups most at risk of chronic disease, with an initial focus on diabetes, and providing appropriate risk modification and early intervention support programs;
- increasing effort in mental health promotion, including suicide prevention programs;
• helping build the skills and capacity of the health workforce in health promotion, illness prevention and self-management through the expansion and evaluation of training programs for different work groups and working with the University of Tasmania, other education providers and Departmental Population Health; and

• dissemination of nutrition resources for practitioners and development and distribution of improved self-help tools for people at risk or with chronic conditions.

In addition, service and workforce re-orientation will bring added services into the primary health sector; focused mainly on the needs of the older population and those with chronic disease.

4. The prevention and management of chronic conditions
Community-based health services will be changed and expanded over time to better respond to the changing needs of the Tasmanian population. Service change will be implemented to enable:
• greater capacity to treat diabetes and other chronic diseases at the primary health level;
• greater access to home-based services such as post-acute care and specialised community nursing;
• more emphasis on health promotion;
• working with young people, through collaborative partnerships, to adopt healthy lifestyles;
• development of new models to expand rehabilitation services in the community;
• increased access to mental health and alcohol and drug programs in rural areas; and
• an expansion of the approaches to chronic disease self-management.

Each health centre to 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.

7.5 General practice
General practice plays a significant role in providing services, information and referral to people who need primary health services, 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 will produce many benefits for consumers, GPs, and other primary health care providers.

In some settings, general practice will be funded by the Department to deliver allocated 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. General practice would be accountable to the Department for equitable use of these resources according to the intended purposes. These arrangements will operate within clearly defined service areas and target population groups and will be used as a mechanism to improve the availability of, or access to, primary health care resources. Recent evidence in Australia indicates that these arrangements improve patient wellbeing and lead to significant changes in service mix, which may in turn produce longer-term health gains.
5. **General practice**

A new relationship between general practice and the Department of Health and Human Services will be established that better supports the sustainability of the sector and provides additional capacity to respond to the challenges of chronic disease:

- the Department will work with general practice representatives to progress general practice provision of state-funded community health services;
- a demonstration site in Launceston will be developed and operational within one year;
- a consistent Departmental policy concerning the availability of support arrangements for general practice will be developed in collaboration with general practice organisations;
- closer links between rural General Practitioners and acute hospitals, especially for training and support;
- co-location of general practice and state health services where this is possible and would benefit service arrangements;
- funding demonstration sites, in both urban and rural communities, of new chronic disease/community and population health initiatives using a team approach incorporating community health and general practice; and
- following the evaluation of demonstration sites, as benefits are proven and resources become available, it is envisioned that these initiatives will become established elements of Tasmania’s primary health service system.

7.6 **Rural health centres**

All rural health centres will be maintained. There will be an increased focus on the prevention and management of chronic disease, on services aimed at maintaining people in their own homes, on 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 will be some changes in bed usage where safety and sustainability cannot be assured.

In applying the health planning principles to rural health sites within Tasmania, it is clear that some are not meeting the criteria established to demonstrate sustainability. It is not possible for them to deliver the current service to their community in a way that is safe, effective and at an acceptable cost. Nor will it be possible to continue to provide these services in the future when workforce issues worsen. Consultation has occurred with the communities of St Marys, Ouse and Rosebery in relation to this issue. Work is now occurring to develop models of service that will better meet their needs on a more sustainable basis. Ouse and Rosebery will be developed as Tier 1 sites in the short term (refer to Primary Health Services: Community Profiles, page 73).

The recruitment of a General Practitioner remains very difficult within the current service model at the St Marys Community Health Centre and maintaining it at a Tier 2 level is not sustainable in the long term. The Department has recently received a submission which raises the potential for a new approach to the delivery of services in the Break O’Day municipality. This requires further investigation and extensive consultation with the communities of St Marys and St Helens before a firm direction can be established. This proposal may provide significant improvement in health services for the whole municipality and deserves further consideration.

The two beds at Longford are exclusively utilised for aged care and discussions will occur with the management of the nursing home as to their appropriate future use.
6. Rural health centres

A changed and expanded role for rural health centres will be implemented to ensure these services better meet the needs of the Tasmanian population and their local communities. This will include:

- greater access to home-based services such as post-acute care;
- increased day respite services;
- more health promotion and management of chronic disease;
- increased access to community nursing; and
- increased access to visiting services, such as allied health or mental health services.

Monitoring services against standards of quality, safety and sustainability is an ongoing process and, as the needs of the community change, and as health workforce issues arise, the roles of rural health centres may need to change. Changes in inpatient services will include:

- planned overnight non-medical respite as required in two sites (Rosebery, Ouse); and
- increase in inpatient beds in two sites (New Norfolk, and over time in Swansea).

All rural health centres which require 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.

7.6.1 Emergency response in rural areas

Medical emergencies need to be responded to in all rural settings, and Rural Health Centres will continue to participate with a coordinated response with ambulance and other parts of acute health services. It is proposed to strengthen their capacity to work within a state-wide emergency medical 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 implementation of this planning process. This will include a range of initiatives to improve service coordination and support from major hospitals in managing emergencies.

All rural health centres which require 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 following actions will be taken to support emergency capability/response in rural areas:

- developing 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.
- developing a process for joint clinical review across Acute Health and Primary Health to review shared cases.
- enhancing the State-wide Medical Advice, Referral and Transfer Network which will support state-wide rural and remote medical emergencies and assist with the coordination of pandemic responses.

7.7 Communication and collaboration between service providers

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

7.7.1 Clinical networks

Clinical networks operate formally in many states and territories in Australia. Examples of clinical networks, and the role they fulfil, are provided below:
• **NSW Health.** The Greater Metropolitan Clinical Taskforce has developed approximately 24 specialty services networks. The networks gather information, develop consensus documents to standardise and guide clinical practice – referral protocols, clinical practice guidelines, resources for patients, educational resources for staff – undertake research, coordinate clinical services and provide advice to NSW Health.

• **WA Health.** WA has established clinical networks to improve the integration and coordination of clinical services through interaction between service providers and other enabling stakeholders by collaborating across facility boundaries. Each clinical network has six major functions including the planning of services based upon the needs of the population and changes in the health system (ie changing demographics and technology); developing policy that supports the changing needs of the population and fosters innovation in the system; defining meaningful performance measures, setting targets and monitoring outcomes for patients and services; developing protocols to ensure efficiency, effectiveness and safety in service delivery; investing in people, providing opportunities to develop skills and knowledge; fostering leadership and advising on future workforce planning which will influence the priorities on how resources are allocated across the system.

Clinical networks will be developed in association with Acute Health Services. 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 allow 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. Areas of consideration for further work will include cancer, diabetes, mental health, frail aged and disability services and emergency response.

In the Tasmanian context, clinical networks will have seven major operating goals:

- quality improvement ie credentialling, monitoring and evaluation;
- planning and policy advisory role;
- knowledge network and support;
- peer review;
- clinical protocols and referral pathways;
- clinical governance; and
- management of training programs.

Clinical networks should be established to:

- enable integration across the acute sector, including integration across public acute facilities and between the public and private sector;
- enable integration across the acute and primary care setting, including integration with rural hospitals, general practitioners and other primary care providers; and
- enable integration across levels of government, different government portfolios, and other service areas, such as residential aged care and disability support services.

Each clinical network would be underpinned by the following governance structure:

- equitable regional representation;
- operating under a framework set out by the Department.
State-wide clinical networks will be developed, with the goal of strengthening the links between local service delivery and the secondary and acute sectors. Priority areas will include emergency medicine, aged care, rehabilitation, and obstetrics.

A new multi-disciplinary Clinical Advisory Council will be convened, comprising clinicians from the primary and acute service systems. The Clinical Advisory Council will lead and coordinate the clinical networks and will be the principal vehicle for clinical advice to the Department about the structure and performance of the service system as a whole.

7.7.2  Integrating primary and acute care

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 health 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.

The following actions will be taken to strengthen the linkages between hospitals and the community:

• through the development of cross program integrated care centres to extend dialysis and chemotherapy services to some community-based sites, facilitate the introduction of more after hours GP clinics and work together to develop processes to deliver more specialised care in the community;

• the role of Community Nursing will be redefined in order to provide more acute level care in the community, for example, cancer nurses, Hospital in the Home arrangements;

• 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, as practical application of the clinical networks concept;

• the concept of Community Health services having an “in-reach” role into the major hospitals has already been established within Palliative Care and will act as a model for the further development of this concept in other areas, eg alcohol and drug services;

• admission and discharge processes will be reviewed jointly by Community Health Services and Acute Health Services;

• arrangements for continuing professional development for staff providing rural inpatient services will be formalised; and

• the major acute hospitals will establish a specifically designated staff member to act as rural liaison officer within each hospital to ensure how best care can be provided for those who need to travel to access it.

7.7.3 Primary Health – Interface with other community health services

Most people who access other community health services, such as Mental Health, Oral Health and Alcohol and Drug 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.

Cooperation between Primary Health and other Community Health services will be strengthened.
Alcohol and Drug Services
Currently a review into Alcohol, Tobacco and other Drug Services is being undertaken in Tasmania. Preliminary advice is that the Review has recognised the need for closer liaison and support from specialist services to the primary care sector, especially in rural areas. In recognition of this, Alcohol and Drug Services will implement the following strategies:

- development of consultation, liaison and outreach services from Alcohol and Drug Services to primary health centres.
- additional resources will be invested in education and support to primary health workers and non-government organisations in relation to alcohol and drug clinical practice.
- improved support and backup to general practice in relation to alcohol and drug issues from additional Alcohol and Drug specialist resources.
- development of the public pharmacotherapy program to better support shared care with general practice.

Mental Health Services
Mental Health Services recognises the prevalence of disease burden, associated disability and the need to progress strong partnerships and encourage active participation to implement primary mental health services across government, community, private health and welfare sectors. Mental Health Services has established a Collaborative Forum as a way of strengthening partnerships and participation with stakeholders to improve the delivery of integrated service in the community. They will develop strategies for consultation with relevant stakeholder groups in order to implement the range of primary mental health initiatives.

- Mental Health Services will continue to fund a GP Liaison Officer to progress partnership initiatives between Mental Health Service and General Practitioners.
- Mental Health Services will develop, in partnership with the non-Government sector, an early intervention and mental health promotion education toolkit for use in secondary and tertiary educational institutions that will provide key linkages with Mental Health Services and primary service providers.
- Mental Health Services will develop innovative recovery group programs in partnership with GPs, psychologists and other health professionals with reference to opportunities presented under the new National Action Plan for Mental Health.
- Mental Health Services will continue to implement the Mental Health Services Helpline on a state-wide basis.
- The Kids in Mind Tasmania initiative will be extended over a 5-year period to build upon and expand focus on the needs of, and support for, children and young people in families where a parent has a mental illness.
- Mental Health Services will, in partnership, develop an education resource by way of a Mental Health Services Education Framework that builds upon and expands existing programs and initiatives to improve the delivery of educational services to young people aged 16-25.

7.7.4 Primary Health partnerships: working with general practice and the community care 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.

In the planning of such partnerships the Department will undertake a comprehensive assessment of the experience of other States including canvassing the views of government departments, interstate Divisions of General Practice and other stakeholders that have already gone down this path to capitalise on their experience and the lessons learned. Representatives from other stakeholder groups that are envisaged to be involved in the partnerships will also be given the opportunity to participate in such an assessment.

The newly appointed Primary Health Coordinators within the Department will be a key resource in the development of local Primary Health Partnerships. They will:

- Lead the development of coordinated and integrated primary health services within the designated municipal areas.
- Work with local councils and other key stakeholders to develop a planned and coordinated approach to providing primary health services.

Primary Health Partnerships will be developed, with the goal of strengthening the links between primary health, community health services and the local community.

### 7.7.5 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). This national work will provide guidance on how to improve collaboration between service providers and integration of services across the sector.

The following actions will be taken to support the community care sector:

- A project to demonstrate models and mechanisms for simpler access to community care services and consistent assessment approaches for individuals seeking access to community care.
- Clarification of the relative roles of the State and the non-government sector in the provision of Home and Community Care services.
- The HACC Program will actively develop/implement services which prevent or delay decline and promote client independence. A percentage of the funding allocation will be attributed specifically to rural and remote areas.
- Inclusion of the non-government sector in Primary Health Partnerships.

### 7.7.6 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. It is essential that these activities continue. 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.

The following actions will be taken to strengthen the links with local government:

- strengthening the primary health aspects of the Tasmanian Local Government Partnership arrangements;
- expansion of local government partnerships in health promotion;
- working with local communities to establish health service priorities and to build awareness and ownership of any new directions in health service provision; and
- inclusion of local government in Primary Health Partnerships.

### 7. Communication and collaboration between service providers

Improved communication and collaboration between service providers will be a priority:

- through the establishment of Clinical Networks across the acute, primary and other services, especially in relation to emergency medicine, aged care, rehabilitation and obstetrics;
- through the development of cross-program integrated care centres, to extend dialysis and chemotherapy services to some community-based sites, facilitate the introduction of more after-hours general practice clinics and work together to develop processes to deliver more specialised care in the community;
- through enhancing the role of Community Nursing in relation to the development of specialist nurses able to provide higher level care in the community eg cancer nurses, Hospital in the Home arrangements;
- through the development of Community Health “in-reach” services into the major hospitals;
- through the development of consultation, liaison and outreach services from Alcohol and Drug Services and Mental Health Services to primary health centres;
- through the development of Home and Community Care services which prevent or delay decline and promote client independence (with a percentage of the funding allocation attributed specifically to rural and remote areas); and
- through the development of Primary Health Partnerships at the local level incorporating local service providers from general practice, non-government organisations and State and Local Government as well as community representation.

### 7.7.7 Strengthening community participation in Primary Health

Community and consumer participation both enhances quality and safety, and improves local planning, through supporting accountability, stimulating review and improvement, and providing a means of integrating community priorities into policy and practice.

At an individual level, consumer participation in making decisions about his/her own health plays a key role in improving individual health outcomes.

The Departmental Primary Health unit will continue to receive feedback from consumers either through client satisfaction surveys or through complaints procedures and will continue to use this information to increase service responsiveness, and to establish priorities for future directions.
8. Strengthening community participation in Primary Health

In addition to existing processes, the following priority actions will be taken to strengthen community participation in primary health:

- the development of departmental community and consumer engagement policies and processes;
- strengthening community and consumer engagement through engagement with community representatives, local government and community organisations in local Primary Health Partnerships; and
- the development of regional consumer engagement processes involving primary health and acute health services that will provide an opportunity for community representatives to be involved in the implementation of the Tasmanian Health Plan, along with service providers, local government and other stakeholders.

7.8 Other factors influencing service system sustainability

7.8.1 The health workforce

For a sustainable health system that provides reliable access to high-quality and safe care Tasmania needs a workforce that is available, appropriately skilled and supported.

The new health service models arising from the Plans generate a specific set of health workforce issues that require an overarching health workforce plan. This will include a long-term strategy to link Tasmania’s workforce needs to health care education and training and research.

Workforce development is integral to the major changes facing primary health care services, and ongoing workforce sustainability. A more flexible approach to vocational, undergraduate and postgraduate training, new job structures and ongoing commitment to training and skill enhancement by both the Department and providers, are key elements for a sustainable future workforce.

The following actions will be taken to address workforce challenges:

- increased support, through General Practice Workforce Tasmania, 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 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 the 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.
- implementing Nurse Practitioners working in rural health teams in 2008.
- consideration of new workforce models to meet the new service requirements eg generic health degrees that will equip health providers to undertake lifestyle counselling and support in relation to chronic disease, increased utilisation of therapy assistants, direct care providers and expanded scope of practice for rural paramedics.
- workforce development – additional training in chronic disease, especially diabetes. Nurses and health professionals working in primary health services will be able to access diabetes training through accredited training programs.
9. The health workforce

The new health service models arising from the planning process generate a specific set of health workforce issues that require an overarching health workforce plan. This will include a long-term strategy to link Tasmania’s workforce needs to health care education and training and research. Priority actions include:

- increased support, through General Practice Workforce Tasmania, to aid in the recruitment of general practitioners to Tasmania;
- implementing Nurse Practitioners working in rural health teams in 2008;
- consideration of new workforce models to meet the new service requirements eg generic health degrees that will equip health providers to undertake lifestyle counselling and support in relation to chronic disease, increased utilisation of therapy assistants and direct care providers; expanded scope of practice for rural paramedics; and
- consideration of retention strategies that can assist existing health professionals to stay in the workforce.

7.8.2 Quality and safety initiatives

Primary health care services must meet appropriate standards of quality and safety. The Departmental Primary Health unit will continue to place a high priority on quality and safety through the development and maintenance of its clinical governance framework. Credentialling of primary health care service providers will also continue, ensuring qualifications and registrations are those required for the services to be provided.

10. Quality and safety initiatives

In addition to existing processes, the following priority actions will be taken to address service quality and patient safety issues:

- The results of the clinical role delineation (Capability Framework) assessment will be applied to all rural inpatient sites. In the event that services do not have appropriate access to clinical support services, an appropriately skilled and available workforce, equipment, suitable facilities and appropriate capacity to maintain clinical standards, alternative arrangements for delivery of services will be considered.
- The clinical role delineation process will be extended to Community Health Centres.
- External accreditation of broader primary health care services will be established to underpin the quality agenda, and to ensure the community can have confidence in its services. This will augment the well-established accreditation system for general practice and residential aged care.
- All Community Health sites will be subject to a quality auditing system.

7.8.3 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 Department 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.
II. Education and training

The Department will work with the University of Tasmania and other educational providers to provide sustainable health workforce training and development, including a commitment to vocational, undergraduate and postgraduate student placements in primary health care and multidisciplinary settings. This will encompass an increased emphasis on training in community and rural primary care settings. Actions include:

- strengthening the Partners in Health agreement with the University of Tasmania in order to further develop primary health research and education in this state.
- undertaking research and evaluation of the outcomes of demonstration sites established as part of the implementation of the Primary Health Services Plan.
- exploring the potential to expand allied health tertiary education within Tasmania including consideration of addressing priority workforce issues such as access to physiotherapy, nutrition and dietetics.
- further development of a degree course for Environmental Health Officers in Tasmania.
- 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. General practice services to the community will continue under this arrangement.
- working with the University of Tasmania to examine the feasibility of developing the Launceston General Hospital precinct as an enhanced primary/secondary Education Centre providing interprofessional learning for health professional students.
- developing all Rural Health Centres as Rural Health Teaching sites.
- increased workplace clinical psychology training across the Department.

7.8.4 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 Department will undertake infrastructure planning that will both reflect flexibility of services and be informed by population changes and projections, migration patterns and quality and safety parameters. Facility design will also be based on the need for integration of services, taking advantage of the considerable benefits that result from bringing primary health service providers within the same precinct.

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. In the 2006-07 HACC growth funding round, recurrent funding for increased provision of community transport has been directed to a number of rural and remote areas including Scottsdale/Bridport, Huonville, Tasman, Dover and Sorell and South East District.

Additionally, funding for new vehicles will be provided to HACC-funded organisations for Flinders Island, the North West region and South East district. Red Cross and St John’s Ambulance have been funded specifically for vehicles to expand the provision of non-urgent medical transport. However more needs to be done especially in rural and remote areas.
12. Community transport

Access to community transport will be improved.

The Department of Health and Human Services will commence a project to establish community transport networks that will better coordinate and improve transport options for people attending health care services where public transport is either not available or is inappropriate. To advance the project, the following actions will be undertaken immediately:

- provision of additional funding to assist in meeting the needs of people who are transport disadvantaged but outside the HACC target group to access transport for non-urgent health related needs; and
- engagement of a project manager to maintain linkages with the Department of Infrastructure, Energy and Resources, map existing resources, develop a working model and project plan and undertake the necessary liaison with the community sector and local communities to engage them in the process.

The Home and Community Care program will continue to expand the community transport resources in line with the established needs of its target population.

7.8.5 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, information technology offers the potential to improve service quality, deliver services closer to local populations and manage workforce shortages.

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

The use of technology where appropriate can support good service coordination practice, including the transfer of client information where appropriate consent has been provided.

The following actions will be taken to address information challenges:

- development of additional Telehealth and other electronic facilities to support state-wide rural and remote medical consultations and emergencies and assist with the co-ordination of pandemic responses.
- development of support for coordinating cross-jurisdictional care for our ageing 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.

7.8.6 Intergovernmental policy and planning

While the broader context of intergovernmental relations cannot be addressed in the Tasmanian Primary Health Services Plan, meaningful advances can be made at a local level through intergovernmental work at State and Commonwealth level.

The following actions will be taken to address intergovernmental challenges:

- working with the Australian Government, other Tasmanian Government Departments and services/groups within the Department to provide comprehensive responses to service challenges through existing mechanisms (such as the Tripartite Agreement for Population Ageing) and new arrangements.
- addressing health inequalities by playing a lead role in Whole-of-Government approaches to develop a broader framework for health which encapsulates and coordinates existing programs addressing social, economic, geographic and other disadvantage, identifies gaps in those programs and establishes coordinated programs to address those gaps and to bridge the health inequality gap.
- a commitment to ongoing planning at local and state-wide levels.

7.8.7 Public – private partnerships

While the broader context of intergovernmental relations cannot be addressed in the Tasmanian Primary Health Services Plan, meaningful advances can be made at a local level through intergovernmental work at State and Commonwealth level.

The following actions will be taken to address service development issues:

- identifying opportunities for closer relationship between industry and health service provision, including the mining, agricultural and tourism industries. Examples may include a more coordinated response to emergency issues requiring a health response on the West Coast and development of a Sustainable Farm Families project in Tasmania.
- advocacy for supportive environments that make healthy choices easy choices, such as local level planning and programs that support physical activity, healthy diet and social engagement through engagement with private industry.
- further development arrangements whereby private health professionals can access community health facilities in order to provide necessary services in rural areas eg optometry, audiology, other private allied health services.
8. Primary Health Services: Community profiles

Each primary health services area is made up of a number of local government areas.61

- **Fawkner**: Derwent Valley, Central Highlands, Southern Midlands, Glenorchy and Brighton
- **Wellington**: Hobart, Kingborough and Huon Valley
- **Rumney**: Clarence, Sorell, Tasman and Glamorgan Spring Bay
- **North Esk**: Break O’Day, Dorset, Flinders Is, Northern Midlands and George Town
- **South Esk**: Launceston, West Tamar and Meander
- **Mersey**: Latrobe, Kentish, Devonport and Central Coast
- **Hellyer**: Burnie, Circular Head, King Island, Waratah-Wynyard and West Coast

61 More details about services within each of these local government areas may be found at http://www.dhhs.tas.gov.au/agency/chs/lga_profiles.php
8.1 Southern region: Rumney

Figure 14 Rumney

8.. Clarence

Demographics

The Clarence Local Government Area is classified as an urban/adjacent urban area. The Clarence population was 50,257 in June 2005. The population is projected to decrease by 1% between 2006 and 2018. In terms of population change, the 75 years and over cohort is projected to increase by 42% and the proportion of the population 75 years and over will be in the order of 10.5% of the population by 2018. Currently the Clarence Local Government Area has one of the highest proportions of population aged over 65 years in Tasmania.

Service profile

Clarence has a range of primary health and community care services provided across the municipal area. The Clarence Community Health Centre (CCHC) is the major service site although there are smaller services at Risdon Vale Community Health Centre and Rokeby (the Clarence Plains Community Health Centre).

Table 16 lists departmental services provided within the Clarence municipal area.

---

62 Based on Australian Bureau of Statistics Census Projections at Local Government Area level.


Table 16 Departmental services: Clarence municipal area

<table>
<thead>
<tr>
<th></th>
<th>Acute Health Services</th>
<th>Community Health Services</th>
<th>Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bellerive</td>
<td></td>
<td>Mental Health Services –</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Adult Community</td>
<td></td>
</tr>
<tr>
<td>Clarendon Vale</td>
<td></td>
<td></td>
<td>Child Health Centre</td>
</tr>
<tr>
<td>Howrah</td>
<td></td>
<td></td>
<td>Child Health Centre</td>
</tr>
<tr>
<td>Lauderdale</td>
<td></td>
<td></td>
<td>Child Health Centre</td>
</tr>
<tr>
<td>Lindisfarne</td>
<td>Shore Street Day Centre</td>
<td></td>
<td>Child Health Centre</td>
</tr>
<tr>
<td>Mornington</td>
<td>Ambulance Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Richmond</td>
<td></td>
<td>Physiotherapy – Community</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outreach Service</td>
<td></td>
</tr>
<tr>
<td>Risdon Vale</td>
<td>Community Health Centre and general practice</td>
<td></td>
<td>Child Health Centre</td>
</tr>
<tr>
<td>Rokeby</td>
<td>Community Health Centre</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rosny Park</td>
<td>Community Health Centre including general practice and a nursing clinic</td>
<td>Alcohol and Drug Service,</td>
<td>Housing Service Centre</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Oral Health Services – Children</td>
<td>Child Health Centre</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community Nursing,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Telehealth Tasmania Network,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Occupational Therapy – Community</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Social Work – Community</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outreach Service,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Podiatry – Community</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Home Maintenance Services, Home help</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Physiotherapy</td>
<td></td>
</tr>
</tbody>
</table>

Source: Department of Health and Human Services, 2007.

As at June 2006, 143 Departmental Community Health staff (98 FTE) provided services from these sites. The CCHC includes the only state-managed GP service, with an additional surgery operating also from Risdon Vale.

The Tasmanian Ambulance Services station at Mornington provides 24-hour, seven-days-a-week coverage with a two-person salaried crew.

There are several residential aged care facilities in the Clarence municipal area.

In May 2006 the Census of Tasmanian GPs found that there were 57 GPs providing 353 sessions (3.5 hour sessions) of care; this equated to 35.3 FTE GPs.

**Commentary**

The CCHC performs a valuable and well-recognised service within its local community. It already acts as a base for outreach services to the surrounding rural areas. It also has a role in the training of medical students and overseas-trained doctors. The Clinical Services Plan and the Primary Health Services Plan offer the opportunity for building on this resource to extend its role through co-location with other health services and incorporation of a more acute role. There will need to be new infrastructure developed to support this change in role.

The Department will assess the feasibility of developing the CCHC as an inter-professional Primary Health Clinical Education Centre in conjunction with the University of Tasmania. A Tier 3 integrated care centre will be developed on the Eastern Shore (Clarence/Sorell). This service will supplement services currently provided from within the Royal Hobart Hospital as well as traditional primary health services. CCHC may be part of this development. General practice services to the community will continue under this arrangement.
The recent community nursing audit report notes the large proportion of low acuity of community nursing patients across the state (88%). With 33% of their patients identified as high-dependency, the CCHC has the most acute caseload in the state. (All other sites have between 8 and 16% high acuity clients). This experience positions them to undertake Hospital in the Home activity in this local area. The exploratory work between the Royal Hobart Hospital and the Community Nursing managers at Clarence and Hobart will continue with the aim of developing a Hospital in the Home service in the area.

The Risdon Vale Community Health Centre and the Clarence Plains Community Health Centre at Rokeby will continue to be required as bases for community health service provision. A general practice at Risdon Vale will continue in recognition that this is a high-needs area.

Under the Primary Health Services Plan, there is the potential to bring together health providers from general practice, community health, local government and non-government organisations to better coordinate health service planning in the area and to develop an expanded range of services in relation to chronic disease.

### 8.1.2 Glamorgan Spring Bay

#### Demographics

Glamorgan Spring Bay is a rural/remote area. The Glamorgan Spring Bay population numbered 4,296 in June 2005. The Glamorgan Spring Bay population is projected to decrease by 6% between 2006 and 2018. Within that total, the population is likely to experience a major increase (31%) in the 75 years and over cohort, which is expected to stand at 11.7% of the population by 2018. It currently has one of the highest proportions of people over 65 years in Tasmania. During the summer period the area is subject to a population increase.

#### Service profile

Table 17 lists departmental services provided within the Glamorgan Spring Bay municipal area.

**Table 17 Departmental services: Glamorgan Spring Bay municipal area**

<table>
<thead>
<tr>
<th></th>
<th>Acute Health Services</th>
<th>Community Health Services*</th>
<th>Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Swansea</strong></td>
<td></td>
<td>Community Health Centre</td>
<td>Child Health Centre</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Physiotherapy – Community</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Social Work – Community</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community Nursing</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Home Help and Personal Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Visiting Podiatry service</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dental therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health promotion</td>
<td></td>
</tr>
<tr>
<td><strong>Triabunna</strong></td>
<td></td>
<td>Community Health Centre</td>
<td>Child Health Centre</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Alcohol and Drug Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Occupational Therapy – Community</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Physiotherapy – Community</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mental Health Services,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Podiatry – Community</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Social Work – Community Outreach Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community Nursing</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diabetes Education Service</td>
<td></td>
</tr>
<tr>
<td><strong>Bicheno</strong></td>
<td></td>
<td>Community Nursing</td>
<td>Child Health Centre</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diabetes Education Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Palliative Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community Health Centre</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Telehealth Tasmania Network</td>
<td></td>
</tr>
<tr>
<td><strong>Coles Bay</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Swansea, Bicheno and Coles Bay have independent ambulance stations and Triabunna has a volunteer ambulance station.

# Many of these services are not available on a full-time basis but are provided on an outreach basis from another centre.

Source: Department of Health and Human Services, 2007.
The Swansea and Spring Bay (Triabunna) Community Health Centres provide a range of primary
health and community care services to this municipal area. As at June 2006, ten Departmental
Community Health staff (four FTE) provided services from these sites.

The May Shaw Nursing Centre at Swansea has two Department-funded subacute inpatient beds.
The average patient age is 66 years. Over the last five years the number of inpatient separations has
declined, while average occupied beddays and the average length of stay have increased. In 2005-06
the average occupancy level was 2.3 beds (113% – when there are a very small number of beds, the
discharge of one long-stay patient can push the average occupancy rate above the number of actual
beds), with an average length of stay of 5.25 days. In 2005-06 the May Shaw Nursing Centre received
a grant payment of $360,000. Additional funding was also provided for a capital development.

2005-06 data indicates that at the May Shaw Nursing Centre:

• May Shaw has a somewhat more acute profile than the other residential aged care-based
  services. There is also a low rate of repeat admissions (lowest in State at 38%), and low rate of
  same-day admissions (16%).
• The 25 day-patients were generally admitted for observation (and not for repeat day procedures as
  at some other sites). Two of these were subsequently transferred to the Royal Hobart Hospital.
• The patient mix generally covers short-stay medical conditions, psychiatric conditions, some step-
  down transfers from the Royal Hobart Hospital, and some palliative care and terminal care.

Bicheno, Coles Bay, Swansea and Triabunna also have volunteer ambulance stations run by the
Tasmanian Ambulance Service. The increasing development along the East Coast has put considerable
pressure on these services.

The May 2006 Census of Tasmanian GPs found that there were less than three GPs in the municipal area.

The May Shaw Nursing Centre is a University Department of Rural Health teaching site providing
facilities for students to stay and undertake clinical placements in Swansea.

The Australian Government provides funding in Swansea and Bicheno for the visiting optometrist
scheme as well as the Glamorgan Spring Bay Regional Health Services with its primary health
coordinator; social worker; psychologist and youth worker.

Commentary

The Swansea and Spring Bay (Triabunna) Community Health Centres would benefit from expanded
primary health/community health services developed through outreach arrangements to better
address chronic disease in the population.

The inpatient beds at May Shaw Nursing Centre are more than fully occupied. While the number of
separations have declined, the increase in the proportion of older people in the municipal area suggests
that there may be a need for additional beds in the future. These will be considered over time as
resources become available.

Under the Primary Health Services Plan, there is the potential to bring together health providers from
general practice, community health, local government and non-government organisations to better
coordinate health service planning in the area.
8.1.3 Sorell

**Demographics**

Sorell is classified as an urban/adjacent urban area. The Sorell municipal area numbered 11,454 in June 2005. The population for Sorell is projected to increase by 4% between 2006 and 2018. In terms of population change, the 75 years and over cohort is projected to increase by 58%, and the proportion of the population 75 years and over will be approximately 7.6% of the population by 2018.

**Service profile**

Table 18 lists departmental services provided within the Sorell municipal area.

<table>
<thead>
<tr>
<th>Service</th>
<th>Sorell</th>
<th>Dodges Ferry</th>
<th>Dunalley</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Health Services</strong></td>
<td>Ambulance Service</td>
<td>Ambulance Service</td>
<td>Community Health Centre</td>
</tr>
<tr>
<td><strong>Community Health Services</strong></td>
<td>Community Health Centre</td>
<td>Child Health Centre</td>
<td>Community Health Centre</td>
</tr>
<tr>
<td><strong>Human Services</strong></td>
<td>Child Health Centre</td>
<td>Community Transport</td>
<td>Physiotherapy – community outreach</td>
</tr>
<tr>
<td><strong>Community nursing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Home help</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Personal care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Physiotherapy</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Podiatry – Community outreach</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Community Transport</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Department of Health and Human Services, 2007.

The Sorell Community Health Centre is relatively new and provides a range of primary health and community care services. This site is generally regarded as operating at full capacity. A non-government service provider is currently housed in the building, providing a range of community health services.

The Tasmanian Ambulance Services branch station at Sorell currently has high caseloads relative to paramedic staffing levels. Dodges Ferry and Dunalley are volunteer ambulance stations run by the Tasmanian Ambulance Service.

In May 2006 the Census of Tasmanian GPs found that there were 11 GPs providing 69 sessions (3.5 hour sessions) of care; this equated to 6.9 FTE GPs. In terms of GP capacity to provide extra sessions of care it should be noted that Sorell has been declared an Area of Need.

**Commentary**

The Sorell Community Health Centre would benefit from expanded primary health/community health services developed through outreach arrangements to better address chronic disease. The high level of response required of the ambulance service remains a concern.

8.1.4 Tasman

**Demographics**

Tasman is a rural/remote area. The population of Tasman was 2,180 in June 2005. The population is projected to increase by 2% between 2006 and 2018. In terms of population change, the 75 years and over cohort is projected to increase by 33%, and the proportion of the population 75 years and over will make up approximately 8% of the population by 2018.

**Service profile**

Table 19 lists departmental services provided within the Tasman municipal area.
Table 19 Departmental services: Tasman municipal area

<table>
<thead>
<tr>
<th>Nubeena</th>
<th>Acute Health Services</th>
<th>Community Health Services</th>
<th>Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ambulance Service (volunteer)</td>
<td>Physiotherapy – Community</td>
<td>Child Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mental Health Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Podiatry – Community</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Social Work – Community</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Alcohol and Drug Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Telehealth Tasmania Network</td>
<td></td>
</tr>
</tbody>
</table>

# Many of these services are not available on a full-time basis but are provided on an outreach basis from another centre.

Source: Department of Health and Human Services, 2007.

There were 40 Departmental Community Health staff (19.1 FTE) employed in the Tasman municipal area in June 2006.

The Tasman Multi Purpose Service (MPS) at Nubeena is funded and operated under a tripartite arrangement with the Australian Government, the Tasmanian Government and the Tasman Municipal Council. The primary objective of MPS is to provide a more flexible, coordinated and cost-effective framework for service delivery by pooling funds for health and aged care services, particularly in rural and remote areas. The Tasman MPS is funded under the tripartite agreement to provide residential, respite, accident and emergency and acute care, as well as community care.

The Tasman MPS allocates some of its pooled funding for the provision of subacute inpatient services. The average patient age is 58 years. Over the last five years the number of inpatient separations have increased, average occupied beddays have remained approximately the same and the average length of stay has decreased. In 2005-06 the average length of stay was 4.8 days. The 117 separations represent 91 individuals of whom two were transferred from the Royal Hobart Hospital, both elderly and “long-stay”.

The Tasman MPS is funded under a three-year service agreement with the Australian Department of Health and Ageing. These funds can be used flexibly. The Department’s 2005-06 grant payment was $837,908.

The Tasman MPS is a University Department of Rural Health teaching site providing facilities for students to stay and undertake clinical placements in Nubeena.

The Tasman Peninsula also has a volunteer ambulance station run by the Tasmanian Ambulance Service.

In May 2006 the Census of Tasmanian GPs found that there were less than three GPs practising in this municipal area.

Commentary

As with many small rural sites, the Tasman MPS is experiencing difficulties in the sustainability of services, especially in relation to workforce and cost. Management of such a centre is a challenge for a small municipal authority.

The Tasman MPS beds focus on aged care with a small amount of subacute care. Services addressing the increasing level of chronic disease will need to be developed. These issues could be discussed with the Tasman Council during the regular cross-jurisdictional management meetings.

**Summary of actions for Rumney**

**Clarence** – The Clarence Community Health Centre will be developed as a Tier 3 facility and as a Primary Health Clinical Education Centre, subject to the results of the feasibility study. In the future, it may be incorporated into the development of a Tier 3 integrated care centre as part of the implementation of the Clinical Services Plan. This service will supplement services currently provided from within the Royal Hobart Hospital as well as primary health services. The Royal Hobart Hospital and the Community Nursing managers at Clarence and Hobart will develop a Hospital in the Home service in the area. The Risdon Vale Community Health Centre and the Clarence Plains Community Health Centre at Rokeby will be Tier 1 facilities. Opportunities to expand allied health services, especially in relation to chronic disease, will be explored.

**Glamorgan Spring Bay** – The Swansea and Spring Bay (Triabunna) Community Health Centres will be developed as Tier 1 facilities. Expanded primary health/community health services will be developed to better address chronic disease prevention.

Over time, as resources become available, the May Shaw subacute inpatient beds at Swansea will be expanded from two to four and the facility will operate as a Tier 2 service.

**Sorell** – The Sorell Community Health Centre will be developed as a Tier 1 facility. Expanded primary health/community health services will be developed to better address chronic disease prevention.

**Tasman** – The Tasman Multi Purpose Service will be maintained as a Tier 2 facility. Visiting services will continue to be provided from Clarence Community Health Centre.

### 8.2 Southern region: Wellington

**Figure 15 Wellington**

![Map of Wellington area with locations marked](source: Department of Health and Human Services, 2007.)
8.2.1 Hobart

Demographics
Hobart is classified as an urban/adjacent urban area. The Hobart population numbered 48,794 in June 2005. The population of Hobart is projected to increase by 3% between 2006 and 2018. In terms of population change the 75 years and over cohort is projected to increase by 6%, and the proportion of the population 75 years and over will be approximately 7.9% of the population by 2018.

Service profile
The main service delivery sites are the Royal Hobart Hospital, the Repatriation Centre and the St Johns Park service centre. A wide range of primary health and acute local, regional and state-wide services are available. There is a Tasmanian Ambulance Services station with coverage provided 24-hours a day, seven days a week, by two-person salaried crews.

Table 20 lists departmental services provided within the Hobart municipal area.

Table 20 Departmental services: Hobart municipal area

<table>
<thead>
<tr>
<th>Acute Health Services</th>
<th>Community Health Services</th>
<th>Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hobart</td>
<td>Community nursing and nursing clinic</td>
<td>Housing Service Centre</td>
</tr>
<tr>
<td>Royal Hobart Hospital</td>
<td>Home help and personal care</td>
<td>Adoption and Information Service – State-wide</td>
</tr>
<tr>
<td>Ambulance Service</td>
<td>Home maintenance</td>
<td>Parenting Line – State-wide</td>
</tr>
<tr>
<td>Sexual Health Service</td>
<td>BreastScreen Tasmania – Hobart Clinic</td>
<td>Child Health Centre</td>
</tr>
<tr>
<td></td>
<td>Women’s Health – South</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Forensic Community Mental Health</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental Health Adult Inpatient Services – Mistral Place</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental Health Adult Community Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental Health Psychiatric Intensive Care Unit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Palliative Care – Whittle Ward</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Palliative Care Service – Southern community team</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Orthotic and Prosthetic Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Options Service – Hobart Community Rehabilitation Unit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outreach Allied Health and Rehabilitation Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Aged Care Assessment Team</td>
<td></td>
</tr>
</tbody>
</table>

| North Hobart          | Mental Health Adult Community Services | Child Health Centre |
| Alcohol and Drug Services community team | |               |
| Alcohol and Drug Services – Detoxification unit | |               |
| Mental Health – Dementia Support Unit | |               |
| Oral Health Service – Adults and Children | |               |
| Child & Adolescent Mental Health Services | |               |
| Family, Child and Youth Health Service – South | |               |

| Lenah Valley | Mental Health Older Persons services (Roy Fagan Centre) | Child Health Centre |

| South Hobart | Mental Health Adult Community Services | Child Health Centre |
| New Town     | Child and Family Services – South |               |
|             | Disability Services – South |               |
|             | Parenting Centre – South |               |

| Sandy Bay | Mental Health Adult Community Services – University Psychology Clinic | Child Health Centre |

Source: Department of Health and Human Services, 2007.

As at June 2006, 386 Departmental Community Health staff (203 FTE) provided services from these sites.

In May 2006 the Census of Tasmanian GPs found that there were 105 GPs providing 672 sessions (3.5 hour sessions) of care; this equated to 67.2 FTE GPs.
Within the Hobart area there are also a large number of non-government and private organisations providing community-based health care including prevention and management of chronic disease, Home and Community Care services and primary mental health and alcohol and drug services. There are also several residential aged care facilities in the municipal area. The Australian Government funds drug treatment services through the Non-Government Organisations Treatment Grants Program.

**Commentary**

Hobart lacks a focus for community health and health promotion. There may be opportunities to address this in partnership with other service providers.

The recent community nursing audit report notes the large proportion of low acuity community nursing patients across the state (88%). The exploratory work between the Royal Hobart Hospital and the Community Nursing managers at Clarence and Hobart will continue with the aim of developing a Hospital in the Home service in the South East areas.

### 8.2.2 Huon Valley

**Demographics**

The Huon Valley is a rural/remote area. The population of the Huon Valley numbered 14,567 in June 2005. The population is projected to increase by 7% between 2006 and 2018. In terms of population change the 75 years and over cohort is projected to increase by 110% to stand at 9.4% of the population by 2018.

**Service profile**

Table 21 lists departmental services provided within the Huon Valley municipal area.

<table>
<thead>
<tr>
<th>Table 21 Departmental services: Huon Valley municipal area</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Health Services</strong></td>
</tr>
<tr>
<td>Huonville</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Cygnet</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Dover</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Geeveston</td>
</tr>
</tbody>
</table>

* There is a volunteer ambulance service at Dover.

# Many of these services are not available on a full-time basis but are provided on an outreach basis from another centre.

Source: Department of Health and Human Services, 2007.
As at June 2006, 36 Departmental Community Health staff (16 FTE) provided services from these sites (excluding Esperance).

The **Cygnet** and **Huonville Community Health Centres** provide a range of primary health and community care services.

**Huon Eldercare** is a residential aged care provider and has six Department-funded subacute inpatient beds. The average patient age is 79 years. Over the last five years the number of inpatient separations and average occupied beddays have declined and the average length of stay has remained approximately the same (declined slightly). In 2005-06 the average occupancy level was 5.1 beds (84%), with an average length of stay of 27.5 days. This represents 67 separations (45 individuals) of whom 14 were transferred from the Royal Hobart Hospital. These people are generally elderly and long stay. The 2005-06 grant from the Department was $483,184.

The **Esperance Multi Purpose Centre (MPC)** at Dover is managed by the Huon Valley Council and is deficit funded by the Department. It provides a range of community health and other services, including residential aged care. The Department also provides a range of visiting services into the MPC. Through a historical agreement, the Department employs the staff who are managed by the Council. The MPC has two subacute inpatient beds. The average patient age is 72 years. Over the last five years the number of inpatient separations, the average occupied beddays and average length of stay have all increased. In 2005-06 the average occupancy level was 1.3 beds (64%), with an average length of stay of 16.2 days. The 2005-06 grant from the Department was $603,500.

The Esperance MPC receives funding from the Australian Government for its residential aged care beds.

2005-06 data indicates that at the Esperance MPC inpatient activity was as follows:

- There were 29 separations involving 17 individuals.
- The high average age (73 years) and high length of stay (16 days) is consistent with a site providing predominantly subacute/non-acute care.
- Occupancy was 64% but this included two patients who utilised over 200 days between them, accounting for 42% of total occupancy.
- Occupancy has shown a decrease in the last year and is continuing to fall. For the first six months of this financial year occupancy is at 50%, i.e. average of one patient.
- There were seven patients transferred from the Royal Hobart Hospital for care. These seven patients had an average age of 76 years and accounted for 239 beddays at Esperance (51% of all beddays).
- Esperance does play a role in emergency care prior to ambulance transfer to the Royal Hobart Hospital. These patients are usually not admitted prior to transfer, so are not reflected in the inpatient statistics. They average 34 emergency presentations per month, mostly dealt with locally by the doctor and/or nurse, with typically five to ten per month being sent on to the Royal Hobart Hospital.

Inpatient data updated to March 2007 shows that there has been a significant decline in activity, with only four separations recorded in the last full quarter (three months).

The Esperance MPC is a University Department of Rural Health rural health teaching site providing facilities for students to stay and undertake clinical placements in Dover.

There is a Tasmanian Ambulance Service branch station at Huonville. (Currently caseloads are high relative to paramedic staffing.) The Dover volunteer ambulance station, run by the Tasmanian Ambulance Service is experiencing problems in maintaining volunteer numbers.
In May 2006 the Census of Tasmanian GPs found that there were 18 GPs providing 96 sessions (3.5 hour sessions) of care; this equated to 9.6 FTE GPs. However many are ageing and considering retirement and there is a concern about ongoing stability of general practice in the area.

The Australian Government provides funding for the Huon Valley Regional Health Service to provide the following services: youth health outreach, youth health development, seniors’ health, rural health and nutrition.

**Commentary**

The Cygnet and Huonville Community Health Centres would benefit from expanded primary health/community health services developed through outreach arrangements to better address chronic disease prevention.

In the Esperance Multi Purpose Centre the two State-funded beds are used predominantly for interim aged care and respite only. During consultations associated with this Plan, concern has been expressed as to the sustainability of the inpatient and residential aged care services at Esperance. There are ongoing difficulties around the management arrangements at this site and further discussion with the Huon Valley Council and the community will occur.

The beds at Huon Eldercare are also used predominantly for interim aged care and respite. An examination of the feasibility of increasing the step-down role at Huon Eldercare needs to be undertaken given that there is little step-down care in the Huon Valley.

Access to community transport remains a concern in the community; improvements can be expected through the development of community transport networks and the provision of additional funds to assist in meeting the needs of people who are transport disadvantaged and are seeking non-urgent health-related transport across rural areas.

**8.2.3 Kingborough**

**Demographics**

Kingborough is classified as an urban/adjacent urban area. The Kingborough population numbered 31,530 in June 2005. It is projected to increase by 12% between 2006 and 2018. Within that total, a major increase (63%) will be people in the 75 years and over cohort, to stand at 8.2% of the population by 2018. Bruny Island is subject to a large increase in population during the summer months.

**Service profile**

The Kingston Community Health Centre provides a range of primary health and community care services to “mainland” Kingborough while the Bruny Island Community Health Centre serves the island. There is a Tasmanian Ambulance Service station at Kingston. (The caseloads for this station are currently quite high for the staffing model). Bruny Island also has a volunteer ambulance station run by the Tasmanian Ambulance Service.

Table 22 lists departmental services provided within the Kingston municipal area.
Table 22 Departmental services: Kingston municipal area

<table>
<thead>
<tr>
<th></th>
<th>Acute Health Services*</th>
<th>Community Health Services#</th>
<th>Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kingston</td>
<td>Ambulance Service</td>
<td>Community Health Centre</td>
<td>Child Health Centre</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mental Health Services – Child and Adolescent</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Oral Health Services – Adult and Children</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Alcohol and Drug Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Physiotherapy – Community Outreach Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Podiatry – community</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Social Work – Community Outreach Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community Nursing</td>
<td></td>
</tr>
<tr>
<td>Bruny Island</td>
<td>*</td>
<td>Community Health Centre</td>
<td>Child Health Centre</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Home Maintenance Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Physiotherapy – Community Outreach Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Podiatry – community</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mental Health Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Alcohol and Drug Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Social Work – Community Outreach Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community Nursing</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Home Help and Personal Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Telehealth Tasmania Network</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Occupational Therapy – Community</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community Nutrition Unit</td>
<td></td>
</tr>
<tr>
<td>Snug</td>
<td></td>
<td>Child Health Centre</td>
<td></td>
</tr>
</tbody>
</table>

* Bruny Island has a Volunteer Ambulance service.
# Many of these services are not available on a full-time basis but are provided on an outreach basis from another centre.
Source: Department of Health and Human Services, 2007.

As at June 2006, 52 Departmental Community Health staff (22 FTE) provided services from these sites.

In May 2006 the Census of Tasmanian GPs found that there were 36 GPs providing 222 sessions (3.5 hour sessions) of care; this equated to 22.2 FTE GPs. (None of these are located on Bruny Island.)

The Australian Government provides funding to the Bruny Island Regional Health Service for social work, health promotion, physiotherapy and podiatry services.

**Commentary**

Kingston Community Health Centre is occupying rented premises and is short of space. This will need to be addressed in the short term. It would benefit from expanded primary health/community health services developed through outreach arrangements to better address chronic disease prevention.

Opportunities for closer integration with general practice will also be explored.

In the longer term, the Clinical Services Plan recommends that a Tier 3 integrated care centre be developed at Kingston. This would supplement services currently provided from within the Royal Hobart Hospital as well as traditional primary health services.

The Bruny Island Community Health Centre has potential for the introduction of a nurse practitioner service. This will assist in the provision of services especially during the summer months and as it participates in significant emergency response activities.
Summary of actions for Wellington

**Hobart** – The Royal Hobart Hospital and the Community Nursing managers at Clarence and Hobart will develop a Hospital in the Home service in the two areas.

**Huon Valley** – The Huon Valley and Cygnet Community Health Centres will be developed as Tier 1 facilities. Expanded primary health/community health services will be developed using outreach from Hobart to better address chronic disease prevention and management. In the longer term Kingston will provide the base for outreach to the Huon Valley.

At Esperance the role of the beds and the ongoing management arrangements will be discussed with the Council and the community. Examination of the capacity of Huon Eldercare to take on a more acute role will be undertaken. Esperance will be a Tier 2 facility, as will Huon Eldercare.

**Kingborough** – The Kingston Community Health Centre will operate as a Tier 1 facility until the Tier 3 integrated care centre is developed as part of the Clinical Services Plan. This service will supplement services currently provided from within the Royal Hobart Hospital as well as primary health services. It will then perform a significant outreach role through its local communities.

The Bruny Island Community Health Centre will be developed as a Tier 1 centre. It will retain its capacity to participate in emergency responses.

8.3 Southern region: Fawkner

Figure 16 Fawkner
8.3.1 Brighton

**Demographics**
Brighton is classified as an urban/adjacent urban area. The Brighton population was 13,819 in June 2005. The population of Brighton is projected to increase by 2% between 2006 and 2018. In terms of population change the 75 years and over cohort is projected to increase by 82%, and the proportion of the population 75 years and over will be approximately 4.8% of the population by 2018. This is an area with significant disadvantage in socio-economic and health status.

**Service profile**
Bridgewater Community Health Centre provides a range of primary health and community care services. There are also many visiting services to the area. Bridgewater has a Tasmanian Ambulance Service station. (The caseload is relatively high for the current staffing levels at this station.)

Table 23 lists departmental services provided within the Brighton municipal area.

**Table 23 Departmental services: Brighton municipal area**

<table>
<thead>
<tr>
<th>Acute Health Services</th>
<th>Community Health Services*</th>
<th>Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bridgewater</td>
<td>Ambulance Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Health Centre</td>
<td>Child Health Centre</td>
</tr>
<tr>
<td></td>
<td>Oral Health Service – Children</td>
<td>Housing Service Centre</td>
</tr>
<tr>
<td></td>
<td>Community Nursing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alcohol and Drug Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physiotherapy – Community Outreach Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental Health Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Podiatry – Community</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Occupational Therapy – Community</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social Work – Community Outreach Service</td>
<td></td>
</tr>
</tbody>
</table>

* Some of these services are not available on a full-time basis but are provided on an outreach basis from another centre.

Source: Department of Health and Human Services, 2007.

As at June 2006, 18 Departmental Community Health staff (ten FTE) provided services from these sites.

The Australian Government has funded a program for early childhood development and better coordination of services for early years in this district. There has been work across all levels of government to provide a service directory targeted at parents of young children.

In May 2006 the Census of Tasmanian GPs found that there were seven GPs providing 57 sessions (3.5 hour sessions) of care; this equated to 5.7 FTE GPs.

The Australian Government Non-Government Organisations Treatment Grants Program funds drug treatment services through Holyoake, the Salvation Army, Anglicare and The Link Youth Health Service.

**Commentary**
The Bridgewater community is relatively younger than other Tasmanian communities but there is a high burden of chronic disease in the area. There is already a high level of community and health service activity in the municipal area from a wide range of funding sources and service providers and a process has been in place to coordinate this effort at state government/local government level.

Under the Primary Health Services Plan, there is the potential for an expanded range of services provided in relation to chronic disease, bringing together health providers from general practice, community health, local government and non-government organisations.
8.3.2 Central Highlands

Demographics

The Central Highlands is a rural/remote area. The Central Highlands population numbered 2,294 in June 2005. Projections from 2006 to 2018 predict a decrease by 7%. Within that total, the 75 years and over cohort is projected to increase by 100%, to stand at 9.3% of the population by 2018.

Service profile

Table 24 lists departmental services provided in the Central Highlands municipal area.

Table 24 Departmental services; Central Highlands municipal area

<table>
<thead>
<tr>
<th></th>
<th>Acute Health Services</th>
<th>Community Health Services*</th>
<th>Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ouse</td>
<td>*</td>
<td>District hospital</td>
<td>Child Health Centre</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community nursing (outreach from New Norfolk)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Podiatry</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Physiotherapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mental Health Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diabetes Education</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Occupational Therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Speech Pathology</td>
<td></td>
</tr>
<tr>
<td>Bothwell</td>
<td>*</td>
<td>Podiatry</td>
<td>Child Health Centre</td>
</tr>
<tr>
<td>Wayatinah</td>
<td>*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Ouse, Bothwell and Wayatinah have volunteer ambulance services.
# Many of these services are not available on a full-time basis but are provided on an outreach basis from another centre.

Source: Department of Health and Human Services, 2007.

As at June 2006, 41 Departmental Community Health staff (20 FTE) provided services from these sites.

The Ouse District Hospital delivers a range of primary health and community care services. It also provides inpatient and residential care. It has four subacute inpatient beds and six residential aged care beds.

In relation to the subacute inpatient beds, the average patient age is 66.5 years. Over the last five years the number of inpatient separations have declined, average occupied beddays have remained approximately the same and the average length of stay has increased. In 2005-06 the average occupancy level was 1.3 beds (32%), with an average length of stay of 16 days. (During 2005-06 three elderly long-stay patients accounted for 28% of the hospital’s inpatient activity.)

This combination of high average age and long stay is indicative of a facility providing predominantly aged care services. It is not indicative of an acute care facility where most patients are discharged in three days or less. During the year; only 29 individuals were admitted as inpatients, but these individuals were often admitted multiple times. The hospital beds were therefore being used by just over 1% of the catchment population. During 2005-06 eleven patients were transferred in from the Royal Hobart Hospital; this represents 24% of occupied beddays.

The recent difficulty in securing a GP service at Ouse alerted the community to sustainability issues. This was followed by significant difficulties in recruiting sufficient nursing staff to maintain the 24-hour roster.

The six Australian Government-funded aged care beds have an occupancy level of 5.8 (96%). The revenue received from the Australian Government for aged care beds in 2005-06 was $276,721.
Overall occupancy across all beds is 7.1 beds (71%). The 2005-06 actual costs were $1,525,478. This means that the actual annual cost per occupied bed was $216,115. It is the fifth most costly rural inpatient facility in Tasmania.

There is no ambulance service at Ouse. Bothwell, Miena and Wayatinah have volunteer ambulance stations run by the Tasmanian Ambulance Service. (Miena currently relies on a small number of volunteers to function.)

Regional Health Services provide Youth Worker, Social Worker, Podiatry, Mental Health and Health Promotion programs.

In May 2006 the Census of Tasmanian GPs found that there were no GPs providing care in the Central Highlands LGA. There is currently a GP presence on a part-time basis.

**Commentary**

There are significant concerns in relation to ongoing staffing of the Ouse hospital. The service has been struggling to attract enough nursing and care staff to maintain a 24-hour service. It is also not reasonable to expect a single GP to be available on call 24-hours a day, seven days a week.

In applying the health planning principles to rural health sites in Tasmania, it is clear that some are not meeting the criteria established to demonstrate sustainability. It is not possible for them to deliver the current service to their community in a way that is safe, effective and at an acceptable cost. Nor will it be possible to continue to provide these services in the future when workforce issues worsen. Consultation has occurred with the Ouse community in relation to this issue. Work is now occurring to develop models of service that will better meet the needs of this community on a more sustainable basis at a Tier 1 level.

There are alternatives to the current service model which will meet the needs of the community, especially in relation to care of the elderly. More flexible models of care, with a combination of planned respite beds (for non-health-related situations), day centre respite and nursing and personal care in the home will enable older people to remain within the local community. Developed as a Tier 1 site the Ouse Community Health Centre would provide a broader range of primary health and community aged care services which would include:

- overnight planned respite capacity as required for non-health-related conditions (ageing and social support situations);
- individualised packages of care for older people to enable them to remain in their own homes (both post-acute and community care);
- additional day centre respite;
- more allied health services as an outreach;
- maintenance of general practice rooms for usage when the GP is there;
- community nursing and on-site nurse clinics (especially for chronic disease treatment, including diabetes); and
- increased focus on health promotion and healthy lifestyle activities.

Improved training and linkages with acute health services for continuance of the emergency response function would be provided. An injury treatment room would remain available on site.

The Department will work with the Australian Government to identify opportunities for further community aged care packages in the Central Highlands community.
Under the Primary Health Services Plan, there is the potential for an expanded range of services provided in relation to chronic disease, bringing together health providers from general practice and community health, local government and non-government organisations.

Access to community transport remains a concern in the community and improvements can be expected through the development of community transport networks and the provision of additional funds to assist in meeting the needs of people who are transport disadvantaged and are seeking non-urgent health-related transport across rural areas.

These changes will require that the inpatient care beds be relocated to New Norfolk District Hospital and inpatient services provided from that base. Discussions will occur with the Australian Government about future arrangements for residential aged care. The Department will work with the residents and their families through this process.

General practice will remain a concern in relation to long-term sustainability but the current levels of support provided to the GP would continue to assist him in maintaining a role in the Community Health Centre.

8.3.3 Derwent Valley

**Demographics**

The Derwent Valley is classified as an urban/adjacent urban area. The Derwent Valley population numbered 9,517 in June 2005. The Derwent Valley population is projected to decrease by 11% between 2006 and 2018. In terms of population change the 75 years and over cohort is projected to increase by 64% to stand at 9.0% of the population by 2018.

**Service profile**

Table 25 lists departmental services provided within the Derwent Valley municipal area.

**Table 25 Departmental services: Derwent Valley municipal area**

<table>
<thead>
<tr>
<th>Acute Health Services</th>
<th>Community Health Services*</th>
<th>Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Norfolk</td>
<td>Community Health Centre</td>
<td>Child Health Centre</td>
</tr>
<tr>
<td>Ambulance Service</td>
<td>Social Work – community outreach service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Oral Health Services – Children</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Podiatry – Community</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Nursing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>District Hospital</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental Health Services – respite, inpatient and community services</td>
<td></td>
</tr>
<tr>
<td>Maydena *</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Maydena has a volunteer Ambulance Service.
# Some of these services are not available on a full-time basis but are provided on an outreach basis from another centre.

Source: Department of Health and Human Services, 2007.

As at June 2006, 35 Departmental Community Health staff (31.4 FTE) provided services from these sites.

The New Norfolk District Hospital and Community Health Centre provides a range of primary health and community care services as well as inpatient care.

The facility has recently been refurbished. It has ten subacute inpatient beds— the aged care beds were transferred to a non-government provider (Corumbene) in 2004-05. The average patient age is 71 years. Over the last five years the number of inpatient separations and occupied beddays have increased while the length of stay has marginally decreased. In 2005-06 the average occupancy level
was 7.3 beds, with an average length of stay of 9 days. The 2005-06 actual costs were $1,802,125. This means that the actual annual cost per occupied bed was $245,989.

2005-06 data indicates at the New Norfolk District Hospital:

- There were 296 separations involving 174 individuals in 2005-06.
- Thirty-three separations were for day procedures. This substantially resulted from two individuals having multiple same-day admissions.
- Among the overnight patients there were also a high number of repeat admissions. For example, one 85-year-old patient was admitted on three occasions for a total of 73 days.
- Bed numbers fluctuate and this affects bed occupancy. New Norfolk District Hospital had ten beds until 2004-05 when it rose to 16 beds, with the extra six being funded through Royal Hobart Hospital. This funding did not continue and during 2005-06 the bed count reverted to ten.
- The high average age (71.6 years) and high average length of stay (9.03 days) is consistent with a subacute/non-acute role. In 2005-06, 73% of admissions were aged 65 years and over and they accounted for 83% of beddays.
- There were 57 patients transferred from the Royal Hobart Hospital. These were more elderly (having an average age of 74 years) with a longer stay (average 14 days) than the remainder of admissions. This group accounted for 19% of admissions and 30% of beddays.
- There were 18 deaths at the hospital (6% of separations). This helps emphasise the significant role it plays in palliative and terminal care.

There is a Tasmanian Ambulance Service branch station at New Norfolk. (Currently caseloads are high relative to paramedic staffing.) Maydena also has a volunteer ambulance station run by the Tasmanian Ambulance Service.

In May 2006 the Census of Tasmanian GPs found that there were seven GPs providing 51 sessions (3.5 hour sessions) of care; this equated to 5.1 FTE GPs. In terms of GP capacity to provide extra sessions of care it should be noted that Derwent Valley has been declared an Area of Need.

**Commentary**

The New Norfolk District Hospital and Community Health Centre already acts as a base for provision of a broader range of community health services for both the Central Highlands and Derwent Valley municipal areas. There is the capacity for it to perform this role in relation to inpatient care. In order to do this the regularly available beds would need to be expanded from 10 to 14 beds.

Under the Primary Health Services Plan, there is the potential for an expanded range of services provided in relation to chronic disease, bringing together health providers from general practice and community health, local government and non-government organisations.

There is also a need to bring together health providers from general practice, community health, regional health services and residential aged care in order to address the health needs of the broader Derwent Valley/Central Highlands localities.

Access to community transport remains a concern in the community and improvements can be expected through the development of community transport networks and the provision of additional funds to assist in meeting the needs of people who are transport disadvantaged and are seeking non-urgent health-related transport across rural areas.

A subacute role in relation to rehabilitation could be possible with both therapy assistants and health professionals on site. An expanded role in the treatment of chronic disease will be developed.
8.3.4 Glenorchy

Demographics
Glenorchy is classified as an urban/adjacent urban area. The population of Glenorchy numbered 44,615 in June 2005. It is projected to decrease by 4% between 2006 and 2018. Within that total, a major increase (26%) will be people in the 75 years and over cohort, to stand at 10.6% of the population by 2018. Currently Glenorchy has one of the highest proportions of people aged over 65 years in Tasmania and this will increase in future years.

Service profile
Glenorchy is well represented in terms of youth health, mental health, residential aged care and Home and Community Care services. It has a Community Health Centre and a relatively large number of disability group homes and mental health facilities within its geographic boundary. It is the base for a large non-government provider of community nursing and other in-home support services.

The Glenorchy Community Health Centre provides a youth health service but also acts as accommodation for other services such as allied health.

Table 26 lists departmental services provided within the Glenorchy municipal area.

Table 26 Departmental services: Glenorchy municipal area

<table>
<thead>
<tr>
<th>Acute Health Services</th>
<th>Community Health Services</th>
<th>Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glenorchy Ambulance Service</td>
<td>Community Health Service</td>
<td>Child Health Centre</td>
</tr>
<tr>
<td></td>
<td>Community Transport Service</td>
<td>Housing Service Centre</td>
</tr>
<tr>
<td></td>
<td>Mental Health Services – Rehabilitation and Respite Services and Gavitt House</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Oral Health Service – Children</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Podiatry – Community</td>
<td></td>
</tr>
<tr>
<td></td>
<td>‘Pulse’ Youth Health Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Allied Health</td>
<td></td>
</tr>
<tr>
<td>Claremont Child Health Centre</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moonah Child Health Centre</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Department of Health and Human Services, 2007.

As at June 2006, 55 Departmental Community Health staff (27 FTE) provided services from these sites.

There is a Tasmanian Ambulance Service station with coverage provided 24-hours a day, seven days a week by a two-person salaried crew.

In May 2006 the Census of Tasmanian GPs found that there were 58 GPs providing 369 sessions (3.5 hour sessions) of care, this equated to 36.9 FTE GPs.

The Australian Government Non-Government Organisations Treatment Grants Program, funds drug treatment services in the municipal area.

Commentary
The role of the Glenorchy Community Health Centre needs to be expanded with a view to further development of its community development and health promotion roles. Glenorchy services would benefit from greater coordination and the municipal area has the potential to act as a major base from which outreach services can be delivered to other municipalities within the primary health coordination area.

Under the Primary Health Services Plan, there is the potential to bring together health providers from general practice, community, health, local government and non-government organisations to better
coordinate health service planning in the area and to develop an expanded range of services in relation to chronic disease.

8.3.5 Southern Midlands

Demographics
The Southern Midlands is a rural/remote area. The Southern Midlands population numbered 5,736 in June 2005. The Southern Midlands population is projected to increase by 3% between 2006 and 2018. Within that total, a major increase (52%) will be people in the 75 years and over cohort, to stand at 6.7% of the population by 2018.

Service profile
Table 27 lists departmental services provided within the Southern Midlands municipal area.

<table>
<thead>
<tr>
<th>Acute Health Services</th>
<th>Community Health Services*</th>
<th>Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>*</td>
<td>Midlands Multi Purpose Centre providing residential aged care and subacute care</td>
<td>Child Health Centre</td>
</tr>
<tr>
<td></td>
<td>Home maintenance services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physiotherapy – community outreach service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental Health Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social work – community outreach service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community nursing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home help and personal care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diabetes education service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community care services</td>
<td></td>
</tr>
</tbody>
</table>

* Oatlands has a volunteer Ambulance Service.
# Several of these services are not available on a full-time basis but are provided on an outreach basis from another centre.

As at June 2006, 50 Departmental Community Health staff (28 FTE) provided services from this site.

The Midlands Multi Purpose Centre (MPC) at Oatlands provides a range of primary health and community care services. It also provides inpatient and residential aged care. It has four subacute inpatient beds.

In relation to the subacute beds, same-day admissions include chemotherapy and other post-acute procedures. The average patient age for the inpatient beds is 64 years. Over the last five years the number of inpatient separations has decreased, average occupied beddays have remained approximately the same and the average length of stay has increased. In 2005-06 the average occupancy level was 2.9 beds (72%), with an average length of stay of 6.2 days.

2005-06 data indicates the following activity at the Midlands MPC:

- There were 168 separations involving 110 individuals.
- Forty-three separations (26%) were admitted and discharged on the same day. This was higher than the rural site average of 20%.
- Fifteen of these 43 same-day separations were attributable to two individuals having multiple short-stay episodes. It is accepted practice to admit these as day patients but for a small site it does have a significant impact on the total statistics.
- For this facility, there are two distinct client groups, a younger group (age over 65), generally short stay, admitted for medical conditions able to be managed in a rural hospital, and an older group, generally longer stay, and including some palliative care. Ten patients died in the hospital after an average stay of 22 days.
The Midlands MPC has 19 aged care beds with an average occupancy of 17.9 beds (94%). When the aged care beds are full there tends to be an overflow effect into the hospital beds. Commonwealth aged care revenue received in 2005-06 was $662,563.

The most recent aged care data (updated to December 2006) shows that the average resident classification for the low-care beds has been climbing steadily and is very high at 4.1. (Low-care residents should be in the range 6-8.) The high occupancy of the high-care beds, coupled with the rising resident classification of residents in the low-care beds, points to an overflow of additional high-care residents into the low-care beds.

Overall occupancy, across all bed types in 2005/06 was 20.8 beds (90%). The 200/06 actual costs were $2,298,467. This means that the actual annual cost per occupied bed was $110,618.

The Midlands MPC is a University Department of Rural Health teaching site providing facilities for students to stay and undertake clinical placements in Oatlands.

Oatlands also has a volunteer ambulance station run by the Tasmanian Ambulance Service. The Midlands MPC devotes significant resources to supporting the local ambulance service, mostly for emergency retrieval and transfer to Royal Hobart Hospital. There was an average of 18 occasions per month involving a total of 43 staff hours per month in 2005-06.

In May 2006 the Census of Tasmanian GPs found that there were less than three GPs practising in this municipal area.

The Australian Government provides funding for visiting optometrists, as well as social work, podiatry and physiotherapy services through the Regional Health Services program.

**Commentary**

The Midlands MPC at Oatlands is currently operating as a Tier 2 facility. There is a developing issue in the sustainability of the facility’s various roles (eg ambulance/emergency response, acute care inpatients and residential aged care) due to the difficulties in recruiting and retaining nursing and care staff. This situation will be monitored and services will be reviewed should it not be possible to secure sufficient staff resources on an ongoing basis.

Under the Primary Health Services Plan, there is the potential for an expanded range of services provided in relation to chronic disease, bringing together health providers from general practice and community health, local government and non-government organisations.
Summary of actions for Fawkner:

**Brighton** – The Bridgewater Community Health Centre will be developed as a Tier 1 facility with an expansion in its capacity to provide services that address chronic disease.

**Central Highlands** – The Ouse District Hospital will be developed as a Tier 1 Community Health Centre providing a wider range of services including non-medical overnight planned respite on an as-required basis and maintaining an emergency response role, with an injury treatment room available on site. The existing four subacute inpatient beds will transfer to the New Norfolk District Hospital.

The Department will work with the Australian Government and local organisations regarding the aged care beds and to seek community aged care packages for the Central Highlands area.

**Derwent Valley** – The New Norfolk District Hospital and Community Health Centre will be maintained as a Tier 2 facility, servicing the Central Highlands and Derwent Valley municipal areas. In order to do this, the regularly available beds will be expanded from 10 to 14 beds.

**Glenorchy** – The Glenorchy Community Health Centre will be developed as a Tier 3 facility with outreach services to the Brighton, Derwent Valley, Southern Midlands and Central Highlands municipal areas.

**Southern Midlands** – The Midlands Multi Purpose Centre at Oatlands will be maintained as a Tier 2 facility. It will maintain its capacity to contribute to emergency responses, but the situation will continue to be monitored in relation to the ongoing sustainability of its role relating to ambulance, subacute inpatient and residential aged care services due to staffing issues.

8.4 Northern region: South Esk

*Figure 17 South Esk*
8.4.1 Launceston

**Demographics**

Launceston is classified as an urban/adjacent urban area. The Launceston population was 65,021 in June 2005. The population for Launceston is projected to decrease by 2% between 2006 and 2018. In terms of population change the 75 years and over cohort is projected to increase by 27%, and the proportion of the population 75 years and over will make up approximately 9.8% of the population by 2018.

It is estimated that the catchment for services in Launceston extends through the West Tamar, Meander Valley and Northern Midlands to take in approximately another 20,000 people.

**Service profile**

Services are spread across the municipal area – the Launceston General Hospital in Central Launceston and Community Health Centres in Kings Meadows and Ravenswood. These two offer a range of primary health and community care services. Other services are provided on a regional basis from facilities in the precinct close to the Launceston General Hospital.

Table 28 lists departmental services provided within the Launceston municipal area.

**Table 28 Departmental services: Launceston municipal area**

<table>
<thead>
<tr>
<th>Launceston</th>
<th>Acute Health Services</th>
<th>Community Health Services</th>
<th>Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Launceston General Hospital</td>
<td>Alcohol and Drug Service</td>
<td>Child and Family Services – North</td>
</tr>
<tr>
<td></td>
<td>Ambulance Service</td>
<td>Breast Screen Tasmania</td>
<td>Child Health Centre (x2)</td>
</tr>
<tr>
<td></td>
<td>Sexual Health Service</td>
<td>Child and Adolescent Mental Health Service</td>
<td>Disability Services – North</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community Assessment and Case Management – North</td>
<td>Housing Service Centre</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community Mental Health Team</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Oral Health Service – Adult and Children</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Palliative Care Service – North</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Women’s Health – North</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Youth Health Program – North</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Kings Meadows</th>
<th>Acute Health Services</th>
<th>Community Health Services</th>
<th>Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Community Health Centre</td>
<td>Community Health Centre</td>
<td>Child Health Centre</td>
</tr>
<tr>
<td></td>
<td>Community Nursing</td>
<td>Community Nursing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Continence Service</td>
<td>Continence Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Help and Personal Care</td>
<td>Home Help and Personal Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Maintenance Services</td>
<td>Home Maintenance Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Oral Health Services – Children</td>
<td>Oral Health Services – Children</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physiotherapy – Community</td>
<td>Physiotherapy – Community</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outreach Service</td>
<td>Outreach Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Podiatry – Community</td>
<td>Podiatry – Community</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social Work – Community Outreach Service</td>
<td>Social Work – Community Outreach Service</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ravenswood</th>
<th>Acute Health Services</th>
<th>Community Health Services</th>
<th>Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Community Health Centre</td>
<td>Community Health Centre</td>
<td>Child Health Centre</td>
</tr>
<tr>
<td></td>
<td>Community Nursing</td>
<td>Community Nursing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Help and Personal Care</td>
<td>Home Help and Personal Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Maintenance Services</td>
<td>Home Maintenance Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Podiatry – Community</td>
<td>Podiatry – Community</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social Work – Community Outreach Service</td>
<td>Social Work – Community Outreach Service</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mowbray</th>
<th>Oral Health Service – Children</th>
<th>Oral Health Service – Children</th>
<th>Child Health Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rocherlea</td>
<td></td>
<td></td>
<td>Child Health Centre</td>
</tr>
<tr>
<td>Newstead</td>
<td></td>
<td></td>
<td>Child Health Centre</td>
</tr>
<tr>
<td>Summerhill</td>
<td></td>
<td></td>
<td>Child Health Centre</td>
</tr>
<tr>
<td>Newnham</td>
<td>Walker House</td>
<td>Walker House</td>
<td>Parenting Centre</td>
</tr>
</tbody>
</table>

Source: Department of Health and Human Services, 2007.
As at June 2006, 370 Departmental Community Health staff (242 FTE) provided services from these sites. Some community allied health services are provided by arrangement with the Launceston General Hospital.

There is a Tasmanian Ambulance Service station with coverage provided 24-hours a day, seven days a week by two-person salaried crews.

In May 2006 the Census of Tasmanian GPs found that there were 72 GPs providing 528 sessions (3.5 hour sessions) of care; this equated to 52.8 FTE GPs. In terms of GP capacity to provide extra sessions of care it should be noted that Launceston has been declared an Area of Need.

A wide range of non-government organisations provide Home and Community Care, mental health services, residential aged care etc within the municipal area. The Corner is a youth health service provided by a partnership of organisations including GP North and the Department.

The Australian Government funds drug treatment services delivered by the Launceston College and Salvation Army through the Non-Government Organisations Treatment Grants Program.

Commentary
Community health services are disaggregated across Launceston and there has long been a recognition that a consolidated central site would assist in coordination of service delivery and in attaining critical mass. Under the Clinical Services Plan it is envisaged that a Tier 4 integrated care centre will be developed in a site close to the Launceston General Hospital. This will include services currently provided from within the hospital as well as primary health services.

In addition, there is a proposal before the Department for Launceston to be the site for a major demonstration of an integrated approach to primary health care between general practice and the Department. This offers opportunities for an expanded range of services provided in relation to chronic disease. There would need to be a careful analysis of how this might occur, what the relationship would be with the future integrated care centre and further consultation with stakeholders before implementation.

The Ravenswood and Kings Meadows Community Health Centres will continue in their current roles in the short- to medium-term.

8.4.2 Meander Valley

Demographics
Meander Valley is classified as an urban/adjacent urban area. The Meander Valley population numbered 17,300 in June 2005. The population for Meander Valley is projected to increase by 14% between 2006 and 2018. In terms of population change the 75 years and over cohort is projected to increase by 52%, and the proportion of the population 75 years and over will be in the order of 7.8% of the population by 2018.

Service profile
Table 29 lists departmental services provided within the Meander Valley municipal area.
Table 29 Departmental services: Meander Valley municipal area

<table>
<thead>
<tr>
<th>Acute Health Services</th>
<th>Community Health Services*</th>
<th>Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deloraine</td>
<td>Deloraine District Hospital inpatient, outpatient care</td>
<td>Child Health Centre, Ashley Youth Detention Centre</td>
</tr>
<tr>
<td>Ambulance Service (branch station/ paramedic on site of District Hospital)</td>
<td>Aged Care Assessment Program, Audiology, Child Speech Pathology, Community Development and Health Promotion, Community Equipment Scheme, Community Nursing, Community Podiatry (privately brokered service), Community Social Work, Continence, Day Centre, Dietetics/Community Nutrition, Diversional Therapy, Drug and Alcohol Services, G.P. Dermatologist, Hearing Aid Clinic, Home Help and Personal Care, Mental Health services, Occupational Therapy, Oral Health Services – Children, Palliative Care, Physiotherapy – Community Options Service, Psychology, Rheumatologist, School Dental, Transport</td>
<td></td>
</tr>
<tr>
<td>Westbury</td>
<td>Westbury Community Health Centre, Social Work – Community Outreach Service, Community Nursing, Home Help, Personal Care, Podiatry – Community</td>
<td>Child Health Centre, Ashley Youth Detention Centre</td>
</tr>
<tr>
<td>Mole Creek</td>
<td>Community Nursing</td>
<td>Child Health Centre</td>
</tr>
<tr>
<td>Hadspen</td>
<td></td>
<td>Child Health Centre</td>
</tr>
</tbody>
</table>

# Many of these services are not available on a full-time basis but are provided on an outreach basis from another centre.
Source: Department of Health and Human Services, 2007.

As at June 2006, 92 Departmental Community Health staff (45 FTE) provided services from these sites.

The Deloraine Hospital provides a range of primary health and community care services. It also provides inpatient care with 20 subacute inpatient beds. Same-day services include chemotherapy and other post-acute procedures.

In relation to inpatient services, the average patient age is 66 years. Over the last five years the number of inpatient separations have remained constant, while average occupied beddays and average length of stay have declined. In 2005-06 the average occupancy level was 13.8 inpatient beds (69%), with an average length of stay of 12.2 days. The 2005-06 actual costs were $2,050,076. This means that the actual annual cost per occupied bed was $148,911.

# Many of these services are not available on a full-time basis but are provided on an outreach basis from another centre.
2005-06 data indicates the following activity at the Deloraine Hospital:

- There were 516 separations involving 259 individuals.
- Deloraine has a high rate of “regular” patients having multiple admissions: 66% of all separations. Examples include one patient with nine admissions totalling 30 days in hospital, and another with five admissions totalling 39 days.
- 61 separations (12%) were same-day. This was mainly attributable to a small number of patients having repeat same-day admissions.
- There were 107 admissions on transfer from Launceston General Hospital (21% of admissions). Some of these were short-stay post-acute but most were elderly long-stay for slow stream rehabilitation, palliative care or placement awaiting residential aged care.

There are no GPs on site. However GPs have surgeries in the Deloraine township. There is a Tasmanian Ambulance Service branch station at Deloraine.

The Westbury Community Health Centre provides a range of primary health and community care services including social work, community nursing, home care, day respite and community development. It is well supported by volunteers from the community.

In May 2006 the Census of Tasmanian GPs found that there were eight GPs in the Meander Valley LGA providing 59 sessions (3.5 hour sessions) of care; this equated to 5.9 FTE GPs.

The Australian Government provides funding through the Regional Health Services and Medical Specialist Outreach Assistance programs for a physician (rheumatology) service in Deloraine together with a social worker and a youth worker in Westbury. There are two non-government residential aged facilities funded by the Australian Government in Deloraine that are currently working to combine their administrative arrangements.

Westbury and Deloraine community health services have strong links with the University Department of Rural Health.

Commentary
The Deloraine Hospital provides hospital care to its local community and has developed a strong relationship with the Launceston General Hospital in the provision of step-down and interim care for people no longer needing acute hospital services. This has enabled it to maintain higher levels of occupancy than would otherwise be the case. Developments in the acute care sector in the future as a result of the Clinical Services Plan may influence this situation.

There needs to be further work to determine whether there are opportunities for greater integration of general practice with the hospital site.

The Westbury Community Health Centre is a highly active and community-oriented service and is a state-wide leader in the effective provision of a primary health care model. This approach needs to continue and there are opportunities within the Primary Health Services Plan for this service to demonstrate further innovation in community health care.

Under the Primary Health Services Plan, there is the potential for an expanded range of services provided in relation to chronic disease, bringing together health providers from general practice and community health, local government and non-government organisations.
8.4.3 West Tamar

Demographics
West Tamar is classified as an urban/adjacent urban area. The population of the West Tamar was 21,237 in June 2005. The West Tamar population is projected to increase by 8% between 2006 and 2018. Within that total, the majority of that increase (57%) will be people in the 75 years and over cohort, to stand at 9% of the population by 2018.

Service profile
The Beaconsfield District Health Service (Multi Purpose Service [MPS]) provides a range of primary health and community care services. It also provides inpatient and residential aged care. It has four subacute inpatient beds.

Table 30 lists departmental services provided within the West Tamar municipal area.

<table>
<thead>
<tr>
<th>Acute Health Services</th>
<th>Community Health Services</th>
<th>Child Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beaconsfield</td>
<td>Health and Community Service Centre providing subacute care, residential aged care and other services.  Alcohol and Drug Service – visiting Home Maintenance Services Physiotherapy – part of MPS, not outreach Community Nursing Home Help and Personal Care Social Work – part of MPS, not outreach Podiatry – Community</td>
<td></td>
</tr>
<tr>
<td>Ambulance Service</td>
<td>Exeter Oral Health Services – Children</td>
<td>Child Health Centre</td>
</tr>
<tr>
<td></td>
<td>Riverside Child Health Centre</td>
<td></td>
</tr>
</tbody>
</table>

# Many of these services are not available on a full-time basis but are provided on an outreach basis from another centre.

Source: Department of Health and Human Services, 2007.

As at June 2006, 95 Departmental Community Health staff (38 FTE) provided services from this site.

In relation to subacute care, the average patient age is 76 years. Over the last five years the number of inpatient separations and average occupied bed days has declined while the average length of stay has increased. In 2005-06 the average occupancy level was 3.2 beds (79%), with an average length of stay of 21.7 days (the highest for all state-run services in Tasmania).

2005-06 data indicates the following activity at the Beaconsfield District Health Service:

- There were 62 separations but many of these were the same patient admitted multiple times. There were only 41 individuals admitted during the year.
- Twenty-six out of the 62 admissions were transfers from the Launceston General Hospital. Most clients transferred from the Launceston General Hospital were generally elderly and long stay – typically slow-stream rehabilitation, waiting for placement in residential aged care, palliative care, and other subacute care.
- The high average age and high average length of stay strongly confirm Beaconsfield’s role as providing subacute/non-acute care to a small group of elderly people. Patients aged 65 years or over accounted for 82% of admissions and 97% of bed days. Long-stay patients (over two weeks) accounted for 40% of admissions and 81% of bed days.
There is no contracted doctor resident in Beaconsfield. The Department has rural medical practitioner agreements with the Exeter medical practitioners to provide a total of six clinical hours per fortnight. This does not allow for the safe management of complex or unstable conditions and does not enable the site to function as an emergency centre.

An average of ten people per month attended the hospital for emergency treatment. These were treated by the nurse and, where appropriate, transferred by ambulance to Launceston.

The Beaconsfield District Health Service (Multi Purpose Service) has 18 aged care beds (12 high care, 6 low care) with an average occupancy of 17.1 beds (95%).

The Beaconsfield District Health Service is a Multi Purpose Service jointly funded under a three-year service agreement with the Australian Department of Health and Ageing. This agreement expires on 1 June 2008. The Australian Government contributed $990,175 in 2005-06 to the Service Agreement’s pooled funds. The State government contribution through the Department in 2005-06 was $2,824,235.

There is a Tasmanian Ambulance Service branch station at Beaconsfield.

In May 2006 the Census of Tasmanian GPs found that there were 16 GPs providing 117 sessions (3.5 hour sessions) of care; this equated to 11.7 FTE GPs. In terms of GP capacity to provide extra sessions of care it should be noted that West Tamar has been declared an Area of Need.

Commentary
Any changes in service provision will be discussed with the facility’s stakeholders but the most recent inpatient data (updated to March 2007) shows that inpatient activity is continuing to decline while residential aged care occupancy is rising and is now showing over 100% occupancy. This points to a need for the current bed mix to be adjusted to something more appropriate with a greater focus on respite and interim care.

Under the Primary Health Services Plan, there is the potential for an expanded range of services provided in relation to chronic disease, bringing together health providers from general practice and community health, local government and non-government organisations.

Summary of actions for South Esk

Launceston – A Tier 4 integrated care centre will be developed, over time, on a site close to the Launceston General Hospital. This service will include services currently provided from within the hospital as well as primary health services. The Ravenswood and Kings Meadows Community Health Centres will be developed as Tier 1 facilities. Their future roles may need to be redefined following the development of the Launceston integrated care centre as part of the Clinical Services Plan. The Department will actively pursue opportunities for a new service provision relationship with general practice in the Launceston area.

Meander Valley – The Deloraine Hospital will be maintained as a Tier 2 facility. Its ongoing role will be monitored in the future in relation to developments in the acute care sector. The Westbury Community Health Centre will be confirmed as a Tier 1 facility with opportunities to act as a demonstration site for further innovation.

West Tamar – The District Health Service (Multi Purpose Service) is a Tier 2 facility providing a range of primary health and community care services to the community, with the role of the inpatient beds to be reviewed as to whether in the future they should be interim and respite care only.
8.5 Northern region: North Esk

Figure 18 North Esk

Source: Department of Health and Human Services, 2007.

8.5.1 Break O’Day

Demographics
Break O’Day is a rural/remote area. The Break O’Day population numbered 6,194 in June 2005. The population is projected to increase by only 2% between 2006 and 2018. Within that total, the majority of that increase (52%) will be people in the 75 years and over cohort, to stand at 11.3% of the population by 2018. It currently has one of the highest proportions of people over 65 in Tasmania. There is an increase in population during the summer period.

Service profile
The Break O’Day municipality is serviced by two facilities both providing inpatient and community health services. These are located at St Helens and St Marys.

Table 31 lists departmental services provided within the Break O’Day municipal area.
As at June 2006, 124 Departmental Community Health staff (40 FTE) provided services from these sites.

The **St Helens District Hospital** provides a range of primary health and community care services. It also provides inpatient care, with ten subacute inpatient beds. The average patient age is 55 years. Over the last five years the number of inpatient separations, average occupied beddays, and average length of stay have all declined slightly. In 2005-06 the average occupancy level was six beds (60%), with an average length of stay of 3.58 days. It is the third most costly rural inpatient facility in Tasmania with 2005-6 actual costs amounting to $1,986,077. This means that the actual annual cost per occupied bed was $345,035.

The 587 separations from St Helens Hospital in 2005-06 represented 411 individuals, the majority of these were local admissions. Fifty-two patients were transferred from Launceston General Hospital (LGH), representing 9% of the separations and 18% of the occupied beddays. Average length of stay for these patients was 7.4 days, as compared with 3.2 days for all other patients. This includes five patients admitted for post-natal care with their babies.

The Department has recently contracted with a private medical company for the provision of general practice in the St Helens community. Funding has been received from the Australian Government to assist in the construction of a new GP centre in the town.

St Helens also has a volunteer ambulance station run by the Tasmanian Ambulance Service. There is a paramedic service based at Scamander.

The **St Marys Community Health Centre** provides a range of primary health and community care services. It is 40 minutes from the St Helens District Hospital and also provides inpatient care, with eight subacute inpatient beds. The average patient age is 54 years. Over the last five years the number
of inpatient separations have increased, average occupied beddays have remained constant (slight decline), and average length of stay has declined slightly. In 2005-06 the average occupancy level was 1.8 beds (29%), with an average length of stay of 3.38 days. It is the most costly rural inpatient facility in Tasmania with 2005-6 actual costs being $1,759,298. This means that the actual annual cost per occupied bed was $965,630. Costs are high due to the low usage of the facility and the high cost of fixed staffing to maintain the facility in a 24-hours a day, seven days a week model.

Inpatient services at St Marys fulfil two functions: respite and interim care for older people (43 individuals in 2005-6) and short-term stay for younger people (often overnight admissions for mental illness and substance abuse issues).

Same-day separations represent 40% of all separations (more than twice the proportion of other like sites) but include patients transferred to LGH. The number of separations at St Marys is being boosted by this unusual practice of admitting patients awaiting transfer to LGH. All but four waited less than three hours, many only one hour. Most of these “admissions” are occurring during normal community health operating hours.

Of the 197 separations (130 individuals) from St Marys, most were the result of local admissions with 16 patients transferred from LGH. Mostly these were elderly patients and they had an average length of stay of 9.3 days. There was one post-natal admission.

St Marys Community Health Centre is a University Department of Rural Health teaching site, providing facilities for students to stay and undertake clinical placements in St Marys.

St Marys also has a volunteer ambulance station run by the Tasmanian Ambulance Service. There is a proposal to relocate the volunteer ambulance base to a new emergency centre that includes fire and State Emergency Services.

In May 2006 the Census of Tasmanian GPs found that there were five GPs providing 35 sessions (3.5 hour sessions) of care; this equated to 3.5 FTE GPs in Break O’Day. In terms of GP capacity to provide extra sessions of care it should be noted that Break O’Day has been declared an Area of Need.

The Australian Government funds the Break O’Day Regional Health Service to provide services in: mental health, social work, podiatry, palliative care, youth worker and health promotion, while medical specialists in urology and rheumatology are funded through the Medical Specialist Outreach Assistance Program.

Commentary

St Helens

St Helens has the capacity to provide inpatient services across the whole Break O’Day municipal area. There is now stable access to general practice and there are strong links with the local community through the Break O’Day Health Resources Association.

Under the Primary Health Services Plan, there is the potential for an expanded range of services provided in relation to chronic disease, bringing together health providers from general practice and community health, local government and non-government organisations.

Future planning will need to consider what the arrangements should be for better linkages with general practice, particularly in light of the new GP centre being constructed in St Helens.

St Helens is a rural site where there is the potential to significantly improve the clinical usage of Telehealth to increase access to services.

It was recognised through the planning processes that enhanced training and linkages with the acute health services to improve their joint participation in emergency responses are required.
There would be a benefit in St Helens being developed as a rural health teaching site.

Access to community transport remains a concern in the community and improvements can be expected through the development of community transport networks and the provision of additional funds to assist in meeting the needs of people who are transport disadvantaged and are seeking non-urgent health-related transport across rural areas.

St Marys
The Community Health Services at St Marys have the capacity to contribute significantly to the provision of effective community care across the municipal area; however, as long as there is a large investment in maintaining a little-used inpatient facility, this is significantly impeded. While the inpatient beds are highly valued by some people in the community, there are also alternative views that much more could be done with the resources than is currently the case. The absence of primary mental health and alcohol and drug services has lead to a reliance on overnight stays for people with these issues whereas more appropriate clinical practice would see them supported to remain in their own homes in a way that prevents recurring crises. Capacity to recruit and retain both general practice and nursing staff is an ongoing issue: the 24-hours on call being a major disincentive for GPs and low activity and acuity levels hindering retention of nursing staff.

In applying the health planning principles to rural health sites in Tasmania, it is clear that some are not meeting the criteria established to demonstrate sustainability. It is not possible for them to deliver the current service to their community in a way that is safe, effective and at an acceptable cost. Nor will it be possible to continue to provide these services in the future when workforce issues worsen. Consultation has occurred with the St Marys community in relation to this issue.

The recruitment of a General Practitioner remains very difficult within the current service model at the St Marys Community Health Centre and maintaining it at a Tier 2 level is not sustainable in the long term.

There are alternatives to the current service model which will meet the needs of the community, especially in relation to care of the elderly. Under the Primary Health Services Plan, there is the potential for an expanded range of services provided in relation to chronic disease, bringing together health providers from general practice and community health, local government and non-government organisations. The range of services that could be made available in these circumstances could include:

- overnight planned respite capacity as required for non-health-related conditions (ageing and social support situations);
- individualised packages of care for older people to enable them to remain in their own homes (both post-acute and community care);
- additional day centre respite;
- more allied health services as an outreach;
- maintenance of general practice on-site;
- community nursing and on-site nurse clinics (especially for chronic disease treatment, including diabetes);
- mental health support packages in association with Mental Health Services and increased visiting services from Mental Health and Alcohol and Drug Services; and
- increased focus on health promotion and healthy lifestyle activities.

The Department has recently received a submission which raises the potential for a new approach to the delivery of services in the Break O’Day municipality. This requires further investigation and extensive consultation with the communities of St Helens and St Marys before a firm direction can
be established. This proposal may provide significant improvement in health services for the whole municipality and deserves further consideration.

8.5.2 Dorset

Demographics
Dorset is a rural/remote area. The Dorset population numbered 7,120 in June 2005. The Dorset population is projected to decrease by 5% between 2006 and 2018. Within that total, a major increase (50%) will be people in the 75 years and over cohort, to stand at 12% of the population by 2018. It currently has one of the highest proportions of people over 65 in Tasmania.

Service profile
The North East Soldiers Memorial Hospital in Scottsdale provides a range of primary health and community care services. It also provides inpatient and residential aged care.

Table 32 lists Departmental services provided within the Dorset municipal area.

Table 32 Departmental services: Dorset municipal area

<table>
<thead>
<tr>
<th>Acute Health Services</th>
<th>Community Health Services*</th>
<th>Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scottsdale *</td>
<td>North East Soldiers Memorial Hospital and Community Service Centre providing inpatient subacute and residential aged care services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>GP obstetrics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Minor surgery</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Oral health</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Day centre care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Occupational therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Speech therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental health counselling</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Primary health care coordination</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social work</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physiotherapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Radiography</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Nursing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Help</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Personal Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Visiting services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Podiatry</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(privately brokered service)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>There is a Child Health Service located on site</td>
<td></td>
</tr>
<tr>
<td>Bridport</td>
<td>Child Health Centre</td>
<td></td>
</tr>
<tr>
<td>Winnaleah</td>
<td>Child Health Centre</td>
<td></td>
</tr>
</tbody>
</table>

* North East Soldiers Memorial Hospital provides an Ambulance Service.
# Several of these services are not available on a full-time basis but are provided on an outreach basis from another centre.
Source: Department of Health and Human Services, 2007.

As at June 2006, 114 Departmental Community Health staff (68 FTE) provided services from this site.

The facility has 20 subacute inpatient beds. The average patient age is 57 years. Over the last five years the number of inpatient separations, average occupied beddays, and average length of stay have all declined. In 2005-06 the average occupancy level was 14.6 beds (74%), with an average length of stay of 7.6 days.

This facility is the only rural hospital that now undertakes GP obstetrics and also maintains a small minor surgery role. There are close links between Launceston General Hospital and the nursing staff and general
practitioners of Scottsdale, particularly in relation to maintenance of skills for obstetrics. The number of births have declined over time and it is expected that numbers will continue to be modest.

The 703 separations from Scottsdale Hospital represent 490 individuals, the majority from local admissions. 82 patients transferred in from Launceston General Hospital, representing 12% of all separations and 14% of occupied beddays. This includes 16 women admitted for post natal care, generally one to three days in the Scottsdale hospital. Average length of stay for all transferred in patients was 8.8 days while average length of stay for all other patients was 7.4 days.

Residential aged care beds at the North East Soldiers Memorial Hospital increased from 24 to 29 during 2006-07. In 2005-06 the average occupancy level was 22.7 beds (94%). Commonwealth aged care revenue received in 2005-06 was $908,439.

Overall occupancy across all beds is 37.2 beds (85%). The 2005-06 actual costs were $5,352,710. This means that the actual annual cost per occupied bed was $144,215.

The North East Soldiers Memorial Hospital is a University Department of Rural Health teaching site providing facilities for students to stay and undertake clinical placements in Scottsdale.

Scottsdale has an ambulance service run through the North East Soldiers Memorial Hospital and linked to the Tasmanian Ambulance Service communications room.

The Australian Government provides funding through the Regional Health Services and Medical Specialist Outreach Assistance programs for social work, youth work, mental health, general surgery (GP) and dermatology services in Scottsdale. There is a non-government organisation providing Australian Government funded residential aged care (31 low care places) close to the hospital.

In May 2006 the Census of Tasmanian GPs found that there were six GPs providing 55 sessions (3.5 hour sessions) of care; this equated to 5.5 FTE GPs. In terms of GP capacity to provide extra sessions of care it should be noted that Dorset has been declared an Area of Need.

**Commentary**

The North East Soldiers Memorial Hospital at Scottsdale performs a valuable role in its community. Its capacity to continue to provide such a varied role will depend on the availability of staff with the necessary levels of professional expertise and on the development of joint service delivery guidelines in association with the acute hospital services for midwife and GP obstetrics in particular. It has developed an informal role in providing support for the Flinders Island Multi Purpose Centre in relation to nursing leadership and locum staff. Scottsdale is the largest rural hospital site and consequently could potentially undertake service development trials or specific new educational programs (eg rural health education, in which it already has a role as a rural teaching site).

Under the Primary Health Services Plan, there is the potential for an expanded range of services provided in relation to chronic disease, bringing together health providers from general practice and community health, local government and non-government organisations.

**8.5.3 Flinders Island**

**Demographics**

Flinders Island is a rural/remote area that takes in a number of smaller islands, the most populous of which is Cape Barren Island. The Flinders Island population numbered 897 in June 2005. The Flinders Island population is projected to decrease by 10% between 2006 and 2018. Within that total, people in the 75 years and over cohort is projected to increase by 25%, to stand at 11.8% of the population by 2018. It currently has one of the highest proportions of people over 65 in Tasmania.
Flinders Island has a much higher proportion of people of aboriginal descent in its population (17.7%) than the Tasmanian average (3.6%).

Service profile
The Flinders Island Multi Purpose Centre (MPC) provides a range of primary health and community care services. These include community nursing, oral health, allied health, child health and home maintenance. It also provides inpatient and residential aged care.

Cape Barren Island is serviced by a community nurse resident on the island and working from a community health centre funded by the Australian Government. Visiting services are provided, generally through the Australian Government Office for Aboriginal and Torres Strait Islander Health.

Table 33 lists departmental services provided within the Flinders Island municipal area.

<table>
<thead>
<tr>
<th>Acute Health Services*</th>
<th>Community Health Services*</th>
<th>Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flinders Island Multi-Purpose Centre providing residential aged care and sub acute inpatient services</td>
<td></td>
<td>Child Health Centre</td>
</tr>
<tr>
<td>Home Maintenance Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telehealth Tasmania Network</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Health Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physiotherapy – Community Outreach Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Podiatry (Community)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Work – Community Outreach Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Nursing (inc Cape Barren Island)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Help and Personal Care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

# Many of these services are not available on a full-time basis but are provided on an outreach basis from another centre.
* Flinders Island has a Volunteer Ambulance Station.
Source: Department of Health and Human Services, 2007.

As at June 2006, 27 Departmental Community Health staff (five FTE) provided services from this site.

Flinders Island MPC has four subacute inpatient beds. The average patient age is 59 years. Over the last five years the number of inpatient separations has increased, while the average occupied beddays, and average length of stay have declined. In 2005-06 the average occupancy level was 6.7 inpatient beds or 167% (when there are a very small number of beds, like here on Flinders Island, the discharge of one long-stay patient can push the average occupancy rate above the number of actual beds), with an average length of stay of 10.2 days.

The 124 separations from the inpatient beds in the Flinders Island MPC in 2005-06 represent 77 individuals, with seven patients transferred in from the Launceston General Hospital. This represents 6% of separations and 5% of occupied beddays. All patients were elderly. Average length of stay for these patients was 19.3 days, compared to 16.5 for all other patients.

The Flinders Island MPC has nine aged care beds (five high care and four low care). In 2005-06 the average occupancy level was 7.9 beds (88%). Commonwealth aged care revenue received in 2005-06 was $345,899.

Overall occupancy across all bed types was 14.6 beds (112%). The 2005-06 actual costs were $2,021,086. This means that the actual annual cost per occupied bed was $138,618.

Flinders Island MPC is a University Department of Rural Health teaching site providing facilities for students to stay and undertake clinical placements on the island.

Flinders Island also has a volunteer ambulance station run by the Tasmanian Ambulance Service.
There is a general practice service contracted by the Department to a private provider.

Community health outreach services are provided to Flinders Island from Launceston with a fortnightly chartered “health plane” providing regular transport, including transport of the Flinders Island medical officer to Cape Barren Island.

The Australian Government Office for Aboriginal and Torres Strait Islander (OATSIH) Health funds a range of services for the indigenous community of Flinders and Cape Barren Islands, listed in Table 34.

Table 34 Flinders Island: Australian Government OATSIH-funded services June 2006

<table>
<thead>
<tr>
<th>Service location</th>
<th>Program</th>
<th>Type of service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whitemark</td>
<td>Primary Health Care Services</td>
<td>Administrative Staff</td>
</tr>
<tr>
<td></td>
<td>Primary Health Care Access Program Services</td>
<td>Aboriginal Health Worker</td>
</tr>
<tr>
<td></td>
<td>Services Expansion and Enhancement</td>
<td>Doctor</td>
</tr>
<tr>
<td></td>
<td>Strategies and Partners</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td></td>
<td>Workforce</td>
<td>Allied Health Professionals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Visiting Social Worker</td>
</tr>
<tr>
<td>Cape Barren Island</td>
<td>Primary Health Care</td>
<td>Health and Well Being Manager</td>
</tr>
<tr>
<td></td>
<td>Services Expansion and Enhancement</td>
<td>Visiting Health Professionals</td>
</tr>
</tbody>
</table>

Source: Australian Department of Health and Ageing

The Australian Government also funds improved access to allied and mental health services at a local level through programs managed by General Practice North. The State also contributes funding to General Practice North for a psychology service to the island.

Access to services on mainland Tasmania continues to be a problem for Flinders Island residents.

**Commentary**

It is recognised that there is a need for services such as are provided by the Flinders Island MPC in small remote communities such as this one.

Opportunities for the further provision of clinical services through Telehealth can be explored as part of the implementation of this plan.

Under the Primary Health Services Plan, there is the potential for an expanded range of services provided in relation to chronic disease, bringing together health providers from general practice and community health, local government and non-government organisations.

### 8.5.4 George Town

**Demographics**

George Town is a rural/remote area. The population of George Town numbered 6,679 in June 2005. It is projected to decrease by 5% between 2006 and 2018. Within that total, the 75 years and over cohort is to increase by 33%, to stand at 7% of the population by 2018. (These figures do not take into account the potential impact of the proposed Pulp Mill development on the LGA population profile.)

**Service profile**

The George Town District Hospital and Community Centre provides a range of primary health and community care services. It also provides inpatient care, with 15 subacute inpatient beds.

Table 35 lists departmental services provided within the George Town municipal area.
As at June 2006, 40 Departmental Community Health staff (21 FTE) provided services from this site.

With regard to the inpatient services, the average patient age is 60 years. Over the last five years the number of inpatient separations, average occupied beddays, and average length of stay has all declined. In 2005-06 the average occupancy level was nine beds (58%), with an average length of stay of 7.7 days. The 2005-06 actual costs were $1,766,822. This means that the actual annual cost per occupied bed was $202,541.

2005-06 data indicates the following activity at the George Town District Hospital and Community Centre:

- There were 414 separations involving 259 individuals.
- Fifty-one separations were day-only. These were a mixture of repeat admissions for day procedures, and single admissions for observation. Seven of these same-day admissions were subsequently transferred to the Launceston General Hospital for treatment.
- There were 51 patients transferred from the Launceston General Hospital. These were more elderly (average age 65 years) with longer stay (average 15 days) than the remainder of admissions. This group accounted for 12% of admissions and 25% of beddays.
- George Town is typical of many rural sites where a small number of elderly long-stay patients account for most of the activity. Long-stay patients (over 14 days) accounted for 12% of separations and 56% of occupancy.

George Town District Hospital and Community Health Centre is a University Department of Rural Health teaching site providing facilities for students to stay and undertake clinical placements in George Town.

There is a Tasmanian Ambulance Service branch station at George Town.

In May 2006 the Census of Tasmanian GPs found that there were nine GPs providing 61 sessions (3.5 hour sessions) of care; this equated to 6.1 FTE GPs.

The Australian Government funds a range of services through the Regional Health Services program, including mental health, youth health, social work and health promotion. There is a Commonwealth-funded residential aged care provider in the municipal area.

**Commentary**

The current services provided at George Town hospital (ie inpatient beds) tend to be predominantly focused on the needs of aged people; however the demographic profile of the area indicates that younger families, some with low socio-economic status, are a larger population group. Opportunities for utilising current resources in a different way and/or developing a wider range of service models that address family needs should be explored. Examples could include expansion of the information and

---

### Table 35 Departmental services: George Town municipal area

<table>
<thead>
<tr>
<th>Acute Health Services</th>
<th>Community Health Services*</th>
<th>Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Service</td>
<td>Oral Health Service – Children</td>
<td>Housing Service Centre</td>
</tr>
<tr>
<td></td>
<td>George Town District Hospital and Community Health Centre</td>
<td>Child Health Centre</td>
</tr>
<tr>
<td></td>
<td>Home Help and Personal Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Maintenance Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physiotherapy – Community Outreach Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Podiatry – Community</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Nursing</td>
<td></td>
</tr>
</tbody>
</table>

* Some of these services are not available on a full-time basis but are provided on an outreach basis from another centre.

Source: Department of Health and Human Services, 2007.
resource role of the centre, initiation of family-oriented wellbeing programs, introduction of specific medical/health services for children and parents, establishing links with child welfare and development services, encouraging joint research or pilot programs with a focus on children and families.

Under the Primary Health Services Plan, there is the potential for an expanded range of services provided in relation to chronic disease, bringing together health providers from general practice and community health, local government and non-government organisations.

8.5.5  Northern Midlands

Demographics

The Northern Midlands is classified as an urban/adjacent urban area. The Northern Midlands population numbered 12,167 in June 2005. It is projected to increase by 3% between 2006 and 2018. Within that total, there will be a major increase (66%) of people in the 75 years and over cohort, to stand at 9.1% of the population by 2018.

Service profile

The Campbell Town Health and Community Service is a Multi Purpose Service that provides a range of primary health and community care services. It also provides inpatient and residential aged care.

Table 36 lists departmental services provided in the Northern Midlands municipal area.

Table 36 Departmental services: Northern Midlands municipal area

<table>
<thead>
<tr>
<th>Acute Health Services</th>
<th>Community Health Services*</th>
<th>Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Campbell Town</td>
<td>Health and Community Service (MPS) providing residential aged care, subacute inpatient services and community health services</td>
<td>Child Health Centre</td>
</tr>
<tr>
<td></td>
<td>Alcohol and Drug Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Maintenance Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Telehealth Tasmania Network</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental Health Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social Work – Community Outreach Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Oral Health Services – Children</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Nursing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diabetes Education Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Help and Personal Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Podiatry – Community</td>
<td></td>
</tr>
<tr>
<td>Avoca</td>
<td>Oral Health Service – Children</td>
<td>Child Health Centre</td>
</tr>
<tr>
<td></td>
<td>Mental Health Adult Residential Services – Howard Hill Centre</td>
<td></td>
</tr>
<tr>
<td>Longford</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perth</td>
<td></td>
<td>Child Health Centre</td>
</tr>
<tr>
<td>Evandale</td>
<td></td>
<td>Child Health Centre</td>
</tr>
</tbody>
</table>

# Several of these services are not available on a full-time basis but are provided on an outreach basis from another centre.

* Avoca has a volunteer ambulance service.

Source: Department of Health and Human Services, 2007.

As at June 2006, 69 Departmental Community Health staff (41 FTE) provided services from the Campbell Town MPS.

The facility has six subacute inpatient beds. The average patient age is 73 years. Over the last five years the number of separations, average occupied beddays, and average length of stay have all increased. In 2005-06 the average occupancy level was 5.4 beds (90%), with an average length of stay of 14.4 days.
2005-06 data indicates the following activity at the Campbell Town Health and Community Service:

- Eighty-four individuals were admitted.
- There were a significant number of patients admitted for respite – 16 separations and 166 beddays.
- Twenty-five out of 145 admissions (17%) were transfers from Launceston General Hospital. They occupied 371 of 1,968 beddays (19%). These clients were generally elderly and long stay – typically slow-stream rehabilitation, waiting for placement, palliative care, and other subacute care.
- The high average age (73 years) and high average length of stay (14 days) strongly confirm Campbell Town’s role as providing subacute/non-acute care to a small group of elderly people. Patients aged 65 years or over accounted for 73% of admissions and 88% of beddays. Long-stay patients (over 2 weeks) accounted for 16% of admissions and 61% of beddays.

The Campbell Town Health and Community Service has 20 residential aged care beds. In 2005-06 the average occupancy level was 19.8 (99%).

The Campbell Town Health and Community Service is a Multi Purpose Service under a three-year service agreement with the Australian Department of Health and Ageing. This agreement expires on 17 September 2007. The Australian Government’s contribution to pooled funds for 2005-06 was $803,452 and the Department’s funding was $2,263,000. These funds can be used flexibly.

Campbell Town Health and Community Service is a University Department of Rural Health teaching site providing facilities for students to stay and undertake clinical placements.

The Toosey Aged and Community Care service in Longford (a Commonwealth funded aged care facility) has two Department-funded subacute inpatient beds. Average patient age for these beds is 79.7 (the oldest in the state). Over the last five years the number of separations and occupied beddays has decreased, while the average length of stay has increased. In 2005-06 the average occupancy level was 1.2 beds (62%), with an average length of stay of 17.9 days. The most recent inpatient data (updated to March 2007) showed no activity/separations over the last three months.

In 2005-06 Toosey Aged and Community Care received a grant payment of $100,000.

There is a Tasmanian Ambulance Services branch station at Campbell Town where volunteers support paramedics. (Currently there are gaps in the volunteer roster for this service.) Avoca also has a volunteer ambulance station run by the Tasmanian Ambulance Service.

In May 2006 the Census of Tasmanian GPs found that there were 10 GPs providing 54 sessions (3.5 hour sessions) of care in the Northern Midlands; this equated to 5.4 FTE GPs.

The Australian Government provides a visiting optometrist scheme at Campbell Town.

**Commentary**

The Campbell Town MPS provides a range of primary health and community care services to the community, with beds primarily used for interim and respite care. This is expected to be the pattern in future years. Workforce sustainability will however need to be monitored.

Submissions received from the community during the consultations associated with the development of this Plan identified a need for an expansion of community health services in the Longford/Cressy area. While Community Nursing is provided to the Longford area from Launceston (Kings Meadows), it is recognised that additional services may be required and will be considered if resources are available.

Given the low and predominantly aged care usage of the two inpatient beds at Toosey, discussions will occur with the management of the nursing home as to their appropriate future use.
Under the Primary Health Services Plan, there is the potential for an expanded range of services provided in relation to chronic disease, bringing together health providers from general practice and community health, local government and non-government organisations.

**Summary of actions for North Esk**

- **Break O’Day** – The St Helens District Hospital will be maintained as a Tier 2 facility. The future role of the St Marys Community Health Centre will continue to be monitored, given the level of concern as to its future sustainability. The Department will engage further with the St Marys and/or Break O’Day community concerning proposals for a new approach to health service delivery in the municipality.

- **Dorset** – The North East Soldiers Memorial Hospital at Scottsdale will be maintained as a Tier 2 facility. It will develop a formal role providing support for the Flinders Island Multi Purpose Centre. It will retain its capacity to participate in emergency responses in conjunction with acute health services. Its potential to trial service development or new educational programs will be explored.

- **Flinders Island** – The Cape Barren Island Community Health Centre will be maintained as a Tier 1 facility. The Flinders Island Multi Purpose Centre will be maintained as a Tier 2 facility. It will retain its capacity to participate in emergency responses in conjunction with acute health services. Formal links will be developed with the North East Soldiers Memorial Hospital.

- **George Town** – The George Town District Hospital and Community Health Centre will be maintained as a Tier 2 facility. Over time efforts will be made to reorient services as much as feasible towards addressing the health and wellbeing needs of the whole community, especially the younger population.

- **Northern Midlands** – The Campbell Town Multi Purpose Service will be maintained as a Tier 2 facility providing a range of primary health and community care services to the community, with inpatient beds used primarily for interim and respite care – consistent with current practice. Discussions will occur with the management of the Toosey nursing home at Longford as to the appropriate future use of the two inpatient beds. It is recognised that additional primary health resources may be required in the Cressy/Longford area and this will be considered if resources are available.
8.6 North West region: Mersey

Figure 19 Mersey

Source: Department of Health and Human Services, 2007.

8.6.1 Central Coast

Demographics
The Central Coast is classified as an urban/adjacent urban area. The Central Coast population was 20,914 in June 2005. The population is projected to decline by 6% from 2006 to 2018. In terms of population change, the 75 years and over cohort is projected to increase by 40% and the proportion of the population 75 years and over will be in the order of 11.5% of the population by 2018. It currently has one of the highest proportions of people over 65 in Tasmania.

Service profile
The Ulverstone Community Health Centre offers a range of primary health and community care services. This includes the Aged Care Assessment Team for the North West region. The regional Alcohol and Drug services team is also based in a separate location in Ulverstone. There is a Tasmanian Ambulance Service station with 24-hour, seven-days-a-week coverage provided by a two-person salaried crew.

Table 37 lists departmental services provided in the Central Coast municipal area.
Table 37 Departmental services: Central Coast municipal area

<table>
<thead>
<tr>
<th>Acute Health Services</th>
<th>Community Health Services*</th>
<th>Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ulverstone Ambulance Service</td>
<td>Alcohol and Drug Service</td>
<td>Child Health Centre</td>
</tr>
<tr>
<td></td>
<td>Oral Health Service – Children</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Health Centre</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Occupational Therapy – Community</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Maintenance Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physiotherapy – Community Outreach Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HACC Packages of Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Aged Care Assessment Team</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social Work – Community Outreach Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Nursing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Options Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Help and Personal Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Palliative Care</td>
<td></td>
</tr>
<tr>
<td>Penguin</td>
<td>Child Health Centre</td>
<td></td>
</tr>
</tbody>
</table>

# Some of these services are not available on a full-time basis but are provided on an outreach basis from another centre.

Source: Department of Health and Human Services, 2007.

As at June 2006, 55 Departmental Community Health staff (34 FTE) provided services from this site.

In May 2006 the Census of Tasmanian GPs found that there were 18 GPs providing 135 sessions (3.5 hour sessions) of care; this equated to 13.5 FTE GPs. In terms of GP capacity to provide extra sessions of care it should be noted that Central Coast has been declared an Area of Need.

The Australian Government provides funding through the Medical Specialist Outreach Assistance Program for a dermatologist to work out of Ulverstone. Several Commonwealth-funded residential aged care facilities operate from Ulverstone.

Commentary

Ulverstone and Devonport Community Health Centres provide a range of community health services across the North West region. They also have local community health responsibilities for the municipal areas of Latrobe and Kentish.

Under the Primary Health Services Plan, there is the potential for an expanded range of services provided in relation to chronic disease, bringing together health providers from general practice and community health, local government and non-government organisations.

8.6.2 Devonport

Demographics

Devonport is classified as an urban/adjacent urban area. The Devonport population numbered 25,266 in June 2005. The Devonport population is projected to decrease by 6% between 2006 and 2018. Within that total, a major increase (44%) will be people in the 75 years and over cohort, to stand at 12.5% of the population by 2018. It currently has one of the highest proportions of people over 65 in Tasmania.

Service profile

Devonport Community Health Centre offers a wide range of primary health and community care services to this and adjacent municipal areas. There is a large community health centre providing community nursing, allied health, oral health, housing, family and child health and children’s services. Mental Health Services are provided from a separate location in Devonport. There is a Tasmanian Ambulance Services station with coverage 24-hours a day, seven days a week provided by a two-person salaried crew.
Table 38 lists departmental services provided in the Devonport municipal area.

### Table 38 Departmental services: Devonport municipal area

<table>
<thead>
<tr>
<th>Acute Health Services</th>
<th>Community Health Services</th>
<th>Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Devonport</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance Service</td>
<td>Alcohol and Drug Services</td>
<td>Child Health Centre</td>
</tr>
<tr>
<td>Audiology – Women’s</td>
<td>Child &amp; Adolescent Service</td>
<td>Child &amp; Family</td>
</tr>
<tr>
<td>and Children’s Clinical</td>
<td>Community Health Centre</td>
<td>Services Support</td>
</tr>
<tr>
<td>Services (visiting</td>
<td>Community Nursing</td>
<td>Workers</td>
</tr>
<tr>
<td>service)</td>
<td>Contiuence Service</td>
<td>Community</td>
</tr>
<tr>
<td>Cochlear Implant</td>
<td>Diabetes Education Service</td>
<td>Partners</td>
</tr>
<tr>
<td>Service</td>
<td>Health Promotion</td>
<td></td>
</tr>
<tr>
<td>Diabetes Education</td>
<td>Home Maintenance</td>
<td></td>
</tr>
<tr>
<td>Nutrition &amp; Dietetics</td>
<td>Home Help and Personal Care</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>Huntington’s Disease</td>
<td></td>
</tr>
<tr>
<td>Patient Travel</td>
<td>Social Worker</td>
<td></td>
</tr>
<tr>
<td>Assistance:</td>
<td>Mental Health Adult</td>
<td></td>
</tr>
<tr>
<td>Physiotherapy – Adult:</td>
<td>Community Service</td>
<td></td>
</tr>
<tr>
<td>Sexual Health Clinic</td>
<td>Occupational Therapy –</td>
<td></td>
</tr>
<tr>
<td>(visiting service)</td>
<td>Community</td>
<td></td>
</tr>
<tr>
<td>Speech Pathology –</td>
<td>Occupational Therapy –</td>
<td></td>
</tr>
<tr>
<td>Adult/Child:</td>
<td>Paediatric</td>
<td></td>
</tr>
<tr>
<td>Stomal Therapy</td>
<td>Oral Health Services –</td>
<td></td>
</tr>
<tr>
<td>(visiting service)</td>
<td>Adults and Children</td>
<td></td>
</tr>
<tr>
<td>Palliative Care (includes Social Work):</td>
<td>visiting service</td>
<td></td>
</tr>
<tr>
<td>Respiratory advisor (visiting service)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Work – Community Outreach</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telehealth Tasmania Network</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well Women’s Clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>East Devonport</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Health Centre</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Department of Health and Human Services, 2007.

As at June 2006, 131 Departmental Community Health staff (57 FTE) provided services from this site. Two hundred and nine staff from all areas of the Department use this centre to deliver services.

In May 2006 the Census of Tasmanian GPs found that there were 23 GPs providing 152 sessions (3.5 hour sessions) of care; this equated to 15.2 FTE GPs.

For acute health services the Devonport community accesses the Mersey campus of the North West General Hospital at Latrobe. Research associated with the Clinical Services Plan indicates that 36% of cases presenting to the Mersey Department of Emergency medicine could be managed in a GP service.

The Australian Government’s Medical Specialist Outreach Assistance Program supports the following services: physicians in rheumatology and psychiatry, geriatric and general forensic. It also funds Youth and Family Focus to provide a drug treatment service under the Non-Government Organisations Treatment Grants Program.

Several Commonwealth-funded residential aged care facilities operate from Devonport, as do state-funded community care organisations.

**Commentary**

Devonport Community Health Centre already acts as a base for outreach services across the North West. There are opportunities for this role to be expanded over time. The development of closer links with mental health and other services not located within the facility should be pursued; however, co-location possibilities are limited by the lack of available space in the current facility. Opportunities
for better integration across primary health services and the North West Regional Hospital Mersey campus will also be developed.

Opportunities exist for the further development of an after-hours GP clinic in the Devonport area.

Under the Primary Health Services Plan, there is the potential for an expanded range of services provided in relation to chronic disease, bringing together health providers from general practice and community health, local government and non-government organisations.

8.6.3 Kentish

Demographics
Kentish is a rural/remote area. The population of Kentish numbered 5,784 in June 2005. The Kentish population is projected to decrease by 2% between 2006 and 2018. However, a major increase (73%) will be people in the 75 years and over cohort, to stand at 7.6% of the population by 2018.

Service profile
The Kentish community receives community health services on a domiciliary basis from Devonport and Ulverstone Community Health centres. For other services they access the two community health centres or the Mersey campus of the North West General Hospital at Latrobe. A local non-government provider offers a range of health and residential aged care services for the Kentish area.

Table 39 lists departmental services provided in the Kentish municipal area.

Table 39 Departmental services: Kentish municipal area

<table>
<thead>
<tr>
<th>Community Health Services</th>
<th>Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visiting services include:</td>
<td>Child Health Centre (Sheffield)</td>
</tr>
<tr>
<td>Oral Health Service – Children</td>
<td>Family, Child and Youth Health Services</td>
</tr>
<tr>
<td>Breast Cancer Support Service</td>
<td>Visiting services include:</td>
</tr>
<tr>
<td>Community Nursing</td>
<td>Child and Family Services</td>
</tr>
<tr>
<td>Home Help</td>
<td>Child and Family Services Support Workers</td>
</tr>
<tr>
<td>Home Maintenance</td>
<td>Community Youth Justice</td>
</tr>
<tr>
<td>Continence Advisor</td>
<td>Housing Tenancy</td>
</tr>
<tr>
<td>Huntington's Disease Social Worker</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy – Paediatric</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy – Community</td>
<td></td>
</tr>
<tr>
<td>Palliative Care</td>
<td></td>
</tr>
<tr>
<td>Palliative Care – Social Worker</td>
<td></td>
</tr>
<tr>
<td>Social Worker – Community</td>
<td></td>
</tr>
<tr>
<td>Social Work – HACC</td>
<td></td>
</tr>
<tr>
<td>Speech Pathology – Community</td>
<td></td>
</tr>
<tr>
<td>Physio – Paediatric</td>
<td></td>
</tr>
<tr>
<td>Physio – Community</td>
<td></td>
</tr>
</tbody>
</table>

Source: Department of Health and Human Services, 2007.

There is a Tasmanian Ambulance Service branch station at Sheffield.

In May 2006 the Census of Tasmanian GPs found that there were less than three GPs in this municipal area.

The Australian Government provides funding to the Kentish Regional Health Service for health promotion and a youth health worker.

Commentary
Kentish residents will benefit from any further development of services in the Devonport area. Under the Primary Health Services Plan, there is the potential for an expanded range of services provided in
relation to chronic disease, bringing together health providers from general practice and community health, local government and non-government organisations.

### 8.6.4 Latrobe

#### Demographics

Latrobe is classified as an urban/adjacent urban area. The Latrobe population numbered 8,769 in June 2005. The population is projected to continue to increase by 6% from 2006 to 2018. In terms of population change the 75 years and over cohort is projected to increase by 78%, and the proportion of the population 75 years and over will be in the order of 10.1% of the population by 2018. It currently has one of the highest proportions of people over 65 in Tasmania.

#### Service profile

Latrobe is the site of the Mersey campus of the North West Regional Hospital and the community is serviced by the Devonport Community Health Service. There is a Tasmanian Ambulance Service station with coverage provided 24-hours a day, seven days a week by a two-person salaried crew.

Table 40 lists departmental services provided within Latrobe.

### Table 40 Departmental services: Latrobe municipal area

<table>
<thead>
<tr>
<th>Acute Health Services</th>
<th>Community Health Services</th>
<th>Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Latrobe</td>
<td>Adult Day Centre</td>
<td>Child Health Centre</td>
</tr>
<tr>
<td></td>
<td>Visiting services include:</td>
<td>Family, Child and Youth Health</td>
</tr>
<tr>
<td></td>
<td>Oral Health Service – Children</td>
<td>Visiting services include:</td>
</tr>
<tr>
<td></td>
<td>Breast Cancer Support Service</td>
<td>Child and Family Services</td>
</tr>
<tr>
<td></td>
<td>Community Nursing</td>
<td>Child and Family Services Support Workers</td>
</tr>
<tr>
<td></td>
<td>Home Help</td>
<td>Community Youth Justice</td>
</tr>
<tr>
<td></td>
<td>Home Maintenance</td>
<td>Housing Tenancy</td>
</tr>
<tr>
<td></td>
<td>Continence Advisor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Huntington’s Disease Social Worker</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Occupational Therapy – Paediatric</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Occupational Therapy – Adult</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Palliative Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Palliative Care – Social Worker</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social Worker – Community</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social Work – HACC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Speech Pathology – Community</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physiotherapy – Paediatric</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physiotherapy – Adult</td>
<td></td>
</tr>
<tr>
<td>Shearwater</td>
<td>Child Health Centre</td>
<td></td>
</tr>
</tbody>
</table>

Source: Department of Health and Human Services, 2007.

In May 2006 the Census of Tasmanian GPs found that there were 13 GPs providing 77 sessions (3.5 hour sessions) of care; this equated to 7.7 FTE GPs. Research associated with the Clinical Services Plan indicates that 36% of cases presenting to the Mersey Department of Emergency Medicine could be managed in a GP service.

#### Commentary

Developments on the site of Mersey campus contained within the Clinical Services Plan include an after-hours GP clinic. Latrobe residents will benefit from any further development of services in the Devonport area.
Under the Primary Health Services Plan, there is the potential for an expanded range of services provided in relation to chronic disease, bringing together health providers from general practice and community health, local government and non-government organisations.

**Summary of actions for the Mersey area**

**Central Coast** – The Ulverstone Community Health Centre will be developed as a Tier 1 facility.

**Devonport** – The current Devonport Community Health Centre will operate as a Tier 3 community health centre. Infrastructure implications will be further explored in the Infrastructure strategy being developed by the Department as part of its response to the two planning processes. Opportunities for better integration across primary health services and the North West Regional Hospital in Latrobe will also be developed. The potential for after-hours general practice will be explored.

**Kentish** – Outreach services from Devonport will be further developed to serve the Kentish community in accordance with community need.

**Latrobe** – Outreach services from Devonport will be further developed to serve the Latrobe community in accordance with community need. Developments on the site of Mersey campus of the North West regional Hospital will be addressed in the Clinical Services Plan.

8.7 **North West region: Hellyer**

**Figure 20 Hellyer**

Source: Department of Health and Human Services, 2007.
8.7.1 Burnie

**Demographics**

Burnie is classified as an urban/adjacent urban area. The Burnie population was 19,217 in June 2005. It is projected to decrease by 7% between 2006 and 2018. However, a major increase (57%) will be people in the 75 years and over cohort, to stand at 10.1% of the population by 2018.

**Service profile**

Hospital and Ambulance Services are provided through the North West Regional Hospital Burnie campus.

There is a Community Health Centre in Burnie (Jones St) which acts as a base for community nursing services, child and family health services and a Community Health services centre in South Burnie (“Parkside”, Strahan St) providing a wide range of community health services, including oral health, mental health, palliative care and disability. Renal dialysis is also provided from that site. A range of other services are provided in accommodation scattered throughout Burnie.

Table 41 lists departmental services provided in the Burnie municipal area.

<table>
<thead>
<tr>
<th>Acute Health Services</th>
<th>Community Health Services</th>
<th>Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Station</td>
<td>Oral Health Services – Adult and Children</td>
<td>Child and Family Services</td>
</tr>
<tr>
<td>North West Regional Hospital – Burnie Campus</td>
<td>Community Health Centre (Jones St)</td>
<td>Child Development Unit</td>
</tr>
<tr>
<td>Renal dialysis (Parkside – outreach from LGH)</td>
<td>Alcohol and Drugs</td>
<td>Child Health Centre x2</td>
</tr>
<tr>
<td></td>
<td>Home Maintenance Service</td>
<td>Wetaway Program</td>
</tr>
<tr>
<td></td>
<td>Community Nursing</td>
<td>Parenting Centre</td>
</tr>
<tr>
<td></td>
<td>Community Equipment Scheme</td>
<td>Disability Services</td>
</tr>
<tr>
<td></td>
<td>Home Help and Personal Care</td>
<td>Housing Services</td>
</tr>
<tr>
<td></td>
<td>Podiatry – Community</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Palliative Care – North West</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Telehealth Tasmania Network</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Women’s Health</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental Health Services – Child and Adolescent services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental Health Services Adult community team</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Transport Services – North West</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Youth Health Team</td>
<td></td>
</tr>
</tbody>
</table>

Source: Department of Health and Human Services, 2007.

As at June 2006, 151 Departmental Community Health staff (115 FTE) provided services from this site.

The Burnie campus of the North West Regional Hospital provides acute care and supplies allied health services across community and hospital locations in the North West. Research associated with the Clinical Services Plan indicates that 32.5% of cases presenting to the Burnie Department of Emergency medicine could be managed in a GP service.

There is a Tasmanian Ambulance Services station with 24-hour, seven-day-a-week coverage provided by two-person salaried crews.

In May 2006, the Census of Tasmanian GPs found that there were 15 GPs providing 104 sessions (3.5 hour sessions) of care; this equated to 10.4 FTE GPs.

The Australian Government Medical Specialist Outreach Assistance Program funds the following services: dermatology; physician – neurology and palliative care; and psychiatry – general, geriatric and forensic. A drug worker is also funded by the Australian Government through the Non-Government Treatment Grants Program.

Burnie is also the base for several state-funded non-government organisations providing residential care, home and community care and other community-based services to the area.
Commentary

There is an urgent need for a coordinated development of more accessible and appropriate accommodation for community health services in Burnie. The Community Health Services already perform an outreach role to the West Coast and other municipal areas. There is the opportunity for the further development of that role and also for better integration across primary health services and the North West Regional Hospital in Burnie.

Under the Primary Health Services Plan, there is the potential for an expanded range of services provided in relation to chronic disease, bringing together health providers from general practice and community health, local government and non-government organisations.

8.7.2 Circular Head

Demographics

Circular Head is a rural/remote area. The Circular Head population numbered 8,099 in June 2005. The Circular Head population is projected to decline by 10% from 2006 to 2018. Within that total, there will be a percentage increase (35%) of people in the 75 years and over cohort, to stand at 11.5% of the population by 2018.

Service profile

The Smithton Hospital provides a range of primary health and community care services. It also provides inpatient and residential aged care.

Table 42 lists departmental services provided in the Circular Head municipal area.

Table 42 Departmental services: Circular Head municipal area

<table>
<thead>
<tr>
<th>Acute Health Services</th>
<th>Community Health Services</th>
<th>Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Service</td>
<td>Oral Health Services – Children</td>
<td>Child Health Centre</td>
</tr>
<tr>
<td></td>
<td>Smithton District Hospital including inpatient and residential aged care services</td>
<td>Parenting Programs</td>
</tr>
<tr>
<td></td>
<td>Occupational Therapy – Community</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Maintenance Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Telehealth Tasmania Network</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physiotherapy – Community Outreach Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental Health Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social Work – Community Outreach Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Nursing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diabetes Education Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Help and Personal Care</td>
<td></td>
</tr>
</tbody>
</table>

* Many of these services are not available on a full-time basis but are provided on an outreach basis from another centre.

Source: Department of Health and Human Services, 2007.

As at June 2006, 111 Departmental Community Health staff (31 FTE) provided services from this site.

The facility has 16 subacute inpatient beds. The average patient age is 57 years. Over the last five years the number of inpatient separations have remained approximately constant (slight decline), while the average occupied beddays and the average length of stay have increased. In 2005-06 the average occupancy level was 10.7 beds (67%), with an average length of stay of 5.95 days.

The hospital also has 22 aged care beds, with an occupancy level of 21.9 beds (100%). The revenue received from the Australian Government for aged care beds in 2005-06 was $879,809. The aged care beds will transfer to a local aged care provider (Emmerton Park) in 2007-8.
Overall occupancy across all bed types is 32.7 beds (86%). The 2005-06 actual costs were $4,225,090. This means that the actual annual cost per occupied bed was $129,094.

The 658 separations from Smithton Hospital included 408 individuals. Sixty-four patients were transferred from the North West regional Hospital and this represented 21% of the separations and 24% of the occupied beddays. Average length of stay for these patients was 9.8 days compared with 5.5 days for all other patients. This included 22 post-natal care patients, as a result of the changes that have occurred in relation to obstetrics at the hospital.

The Smithton Hospital also acts as a base for community health services in the district and has a student placement role with North West Clinical School. It is a University Department of Rural Health teaching site providing facilities for students to stay and undertake clinical placements.

There is a Tasmanian Ambulance Service branch station at Smithton.

In May 2006 the Census of Tasmanian GPs found that there were six GPs providing 40 sessions (3.5 hour sessions) of care; this equated to 4.0 FTE GPs.

Regional Health Services are provided through a non-government provider and encompass Youth Work, Social Work, Mental Health, Podiatry, and Health Promotion.

Commentary

Smithton Hospital will continue to provide a valued role for its community in relation to subacute care. Staffing difficulties, especially in relation to midwifery, limit the capacity of Smithton Hospital to continue to provide obstetrics services on a regular basis. However a new model of antenatal and post-natal care is currently being trialled.

Services such as rehabilitation can be provided through the use of therapy assistants and health professionals.

Improved training and linkages with the acute health services to improve their joint participation in emergency responses would be beneficial.

Access to community transport remains a concern in the community and improvements can be expected through the development of community transport networks and the provision of additional funds to assist in meeting the needs of people who are transport disadvantaged and are seeking non-urgent health-related transport across rural areas.

Under the Primary Health Services Plan, there is the potential for an expanded range of services provided in relation to chronic disease, bringing together health providers from general practice and community health, local government and non-government organisations.

8.7.3 King Island

Demographics

King Island is a rural/remote area. The King Island population numbered 1,570 in June 2005. The King Island population is projected to decrease by 6% between 2006 and 2018. Within that total, there will be an increase (31%) of people in the 75 years and over cohort to stand at 9.7% of the population by 2018.

Service profile

The King Island Hospital and Health Centre provides a range of primary health and community care services. It also provides inpatient and residential aged care.

Table 43 lists departmental services provided in the King Island municipal area.
**Table 43 Departmental services: King Island municipal area**

<table>
<thead>
<tr>
<th>Acute Health Services</th>
<th>Community Health Services*</th>
<th>Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>*</td>
<td>King Island District Hospital and Health Centre (MPC)</td>
<td>Child Health Centre</td>
</tr>
<tr>
<td></td>
<td>Alcohol and Drug Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physiotherapy – Community Outreach Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Maintenance Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Telehealth Tasmania Network</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social Work – Community Outreach Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Occupational Therapy – Community</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Oral health Services – Adults</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Nursing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Help and Personal Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Podiatry – Community</td>
<td></td>
</tr>
<tr>
<td></td>
<td>King Island Day Centre</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental health Services</td>
<td></td>
</tr>
</tbody>
</table>

*King Island has a volunteer ambulance service.

# Many of these services are not available on a full-time basis but are provided on an outreach basis from another centre.

Source: Department of Health and Human Services, 2007.

As at June 2006, 58 Departmental Community Health staff (28 FTE) provided services from this site.

The facility has six subacute inpatient beds. The average patient age is 53 years. Over the last five years the number of inpatient separations and average occupied beddays have increased while the average length of stay has remained approximately the same (decreased slightly). In 2005-06 the average occupancy level was 2.1 beds (35%), with an average length of stay of three days – the lowest in the state. In 2005-06, overall occupancy across all bed types was 15.3. The 2005-06 actual costs were $2,788,656. This means that the actual annual cost per occupied bed was $183,576.

The King Island Hospital and Health Centre has 14 aged care beds. In 2005-06 the average occupancy level was 13.2 beds (94%). Commonwealth aged care revenue received in 2005-06 was $599,844.

The 247 separations from King Island Hospital and Health Centre represent 173 individuals in 2005-06. In that period there was only one patient transferred from the North West Regional Hospital to King Island Hospital and Health Centre.

The King Island Hospital and Health Centre is a University Department of Rural Health teaching site providing facilities for students to stay and undertake clinical placements.

King Island also has a volunteer ambulance station run by the Tasmanian Ambulance Service.

The general practice service is contracted by the Department to a private provider.

Access to the following services is funded by the Australian Government Medical Specialist Outreach Assistance Program and Regional Health Service: Psychologist, Youth Worker, Health Promotion, Psychiatry – Child, Adolescent and Geriatric, Paediatrics – General.

**Commentary**

It is recognised that there is a need for services such as are provided by the King Island Hospital and Health Centre in small remote communities such as this one.

Opportunities for the further provision of clinical services through Telehealth can be explored as part of the implementation of this plan. The ongoing role of patient transfer to Tasmania and/or Melbourne is a key issue for Island residents and will require further monitoring to ensure the most efficient arrangements are in place.

Under the Primary Health Services Plan, there is the potential for an expanded range of services provided in relation to chronic disease, bringing together health providers from general practice and community health, local government and non-government organisations.
8.7.4 West Coast

Demographics
The West Coast is a rural/remote area. The population of the West Coast was 4,946 in June 2005. It is projected to decrease by 19.0% between 2006 and 2018. In terms of population change, the 75 years and over cohort is projected to increase and will be in the order of 6.6% of the population by 2018.

Service profile
All Departmental services for the West Coast are managed under a single management structure (described as HealthWest). This follows a comprehensive review of clinical services on the West Coast and the subsequent endorsement by Government of the Department as the “single auspice” provider of all services.

HealthWest is an integrated service structure that includes Queenstown, Strahan, Rosebery and Zeehan community health facilities. It fosters coordination and communication across the municipality.

Table 44 lists departmental services provided in the West Coast municipal area.

**Table 44 Departmental services: West Coast municipal area**

<table>
<thead>
<tr>
<th></th>
<th>Acute Health Services</th>
<th>Community Health Services</th>
<th>Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queenstown</td>
<td>HealthWest – West Coast District Hospital (Subacute Care, Residential Aged Care, Accident and Emergency, Ambulance)</td>
<td>Community Nursing, Day Centre, Home Help and Personal Care, Home Maintenance Services, Midwifery Clinic, Regional Health Services, Diabetes Education Service, Oral Health Service – Children, Occupational Therapy, Palliative Care, Physiotherapy, Podiatry, Speech Pathology, Telehealth Tasmania Network</td>
<td>Child Health Centre</td>
</tr>
<tr>
<td>Rosebery *</td>
<td>HealthWest – Rosebery Community Hospital (Subacute Care, Accident and Emergency)</td>
<td>Community Nursing (1 day/wk from Q’town), Diabetes Education Service</td>
<td>Child Health Centre</td>
</tr>
<tr>
<td>Strahan *</td>
<td>HealthWest – Community Nursing, Home Help and Personal Care, Home Maintenance, Regional Health Services, Diabetes Education Service, Palliative Care, Telehealth Tasmania Network</td>
<td></td>
<td>Child Health Centre</td>
</tr>
<tr>
<td>Tullah</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waratah *</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zeehan Ambulance Service</td>
<td>HealthWest – Community Nursing, CACPS, COPS, Day Centre, Home Help and Personal Care, Home Maintenance Services, Palliative Care</td>
<td></td>
<td>Child Health Centre</td>
</tr>
</tbody>
</table>

* Rosebery, Strahan, Tullah and Waratah have volunteer Ambulance Services.
# Many of these services are not available on a full-time basis but are provided on an outreach basis from another centre.
Source: Department of Health and Human Services, 2007.
As at June 2006, 35 Departmental Community Health staff (12.6 FTE) provided services from this LGA.

The West Coast is serviced by two hospitals, one at Queenstown (the West Coast District Hospital) and another at Rosebery (Rosebery Hospital) and two Community Health Centres (at Strahan and Zeehan). There is a Tasmanian Ambulance Service branch station at Zeehan where volunteers support paramedic cover. (There are gaps in the roster for volunteers at present.) Strahan, Tullah and Rosebery also have volunteer ambulance stations run by the Tasmanian Ambulance Service. (The Strahan station currently relies on a small number of volunteers to deliver that service.) Queenstown has an ambulance service run through the West Coast District Hospital.

In May 2006 the Census of Tasmanian GPs found that there were less than three GPs in this municipal area. The Department has acted to support the provision of GP services to the region, through a contract with a private provider which will provide an integrated medical service across the West Coast.

The Australian Government funds a range of services across the West Coast including Chronic Disease Self-Management, social work, mental health, youth health, psychiatry, optometry, obstetrics, gynaecology and women's health services.

Queenstown

The West Coast District Hospital at Queenstown provides a range of primary health and community care services. A new hospital has recently been constructed in a central location in Queenstown. There are now general practice rooms and community health facilities in the new site. It also provides inpatient and residential aged care.

The hospital has ten subacute inpatient beds. The average patient age is 51 years. Over the last five years the number of inpatient separations and average occupied bed days has declined while the average length of stay has remained approximately the same. In 2005-06 the average occupancy level was 3.3 beds (33%), with an average length of stay of four days.

In 2005-06, the 300 separations from the West Coast District Hospital represented 217 individuals, the great majority of whom were local admissions. Seven patients were transferred in from other facilities, representing only 2% of separations and occupied bed days. Most were post-natal patients.

The West Coast District Hospital also has 16 aged care beds with an occupancy of 15 beds (91%). Revenue from the Commonwealth for aged care beds in 2005-06 of $452,175.

Overall occupancy, across all bed types, is 17.8 beds (69%). The 2005/06 actual costs were $3,426,167. This results in an actual annual cost per occupied bed of $192,233.

It is a University Department of Rural Health teaching site providing facilities for students to stay and undertake clinical placements.

Queenstown has an ambulance service run through the West Coast District Hospital.

Rosebery

The Rosebery Hospital provides inpatient care with seven subacute inpatient beds. The average patient age is 52 years. Over the last five years the number of inpatient separations have decreased while the average occupied bed days and average length of stay have increased. In 2005-06 the average occupancy level was 2.1 beds (29%), with an average length of stay of 3.9 days. The 2005-6 actual expenditure was $1,748,090. This means that the actual annual cost per occupied bed was $849,604, the second most expensive in the state.

During 2005-06 the seven beds at Rosebery had an occupancy rate of 29% or an average of two patients per day. A relatively small number of elderly patients accounted for 65% of the inpatient
activity. Rosebery has a lower aged profile than others, mainly due to some same-day patients, some young mothers, some psychiatry and drug and alcohol patients.

In 2005-06, separations from Rosebery hospital amounted to 192 separations or 131 individuals. Nineteen patients were transferred in from the North West Regional Hospital. This represents 10% of the separations and 17% of the occupied beddays. While some (five) of the admissions were for post-natal care, two elderly patients accounted for multiple admissions.

The latest inpatient data (up to March 2007) shows that the number of separations continues to show a significant decline, down to just 30 for the third quarter. Based on year-to-date figures, the full-year outcome is projected at 70 separations, compared to an average of 226 for the preceding two years.

Community health services are provided in association with Health West service providers. A general practice, managed by a private provider, is located in the hospital building and is part of GP arrangements that now cover the whole of the West Coast in an integrated arrangement based on a contract with the Department for service provision to the rural health centres.

Strahan
Services are provided from the Strahan Health Centre and include local as well as visiting services. General practice sessions are delivered by the private GP provider for the West Coast rural health centres. A volunteer ambulance service operates from Strahan. There is an increase in population during the summer months as a result of tourism.

Zeehan
Services are provided from the Zeehan Community Health Centre and include local and visiting services. Australian Government funded Regional Health Services program provides chronic disease self-management, mental health, youth health and social work. General practitioner services are delivered by the private GP provider for the West Coast rural health centres.

Commentary
Queenstown
Queenstown hospital has recently been rebuilt and is now located to a central position in the town. This has provided an integrated site for general practice, community health services, aged care and inpatient care. Recently two long-standing GPs have left Queenstown and the state government tendered for the supply of general practice services for West Coast inpatient services. A medical provider has been selected, with services to commence shortly.

The West Coast District Hospital has the capacity to provide inpatient services across the whole municipal area. There is now stable access to general practice and there is the potential to further develop strong links with the local community which began through the establishment of its advisory committee.

Under the Primary Health Services Plan, there is the potential for an expanded range of services provided in relation to chronic disease, bringing together health providers from general practice and community health, local government and non-government organisations.

Queenstown is a rural site where there is the potential to significantly improve the clinical usage of Telehealth to increase access to services.

It is recognised through the planning processes that improved training and linkages with the acute hospitals for better joint participation in emergency response are required.

Access to community transport remains a concern in the community and improvements can be expected through the development of community transport networks and the provision of additional
funds to assist in meeting the needs of people who are transport disadvantaged and are seeking non-urgent health-related transport across rural areas.

Ongoing support in relation to ante- and post-natal care will continue to be provided through North West Regional Hospital as a result of a successful trial of a new maternity care service model, following cessation of formal obstetrics.

A subacute role in relation to rehabilitation would be possible, relying on therapy assistants rather than health professionals on site.

Rosebery

The Rosebery Hospital has experienced severe staffing shortages over the last few years and this has created difficulties in maintaining services as well as the cost of the facility. While staffing has been relatively stable in the last few months, as with all small rural sites this can change rapidly.

In applying the health planning principles to rural health sites within Tasmania, it is clear that some are not meeting the criteria established to demonstrate sustainability. It is not possible for them to deliver the current service to their community in a way that is safe, effective and at an acceptable cost. Nor will it be possible to continue to provide these services in the future when workforce issues worsen. Consultation has occurred with the Rosebery community in relation to this issue. Work has occurred to develop models of service that will better meet the needs of Rosebery on a more sustainable basis at a Tier 1 level.

The Rosebery Hospital has the capacity to provide more effective community care to its community, however as long as there is a large investment in maintaining a little-used inpatient facility, this is significantly impeded. While the inpatient beds are highly valued by some people in the community, there are also alternative views that much more could be done with the resources than is currently the case. The absence of primary mental health and alcohol and drug services has led to a reliance on overnight stays for people with these issues, whereas more appropriate clinical practice would see them supported to remain in their own homes in a way that prevents recurring crises. Many of the short stays in the hospital beds are for social support and these individuals can be supported through a different model of service much more effectively. Similarly, low levels of community nursing and home care mean that some people in the community are missing out on vital services.

There could also be opportunities for gaining mutual benefit from collaboration on the health aspects of emergency response, across the mines and the broader community.

There are alternatives to the current service model which will meet the needs of the community, especially in relation to care of the elderly. More flexible models of care, with a combination of planned respite beds (for non-health-related situations), day centres and nursing and personal care in the home will enable older people to remain in the local community. Developed as a Tier 1 site, a Rosebery Community Health Centre would provide a broader range of primary health and community aged care services on a seven-day-a-week basis with extended hours (early morning to evening). Services would include:

- overnight planned respite capacity as required for non-health-related conditions (ageing and social support situations);
- after-hours emergency support from local general practice and nursing staff;
- individualised packages of care for older people to enable them to remain in their own homes (both post-acute and community care);
- additional day centre respite;
- more allied health services as an outreach;
- on-site nurse clinics (especially for chronic disease treatment, including diabetes);
• holistic community nursing service expanded from one day a week to a minimum of five with options explored for weekend cover; this will improve sustainability of community nursing across the whole West Coast;

• increased visiting services in relation to Mental Health; and

• increased focus on health promotion and healthy lifestyle activities.

Improved training and linkages with acute health services for continuance of the emergency response function would be provided. Injury treatment, observation and stabilisation facilities would remain available on site.

The Centre will retain an after-hours emergency response capacity with a GP and nurse available on call 24-hours a day.

Access to community transport remains a concern in the community and improvements can be expected through the development of community transport networks and the provision of additional funds to assist in meeting the needs of people who are transport disadvantaged and are seeking non-urgent health-related transport across rural areas.

Under the Primary Health Services Plan, there is the potential for an expanded range of services provided in relation to chronic disease, bringing together health providers from general practice and community health, local government and non-government organisations.

Zeehan and Strahan residents are served by their local health centre and GP availability will be strengthened as a result of the new medical arrangements on the West Coast.

8.7.5 Waratah-Wynyard

Demographics

Waratah-Wynyard is classified as an urban/adjacent urban area. The population of Waratah-Wynyard was 13,318 in June 2005. The population is projected to decrease by 5% from 2006 to 2018. In terms of population change, the 75 years and over cohort is projected to increase by 32% and the proportion of the population 75 years and over will make up approximately 9% of the population by 2018.

Service profile

The Community Health Centre in Wynyard provides a range of primary health and community care services. There is a Tasmanian Ambulance Service branch station at Wynyard. Waratah also has a volunteer ambulance station run by the Tasmanian Ambulance Service.

Table 45 lists departmental services provided in the Waratah-Wynyard municipal area.

Table 45 Departmental services: Waratah-Wynyard municipal area

<table>
<thead>
<tr>
<th></th>
<th>Acute Health Services</th>
<th>Community Health Services</th>
<th>Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wynyard</td>
<td>Ambulance Service</td>
<td>Community Health Centre</td>
<td>Child Health Centre</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Oral Health Services – Adults and Children</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Alcohol and Drug Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Home Maintenance Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sexual Health</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Podiatry – Community</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Social Work – Community Outreach Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community Nursing</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Home Help and Personal Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mental Health Services</td>
<td></td>
</tr>
<tr>
<td>Somerset</td>
<td></td>
<td></td>
<td>Child Health Centre</td>
</tr>
</tbody>
</table>

# Several of these services are not available on a full-time basis but are provided on an outreach basis from another centre.

Source: Department of Health and Human Services, 2007.
As at June 2006, there were 21 Departmental Community Health staff (13 FTE) providing services from these sites.

In May 2006 the Census of Tasmanian GPs found that there were 11 GPs providing 75 sessions (3.5 hour sessions) of care; this equated to 7.5 FTE GPs. In terms of GP capacity to provide extra sessions of care it should be noted that Waratah-Wynyard has been declared an Area of Need.

The Australian Government provides funding through the Medical Specialist Outreach Assistance Program for rheumatology services in Somerset; and through the Non-Government Organisations Treatment Grants Program, for drug treatment services.

Commentary

The Wynyard Community Health Centre acts as a base for community health services in its area and it is envisaged that this will continue.

Under the Primary Health Services Plan, there is the potential for an expanded range of services provided in relation to chronic disease, bringing together health providers from general practice and community health, local government and non-government organisations.

Summary of actions for Hellyer

Burnie – An urban primary health centre will be developed at a Tier 3 level. Infrastructure implications will be further explored in the Infrastructure strategy being developed by the Department as part of its response to the two planning processes.

Opportunities for better integration across primary health services and the North West Regional Hospital in Burnie will be developed with the aim to improve access to these services.

Circular Head – Smithton Hospital will be maintained as a Tier 2 site, developing its chronic disease prevention and management and rehabilitation roles over time.

King Island – King Island will be maintained as a Tier 2 site, with a capacity to participate in emergency responses in conjunction with acute health services, and developing its chronic disease prevention and management role over time.

West Coast – The West Coast District Hospital at Queenstown will be maintained as a Tier 2 facility providing inpatient care for the whole municipal area and developing its chronic disease prevention and management and rehabilitation roles over time. It will retain a capacity to participate in emergency responses in conjunction with acute health services.

The Rosebery Hospital will be developed as a Tier 1 facility providing a wider range of services including non-medical overnight planned respite on an as-required basis and receiving additional mental health and allied health services. The centre will retain a capacity to participate in emergency responses in conjunction with acute health services and an injury treatment room, observation and stabilisation facilities will remain available on-site.

The Zeehan Community Health Centre and the Strahan Community Health Centre will be developed as Tier 1 facilities.

Waratah-Wynyard – The Wynyard Community Health Centre will be developed as a Tier 1 facility and explore opportunities to focus more on prevention, early detection and treatment of chronic disease.
9 Implementation and evaluation

9.1 Implementation processes
Implementation of the changes outlined in this Plan will be carried out through processes which effectively involve local health professionals, health facility staff, local government and community members. It will involve regional Primary Health managers, Primary Health coordinators and, where appropriate, dedicated project managers to carry out the implementation program.

Implementation will be guided by the Tasmanian Government Project Management Guidelines. Governance arrangements will include the formation of regional Advisory Committees to oversee the implementation of the Plans.

Individual projects, around such areas as the development of Primary Health Partnerships, will also feature community engagement at a local level.

9.2 Evaluation processes
One of the actions set out earlier in the document commits to undertake research and evaluation of the outcomes of demonstration sites established as part of the implementation of the Primary Health Services Plan.

Evaluation of the Plan will be undertaken through a number of these methods, as appropriate.
## 10 Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALOS</td>
<td>Average length of stay: the average number of days that a patient was in the hospital</td>
</tr>
<tr>
<td>CACP</td>
<td>Community Aged Care Package</td>
</tr>
<tr>
<td>CCHC</td>
<td>Clarence Community Health Centre</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>CHC</td>
<td>Community Health Centre</td>
</tr>
<tr>
<td>COPS</td>
<td>Community Options Service</td>
</tr>
<tr>
<td>DH</td>
<td>District Hospital</td>
</tr>
<tr>
<td>EACH</td>
<td>Extended Aged Care in the Home</td>
</tr>
<tr>
<td>FTE</td>
<td>Full-Time Equivalent</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HACC</td>
<td>Home and Community Care: a joint Australian Government and State-funded program</td>
</tr>
<tr>
<td>LGA</td>
<td>Local Government Area</td>
</tr>
<tr>
<td>MBS</td>
<td>Medicare Benefits Schedule</td>
</tr>
<tr>
<td>MPC</td>
<td>Multi Purpose Centre</td>
</tr>
<tr>
<td>MPS</td>
<td>Multi Purpose Service</td>
</tr>
<tr>
<td>NC</td>
<td>Nursing Centre</td>
</tr>
<tr>
<td>OBD</td>
<td>Occupied beddays: the total number of days in which hospital beds were being used by patients</td>
</tr>
<tr>
<td>PTAS</td>
<td>Patient Travel Assistance Scheme</td>
</tr>
<tr>
<td>RAC</td>
<td>Residential Aged Care</td>
</tr>
<tr>
<td>Separations</td>
<td>Separations: the total number of patients who were discharged, transferred out or died in a hospital</td>
</tr>
<tr>
<td>Subacute beds (rural health beds)</td>
<td>The beds in our rural health facilities are used for a number of levels of treatment including medical care not requiring specialist treatment, post-natal care in some sites, respite and care awaiting placement</td>
</tr>
<tr>
<td>Subacute Care</td>
<td>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</td>
</tr>
</tbody>
</table>
Appendices

11.1 Developing the Primary Health Services Plan: Project governance and activities
11.2 Results of the consultations
11.3 Other related policy and planning frameworks
11.4 Other related Community Health Services
11.5 Bibliography

For a full list of appendices, please refer to www.health.tas.gov.au
11.1 Developing the Primary Health Services Plan: Project governance and activities

11.1.1 Project governance

The Department has developed a strategic framework for health service delivery in Tasmania – The Tasmanian Health Plan. The Tasmanian Health Plan is an overarching document which sets the future direction for a high quality, sustainable, responsive, and integrated health system to meet the future needs of the Tasmanian community.

The Tasmanian Health Plan is supported by:

- The Primary Health Services Plan (this document)
- The Clinical Services Plan.

Mary Bent, Deputy Secretary, Community Health Services, led the development of the Primary Health Services Plan, with assistance from Dr Elizabeth Shannon, Project Manager, Community Health Services. In accordance with the Tasmanian Government’s Project Management methodology, a project team, Advisory Committee and series of working groups were established to undertake this work. A large number of individuals contributed to the project.

The function of the Advisory Committee is to integrate stakeholder and Departmental interests to ensure effective governance, planning and delivery of the project. The Primary Health Services Plan project Advisory Committee consisted of the following members:

- Mary Bent (Deputy Secretary, Community Health Services, DHHS): Chair and Project Director.
- An observer from the Secretary’s Office, DHHS (Julie Crowe or Helen Mulcahy)
- Carole Owen (State Manager, Population Health, DHHS)
- Catherine Katz (Deputy Secretary, Acute Health Services, DHHS)
- Dr Elizabeth Shannon (Project Manager, Community Health Services, DHHS)
- Helen Wilkinson or Catherine Brown (Australian Department of Health and Ageing)
- Pip Leedham (Director Primary Health, DHHS)
- Professor Judi Walker (Deputy Dean, Faculty of Health Science, University of Tasmania)
- Sarah Male (CEO, Tasmanian General Practice Divisions)
- Sean Terry (Manager, Planning, Performance and Evaluation, DHHS)

The Project Team works for the successful delivery of the project. The Project Team includes representatives from the Business Units affected by the project. The Project Team consists of the following members, from DHHS:

- Dr Elizabeth Shannon (Project Manager, Community Health Services): Chair
- Anne-Marie Stranger (Transition Manager, Acute Health Services)
- Carole Owen (State Manager, Population Health, Community Health Services)
- Doug Drever (Manager/Principal Advisor, Cradle Coast Project) – until January 2007
- Dr George Cerchez (Senior Medical Advisor, Primary Health)
- Dr Vicki Sherburd (Senior Policy Analyst, Shared Services)
- Gina Butler (Director of Nursing, Aged Rural and Community Health)
- Ian Bell (Project Manager, Community Assessment and Care Management)
- Janet Carty (Acting Manager, Home and Community Care)
• Mary Bent (Deputy Secretary, Community Health Services)
• Pip Leedham (Director Primary Health, Community Health Services)
• Rod Meldrum (Senior Policy Consultant, Primary Health)

Although there were a number of Working Groups, only the Data Working Group involved representation from outside the Department. The Data Working Group supported the project through the development of relevant, accurate data and advice. It consisted of the following members:

• Sean Terry (Manager, Planning, Performance and Evaluation): Chair
• Andy Boote (Project Officer, Primary Health)
• Cassy Short (Director, Client and Statistical Services Branch, Australian Bureau of Statistics)
• Doug Drever (Manager/Principal Advisor, Cradle Coast Project) – until January 2007
• Dr Kelly Shaw (Specialist Medical Advisor, Population Health)
• Dr Vicki Sherburd (Principal Policy Analyst, Planning, Performance and Evaluation)
• Helen Wilkinson or Catherine Brown (Australian Department of Health and Ageing)
• Kevin O’Loughlin (Policy Officer, Aged Care, Primary Health)
• Lisa Wardlaw-Kelly (Regional Director, Tasmanian Office, Australian Bureau of Statistics)
• Louise Hawker (Project Officer, Australian Bureau of Statistics)
• Mary Bent (Deputy Secretary, Community Health Services)
• Phil Liebeknecht (Project Manager, Asset Strategies)
• Rod Meldrum (Senior Policy Consultant, Primary Health)
• Steve Webber (Senior Consultant, Care Reform, Home and Community Care)
• Tony Sansom (Manager Planning/Reporting, Acute Health Services)

The project Reference Group (the Clinical Services Network) consisted of over 60 individuals from across the range of primary health services in Tasmania.

11.1.2 Project activities

The commencement of the Primary Health Services Plan project was announced on 27 September 2006, by the Minister for Health and Human Services, Lara Giddings. The summary of activities below indicates the range of individuals and organisations involved in the development of this Plan.

October 2006

Following on from the 27 September Ministerial announcement, a memo from the Deputy Secretary, Community Health Services, and Director, Primary Health, was sent to Primary Health staff, announcing the commencement of the project.

A project manager was engaged, project business plan developed, and departmental staff invited to participate in the work of the project. Key stakeholders external to the Department were also invited to participate, including representatives from the Australian Department of Health and Ageing, University of Tasmania, Divisions of General Practice and Australian Bureau of Statistics.

A broader reference group was also developed, the Clinical Services Network, which included representation from the Royal Australian College of General Practitioners and General Practice Workforce Tasmania.
November 2006

Meetings were held with key stakeholders, including the Local Government Association of Tasmania, the Australian Medical Association, Australian Nurses Federation, Cradle Coast Authority, Community and Public Sector Union, and Health and Community Services Union.

Departmental internal stakeholders to the project were also briefed on the project’s proposed timeframe and outcomes. A range of communication strategies were used to provide information throughout the Department, as the project teams formed working groups to provide a series of information papers, covering all aspects of primary health services in Tasmania. These brought together a range of expert opinion on the current challenges to the primary health services system.

December 2006

On December 5 2006, Lara Giddings MHA, Minister for Health and Human Services, launched the discussion paper: A Primary Health Strategy for Tasmania.\textsuperscript{65} The Departmental internal news Links Quarterly featured the project, as did the Tasmanian Regions magazine.

Mary Bent, Deputy Secretary Community Health, and Pip Leedham, Director Primary Health, addressed local stakeholders at information sessions held at 20 locations around the state. These sessions included service providers, local councils and consumer and community representatives, and focused on the need for change in the delivery of primary health services. Each of these sessions ended with a request for ideas, opinions and feedback on what should be included in the Plan.

<table>
<thead>
<tr>
<th>Date</th>
<th>Participants</th>
<th>Venue</th>
</tr>
</thead>
<tbody>
<tr>
<td>27.11.06</td>
<td>Triabunna, Swansea</td>
<td>Triabunna CHC meeting room</td>
</tr>
<tr>
<td></td>
<td>St Helens</td>
<td>St Helens Hospital meeting room</td>
</tr>
<tr>
<td></td>
<td>St Marys</td>
<td>St Marys CHC meeting room</td>
</tr>
<tr>
<td>29.11.06</td>
<td>Devonport, Ulverstone</td>
<td>Devonport CHC meeting room</td>
</tr>
<tr>
<td></td>
<td>Deloraine, Westbury</td>
<td>Deloraine Hospital meeting room</td>
</tr>
<tr>
<td></td>
<td>Kings Meadows, Ravenswood</td>
<td>Kings Meadows CHC meeting room</td>
</tr>
<tr>
<td>30.11.06</td>
<td>Clarence, Brighton, Clarendon Vale, Sorell</td>
<td>Clarence CHC meeting room</td>
</tr>
<tr>
<td>4.12.06</td>
<td>Campbell Town</td>
<td>Campbell Town MPC meeting room</td>
</tr>
<tr>
<td>5.12.06</td>
<td>Scottsdale</td>
<td>NESM staff development room</td>
</tr>
<tr>
<td></td>
<td>George Town</td>
<td>Ambulance Service meeting room</td>
</tr>
<tr>
<td></td>
<td>Beaconsfield</td>
<td>Beaconsfield MPS meeting room</td>
</tr>
<tr>
<td>8.12.06</td>
<td>Hobart, Kingston, Bruny Island CHC</td>
<td>Repat Centre lecture theatre</td>
</tr>
<tr>
<td>12.12.06</td>
<td>New Norfolk</td>
<td>New Norfolk group room</td>
</tr>
<tr>
<td></td>
<td>Ouse</td>
<td>Ouse Golf Club</td>
</tr>
<tr>
<td></td>
<td>Health West</td>
<td>West Coast District Hospital, Queenstown</td>
</tr>
<tr>
<td></td>
<td>Smithton</td>
<td>Smithton Community Nursing meeting room</td>
</tr>
<tr>
<td>13.12.06</td>
<td>Burnie, Wynyard</td>
<td>Jones St meeting room</td>
</tr>
<tr>
<td>14.12.06</td>
<td>Flinders Island, King Island</td>
<td>Video conference</td>
</tr>
<tr>
<td>18.12.06</td>
<td>Huonville</td>
<td>Huonville CHC meeting room</td>
</tr>
<tr>
<td>20.12.06</td>
<td>Oatlands</td>
<td>Midlands MPC Oatlands meeting room</td>
</tr>
</tbody>
</table>

As a follow-up to these sessions, Local Government Area community profiles started to be developed and distributed to communities.\textsuperscript{66} This process continued into January.

\textsuperscript{66} These are available publicly at http://www.dhhs.tas.gov.au/agency/chs/lga_profiles.php
Friday 8 December brought together a range of internal and external stakeholders to discuss the challenges facing primary health in Tasmania. In addition to Departmental staff, there was strong representation by general practice (including the General Practice Tasmania network, the Royal Australian College of General Practitioners, and the Rural Doctors Association). Local Government, the Department of Health and Ageing, non-government service providers and the University of Tasmania also participated.

In another communications and consultation initiative, three regional consumer/community focus groups were held, in cooperation with the Clinical Services Plan project team, exploring community expectations of their health services and, in particular, the interface between hospital and community care.

January 2007
The remaining Local Government Area community profiles were developed and distributed to communities, to help them in their thinking about how services may be made more sustainable into the future, reflecting our workforce and our population. A written invitation to the local community to contribute input and advice to the development of the Plan accompanied each profile.

Three municipal areas took the initiative and set up local meetings on this issue: Break O’Day, Dorset and West Tamar.

February 2007
On 14 February, a multi-site video conference was held with the General Practice Tasmania network, to discuss issues of importance to general practice. On 22 February, education and training providers around the state met to discuss workforce issues – this also included General Practice Workforce Tasmania and the University of Tasmania, and organisations from the Vocational Education and Training sector.

Key stakeholder meetings were held with the Australian Department of Health and Ageing, and the Tasmanian Council of Social Services (TasCOSS) at this time.

March 2007
Over the last three months, 72 responses to the Discussion Paper had been received from a broad range of individuals as well as professional and community organisations. A second workshop was held on 2 March, to bring together all the contributions received thus far into a proposed action plan.

Public submissions, and the outcomes of local consultations and workshop discussions, were collated and analysed. At this point, Professor Judith Dwyer, Professor of Primary Health, Flinders University, conducted a quality review process of the process to date, ensuring that the directions were in line with national and international contemporary thinking. This process and the results of consultations, research and workshops to date were used in the development of an Issues Paper, launched by Minister Giddings on 27 March 2007.  

Mary Bent, Deputy Secretary Community Health and Pip Leedham, Director Primary Health, along with other senior staff in the Department’s Primary Health unit, revisited communities around the state, as part of the consultation around the Issues Paper. Dr Felicity Jefferies, Chief Executive Officer (CEO) of the Western Australian Centre of Rural and Remote Medicine and Mr Kim Snowball, a Western Australian rural health policy expert and service manager also led consultations during this time.

<table>
<thead>
<tr>
<th>Date</th>
<th>Participants</th>
<th>Venue</th>
</tr>
</thead>
<tbody>
<tr>
<td>28.3.07</td>
<td>Rural Doctors Association</td>
<td>Richmond</td>
</tr>
<tr>
<td></td>
<td>Briefing for Mayors Hobart</td>
<td></td>
</tr>
<tr>
<td>29.3.07</td>
<td>Ouse District Hospital: Staff</td>
<td>Ouse District Hospital</td>
</tr>
<tr>
<td></td>
<td>Ouse Community</td>
<td>Ouse Golf Club</td>
</tr>
<tr>
<td></td>
<td>New Norfolk Staff and Community</td>
<td>New Norfolk District Hospital Community Health Centre meeting room</td>
</tr>
<tr>
<td></td>
<td>Clarence Community Health Centre: Staff, GPs Council, Auxiliaries (includes</td>
<td>Clarence Community Health Centre</td>
</tr>
<tr>
<td></td>
<td>Brighton)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HealthWest Staff</td>
<td>Queenstown Hospital Meeting Room</td>
</tr>
<tr>
<td></td>
<td>Meeting with Mayor Gerrity</td>
<td>West Coast Council, Sticht Street</td>
</tr>
<tr>
<td></td>
<td>Queenstown/West Coast Community</td>
<td>West Coast Council, Sticht Street</td>
</tr>
<tr>
<td>30.3.07</td>
<td>HealthWest staff</td>
<td>Rosebery Hospital, Physio Room</td>
</tr>
<tr>
<td></td>
<td>Rosebery Community</td>
<td>Rosebery Neighbourhood Centre, Agnes St</td>
</tr>
<tr>
<td></td>
<td>Staff and Community Presentation</td>
<td>Smithton District Hospital</td>
</tr>
<tr>
<td></td>
<td>Launceston: Primary Health staff, Youth Health, GP North, community groups,</td>
<td>LGH Auditorium</td>
</tr>
<tr>
<td></td>
<td>auxiliaries</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Glenorchy and Repat Centre Staff/Councils/Youth Health</td>
<td>Repat Centre, Hobart</td>
</tr>
<tr>
<td>31.07</td>
<td>Rural Doctors Conference</td>
<td>Shearwater</td>
</tr>
<tr>
<td>2.4.07</td>
<td>Deloraine and Westbury Staff</td>
<td>Deloraine Hospital</td>
</tr>
<tr>
<td></td>
<td>Beaconsfield Staff</td>
<td>Beaconsfield District Health Service</td>
</tr>
<tr>
<td></td>
<td>Beaconsfield Community</td>
<td>Beaconsfield District Health Service</td>
</tr>
<tr>
<td></td>
<td>George Town staff</td>
<td>George Town Hospital</td>
</tr>
<tr>
<td></td>
<td>George Town Community</td>
<td>George Town</td>
</tr>
<tr>
<td></td>
<td>Scottsdale staff</td>
<td>NEMS – Scottsdale Hospital</td>
</tr>
<tr>
<td></td>
<td>Scottsdale Community</td>
<td>NEMS – Scottsdale Hospital</td>
</tr>
<tr>
<td></td>
<td>Kingston Community Health Centre Staff</td>
<td>Kingston Community Health Centre</td>
</tr>
<tr>
<td></td>
<td>Kingborough Council</td>
<td>Kingborough Council</td>
</tr>
<tr>
<td></td>
<td>Huon Community Health Centre: Staff, Council, Community Groups, GPs</td>
<td>Huon Community Health Centre</td>
</tr>
<tr>
<td></td>
<td>Huon Eldercare Staff</td>
<td>Eldercare</td>
</tr>
<tr>
<td>3.4.07</td>
<td>Flinders Island MPC Staff and Community</td>
<td>Flinders Island MPC</td>
</tr>
<tr>
<td></td>
<td>St Helens Hospital Staff</td>
<td>St Helens Hospital</td>
</tr>
<tr>
<td></td>
<td>St Helens Community, Council</td>
<td>Portland Hall</td>
</tr>
<tr>
<td></td>
<td>St Marys Hospital Staff</td>
<td>St Marys Hospital</td>
</tr>
<tr>
<td></td>
<td>St Marys Community, Council</td>
<td>St Marys</td>
</tr>
<tr>
<td></td>
<td>Devonport Community Health Centre Staff</td>
<td>Devonport Community Health Centre Room</td>
</tr>
<tr>
<td></td>
<td>Devonport Community, Council</td>
<td>Devonport Entertainment &amp; Convention Centre</td>
</tr>
<tr>
<td></td>
<td>Burnie Staff</td>
<td>Burnie Community Health Centre – Jones St</td>
</tr>
<tr>
<td></td>
<td>Burnie Community, Council</td>
<td>Burnie Community Health Centre – Jones St</td>
</tr>
<tr>
<td></td>
<td>Sorell/Tasman/Glamorgan Spring Bay communities</td>
<td>Sorell Community Health Centre: Sorell/Tasman/Glamorgan Spring Bay</td>
</tr>
<tr>
<td>4.4.07</td>
<td>Campbell Town Multi Purpose Service Staff</td>
<td>Quorn Hall Room</td>
</tr>
<tr>
<td></td>
<td>Campbell Town Community</td>
<td>Quorn Hall Room</td>
</tr>
<tr>
<td></td>
<td>Midlands MPH: Staff</td>
<td>Midlands MPH: Day Centre Room</td>
</tr>
<tr>
<td></td>
<td>Oatlands Community, Council</td>
<td>Midlands MPH: Day Centre Room</td>
</tr>
<tr>
<td></td>
<td>King Island Staff, community</td>
<td>King Island Day Centre room</td>
</tr>
</tbody>
</table>
April 2007

Additional consultations were held in selected rural communities over the course of this month. The 74 responses to the Issues Paper, and further local consultations, have informed the development of the Primary Health Services Plan.

In the Issues Paper, it was noted that contributors would be acknowledged in the Plan, unless they chose to be anonymous. Only two submissions requested anonymity. Table 48 lists all other respondents to the Issues Paper, and their affiliations, where known.

Table 48 Respondents to the Primary Health Services Issues Paper

<table>
<thead>
<tr>
<th>Respondents to the Primary Health Services Issues Paper</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alan Melton</td>
</tr>
<tr>
<td>Anna Burgess, for Community Health Social Work team</td>
</tr>
<tr>
<td>Anne Gillespie, Community Nursing</td>
</tr>
<tr>
<td>Caroline Wells, CEO, Diabetes Australia – Tasmania</td>
</tr>
<tr>
<td>Cathryn Sykes, Clarence Plains Community Health Centre</td>
</tr>
<tr>
<td>Christine Beven, Chief Executive Officer, South Eastern Community Care, Sorell</td>
</tr>
<tr>
<td>Christine Maloney, Rosebery</td>
</tr>
<tr>
<td>Claire Massey, Ravenswood Community Health Centre</td>
</tr>
<tr>
<td>Dick Adams, MHR for Lyons</td>
</tr>
<tr>
<td>Dr Craig White, Chief Executive Officer, Royal Hobart Hospital</td>
</tr>
<tr>
<td>Dr Eric Colquhoun, Rural Doctors Association of Tasmania</td>
</tr>
<tr>
<td>Dr Graeme and Lucy Alexander</td>
</tr>
<tr>
<td>Dr Michael Aizen, President, Australian Medical Association – Tasmania</td>
</tr>
<tr>
<td>Dr Michael Smallwood and Dr Catrina Leesong</td>
</tr>
<tr>
<td>Dr Natalie Burch, GP and Visiting Medical Officer, Scottsdale</td>
</tr>
<tr>
<td>Dr. Adrian Reynolds, Clinical Director, Alcohol and Drug Service, Statewide Specialist Services</td>
</tr>
<tr>
<td>Elizabeth Walker, Midwife, Royal Hobart Hospital</td>
</tr>
<tr>
<td>Executive Committee, Break O’Day Health Resource Association</td>
</tr>
<tr>
<td>Fred Howard, Manager, Community Care Services</td>
</tr>
<tr>
<td>Gayle Newbold, Clinical Liaison Officer, Cancer Council Tasmania</td>
</tr>
<tr>
<td>Gordon Mallett, General Manager, Glamorgan Spring Bay Council</td>
</tr>
<tr>
<td>Gordon Sutton, Queenstown</td>
</tr>
<tr>
<td>Gwyn Jolley, Senior Research Officer, South Australian Community Health Research Unit, Flinders University, SA</td>
</tr>
<tr>
<td>Helen Burnet, Manager, Community Podiatry</td>
</tr>
<tr>
<td>Helen McDonald, Acting Manager, Community Physiotherapy</td>
</tr>
<tr>
<td>Helen McDonald, Senior Consultant, Quality and Consumer Safety</td>
</tr>
<tr>
<td>Hon Ruth Forrest MLC, Independent Member for Murchison</td>
</tr>
<tr>
<td>Ian Brown, Project Manager, Valley Vision, New Norfolk</td>
</tr>
<tr>
<td>Jeanette Voss, Board of May Shaw Health Centre, Swansea</td>
</tr>
<tr>
<td>Jenni Kennedy, Rosebery Nurses</td>
</tr>
<tr>
<td>John Lamb, Anne Drake, Ziniflex Rosebery Mine</td>
</tr>
<tr>
<td>John MacKean, Hobart</td>
</tr>
<tr>
<td>Joy Burch, Executive Officer, Australian Rural Health Education Network</td>
</tr>
<tr>
<td>Kahlie Walker, Community Podiatry, Ravenswood</td>
</tr>
<tr>
<td>Karen Bell, Continence Service</td>
</tr>
<tr>
<td>Karen Schnitzerling, Manager, Director of Nursing, HealthWest</td>
</tr>
</tbody>
</table>
**Respondents to the Primary Health Services Issues Paper**

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization/Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kathy O’Dea, State Manager Community Assessment and Care Management</td>
<td></td>
</tr>
<tr>
<td>Lee McGovern, Chair, Allied Health Professional Reference Group</td>
<td></td>
</tr>
<tr>
<td>Lester Jones, Director of Nursing/Manager, Deloraine District Hospital and Community Care</td>
<td></td>
</tr>
<tr>
<td>Liz Bingham, Diabetes and CVD Policy Officer, Population Health Priorities and the Tasmanian Nationally Accredited Diabetes Centres Community Nurse Managers – Anne Musket, Clinical Nurse Manager, Diabetes Centre, Royal Hobart Hospital; Andrea Radford, Clinical Nurse Manager, Diabetes Centre, Launceston General Hospital; Giuliana Murfet, Clinical Nurse Manager, Diabetes Centre, North West Diabetes Services (campuses at North West Regional Hospital and Devonport Community Health Centre)</td>
<td></td>
</tr>
<tr>
<td>Malcolm Tyler, Social Work Department, Royal Hobart Hospital</td>
<td></td>
</tr>
<tr>
<td>Marie Toth, Rosebery</td>
<td></td>
</tr>
<tr>
<td>Marie-Louise Bird, President, Australian Physiotherapy Association,</td>
<td></td>
</tr>
<tr>
<td>Marina Campbell, Community Services Board, Campbell Town Health and Community Service</td>
<td></td>
</tr>
<tr>
<td>Mark Dwyer, Australian Institution of Environmental Health</td>
<td></td>
</tr>
<tr>
<td>Mark McKenna, Clinical Nurse Manager, Strahan</td>
<td></td>
</tr>
<tr>
<td>Mat Rowell, Chief Executive Officer, Council of Social Service</td>
<td></td>
</tr>
<tr>
<td>Michael Minchin, Southern Business Services Pty Ltd</td>
<td></td>
</tr>
<tr>
<td>Michael Perkins, Beaconsfield District Health Service Community Advisory Board</td>
<td></td>
</tr>
<tr>
<td>Michelle Nicholson, Family Violence Counselling and Support Service North</td>
<td></td>
</tr>
<tr>
<td>Miriam Herzfeld, Executive Officer, Eat Well Tasmania</td>
<td></td>
</tr>
<tr>
<td>Mrs Toni van Dalen, Ms Catherine Davies and Mrs Lee Wright, Tullah</td>
<td></td>
</tr>
<tr>
<td>Name withheld by request, Community Health Social Worker</td>
<td></td>
</tr>
<tr>
<td>Name withheld by request, Community Nursing – Kings Meadows</td>
<td></td>
</tr>
<tr>
<td>Neroli Ellis, Branch Secretary, Australian Nurses Federation, Tasmanian Branch</td>
<td></td>
</tr>
<tr>
<td>Paul Shinkfield, Manager Community Rehabilitation Services, Community Assessment and Care Management</td>
<td></td>
</tr>
<tr>
<td>Peter Barnes, CEO, General Practice Workforce</td>
<td></td>
</tr>
<tr>
<td>Peter Ryan, Community Transport Services Tasmania</td>
<td></td>
</tr>
<tr>
<td>Professor John Wakerman, Director, Centre for Remote Health, email, 3 April 2007, Alice Springs NT</td>
<td></td>
</tr>
<tr>
<td>Professor Judi Walker (Rural Health) Acting Dean, Faculty of Health Science, University of Tasmania</td>
<td></td>
</tr>
<tr>
<td>Raymond Shea, email, 16 April 2007, Queenstown (NW)</td>
<td></td>
</tr>
<tr>
<td>Richard Muir Wilson, Community Development Officer, Waratah-Wynyard Council</td>
<td></td>
</tr>
<tr>
<td>Rick Cragg, Rosebery</td>
<td></td>
</tr>
<tr>
<td>Rod Walsh, General Manager, Central Highlands Council</td>
<td></td>
</tr>
<tr>
<td>Roslyn Rogers, Secretary, Midlands Multi Purpose Health Centre Advisory Committee</td>
<td></td>
</tr>
<tr>
<td>Ruth Chalk, Co-Manager Speech Pathology Services North West/Acting Director Allied Health NWRH</td>
<td></td>
</tr>
<tr>
<td>Sarah Male, CEO, General Practice Tasmania</td>
<td></td>
</tr>
<tr>
<td>Shelagh Lowe, Services for Australian Rural and Remote Allied Health, Fingal TAS</td>
<td></td>
</tr>
<tr>
<td>Sue Jenkins, Office for the Commissioner for Children</td>
<td></td>
</tr>
<tr>
<td>Susan Powell, District Manager; South East, Clarence Community Health Centre</td>
<td></td>
</tr>
<tr>
<td>Teresa Hinton, Research And Policy Officer, Anglicare</td>
<td></td>
</tr>
<tr>
<td>Tess Steel, Clinical Nurse Manager Repatriation Centre, Hobart</td>
<td></td>
</tr>
<tr>
<td>Tim Kirkwood, General Manager, Southern Midlands Council</td>
<td></td>
</tr>
<tr>
<td>William Suitor, Queenstown</td>
<td></td>
</tr>
</tbody>
</table>
11.2 Results of the consultations

The Primary Health Services Plan project has conducted an extensive communication and consultation program in the development of the final Plan. This part of the Plan looks at the issues raised during the consultations.

11.2.1 Notes from the first community consultations

On 5 December 2006, Minister Lara Giddings launched the Primary Health Strategy Discussion Paper. Information sessions were held at 20 locations around the state. Attendees included community members, staff, service providers, local councils, consumer and community representatives and GPs. Over 318 people attended these information sessions to have their say on the future of the State’s Primary Health services.

These staff and community consultations expressed concern about workforce shortages – there was a feeling that Tasmania was not training for the positions, career structure, and skill mix we would need in the future. This is a “chicken and egg” situation – workforce shortages require new staff but create difficulty in providing adequate levels of supervision required for new graduates. While acknowledging this is already happening, working with the University of Tasmania was suggested as a way forward here – perhaps new strategies could be developed. Other areas of concern were the ageing of the workforce and the impact of shift work on older workers. It was felt that recruitment and retention practices needed to be more flexible to remain competitive with other parts of Australia. There was a concern that not all rural sites had enough staff and patients (“critical mass”) for them to be a stimulating place to work, and this was working against recruitment and retention of staff in these areas.

Staff also expressed an interest in access to more ongoing education and training for health professionals in rural areas. There was an interest in expanding the scope of practice for rural health professionals – for example, nurse practitioners. Nurses also supported a greater emphasis within Community Nursing on health promotion and prevention.

Relationships between the services and their communities were discussed in detail. There was a strong feeling that the community expectations were increasing but the ability of services to meet those expectations was not. More community engagement was seen as a way of getting all sides to have the same picture of what could be achieved.

Access to services and transport was raised as an issue. This took in aged care, acute care, and some primary care services. The availability of after-hours medical services was raised as an issue also.

Suggested ways to resolve these issues included providing assistive technology and equipment; better networks to build communication and trust with other services, including non-government providers and local governments.

Other service development opportunities, such as improving quality of care, benchmarking caseloads for best practice and improving the collection of statistical information, in order to improve its accuracy, were expressed. These consultations suggested an increased focus on health promotion and early education programs, and a focus on prevention to “keep the well well”.

11.2.2 Summary of responses to the Discussion Paper

Respondents

The December 2006 Discussion Paper attracted 72 responses, commenting on the strategic framework for primary health services in Tasmania. Half of all responses were from Departmental staff, one quarter of responses were from non-government organisations, with the remainder being received from professional organisations, consumers and local governments. The majority of responses took a
state-wide approach, with regional responses arriving in roughly equal numbers from the North, South and North West.

**Responses**

Less than half of all responses received addressed the proposed principles and key areas for action directly, although many of the comments provided were related to the material set out in the Discussion Paper. The majority of those that did comment specifically on these proposals were supportive of the concepts.

Service coordination strategies to place consumers and communities at the central focus of service delivery were strongly supported. Some Departmental responses noted the necessity of administrative support for health service providers to achieve this aim. Other responses focused on the service coordination role of the GP in the primary health service system.

There was no disagreement with the commitment that primary health care services will meet appropriate standards of quality and safety. Some responses noted that workforce instability, and the regular use of locum staff, presented risks to accepted standards.

The commitment to strengthen partnerships to deliver better primary health care services was supported. Some respondents noted that the funding for service providers working together in partnership was supported by initiatives like the Medicare funded Enhanced Primary Care Scheme, which provides patients with chronic conditions access to allied health practitioners for up to five sessions per year. Other respondents noted the benefits of partnerships with the Divisions of General Practice, particular local communities and industry.

While it was agreed that promoting health, resilience and wellbeing, and enabling people and communities to increase capacity to manage their own health will represent a major change in the approach to primary health care services in Tasmania, this was strongly supported. Several respondents suggested a focus on preventative health, and it was noted that areas not previously considered as part of “the health system” such as the arts can play a valuable role in this area. Several respondents suggested that the Department identify and support opportunities for flagship or pilot projects that contribute to the health and wellbeing of clients and staff. Other respondents noted the need for proactive comprehensive community education in this area. Some respondents suggested that there should be an increase for infrastructure project funding to municipal councils to encourage greater physical activity in the community.

A range of respondents supported the continuum of chronic disease and prevention whereby a primary health care system will encompass both treatment services to individuals and services to improve both individual and community wellbeing, recognising these as complementary, not competing, services. This was supported as part of the primary health approach that dealt with both the individual and the social circumstances in which that individual lives. A combined submission from key stakeholders in the North West recommended that the Department take a regional approach to identify the mix of specialist services able to be provided on a sustainable basis in the Cradle Coast region, as a first step in this process.

Responses specifically dealing with the issue of chronic disease noted pilot programs within the community such as having a nurse based at community pharmacies as an accessible source of asthma advice. It was suggested that this could be extended to include smoking and management of other respiratory problems, weight management and diabetes.

The proposition that workforce development is integral to the major changes facing primary health care services, and to ongoing workforce sustainability, was firmly accepted. Some respondents suggested that an appropriate action to be undertaken would be for the Department to enter into a partnership
with General Practice Workforce to support and resource an integrated approach to workforce development at a community level. Strong clinical governance, consistent policies and practices, supported placements and the provision of professional development opportunities were also put forward as fundamental to facilitating a sustainable workforce.

The proposal to plan and fund service delivery models that are accessible, flexible, equitable and sustainable was also supported. Responses from allied health professionals recommended exploring opportunities for public sector physiotherapists to generate revenue through the extension of private practice rights.

Developing facilities and other infrastructure that support contemporary service models was also supported by respondents. Many respondents indicated that transport was a major issue – both for clients and service providers. Other responses noted opportunities to increase the utilisation of Telehealth equipment and utilisation sites. Some respondents noted the need to invest in information and communication technology infrastructure to support efficient, timely and seamless communication between the public health system at both a primary and acute care level and general practice.

Many other issues were raised by respondents to the Primary Health Strategy Discussion Paper. Some of these provided up-to-date information on such matters as chronic kidney disease, cardiovascular disease and respiratory illness in Tasmania. Other submissions stressed the value of the health promotion approach, initiatives to reduce the amount of drug taking and cigarette smoking in the community, and the Chronic Care model of treatment. These helped shape the development of an Issues Paper that raised issues impacting on Primary Health in Tasmania and suggested broad approaches for responding to them.

11.2.3 Notes from the second community consultations

On 19 March 2007, Minister Lara Giddings launched a second consultation document, the Primary Health Services Plan Issues Paper. Communities around the state were revisited as part of the consultation process around the Issues Paper. Consultations were well attended at the 23 sessions, with over 416 attendees state-wide. From over 237 staff attendees, there was strong support for the focus on primary care. Over 161 community members attended the meetings and were generally supportive for the primary health care focus.

Consultation with staff noted a range of issues, some of which had been raised previously. Staff again expressed the opinion that there was a need for resources for staff training, as skilled staff underpin the provision of quality health care. Departmental recruitment and retention practices need to be more flexible, to remain competitive with other parts of Australia and to meet the changing needs of the community.

Communication with the community remained an issue with staff again identifying an information gap on the services provided within communities. Support for creating opportunities for community engagement and strengthening community support programs was expressed. Staff also suggested that outreach services planning and accountability needed to be addressed.

Support for new models of care was expressed – with an increased focus on health promotion, early education and health coaching. Many staff believed that the focus has traditionally been on services and resources, not on risk factors and how to address them.

The consultations with the community again noted transport as a major area of concern. Issues such as service costs, the needs of lower income earners, and the need to take into account the social determinants of health (poverty and unemployment) in any strategies developed were also raised. Concerns were raised in some communities that the Issues Paper foreshadowed unwelcome changes. It was suggested that a focus on sustainability brings with it the constant threat to the community that
services have to be justified. It was strongly asserted that communication with the community, and active consultation with other organisations, is required for any change to be successful.

At the same time, it was recognised that the issues raised in the paper were valid: the community held concerns about recruitment and retention of staff, and about the way state-run primary health services worked with GPs, and there was a general recognition and support for an increased focus on chronic disease.

No matter what changes were to come out of the planning process, the community consultations emphasised that further investment in primary health services was essential.

11.2.4 Responses to the Issues Paper

Respondents
A total of 74 responses to the Primary Health Services Plan Issues Paper have been received. The greatest single source of respondents was from within the department, with departmental staff sending in 39% of all submissions. Almost half of the departmental submissions were from allied health professionals, with the other half coming from nursing staff and managers (who may have health qualifications but did not identify with a particular profession).

Consumers were responsible for 16% of responses and professional organisations (such as the Australian Medical Association, General Practice Tasmania and the Australian Nurses Federation) for 10%. Non-government organisations (such as the Tasmanian Council of Social Services, Diabetes Australia Tasmania and Community Transport Services Tasmania) were responsible for 9% of submissions, local councils 7%, and interstate primary health institutes 6%. Individual GPs made up 6% of the submissions, politicians 3%, educational facilities 1% and private businesses 1%.

The largest single group of submissions looked at issues from a state-wide perspective (34%), with Southern (25%), North Western (19%) and Northern (15%) perspectives making up the rest, with the exception the 6% of interstate responses that did not see Tasmanian primary health services in isolation and brought an interstate and international comparison to bear.

Responses
Approximately half the responses answered the questions posed in the Issues Paper:

There was a broad range of responses to Question 1 “Do the principles proposed as a basis for the Primary Health Services Plan offer appropriate balance between access to health care services, safety and effectiveness and efficiency? Should other principles be considered?” Most submissions expressed general agreement with the principles as a sound basis for service delivery. Many submissions had additional principles they wished to add to the list. A number of submissions questioned the meaning of the phrase “acceptable cost” and offered a range of alternatives.

The response to Question 2, on whether services were grouped appropriately within the three tiers model, indicated that many respondents wanted greater detail on the tiers. While accepting that the three-tier model had the advantage of providing an organising structure for service provision, most respondents wanted examples to better understand how this would work in practice. There was also some confusion as to the application of the tiers, with some respondents applying the tiers to a profession as a whole, rather than as a suite of services to be delivered at a particular site.

The responses to Question 3, on the proposed structure for communication and collaboration between service providers, were generally supportive. A number of respondents, however, noted that all networks and partnership agreements need to be appropriately defined/drafted, managed and reviewed/
monitored. In particular, they must adequately describe roles/responsibilities and levels of accountability in providing services to clients to meet their needs.

Detailed comments on clinical networks and primary care partnerships were also received. In relation to clinical networks, one respondent noted that an effective one currently exists for rehabilitation services in the south of the state, linking acute and non-acute services in this area. Other respondents were concerned that new clinical networks be built around existing relationships, and did not duplicate current effort. The idea was seen as a good one but questions about implementation remained.

Similar sentiments were expressed in relation to primary health partnerships. These were seen as having great promise but some respondents suggested that a comprehensive assessment of the experience of other States, prior to implementation, would be wise. Further, it was suggested that representatives from the other stakeholder groups that are envisaged to be involved in the partnerships should participate in the development of the Tasmanian model.

Question 4, on the other important types of infrastructure support that should be addressed in the Plan, drew a wide range of responses. For primary health service providers, improvements in information and communications technology were generally close to the top of the list. Many health professionals also felt that they suffered from a lack of administrative support. Supporting arrangements for ongoing education and professional development were seen as a key infrastructure support to the workforce. Recruitment and retention of the primary health workforce was noted as an essential ingredient by many respondents. This was particularly noted as an issue for rural and remote areas, where workforce shortages have resulted in the use of high-cost locum staffing. A range of infrastructure investments (such as the development of staff accommodation) were proposed to counter this. The co-location of GP practices with health centres and the secondment of appropriate nursing staff to the practices as practice nurses were also suggested as incentives for general practice.

An expansion of the arrangements whereby private practitioners were accommodated in departmental facilities was a suggestion raised by a range of respondents, both primary health providers and consumers. For health consumers, transport was the most common issue raised, with the lack of available transport leading many to the conclusion that services needed to be provided in their immediate area. (Many health service providers also noted the issues around transport but were more likely to recommend an improvement in the current transport arrangements, rather than the further duplication of health services.)

Other comments made by respondents who addressed the questions posed in the Issues Paper were largely to do with the necessity of community consultation and engagement. This ranged from actively involving individuals in their own health care (“self-management” strategies) to local communities having control over every aspect of service delivery in their area. Some respondents wished to increase community participation in health service delivery, rather than health service management. One example presented – that of peer educators – suggests that health consumers are better placed to communicate information about matters such as the quality use of medicines and strategies for preventing falls in non-threatening, conversational ways.

Amongst those respondents that did not address the questions posed in the Issues Paper, a small number of responses were received from individuals and organisations concerned about potential changes to health services on the West Coast. Of these, most related to the Rosebery Hospital and expressed a desire that the service remain unchanged. Others questioned if health benefits resulted from investment in these types of small-scale inpatient services. A late submission focused on potential service delivery options for the Break O’Day communities of St Helens and St Marys, and while more research and consultation is needed concerning its proposals, it will be considered as part of the implementation of the plan.
Strong support was expressed for investment in strategies to promote healthy lifestyles, to prevent the spread of chronic disease, for early intervention in disease treatment, and for self-management strategies in disease treatment. This was one of the most consistent messages across the whole of the consultation response. At the same time, implementation issues were raised as a concern. One of the issues raised by respondents is the integration of services between various health care providers. For example, it was suggested that it may be appropriate for a health centre to refer clients to the Stanford Chronic Disease Management Program that is currently run by Diabetes Australia – Tasmania, rather than develop a new program at their site. This would allow those resources to be used to address another need.

There was a broad range of opinion amongst respondents who were health care providers, as to the relative role of each of the professions in the delivery of primary health services. In general, GPs, nurses and allied health professional respondents saw their profession as participating in a changing model of practice, leading to the development of a primary health care team. A number of opportunities for expanding professional scope of practice were identified. At the same time, limitations to the scope of practice of other professions were also recommended by some respondents. Most positively, however, all professions recognised that each possessed complementary skills to their own.

During the consultation period, the national Primary and Community Health Network circulated the Tasmanian Primary Health Services Plan Issues Paper throughout Australia. The responses received confirmed the broad directions of the Plan as being in keeping with national and international best practice.

11.3 Other related policy and planning processes

The context for Primary Health Services Planning relates to national, state-wide and departmental policy frameworks.

National reform agendas with particular impact on the delivery of primary health services in Tasmania include:

- The Council of Australian Government reforms, particularly those relating to health workforce, rural health, health promotion and illness and injury prevention, and chronic disease.68
- Australian Health Ministers Conference and Australian Health Ministers Advisory Council initiatives, particularly those relating to the health workforce supply.69

The balance between the social, economic, financial and political aims of the Tasmanian Government and the co-ordination of State-wide policy positions in regard to Commonwealth-State negotiations are undertaken through the operations of central agencies such as the Department of Premier and Cabinet. Relevant policy and planning frameworks include the Tasmania Together process and the operation of State/Local Government Partnership Agreements.70

Other policies which guide the delivery of departmental primary health service in Tasmania include:

- **Aboriginal Health and Well-being Strategic Plan 2006-2010** (2006)
- **Aged and Rehabilitation Services Plan** (currently being developed)
- **Mental Health Service Strategic Plan 2006-2011: partners toward recovery** (2006)
- **MOU with General Practice Tasmania Network** (ongoing)
- **Palliative Care in Tasmania: current situation and future directions** (2004)
- **Partners in Health** (ongoing)

---

68 The Council of Australian Governments (COAG) is the peak intergovernmental forum in Australia. COAG comprises the Prime Minister, State Premiers, Territory Chief Ministers and the President of the Australian Local Government Association. More information on COAG may be found at http://www.coag.gov.au/about.htm

69 The Health, Community and Disability Services Ministerial Council is established under the authority of COAG and includes the Australian Health Ministers’ Conference (AHMC) and the Australian Health Ministers’ Advisory Council (AHMAC). More information on these organisations may be found at http://www.ahmac.gov.au/site/home.aspx

70 More information on these and other key policy directions may be found at http://www.dpac.tas.gov.au/divisions/policy/
• Strategic Framework for State-wide Cancer Services (currently being developed)
• Strengthening the Prevention and Management of Chronic Conditions Policy Framework (2005)
• Tasmanian Drug Strategic Plan 2005-2009 (2005)
• The fit Program (2005)
• The Tasmanian Hospital System: Reforms for the 21st Century (2004)
• Tasmanian Diabetes Action Plan.

11.4 Other related Community Health Services

11.4.1 Alcohol and Drug Services

The Department’s Alcohol and Drug Services unit offers community treatment from three regional centres: St Johns Park New Town, Mulgrave Street Launceston and Grove Street Ulverstone. These services support rural and remote services sites and provide screening and assessment; treatment planning and/or referral; targeted health promotion activities; information and advice.

A 10-bed inpatient detoxification facility is located at St Johns Park New Town and accepts referrals state-wide from both primary and acute health services.

The Service also works closely with a diverse range of service providers from the non-government and private sector, including GPs and pharmacies.

11.4.2 Mental Health Services

The Department’s Mental Health Services provides a comprehensive range of services to Tasmanians directly or indirectly suffering from a mental illness. Historically, services have been focused on secondary and tertiary level care primarily to people with serious mental disorders and are concentrated around the major population centres. Services include:

• Adult Community Mental Health Services
• Child and Adolescent Community Mental Health Services
• Adult Inpatient and Extended Care Services
• Older Persons Mental Health Services
• Consultation and Liaison Service.

Since its inception in October 2006, the Mental Health Helpline has provided an improved means for all Tasmanians in accessing Mental Health Services. It also acts as the entry point to our services, providing referral and information.

The primary health sectors, being mainly general practitioners, treat less severe and milder forms of illness such as depression and anxiety. Private specialist psychiatrists see persons presenting with a range of disorders; in general terms people, requiring longer-term and more intensive treatments utilise public sector services. These are generally funded through the Commonwealth MBS and direct patient contribution. Recent changes to the MBS arrangements allow other professionals such as psychologists, social workers etc to be funded for mental health services if patients are referred by a GP or Specialist.

The non-government sector, funded in whole or part by the Department, provides long-term support in daily living to people with mental illness living in the community. They also deliver a range of complementary mental health roles including advocacy and self-help.

11.4.3 Oral Health Services

Oral Health Services provides emergency, general, and prosthetic dental services for eligible Tasmanian adults and all Tasmanian children up to the age of eighteen. Oral Health Services places great importance on prevention – regular dental care is the recommended regime to ensure ongoing healthy teeth and mouth. Dentists and Dental Therapists provide dental care within Oral Health Services. Dental Therapists work with communities, promoting oral health and general wellbeing. Community-based Dental Clinics located in Burnie, Devonport, Launceston and Hobart offer a range of dental services for adults and children. Dental clinics for children are located in 33 sites across Tasmania and are also provided through mobile units.

11.4.4 Population Health

The Population Health business unit within the Department is responsible for Public and Environmental Health, ie monitoring and promoting health through food safety, nutrition regulation, communicable disease prevention and control, radiation regulation, tobacco control, needle and syringe program, pharmaceutical services (drugs and poisons) and environmental health.

It is also responsible for the Cancer Screening and Control Service, which includes BreastScreen Tasmania, the Cervical Cancer Prevention Program, Pap Smear Register and cancer control policy.

The Population and Health Priorities section focuses on preventing and reducing common population risk factors such as physical inactivity and poor nutrition, and addressing national health priorities including diabetes, cardio-vascular diseases, cancer, asthma and arthritis.

The Epidemiology Unit provides information to contribute to good policy-making and services, with statistics on the incidence and distribution of diseases in Tasmania and elsewhere.

11.4.5 Correctional Health Services

The Department currently supplies primary health services to the Department of Justice based on a Memorandum of Understanding. The Correctional Health Service provides inpatient and outpatient health services to inmates and detainees at Risdon Prison, Hobart and Launceston Remand Centres and Hayes Prison Farm.

11.4.6 Forensic Mental Health Services

The Forensic Mental Health Service is a highly specialised community-based service providing support to people with severe mental illness who are also involved in the criminal justice system.
11.5 Bibliography


Australian Bureau of Statistics (2001) Census of Population and Housing: Socio-Economic Indexes for Areas, catalogue number 2033.6.55.001


Tasmanian General Practice Divisions (2006) *Census of Tasmanian General Practitioners, 2006 Results,* TGPD: Hobart

