

**Response**

**PRIMARY HEALTH SERVICES PLAN**

**Discussion Paper No 2**

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**HON RUTH FORREST MLC**

The benefits of a strong and sustainable primary health service have been well documented. As stated in the issues paper a well developed primary care system has healthier populations and reduced health care costs, primarily due to the health promotion and illness prevention approaches that form the basis of primary health care. However for any health service to succeed in terms of safety, cost efficacy, efficiency and equitable access, an integrated approach across the entire health service provision sectors with an appropriate degree of adaptability and flexibility must be established.

The funding ideal of an integrated public health service would be heavily weighted in the primary health area, through health promotion, illness prevention and patient directed and self managed illness or disease strategies and plans, with the resultant reduction of reliance on the acute hospital services, which are cost and personnel intensive. However, the reality is that Tasmania has an aging population with high rates of chronic disease, already evident and requiring acute care. Therefore forward, flexible and adaptable strategic planning to meet the health needs of the future as well as current needs is vital. It is evident that both primary health and acute clinical services will require significant funding and ongoing review to keep pace with the changing needs of the wider community.

The issue of maintaining the rural hospitals is a very real and pressing issue for the communities they serve. I believe it is widely acknowledged that such a facility will have associated high fixed costs that can make it more difficult to make a smaller rural hospital financially sustainable into the future. The fact that there are also wide variations in the annual cost of an occupied bed across Tasmania's rural sites, does not make the issue of the need for change any easier for these communities to accept. Therefore it is vital these communities where change is required, are fully consulted and informed of not only the need for change but the rationale behind the decision and the improvements or benefits to health services that will result from any change.

The issues paper has a very narrow focus and is quite short on detail with no detail about the impact of the private sector funding to the rural hospitals and no consideration for other services provided in close proximity to these facilities. For example, some facilities receive Federal Government funding for some services and beds. A multi purpose bed option, for example, should be considered to address aspects of funding shortfalls or apparent overspending, particularly in rural hospitals such as Rosebery Community Hospital, rather than having all beds allocated as acute. In reality, these beds are often utilised as respite beds, palliative care, nursing care or social admissions through the lack of other alternatives. In addition, the lack of allied health services and an appropriate level of community based health services and nursing, this situation is compounded.

I note that the occupancy rates in rural hospital continue to decline, which is not surprising as the way many medical conditions and health events are managed has changed in recent times. Many of these changes are well understood by not only the medical profession, but the community at large, for example, it is well recognised that surgery is often less invasive, with many procedures now conducted through 'keyhole' and other less invasive techniques and hospital stays following surgery and even childbirth are much shorter. It is acknowledged

that lengthy hospital stays may increase the risk of iatrogenic infections and other complications that may not occur if a person is able to recuperate and/or rehabilitate in their own home, with the appropriate support.

The reduced acute bed occupancy rate do reflect changing clinical practice, as stated in the issues paper, as well as difficulties in maintaining adequate staffing levels and the reliance on agency nurses and locum medical staff, further increasing the cost of providing these often under-utilised services. The issue of risks to safe clinical practice, due to low patient throughput, thus staff may diminish or lose important clinical skills, coupled with high turnover of staff, have been noted in the issues paper. This is compounded with the advanced average age of many health practitioners, difficulty in recruitment in many areas including general practice and the challenges faced in the remote and rural settings for staff wishing to maintain all necessary skills to provide a safe service. However, some facilities may not need the number of acute beds maintained, but would benefit and utilise multipurpose beds.

It is also interesting to note that the number of Departmental Community Nursing occasions of care have decreased over the last 5 years. This data when considered with the lower occupancy rates of the rural hospitals, would indicate that more people are relying on the acute clinical setting, possibly tying up beds that result in delays to elective surgery and other acute services. Clearly this needs to be addressed and community health services modified to ensure the services provided are contemporary and meeting the needs of the people they serve.

I fully support the view that Tasmania requires a major review and evaluation of health services and health service provision in order to ensure a sustainable public health care system. This must be provided within budgetary constraints that focus on supporting healthy lifestyles and access for all Tasmanians to high

quality health services regardless of where people live. This will only be achieved if access to services is considered as the guiding principle.

Equity of service is a concept that in this State or any other in Australia, in reality, due to the dispersed population, is almost impossible to achieve. People who live near a major tertiary hospital or health facility, will naturally have more direct access to a wider range of services, however this inequity can be addressed through equity of access. This is possibly the most important aspect of an integrated public health service.

The comment made in the issues paper that the primary health care system would be strengthened with improved integration is only meaningful if the entire delivery of health services including acute clinical services and primary health services are integrated and considered as a whole. Communication and use of new technologies, including the use Telehealth to enable transfer of diagnostic information between service providers, as well as remote monitoring capacities and the transmission of information across distance needs to not only be provided but also supported through staff training and education. The provision of high speed, reliable internet access must be provided and maintained in rural and remote locations as without this infrastructure support and access to these opportunities, even technologies such as videoconferencing will not overcome the professional isolation issues many health care professionals in the rural and remote areas experience.

For Tasmanians living outside the major metropolitan areas in the State, and this is by far the greater proportion of Tasmanians, the need for the integration of services as well as infrastructure is particularly important. This is highlighted by the most often cited issue of access to services and the common occurrence of patients traveling four to five hours to access a service, often accompanied by a carer if they are elderly, frail or infirm, only to be informed that they were

telephoned two hours ago to inform them that the health service needed to be postponed or cancelled.

Alternatively, patients in the same situation are expected to travel significant distances and times to see different specialists, such as the anaesthetist, the physician and then the surgeon on consecutive or different days, all to affect the one medical procedure. These patients are also often expected to present to the facility providing these health services at times such as 7-8 am, which would require them to leave their homes at 4-5 am unless they have an overnight stay at the receiving location. This is a costly exercise in terms of the cost to the patient as well as the aged care provider if they are required to fund the carer to travel with and assist the patient.

This situation could be partly overcome by providing on-site accommodation for the patient and their accompanying person at the receiving location and fully funded travel through a patient transport service or reimbursement of costs, not just to those eligible to health care card concessions.

Figures obtained through a variety of reliable sources clearly show the increasing challenges of meeting the health needs of a population that is aging more rapidly than the National rate. These issues are compounded as a result of increasing incidence of chronic disease, ever increasing costs of health service provision, increasing community expectations of treatments and outcomes and international shortages of health care professionals. These issues further challenge existing health services in Tasmania due to the greater increases in the incidence of chronic diseases such as heart disease, stroke, cancer, emphysema, depression, dementia, diabetes, asthma and arthritis. The incidence of diabetes in particular, is increasing at an alarming rate in Tasmania with rates currently and projected to be above the National rates, as are conditions often related to poor lifestyle choices including obesity, poor nutritional status and smoking related illnesses.

Nutrition advice, smoking cessation and avoidance programs and healthy lifestyle promotion must be priorities within any effective primary health care plan and service.

According to the Issues Paper, primary health services have been defined by the World Health Organization as:

*“...essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain...”*

*It is the first level of contact of individuals, the family and the community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.”*

I would suggest that if we are to provide a comprehensive and contemporary primary health service, much more funding and focus must go into health promotion and illness prevention. Further to that, and I believe to be possibly the most important aspect of the health service provision is the shift in thinking of the public of ‘wait until I am sick/unwell, and then seek medical attention’. When this approach is taken, patients often become quite unwell before seeking attention, often due to the fact that they have difficulty accessing a General Practitioner or other appropriate health care professional, whilst their symptoms are mild or moderate. Therefore, it is vital that these ‘first line’ health professionals are available and accessible to the general public, and the general public are well informed of who, when and where they can and should access these services. A public health promotion education program is an essential part of this process

and will require significant investment in financial, human resource and public awareness terms.

The general public must be assisted through the establishment of a truly integrated public health service, to a point where they are empowered to take responsibility for their own health or wellness, through the adopting of healthy lifestyle choices and risk or harm minimisation, right through to assisting people to manage and control their own illness or disease as much as possible. The general public must take some responsibility for their own health as well as their own illness. This can only be achieved through adequate resourcing of services focused on these areas of health promotion, illness prevention and individual illness management.

Below are responses to the specific questions posed in the issues paper.

**Question 1**

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

The objective of the Primary Health Services Plan as stated is that;

*“Tasmania will have a sustainable primary health care system that provides reliable access to safe care, with a balance of health promotion, illness and injury prevention, early detection and treatment services and that the primary care system will work with other health and human services to support the health and wellbeing of the Tasmanian community.”*

I would tend to agree that the broad objectives are appropriate and comprehensive enough to encompass the needs of all Tasmanians, however, there is no clear direction or detail that will guide these principles in the delivery of health services to the rural and remote regions of the State. In other words, how will this objective and the principles, actually be applied at the 'coal face'? Generally I believe most Tasmanians agree that health needs and health service provision has changed over the last decade or more and that if we are to meet the health needs of all Tasmanians, services need to change to reflect this. If we are serious about reducing the demands on the acute clinical/hospital services, we need to help people to stay well and out of these facilities. I do not believe this will be achieved through the removal of health services from rural and remote regions of Tasmania. I do acknowledge that services provided within these areas need to be contemporaneous, but also adaptable to meet the emerging health needs of a community. This can be a challenge for some people living in rural and remote regions, but with public education and expansion of primary health services within these areas, I believe it can be achieved in a positive way.

Public education regarding who may be the most appropriate health professional to assist a patient manage their chronic illness in particular, may not be the GP in the first or even second instance. This is particularly important to 'get across' to people where a shortage of GP's makes it very difficult to obtain support, treatment or advice in a timely manner, that is before their condition deteriorates to a point where a doctor or acute hospital setting is the only appropriate option for their care.

Public education is one of the crucial elements of success in the implementation of any health service plan, as in the end, everyone will require health care and advice, even if it is only preventative screening.

The principles as described in the issues paper are generally comprehensive and appropriate, however, I do go back to the question, how will the principles be delivered through health care services at the 'coal face'? I do believe that there does need to be a greater emphasis in the principles not just on health promotion and illness prevention, but also on illness awareness and self management particularly for those with existing chronic illness.

I agree that services should be client focused, appropriate to the community's needs, accessible as close as possible to where people live provided they can be provided safely, effectively and at an acceptable cost and integrated with the other elements of the health services. However the focus on health promotion and illness prevention needs to be expanded to include illness awareness and self management.

These principles are very similar to those of the clinical services plan, which suggests that my comment that the entire continuum of health services should be considered as a whole and integrated approach to be effective, safe, appropriate, efficient and cohesive, is the only way forward to ensure the health needs of all Tasmanians are addressed.

When considering the delivery of services that are appropriate to community needs, this is most important in light of work practices and shift times particularly in the mining industry, where twelve hour shifts are the norm. After hours support is crucial in these areas, not only for the workers, but also for their families. Workers in the mining industry generally have a social network comprising fellow workers on the same shift, which will limit the resources they have access to assisting family members seek medical attention outside the local region. Therefore, if health services cannot be provided in the local community, and it is acknowledged that some services cannot be in all areas, then access to these services through reliable, free and convenient patient travel service, must be provided under this principle. Equity of access also insists that this service is

provided. Many, if not all of the rural and remote areas of Tasmania have very limited or no public transport options at all, including taxi services. For example, there is no taxi service in Rosebery, Granville or Trial Harbour or Tullah and therefore the cost of a taxi to collect a person from the neighboring service base, up to over an hour away, would incur enormous cost to the individual.

The current Patient Transport Assistance Scheme (PTAS), is I understand, under review and has been for considerable time, however currently this scheme does not meet the needs of many patients in rural and remote areas.

The second principle which states that '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', is particularly important with regard to transport assistance to enable access services. I have discussed this in more detail above and cannot underestimate or speak more strongly in support of the need for transport access and assistance to access services away from the patient's local environment. What is not mentioned here and I believe is an oversight, is the need for overnight accommodation for patients and the accompanying person, in cases where many hours travel are required to access a health service or the patient may require an overnight stay, not necessarily in a hospital bed, but cannot travel home the same day as the consultation, treatment or procedure, due to travel times and distances.

There is clearly a role for local government in the provision of some primary health care services and currently we see many examples of this through support of health promotion education programs, immunisation programs, illness and injury prevention programs, to name a few. The Circular Head Council is one such local government body that is very pro-active in this way as are others. I acknowledge that for a quality service to be provided safely, appropriately and

cost effectively a critical mass of patient throughput is necessary and a professional workforce, with the appropriate skills and expertise is essential. This is a constant challenge in rural and remote communities, however if a truly integrated and supported service can be provided, attraction and retention of skilled staff should not be such an issue. Current work practices and demands have and will continue to lead to a lack of job satisfaction, burn out and increasing sick leave and resignations to seek work in more supported workplaces unless significant change is implemented.

**Question 2**

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

I would agree that the services as listed in the issues paper regarding grouping of services under the three tier model appear to be appropriate. Actually delivering many of the services listed, will no doubt continue to be a major challenge due to skills or workforce shortages, advancing average age of many health practitioners and isolation of some services. However, workforce shortages are often a distribution problem rather than a supply problem. For example, midwives may be working in rural settings but are required to spend almost all their time undertaking nursing duties rather than practicing midwifery. If these midwives were employed under a different model of care that provided an annualized salary and provided care for approximately 40 women per year (or the equivalent to one FTE), where low risk birthing services are provided, the perceived shortage of midwives may be relieved.

Furthermore, the appointment and employment of more nurse practitioners to relieve the workload on rural GP's, especially in the management of chronic disease, could relieve the demands on GP numbers and hours of work.

One point that does require clarification is that made with regard to the 'Tier One' description of core community health services as health services that are provided by non specialist staff within a local community. I believe it is imperative that a health service is provided by appropriately qualified and skilled staff. Therefore any community nursing service must have a registered nurse managing the services and any antenatal, labour and birth and postnatal care, must be provided by a midwife, diabetes education and support must be provided by a nurse with specialised training and education in this field, to name but a few examples. Unless midwives and nurses are considered 'specialist staff' under this heading this point must be heeded to avoid the use of unskilled and untrained persons providing health services.

The regulation and oversight of unqualified health professionals, such as carers for example, must be considered to ensure all people receive a high quality, safe, appropriate and efficient service. There does not appear to be any consideration given to this important issue.

To comment further on the establishment of a state-wide service model for the delivery of primary health care, it is important that such a service should enable greater scope for planning and delivery of services provided the regional areas that must not be disadvantaged due to their physical separation from the planning body. I note a statewide service will be based on clear expectations about what services will be available where and it will enable planners of services to improve the match between service distribution and population need, provide the minimum requirements for a safe and effective service and provide a level of certainty for both communities and staff.

There are current examples of a 'statewide services' that fall well short of these ideals. A Hobart or Southern based service, for example, must provide equity of access to all Tasmanian and patients in the South of the State should not be able

to 'queue jump' simply because they can access the service more quickly in terms of traveling time.

I also note that whilst the model will be state-wide, implementation will adapt to local circumstances and encourage innovation. It will be based on a commitment to the role of community health facilities as a key resource and act as an access and referral point for community health services and intrinsically linked to other parts of the health care system. Whilst these ideals reflect what should occur, currently a number of services that are funded from a North West base, for example, to provide a service to the West Coast are not providing a level of service that is expected or required. It has been stated that the providers deliver such services on a needs basis. As these services are not widely known or publicized and not a consistent and regular service to the area, patients either may not even know the service is available, or when they do make a call they are informed of a 3 - 6 month waiting time. As a result these services are not well utilised and are considered underutilised or unnecessary and therefore fail to deliver the intended service. These services must be provided locally, on a regular basis to be effective, especially in the area of health promotion, illness prevention and illness management.

The three tier model suggests that the sharing of human resources will be supported. One of the major challenges for health care professionals in the rural settings or tier one and two in the model is the ongoing education and training and opportunities for up-skilling, maintaining vital skills and peer interaction and support. This can only be achieved through back-filling of positions and ready access to programs that enable these learning and experiential opportunities. State of the art Information, Technology and Communication (ITC) infrastructure and support is vital as is staff education and training in this area. Many residents from rural and remote Tasmania have very limited access to current ITC services and therefore will require significant support and education in this field to enable full utilisation of advances in technology.

The three tier model suggests that the redirection of resources to services that match the community's current health care needs, such as chronic disease, including diabetes, mental health, alcohol and drug or rehabilitation services will be undertaken under this model. It is particularly important that the individual needs of individual communities is assessed prior to implementing any redirection of services as services in some communities in rural Tasmania achieve very good outcomes within appropriate models within the existing structure. There will not be a 'one size fits all' model and the risk of 'throwing the baby out with the bath water' must be avoided.

The following statement made in the issues paper:

*“During the consultation period, senior Department staff will engage with each rural health centre in discussions about the assessment, the future growth path, and the potential implications for their services”*

This does not give a clear commitment to discuss changes to the health services of any community with community members. Whilst this may be the intention, from this statement, it could be concluded that only people directly involved at the rural health centre will be engaged. In many communities the role and importance of the health facility is much broader than the people actually managing the service. This is particularly important on the West Coast with the needs of the mining community and the financial and in kind support the mining industry provides to these facilities is significant. Therefore, broad community consultation, especially in these areas, is vital in economic terms, human resources and community ownership and acceptance.

The acknowledgement that there may be some changes in bed usage, in cases where safety and sustainability cannot be assured, is appropriate and reasonable. However, this decision should be more focused on pursuing various

options for bed allocation, including multipurpose use and multiple sources of funding.

As stated, Rural Health Centres need to respond effectively to medical emergencies. To achieve this staff providing the 'front line' emergency service/treatment, must have ongoing training, education and opportunities to maintain the necessary skills to ensure best possible outcomes in treating minor injuries as well as the stabilisation and preparation for transfer of patients requiring a 'higher level' of or more complex health service. The efficiency and efficacy of an emergency transport and retrieval service cannot be underestimated. To achieve this, a state-wide emergency system is appropriate, but must include fixed wing and helicopter air transport services that are centrally based.

Examples listed of initiatives that could be implemented to support emergency response included examining ways to enhance access to retrieval services for rural sites, for example having a single contact point for service providers that can take responsibility for all aspects of transport and arrange clinical advice and support and bed allocation. This is particularly important when arranging the transfer of a patient to a tertiary center from a smaller rural health centre, with a limited number of medical staff. Currently, the logistics and administrative tasks required to transfer a patient can result in the medical staff being removed from the patients' bedside for extended periods making the necessary arrangements.

Support for and promotion of sustainable health promoting, injury and illness-preventing programs are indeed an essential component of primary health care. There are many examples of industry, in particular the mining industry, where many such programs are already in place and providing significant positive impacts for not only workers, but the broader community. Collaborative approaches with industry should be considered. These industries should be considered key stakeholders in the provision of health services within the region.

### **Question 3**

***The proposed structures for communication and collaboration between service providers.***

***Will clinical networks provide the right links between primary health care and other types of care?***

***Will Primary Care Partnerships strengthen the relationship between General Practice and Community Health Services?***

The issues paper states that the primary health services plan will also provide the basis for specifying linkages and methods of support between primary care providers and other parts of the health and human services system. An aspect of this that will require a very close and specific focus is the proposed state-wide clinical networks that are to be developed, with the goal of strengthening the links between local service delivery and the secondary and acute sectors.

As I stated previously, the need for a fully integrated approach to service provision is needed to enable a seamless process and service delivery from original point of contact through to and including all health care providers through to separation ideally to the person's home. Good communication between all sectors is the key here as is respect for traveling times and distances to access services for people from the more regional and remote areas of the State.

The suggestion that joint protocols for clinical management will be developed to reduce inefficiencies and duplicated effort within the current system, are quite valid, however, these will need to be consistent across all service levels. This may well present significant challenges across sectors that are funded and managed by differing levels of Government. I would expect the primary health plan to clearly articulate how this can be achieved.

The plan to establish networks that 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, will require clear and unambiguous guidelines and protocols as well as a degree of flexibility that can consider individual cases or circumstances individually. If this is achieved then the coordination of care across the continuum from community to acute, and back again, may well be a reality and show benefits in improved safety, and increased support for rural service providers.

This point could be related to a situation some time ago when a critically ill neonate was born at the Smithton District Hospital. It was clear that this baby required the services only provided by a neonatal intensive care unit (NICU). Tasmania can only support one NICU in the State, and all those who live outside the Hobart area acknowledge this and are aware that if they have a baby that requires this level of care that they and their baby will be transferred to the NICU at the Royal Hobart Hospital. In this case, the baby was stabilised by medical practitioner, midwives and support staff at the Smithton Hospital with the assistance of a paediatrician from North West Regional Hospital, Burnie Campus. The baby was then transferred by air ambulance from Smithton direct to Hobart. This was a far better outcome for this baby, only having to be transported once and shows the importance of this collaborative and individual response.

Mechanisms to improve the general practice/hospital interface and for support to be provided from the major hospitals to rural GPs and allied health professionals including nurses and midwives in these areas is vitally important. Sharing of resources, human, equipment and other resources needs to be coordinated and supported through the principles mentioned in the issues paper of cooperation and integration between service providers and collaboration across health service and institutional boundaries.

One area that will need to be addressed if this is to be successful, is the support for 'back-filling' of positions for staff from regional and remote centers to up-skill or to maintain skills needed within their communities. If health care providers are skilled and confident to provide a range of services within their local area, that is, within the community, the demand on acute health services can be reduced. I agree that primary health care facilities should not be seen predominantly as 'step down' facilities, but facilities that provide many services within their own right. It is important to note that rural hospitals will continue to provide some post acute or 'step down' care and services, and that good communication, clear and unambiguous policies and protocols are in place to enable seamless transition between services occurs.

The extension of dialysis and chemotherapy services to some community-based sites, is a valid and appropriate consideration, however, public education and acceptance of home dialysis for example, will take some time to achieve. Expansion of chemotherapy services to the rural settings would be a very positive step with many benefits to the patient and their families and should be pursued. Support and training of staff will be an important consideration of these decisions.

The 'Hospital in the Home' concept is generally welcomed in most communities as many people prefer to stay within their own environment and the risk of iatrogenic complications is significantly reduced. This debate could and should extend to the provision of home birth options for low risk women. However, where the population is dispersed and family or other support for an individual is limited, the 'Hospital in the Home' concept doesn't work well. In small rural towns and settlements the concept can be most effective, but for people who live more than approximately 30 minutes from the local 'population centre' the service is generally ineffective and inappropriate. Therefore the capacity to provide some in patient services must be maintained in areas such as this, including Circular Head, the West Coast, including Rosebery and other parts of rural Tasmania.

Secondary services, as stated, are those specialised areas that are not centered on acute hospitals, and are much better served being based in the community. These services include, but should not be limited to, low risk maternity services, family and child health, mental health, oral health, palliative care and alcohol and drug services.

Primary Health Partnerships, if established through a consultative and supportive process, should strengthen the relationship between General Practice and Community Health Services. Public education to assist patients identify which is the most appropriate health professional to consult will be an important part of this relationship and process. A number of partnerships that bring together the three levels of Government, the medical profession, allied health professionals and the Departmental service providers, do exist but a lack of communication has resulted in much duplication in some cases and gaps in service in others. A clearly defined and fully integrated process needs to be established with communication at all levels being a priority is imperative.

Collaboration and communication with the Federal Government during this process is most important for a number of reasons. Firstly, the Federal Government is responsible for funding a number of sectors of health and aged care. Secondly, consideration should be given to providing Medicare Provider numbers to other health care providers, such as midwives who provide caseload care for low risk women and some nurse practitioner roles may also be considered. Thirdly, duplication of services and support for sectors of the community accessing services and gaps in service are common under the current arrangement. Furthermore, many of the past problems and complaints that are received regarding access to, utilisation of and outcomes of health services, relate to poor or an absence of communication.

The suggestion that, in some settings, general practice could be funded by DHHS to allocate allied health services and other necessary support to GP practices and their patients, has considerable merit. This is particularly relevant in rural areas where patients may work either long hours as shift workers and as such have limited opportunity to access services if they are not co-located, or workers on the land who have significant distances to travel even to access a local rural service and have limited time available to seek or utilise health promotion, illness prevention and illness management services. These people often only attend a GP surgery when they are already unwell, however if other health services are co-located these are more likely to be sought and accessed.

The role of the private sector in the provision of health services hardly rates a mention in this paper. Without the support of the private sector, the public health system and services would collapse. Therefore it is also vitally important that collaboration with the private sector continues and patients with private health insurance are encouraged to utilise those services. However, it is important to assure equity of access to health services for all Tasmanians and if services are to be contracted to the private sector, a full cost-benefit analysis that considers social as well as economic impacts is undertaken and any agreement reviewed and audited on a regular basis.

**Question 4**

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

The major infrastructure issue that requires significantly more consideration above that given in this paper, is that of patient transport, accommodation and support for accompanying person where the patient has traveled significant time and distance to access service and financial assistance to cover costs of access a service outside the patients local region.

The patient travel assistance scheme must be reviewed and contemporised to reflect current costs in accessing health services, not just for those eligible for health care concessions. Another factor that must be assessed under this scheme and the issue of access is for patients on the North West and West Coasts who require complex surgery such as neurological or cardio-thoracic surgery, currently only receive financial support if they access the service in Tasmania. In a number of cases, patients have been informed of lengthy waiting times – even several months for urgent cases and have elected to travel to Melbourne to access the service in a much shorter time frame. This must be considered in light of the traveling time from almost anywhere on the North West Coast where a patient can be in a major Melbourne Hospital in less time than it takes to drive to Hobart. In cases such as this, where the Tasmanian service clearly is unable to meet the needs of these patients in a timely manner, financial support should be afforded to these patients to reimburse their travel costs.