Response to **LEGISLATIVE COUNCIL GOVERNMENT ADMINISTRATION COMMITTEE 'A' SUB COMMITTEE INQUIRY INTO ACUTE HEALTH SERVICES IN TASMANIA**

from Clinical Associate Professor Robyn A Wallace, Hobart, July 2018

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Thank you very much for the opportunity to contribute to your enquiry on this important matter for Tasmanians.

By way of background, I am a specialist physician in internal medicine currently working in the private health sector in Tasmania, though have previously worked for many years in public health systems outside of Tasmania. My areas of specialty involve working daily in the hospital, both in acute care and at outpatients where a good deal of of time is spent in planning prevention of acute adverse medical events in the hospital or at home. More specifically, I provide physical health medical care to adult patients undergoing surgery via a dedicated peri-operative medical service, to adults with intellectual disability, and to adults with mental illness. I also have the pleasant opportunity to teach students, participate in educational and clinical review activities with Colleagues and hospitals, involve myself in easy-level research, and participate in groups on the NDIS-health-disability interface. All three groups of patients for whom I provide physical healthcare are high users of the acute healthcare services.

From that perspective, I would like to offer the following comments to be taken into consideration in your enquiry.

(1) Factors and projected state demand for acute health services

The general community, medical organisations, advocacy groups, and high-level government appointed commissions are increasingly pointing out the need for health professionals, services and systems to cater better for the physical health needs of people with disabilities such as those with intellectual disability or mental illness, for example. Among Australian states, Tasmania has the highest number of people with disability. The numbers are not decreasing. Members of this diverse group are well known to be high users of acute hospital care, and data showing their poor and inefficient outcomes in acute health settings are well recorded in Australian and International literature. So, the demand for acute health services involving hospitalisation by people with disability is high in Tasmania, not expected to decline, and the successful health outcomes are lower, the rates of adverse medical events higher, and speculated to be more expensive and inefficient compared to the care given to people without disabilities accessing acute health services.

Pleasingly however, the disparity in acute health outcomes between people with disabilities compared to those without is being recognised, and standards are being set, benchmarks made, guidelines and examples of ideal service delivery models are being produced to improve the person-centred care of such patients in acute health care settings such as hospitals).

In Tasmania, generally such proposed changes are not yet implemented or integrated into acute health services at the hospital level but need to be. These

modifications focus on a proactive approach to aim to reduce health crises, and include, for example, better access to outpatient and primary care, and refinement of the organisation of these services. Such models, although seemingly requiring more resources to start with, also provide strategies to improve efficiency of care in acute health episodes requiring inpatient care, and therefore improve capacity of the hospital facility.

In particular, an opportunity to reduce the requirement for acute health services such as hospitals, is optimal use of outpatient services for such patients. The outpatient setting with specialists working in conjunction with primary care doctors, provides scope for attention to the provision of care of chronic health problems thus leading to prevention of health deterioration to avoid acute health crises requiring hospitalisation. Unfortunately, a proactive approach to providing such outpatient services for patients with disability in the public health system are virtually non-existent. There is a great need for dedicated outpatient services for attention to the physical health of people with disabilities and mental illness. Although such patients require sub specialist care such as from neurologists or cardiologists, the physician in internal medicine is ideally trained to manage the complex biopsychosocial situations of such patients.

Inherent in the successful improvement of acute health services is improved stakeholder identification and collaboration and involvement in acute healthcare service provision. For example, for improved acute healthcare provision for people with disabilities and cognitive impairment is a requirement to work better with the carers, families and disability service providers. The National Disability Insurance Scheme for participants with complex communication and behavioural problems will provide some funding for their usual disability supports to be present when the participant requires access to mainstream acute health services. As another example, In the provision of acute physical health care for patients with mental illness, documentation from psychiatrists in the hospital or community needs to be accessible to assist in the planning of physical health care. Such documentation is rarely available.

In summary on this point, Tasmania has a high number of residents with disability, who are also high users of the acute health systems but with poorer outcomes and they experience increased inefficiency in care. The numbers of people with disability is not anticipated to decline, but their acute health service demand may reduce with dedicated, better designed and reasonably adjusted generic outpatient services, and the quality of acute inpatient health services for people with disabilities may improve with integration of disability dedicated recommended reasonable adjustments to generic inpatient care. Identification of stakeholders within disability and mental health sectors and subsequent engagement with them will help in development of reasonable adjustments to generically delivered acute health services. Quality information about such modifications is abundant.

(2) Factors impacting on the capacity of each hospital to meet the current and projected demand in the provision of acute health care

Currently the capacity of each hospital to meet the current and projected demand in the provision of acute healthcare for people with disabilities, is preventably limited because of the systemic lack of expertise in disability, systemic lack of efficiency, lack of system flexibility, and lack of stakeholder collaboration to guide system improvement. These features create barriers and reduce the capacity of hospitals to provide optimal care. Patients with disabilities are sent home early because they take up too much time, or are too complicated, or it is just too hard, or they present with inadequate disability supports. People with disabilities often present multiple times to hospital for acute health concerns before their health needs are properly met. This sort of gross inefficiency drastically reduces capacity of acute health services to deliver both quantitatively and qualitatively.

There is no lack of theoretically suitably qualified and expert clinicians in the provision of acute healthcare for patients with disabilities, yet there is a lack of advocacy among individual clinician groups to fix up the avoidable mistakes, the inefficiencies, and there is a sort of nihilism that pervades the approach to acute health crises in people with disabilities., with the thinking "well that's what happens to people with disability". Individual leadership is relevant. Someone in the front-line health sector must speak up and act out on behalf of people with disability and their requirements for better acute health services. Traditionally this is a group of patients with a fairly quiet voice in the community, disempowered, socioeconomically disadvantaged, less educated and less able to speak out in the complicated world of health systems. So individual clinician leadership, backed up by bureaucratic teams, is required to get the ball rolling. Improvement of services to groups where there are known inefficiencies will improve the overall capacity of acute health services for patients without disabilities too.

Traditional clinical review committees in hospitals reviewing morbidity and mortality must review and scrutinise adverse acute health events among their patients with disabilities and come up with responses to reduce adverse events. External hospital standards for the care of patients with disabilities set by Australian health and safety commissions are frequently not met yet passed over in the case of patients with disability.

(3) The adequacy and efficiency of current state and commonwealth funding arrangements

This is particularly relevant in the care of high needs patients, frequently those identified as having disabilities. Currently, there is scope for state hospitals to receive more Commonwealth funding for high needs patients, but the arrangements are often vague, perhaps purposely. For example, some but not all disability service providers have an arrangement with their state hospital so that funding bill for disability support workers to provide the required disability supports for their clients while in hospital for acute health events is invoiced to that state hospital. The state hospital, in turn, then applies to the National Health Reform Body to be reimbursed. This state and commonwealth funding arrangement is far from being advertised to disability service providers- it should. Often, it turns out instead that the required disability supports to enable the person with disability to access the mainstream acute health service are not provided, leaving the patient very vulnerable. Moreover, with the National Disability Insurance Scheme (NDIS),

participants with complex communication and behavioural issues who require disability support to access mainstream health during and acute health event, may have some of the funding for their disability support paid by their NDIS package. The arrangements are very vague and need to be transparent and proactively the information shared with people with disabilities, their families and their disability service providers. Having a pre-prepared plan for both the required disability supports while in hospital and its funding arrangement should be known. This would seem to involve both state and commonwealth health funding bodies.

(4) The level of engagement with the private sector in the delivery of acute health services

In Tasmania, a small state, best possible engagement between public and private delivery of acute health care with a view to sharing is vital for quality and efficiency of acute health care delivery. Having distinct and separate specialist clinical services in both systems for less frequent health conditions could lead to a reduced quality, given the simply the cases numbers required to ensure safety, skill and quality of health care delivery are not there in one or other of the sectors. Combining both sectors together, the patient numbers could be satisfactory. This is likely a cheaper option than sending patients to the mainland, but in all cases, the quality of patient care is paramount.

(5) The impact, extent of, and factors contributing to adverse patient outcomes in the delivery of acute health services; and

Data published in other Australian states all point out the vulnerability of patients with disabilities, especially intellectual disabilities, in acute health settings. Higher rates of preventable deaths, higher rates of preventable inpatient adverse events, lower life expectancy not due to the disability, all well documented and likely the same in Tasmania. The causes include poor communication, not listening to the carers, support staff not being present, support staff doing their own thing, attributing the physical health symptom to the disability instead of recognising it as a pathology, not enough time, poor attitudes among health professionals, delay in diagnosis, more difficult to take a history, examine and get tests done, providing a palliative approach to acute healthcare on the basis of disability, and more.

Clinical review committees, perhaps inadvertently, may not regard an adverse event experienced by a patient with intellectual disability in the same way as they would for a patient without intellectual disability. Deaths of patients with intellectual disability are not routinely reviewed by the coroner as is the case in other states. Many Tasmanian families of adult children with intellectual disability can recount a near miss in the health sector, or even more tragically an avoidable death of their loved one. Such events must be avoided but also captured, recorded and the data analysed, using it to make acute health service delivery improvements.

In Tasmania, the health and disability sectors do not engage well with each other. They must to improve health outcomes of patients with disability. Both have a lot to learn about sector differences and similarities, about shared values, refining the logistics of working together for clients/patients in common, sorting out funding responsibilities for disability supports in acute health settings, demarcation of roles

and responsibilities, and both would benefit from cross fertilisation of logistics, values and knowledge.

(6) Other matters