Tasmania Medicare Local Limited
ABN 47 082 572 629

SUBMISSION

to the Preventative Health Care Inquiry by Tasmania Medicare Local March 2013

medicare local TASMANIA

Connecting health to meet local needs

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About Tasmania Medicare Local

Tasmania Medicare Local (TML) is a non-government, not-for-profit primary health care organisation working to help coordinate and connect primary health care services for local communities.

TML aims to identify local health care needs, work to address any service gaps and make it easier for Tasmanians to access the health services they need closer to home.

The Australian Government also funds TML to manage a range of programs and services in areas including after hours care, aged care, mental health, Aboriginal health, refugee health, chronic conditions, health promotion and eHealth.

A total of 61 Medicare Locals have been established around Australia as a key part of the Australian Government's national health reforms, representing an increased focus on primary health care – that is, health care provided outside hospitals and closer to people's homes. This includes general practice, allied health and community health.

Since its establishment in November 2011, TML has been building on the significant achievements and reputations of its founding members – the three regional Tasmanian divisions of general practice – plus the statewide General Practice Tasmania. We are collaborating with a broad range of committed and experienced health and social care providers in a renewed focus on the primary health care needs of Tasmanians.

TML has offices in Hobart (central office), Launceston and Ulverstone, aligned with the headquarters of the three Tasmanian Health Organisations.

Our vision

Improved health status for Tasmanians through communication, primary health care integration and collaboration across health and community sectors.

Our mission

To facilitate building and matching of quality, integrated and sustainable primary health services, systems and solutions to community needs.

Our objectives

The objectives of Medicare Locals are to:

- improve the patient journey through developing integrated and coordinated services
- provide support to clinicians and service providers to improve patient care
- identify the health needs of local areas and development of locally focused and responsive services
- facilitate the implementation and successful performance of primary health care initiatives and programs
- be efficient and accountable with strong governance and effective management.

Introduction

Tasmania Medicare Local (TML) welcomes the opportunity to present this submission to the Joint Select Committee on Preventative Health Care and looks forward to the opportunity to supplement this submission with a chance to meet the Select Committee to discuss this document in person.

Prior to the amalgamation and restructuring of the Divisions of General Practice into the TML, the focus of our work was largely on enhancing the role of general practice in the delivery of health care services in Tasmania. Our new mandate has a much stronger focus on working with communities and providers to reform, support and deliver primary health care, of which general practice is one component. In addition, we have been asked by the Federal Government to implement action on the Social Determinants of Health as part of the Tasmanian Health Assistance Package (THAP).

Primary health care refers to health care services that are provided outside the hospital. Primary health care includes a range of services provided by health professionals such as general practitioners, practice nurses, psychologists, physiotherapists and community health workers. Primarh health care helps people better manage their health and plays an important role in preventing disease. A robust primary health care system is strongly and clearly linked with all other parts of the healthcare system and is crucial to ensuring that people can get the health care they need, when they need it, where they need it. It is about providing more care in the community and will help to keep people well and out of hospital.

As part of the THAP TML has been provided with significant resources to act on the Social Determinants of Health.

The Australian Government is investing $325 million over four years in the THAP to ensure the future, long term sustainability of Tasmania's health system across the public, private and non-government organisation sectors. This Program constitutes one of 17 elements for implementation via the THAP.

The Aim of the THAP is to improve the health of Tasmanians through:

1. targeting known lifestyle-related health risk factors such as excessive alcohol consumption, smoking, physical inactivity and poor diet and nutrition; and
2. addressing the social determinants of health such as social status, health literacy, housing and education.

THAP's specific objectives are to contribute to:

Objective 1: Reducing inequalities in health and improve health outcomes across Tasmania.
Objective 2: Improving Tasmanian health system efficiency.
Objective 3: Reducing Tasmanian health system pressure.

The findings of this Program will inform future health policy through evaluations of the impact of these interventions on reducing health inequalities, health system pressure and inefficiency.

This presents an important opportunity for Tasmania to appropriately plan and establish mechanisms that can lead to long-term reforms and gains in health equity and access. In order for TML to be able to facilitate this vital work, there are a number of matters that we wish to present to the Preventative Health Care Joint Select Committee for consideration. In doing this we will address each of the Terms of Reference, commencing with Term of Reference 3 which is fundamental to success and achievement under the other terms of reference.

1.0 Term of Reference 3: Structural and economic reform

TML firstly wishes to address Term of Reference 3.

With appropriate infrastructure for addressing health inequalities in place, the Government, in partnership with its citizens, the non-government and private sectors, will be able to implement mechanisms that will lead to long-term, sustained improvements in health and wellbeing outcomes for Tasmanians.

1.1 The current situation is unsustainable

In addition to Tasmania's poor performance on many Social Determinants of Health indicators (which we discuss in more detail below in part 2.0), factors such as the rising incidence of chronic conditions and Tasmania's ageing population are placing increased demand on health care services. Financially and ethically this situation is not sustainable.

The problem is not unique to Tasmania and we can take leads in this State from action in other states including in South Australia whose Department of Health recognised this situation some years ago, stating the following:

> *'Governments are becoming increasingly concerned that these health care costs are consuming an ever increasing proportion of their country's gross national product, while their revenue base is being eroded through demographic developments such as the ageing of the population. These factors are driving an urgent need to contain the growing cost pressure of ill-health on the limited financial resources of countries.*
>
> *The SA health budget currently consumes close to 30% of the total state budget. In ten years this will be 50% and without change, health will consume the entire state government budget in less than 25 years (see Figure 1)). Much of the increase in health expenditure is related to the rising prevalence of chronic illness conditions. This is clearly unsustainable and a new approach to improving the health and wellbeing of the population is needed.'*[1]

It is clear from any level of scrutiny that our current growth and spending trajectories in Tasmania will render the State with a completely unaffordable and unsustainable system within the next few years.

Our own Premier, the Honourable Lara Giddings MP, has made similar projections:

> *'In ten years' time at the present rate of cost increase, the entire Tasmanian budget will be absorbed by Health alone.'*[2]

Tasmania literally cannot continue to ignore the social determinants of health when considering the health and wellbeing of the community, the crisis in health care expenditure, and assuring the health and wellbeing of future generations. There is a sound evidence base that enables us to argue that the way forward must involve a stronger focus on health equity, addressing the social determinants of

[1] Department of Health (SA) 2011, *The South Australian approach to Health in All Policies: background paper and practical guide*, Version 2, p. 9.

[2] Tasmanian Style Magazine 2012, http://www.tasmanianstyle.com.au/tsm/?c=8&langID=1.

health, and building a stronger primary health care system so as to keep people out of hospitals.

Other desired goals in our society that gain more attention, such as the need to build a healthy economy are important for Tasmania (in fact, this will also contribute to better health outcomes), but this should not come at the expense of recognising that the health and wellbeing of the people more broadly is the most important outcome of all. Health clearly must be Tasmania's central goal. As Duckett (2013) states,

> *'I'm talking about policies which are not "instead of"...., but "as well as" policies. So focussing on growing the economy is not instead of developing the issues of the social determinants report of the WHO.*
>
> *'And so my argument here is this: When we think about the social determinants, we don't think about just this terrible burden on society that is going to cause a whole lot of problems and cost the government a whole lot of money we can't afford.*
>
> *What we should be talking about is this – we can do both. We can in an economically rational way improve the economy, and in so doing, we can improve the life situation of people who are affected by this and in so doing we can start to address the social determinants. I'm not saying this is instead of the other issues – the health in all policies approach and so on. This is as well as, it is an economically sensible way. Don't say we can't afford to do it, because we can.'*[3]

TML is concerned that for too long, the voices that have been driving decisions that have shaped the health system have been confined to the acute care sector. The reality is that the acute system is only one part of the broader health care system. We urge the Government to engage meaningfully with a broad cross-section of primary and tertiary health care providers. This will enable service planners and managers to build a system that enacts the mantra of right care, right place, right person and right time. Furthermore, a collaborative approach will help maximise use of available health infrastructure to its fullest extent.

The Commission on Delivery of Health Services in Tasmania Preliminary Report to the Australian Government and Tasmanian Government Health Ministers stated the following:

> *'The apparent imbalance in spending and efficiency between the hospitals and community health care is of particular importance to us. The methodology used by the Commonwealth Grants Commission (CGC) to estimate what states need to spend to provide services at a national average standard has guided our thinking in this area.*
>
> *In its 2012 update report, the CGC concluded that Tasmania needed to spend 11.6% more than the national average on admitted patient services in 2010-11, in order to provide those services at the national standard. This is largely because the Tasmanian population is older and poorer than the national average, offset somewhat by the fact that distances between Tasmanian population centres are not as great as in other states. The CGC's analysis indicated that Tasmania was in fact spending 34% more than was required to provide hospital services at the national standard, pointing to potential opportunities to improve the efficiency of service provision.*

[3] Duckett S 2013, *Time to ditch the old paradigm of risk factors and behaviours (take note diabetes strategy),* presentation at launch of Social Determinants of Health Alliance, Professor Stephen Duckett, Grattan Institute, February 2013.

The situation with community-based and other health services is quite different. Here, the CGC's analysis indicated that Tasmania needed to spend 19% more than the national average (with demographic disadvantages compounded by low levels of private service provision), but was spending 40% less than was required to offer services at the national standard. This figure is consistent with the view of participants in consultation forums and focus groups, that the community health sector in Tasmania is underdeveloped.*

From this analysis, it appears that Tasmania is spending about 5% more on the health sector as a whole than the CGC estimates is needed to provide services at the national standard. The additional cost of admitted patient services is being offset by under-spending in community health and other health services.

We believe this requires further examination, both from an efficiency perspective and to ensure resources are being directed in the most appropriate way.'

Note:

* The "Community and Other Health Services" category used by the CGC comprises all health expenses except those relating to admitted patients and patient transport. It includes expenses on the administration, inspection, support and operation of non-admitted patient services such as hospital emergency departments and outpatient clinics, community health and public health services.

Clearly structural and economic reform is required to address this situation.

Recommendations:

- The Government, in partnership with its citizens, the non-government and private sectors develop a Health Equity Policy for Tasmania, and a statewide, long-term, whole-of-government plan for reducing health inequities through action on the Social Determinants of Health. Such a plan should be informed by the recommendations of the WHO Commission on the Social Determinants of Health and related documents of significance. It should have clearly defined goals, activities and accountability mechanisms, with adequate resources for their implementation.
- That government reconsiders the decision to split Tasmania's health system, on regional grounds, into three THOs and move to implement a single THO structure.
- That effective investment in and adoption of ehealth initiatives feature as a key enabler in all redesign processes.

2.0 Term of Reference 1: The current impact of inequalities

2.1 The social determinants of health

The social determinants of health are the conditions of everyday living that affect people's health. They are the conditions in which people are born, grow, live, work and age.[4] The social determinants of health are sometimes referred to as *'the causes of the causes'* because they are the underlying reasons why people experience particular health outcomes – positive and negative.

Some of the social determinants that impact on health include:

- How a person develops during the first few years of life (early childhood development)
- How much education a person obtains
- Being able to get and keep a job and the type of work
- Having food or being able to get food (food security)
- Having access to health services and the quality of those services
- Housing status
- How much money a person earns
- Discrimination and social support.[5]

There are numerous resources that can provide background information on the SDoH.[6]. It is understood that others have made submissions to this Inquiry, including the Social Determinants of Health Advocacy Network, of which TML is a member, have provided some important examples of the current impact of inequalities in the major social determinants of health on health outcomes, and TML refer the Committee to this submission for this information.

Figure 1 represents broad estimates of how much five determinants contribute to the health of a population. Whilst it is not possible to quantify the precise contributions of each determinant this diagram provides a crude estimation of the impact that social factors have on health outcomes.[7]

The social determinants of health are shaped by the distribution of money, power and resources at global, national and local levels. They are significantly responsible for health inequities. Health equity is *'when everyone has the opportunity to 'attain their full health potential' and no one is 'disadvantaged from achieving this potential because of their social position or other socially determined circumstance'*.[8]

Addressing the social determinants of health is a primary approach to achieving health equity. Social Determinants of Health such as poverty, unequal access to health care, lack of education, stigma and racism are underlying, contributing factors of health inequities.

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[4] WHO, Social Determinants of Health website, http://www.who.int/social_determinants/en, accessed 26 February 2013.

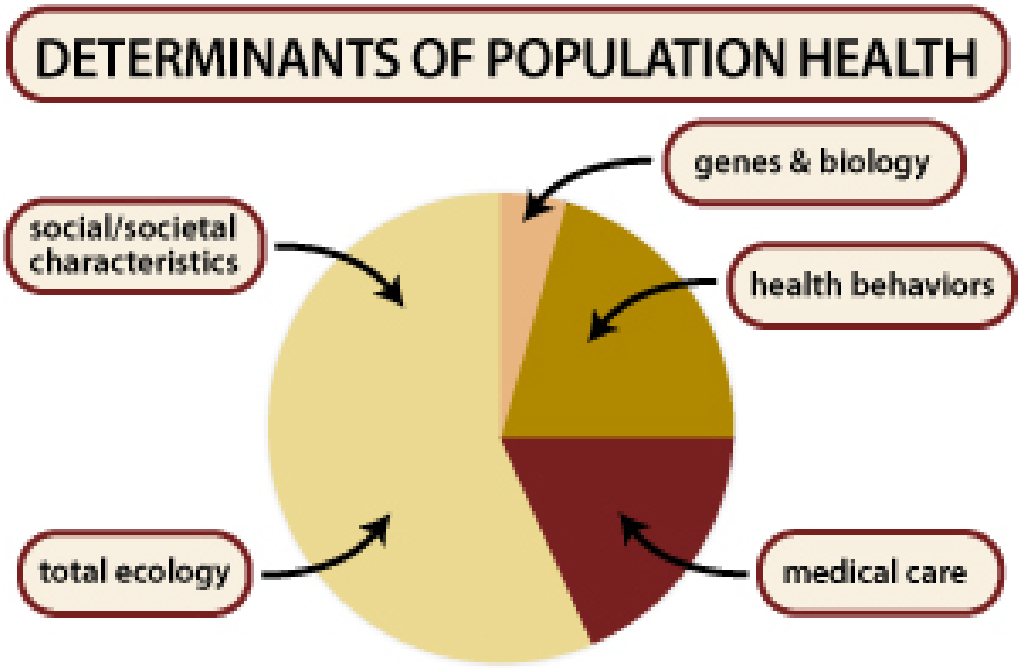
[5] Centre for Disease Control and Management website, http://www.cdc.gov/socialdeterminants/FAQ.html, accessed 26 February 2013.

[6] One example is: WHO 2003, *Social Determinants of Health – The Solid Facts,* 2nd edition, edited by Richard Wilkinson and Michael Marmot.

[7] Centre for Disease Control and Management website, Op-Cit.

[8] Ibid.

Figure 1: Determinants of Population Health



It is well known that in Tasmania, our population is at increased risk of poor health as a result of disadvantage with respect to a number of social and economic conditions. For example, recently published Australian Bureau of Statistics (ABS) 2011 Census data[9] show that:

- The median weekly personal income for people aged 15 years and over in Tasmania was $499 compared to $577 nationally, for the household it was $948 compared to $1234 nationally
- The median weekly family income for families without children (two incomes) was $1,771 in Tasmania and $2,081 nationally. For families with children (two incomes) the median weekly family income was $1,999 compared to $2,310 nationally
- In Tasmania, 30.7% (23.7% nationally) of households had a weekly household income of less than $600 and 5.4% (11.2% nationally) of households had a weekly income of more than $3,000
- More Tasmanians were unemployed than the Australian average, fewer were employed in full time work, and more work away from home and work in part time positions than other Australians. There were 232,126 people who reported being in the labour force in the week before Census night in Tasmania. Of these 54.5% were employed full time (compared to 59.7 nationally), 32.9% were employed part-time (compared to 28.7 nationally) and 6.4% were unemployed (compared to 5.6 nationally)
- The proportion of families where both parents or partners aged 15 years and over were unemployed was 23.1%, compared to 19.2% nationally
- 36.5% of Tasmanians aged 15 years and over (no longer attending school) had completed Year 12 or equivalent, compared to 49.2% nationally

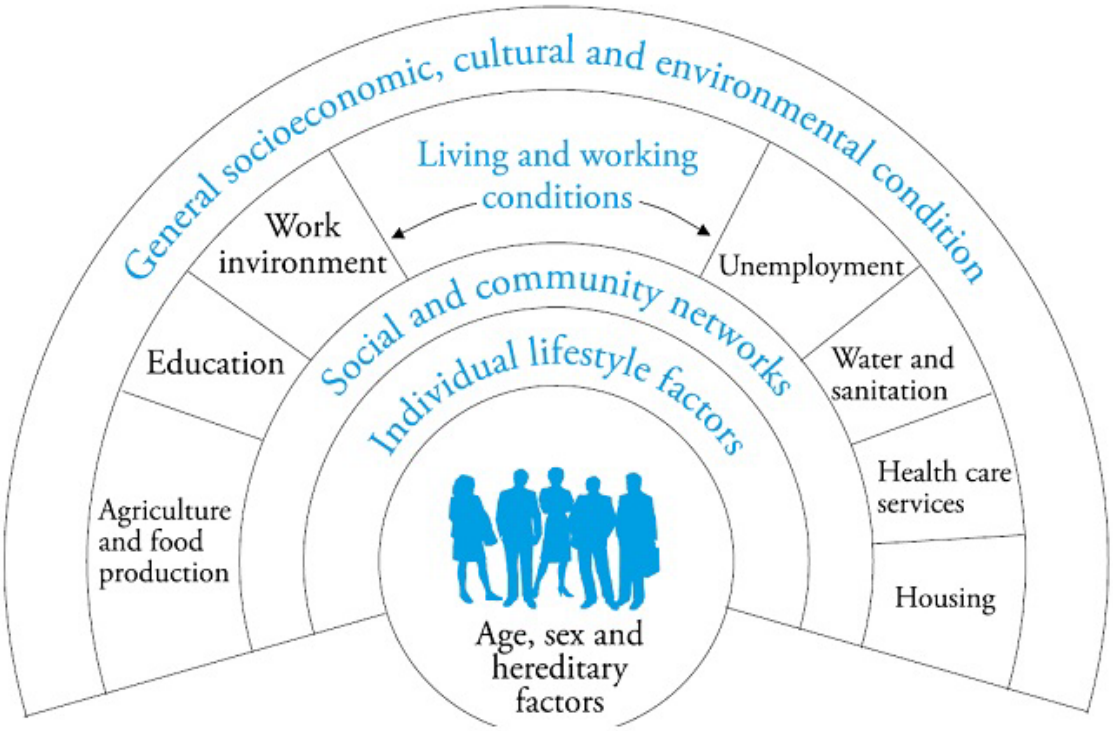
[9] ABS 2012, *2011 Census Quickstats, Tasmania.*

- Most people travel to work by car (63.1% as a driver; and 6.8% as a passenger)
- 11.6% (compared to 10.9% nationally) provided unpaid assistance to a person with a disability
- 4% of the Tasmanian population are Aboriginal, compared to 2.5% nationally.[10]

2.2 Social gradients in health

If a social determinants of health approach is applied (as reflected in the model of health by Dahlgren and Whitehead, 1992[11] - Figure 1) to the data listed in 2.1 above, we can conclude that these data would place many Tasmanians at increased risk of poor health. In fact, research has confirmed this.

Figure 2: Dahlgren and Whitehead's model of the Social Determinants of Health



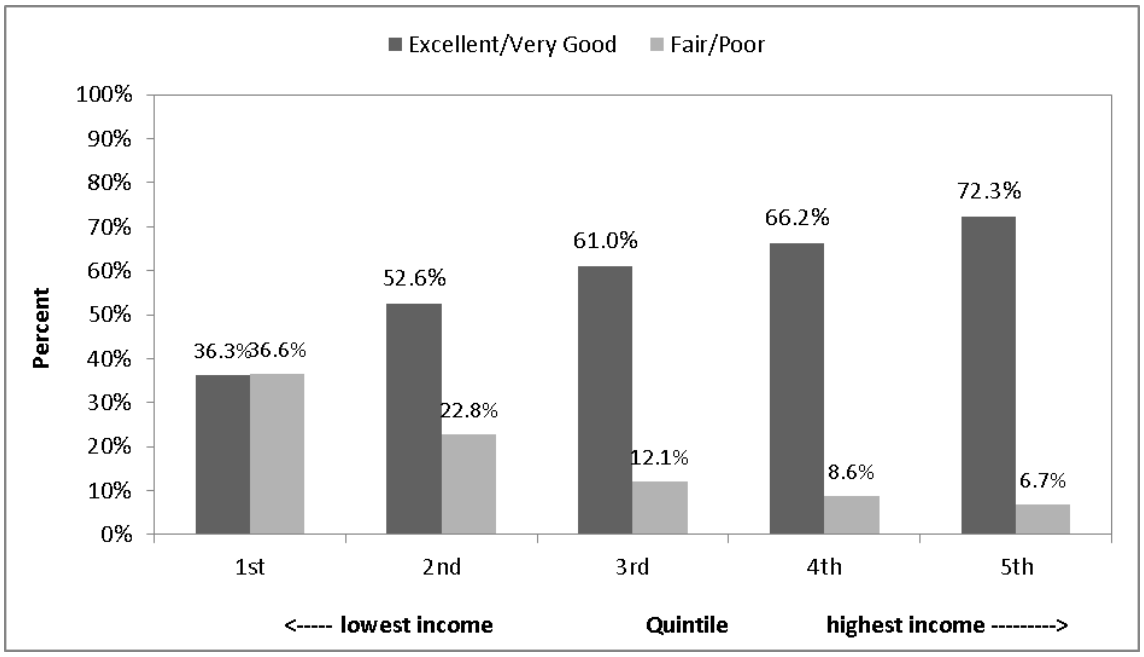
For example, the most recent *State of Public Health Report* (Tasmanian Department of Health and Human Services)[12] illustrates the relationship between household income and self-assessed health (Figure 3).

[10] Ibid.

[11] Dahlgren and Whitehead 1992, *Policies and strategies to promote equity in health,* WHO.

[12] DHHS 2008, *State of Public Health Report,* Tasmanian Government, p.18.

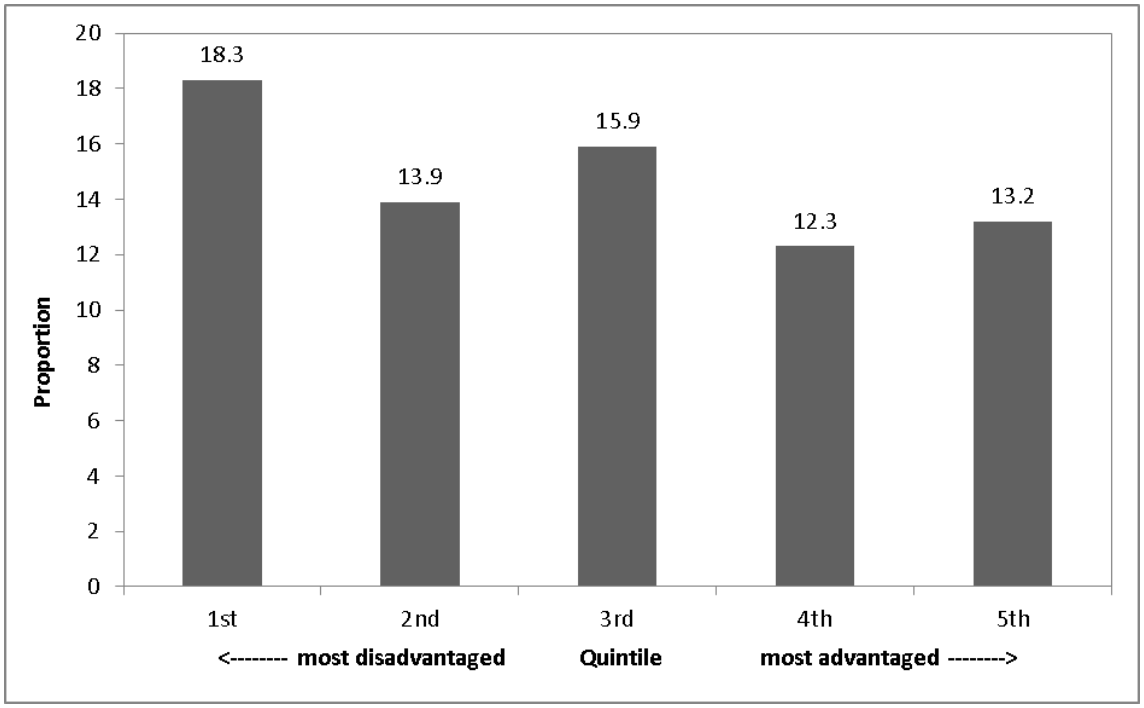
Figure 3: Self-Assessed Health by Household Income Quintile, Tasmania 2004/05



2.2.1 Mental health

The rate of mental health issues is higher among those in the most disadvantaged socio-economic group compared those in the most advantaged group (Figure 4)[13].

Figure 4: Proportion of persons reporting mental or behavioural problems(b)



[13] ABS 2012, *Australian Health Survey: First Results 2011-12*, 4364.0.55.001.

Similar relationships between social and economic factors and health outcomes have been demonstrated elsewhere.[14] What these data are essentially showing is that there is a '*social gradient in health'.* This means that people who are disadvantaged socially and/or economically usually run at least twice the risk of serious illness and premature death as those near the top.[15]

TML has seen evidence of the impact of this in a number of ways. For example, in relation to mental health, there is an increasing number of clients accessing TML provided services for mental health problems and for many their circumstances are compounded by socio-economic disadvantage.

TML manages a number of programs aimed at improving the mental health of Tasmanians. These programs are funded under the Australian Government's Access to Allied Psychological Services (ATAPS) program, which provides access to effective, free or low cost treatment for people with a mental illness who may not otherwise be able to access services. We employ and engage (through commission) mental health clinicians including psychologists, mental health nurses and mental health credentialled social workers. Services are provided for adults and there are specialised services for children, women with perinatal depression and Aboriginal and Torres Strait Islander people.

Short-term psychological treatment (up to 12 sessions) is available for people with mild to moderate mental health issues (such as depression and anxiety) who are likely to respond to short term therapy. This service is available to people who may have difficulty getting to other services because of cost, transport challenges, distance from services or other barriers. Our suicide prevention service is available to people who have a mild to moderate risk of suicide. It is designed to help people who have had a suicide attempt and who are not clients of other mental health services.

TML is aware that we are not the only ones feeling the pressure of increased demand for health care. We are acutely aware that both government and non-government health services as well as social services are under increasing pressure. Many do not have the capacity to address health care needs for patients or clients, let alone own focus on prevention and promotion. This situation needs to change.

2.2.2 Rurality

Another key social determinant of health that TML is acutely aware off is Tasmania's dispersed settlement patterns. In reporting on the indicators of health status and determinants of health in rural, regional and remote areas, the Australian Institute of Health and Welfare (AIHW, 2008) states*:*

> *' Health outcomes, as exemplified by higher rates of death, tend to be poorer outside major cities. The main contributors to higher death rates in regional and remote areas are coronary heart disease, other circulatory diseases, motor vehicle accidents and chronic obstructive pulmonary disease (e.g. emphysema). These higher death rates may relate to differences in access to services, risk factors and the regional/remote environment'.* [16]

The AIHW (2008), has reported:

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[14] Such as the Menzies Research Institute 2009, *Tasmanian Population Health Survey,* University of Tasmania.

[15] WHO 2003, *Social Determinants of Health – The Solid Facts,* 2nd edition, edited by Richard Wilkinson and Michael Marmot.

[16] AIHW 2008. Rural, regional and remote health: indicators of health status and determinants of health. Cat. no. PHE 97. Canberra: AIHW.

- Life expectancy decreases with increasing remoteness. Compared with major cities, the life expectancy in regional areas is 1–2 years lower and in remote areas is up to 7 years lower
- People in regional and remote areas were more likely than those in major cities to report an acute or chronic injury, to drink alcohol in quantities risking harm in the short term, or to be overweight or obese
- Lower birth weights outside major cities were particularly marked for teenage mothers (those aged younger than 20 years)
- Compared with those in major cities, people in regional and remote areas were less likely to report very good or excellent health.[17]

2.3 The way forward

TML wishes to draw bring the Committee's attention to the plethora of research and recommendations that have been published on the SDoH. Most notable at the international level is the WHO Commission on social determinants of health report, *Closing the gap in a generation: health equity through action on the Social Determinants of Health*[18]*.* In addition, the *Rio Political Declaration on Social Determinants of Health* recommended:

- Develop and support policies, strategies, programs and action plans that address the SDoH, with clearly defined goals, activities and accountability mechanisms and with resources for their implementation
- Support the further development of the "health-in-all-policies" approach as a way to promote health equity
- Build capacities among policy-makers, managers, and program workers in health and other sectors to facilitate work on the SDoH
- Give due consideration to the SDoH as part of the deliberations on sustainable development, in particular in the Rio+20 United Nations Conference on Sustainable Development and deliberations in other United Nations forums with relevance to health.[19]

TML advocates the adoption of a Health in All Polices (HiAP) approach in Tasmania. Howard and Gunther (2012) [20] published findings from their examination of key themes for the successful implementation of a HiAP approach. These included:

1. **Leadership** - Explicit political commitment to HiAP at the highest possible level
2. **Governance and strategy** - It is advantageous to have an overarching high-level strategy that specifically endorses HiAP approach. This can help to overcome divisions when there are

[17] Ibdi.

[18] Commission on the Social Determinants of Health 2008, Op-Cit

[19] Sixty-fifth World Health Assembly WHA 65.8, Agenda item 13.6, 26 May 2012, Outcome of the World Conference on Social Determinants of Health.

[20] Howard R & Gunther S 2012, *Health in All Policies: An EU literature review 2006 – 2011 and interview with key stakeholders,* Equity Action.

apparent conflicting objectives between sectors. It can help to identify common aims across government, and support the use of resources to implement a wider HiAP approach.

3. **Partnership and stakeholder engagement** - Working effectively with a wide range of partners is essential. Including stakeholders by using a community participation approach is a critical factor in a successful HiAP approach.

4. **Capacity and technical skills** - Building skills and capacity both within and external to the health sector is seen by most as essential to the development of HiAP.

5. **Health equity** - A greater understanding is needed of the differences between health equality and health equity, and better data are needed to be able to understand health inequalities at a national and local level.

6. **Tactics** - Identifying win-win approaches, where there are clear and evidence based co-benefits to health and other policy areas, is a fruitful area for implementation of HiAP.[21]

We also encourage the Committee to look at action across the social gradient. Poor health is not just about those who are most disadvantaged in other ways - the social gradient in health runs right across society. Marmot ((2010) advocates for an approach known as *"proportionate universalism",* which is described as follows: "*Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. This is called proportionate universalism."* [22]

Recommendations:

The Government, in partnership with the non-government sector, reorient the health care system to take a stronger focus on addressing the Social Determinants of Health, enhancing health equity and preventing poor health outcomes by:

- Implementing a Health in All Policies (HiAP) approach to policy, program and service development. HiAP is a policy strategy, which targets the key social determinants of health through integrated policy response across relevant policy areas with the ultimate goal of supporting health equity; and
- Implementing a 'proportionate universalism' approach to act across the social gradient of health.
- Making action on the issue of health literacy across both community and provider sectors a foundation priority.

[21] Ibid.

[22] Marmot M 2010, *Fair Society Healthy Lives.*

3.0 Term of Reference 2: A Preventative Health Care Model

TML supports the need for an integrated and collaborative prevention oriented primary health care model that focuses on the prevention, early detection and early intervention for chronic disease. However, this effort should be founded on addressing the social determinants of health. Project based methodologies focussing in isolation on 'problem bits' of the system fail to acknowledge the pervasive and lifelong influences associated with the lived and built environment. All too often, we see health promotion and preventative efforts limited to healthy lifestyle interventions and behavioural approaches and while we absolutely believe that this is part of the broader picture, as clearly shown above, we must also prioritise action on *'the causes of the causes'*.

A recent presentation by Duckett (2013[23]) highlightswhy this is important:

> *'And if you just use diabetes as an example, people who live in the poorest areas of Australia, the lowest 20 per cent of areas of Australia, have more than two-and-a-half times the risk of getting diabetes relative to people who live in the top 20 per cent of areas.*
>
> *That difference in risk between a 2 per cent chance of getting diabetes if you live in the best areas versus a 5 per cent chance in the worst areas is a much more significant difference than, say, so-called behavioural factors such as exercise, which is 6 per cent if you are high to moderate exercise person versus 8 per cent if you are sedentary risk of getting diabetes. It's much more important than alcohol, and even more important than obesity.*
>
> *To understand diabetes, for example, you cannot understand the risk of getting diabetes if you don't start by thinking about the broader social factors. And so it shouldn't be possible to develop, for example, a diabetes strategy in Australia without first starting with a social determinants approach, without starting with those broader factors.*
>
> *But if you look at the Department of Health and Ageing website today, it refers to lifestyle-related chronic disease as the determining factor or one of the critical factors, and so that suggests to me that we in our health policy are applying the wrong frame as a starting point.*
>
> *The old paradigm of this was behavioural risk factors led to disease and the intervention was to change the behaviours. But we've got to recognise those behaviours in many case are shaped by the social determinants – the areas in which you live, the income you have and so on. And so we need, in our policies, to be focussing more upstream in that regard.'*

If the State Government was to develop a preventative health care model, TML asserts that it needs to have a strong focus on health equity. Some of the characteristics of a health equity-oriented health care sector include:

- Focusing on comprehensive primary health care
- Decision making processes that involve local communities
- Planning including allocation of resources, based on the needs of populations within a social determinants of health framework
- Presence of health sector advocacy programs

[23] Duckett S, (Grattan Institute), Speaking at the launch of the Social Determinants of Health Alliance, Canberra, February 2013.

- Training of the health workforce in the social determinants of health.[24]

TML has concerns that currently within Tasmania's health care system, primary health care is being eroded through misguided reactionary responses to tertiary unsustainability and system overload which result in reallocation of scarce resources to easily measurable and definable outputs such as elective surgery. Preventive efforts are being marginalised and sustainable health promotion initiatives are virtually non-existent. As stated by Baum et al (2009), *'There is growing international evidence of better population health outcomes and cost reductions in instances in which economic incentives are created for community-based preventive health care provision rather than individual curative care provision.'*[25]

TML advocates strongly for a balanced and scientific approach to system redesign and reinvestment that effectively targets activity at efforts resulting in long-term reductions and demands for tertiary intervention.

Investment in preventative health care across the care continuum

Increased focus is needed to embed a preventative health approach across the care continuum.

This requires:

- Reorientation of service re-design focus from acute care demand management strategies, to a primary focus on client needs for managing their health and /or chronic condition, and from this basis, to identify the associated type and location of resources to support client focused care needs, which includes access as necessary to acute episodic care.

- Embedding a preventative health care approach across all parts of the health care continuum, that moves beyond services responding to presenting issues, to a more robust focus on broader coordinated care planning.

- Strengthen and appropriately resource the targeted approach to 'upstream' preventative health care. The current health service system remains largely focused on those clients who already have a chronic condition, or who are acutely unwell. Increased focus is required at the very least initially, on targeted care for clients identified as 'at risk' of developing a chronic condition', and ultimately on strengthening the focus on preventative health strategies with the broader population, in order to produce any true longer term change to health outcomes and existing service system pressures.

Cross sector coordination and investment

Improved health and wellbeing requires enhanced collaboration both within the health sector and in partnership across sectors including:

- Improved coordination of effort to maximise funding and workforce resources available across a range of health providers, including government, community based organisations, private providers, community groups and carers.

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[24] Baum F, Begin M, Houweling, AJ and Taylor S 2009, 'Changes Not for the Faintheared: Reorienting Health Care Systems Toward Health Equity Through Action on the Social Determinants of Health', *American Journal of Public Health,* vol 99, no. 11, pp. 1967-1974.

[25] Ibid, p. 1971.

- The health sector working with other sectors to embed a preventative health approach, with examples including: curriculum development in schools, and improved allocation of resources and focus on 'health' as part of Workplace Health and Safety policy, working with local government to improve physical environments for health and wellbeing activities and services access.

Strengthening individual contribution to health and wellbeing

There is a need to invest in people's understanding of their contribution to their own health and wellbeing. This is required as a fundamental strategy to support service re-design, to facilitate a shift in public focus. For example, increasing understanding on the importance of access to improved strength and fitness programs as part of falls prevention, rather than the current well established focus on hospital waiting lists for orthopaedic surgery.

Improving health literacy is central to this change, but also, vitally, is supporting people's capacity act on improving their health, through addressing the social determinants of health, as described within this document.

Workforce Redesign

The changing nature of health care, along with significant workforce shortages requires review of a health workforce that has been largely historically based, particularly for government based services that form a large component of the Tasmanian health workforce. This includes:

- Improved service communication systems to support the role of general practice as core providers for people in health prevention, early intervention and chronic conditions management.
- Improved targeted access to current health professional service gaps, including, but not limited to, exercise physiologists, diabetes educators and dieticians.
- Establishment of new roles complementing the existing workforce, to better support and target care, such as advanced care practitioners (nursing and allied health), and allied health/primary care assistants.
- Improved understanding and resourcing of care coordination, to support early intervention and management of people with chronic conditions.
- Improved understanding, collaboration and role delineation with broader service providers who often contribute to health care, including human services, transport services and local government.

Resource Investment

For many years, the strong evidence of the need for enhanced and long-term focus on preventative health strategies has been acknowledged. However, access to resources for these strategies has struggled to compete for resources within an environment of acute service demand.

Where resources are provided, they are often allocated for specific issues, population groups or activities and with significant time and funding constraints. Targeted resource allocation is required that:

- moves beyond specific conditions or lifestyle behaviours and enables consideration of the broader ‘causes of the causes’, as discussed in this document,
- provides resources for timeframes that enable investment over the longer periods of time required to implement and evaluate preventative health strategies that in many cases, may only be demonstrated over generations.

The Government must take heed of such advice. Building a strong primary health care system in Tasmania is the core business of TML. TML welcomes the opportunity to work closely with the Government to this end.

Recommendations:

The Government:

- Work with TML and other key stakeholders to build a strong primary health care system in Tasmania that places health equity as a central goal.
- Utilise the many opportunities existing under the Tasmanian Health Assistance Package to leverage intensive work in this area and to set the system on a course for recovery.
- Embed a requirement in all service planning processes to prioritise the development of integrated cross-sectoral models of care weighted ahead of siloed or regionalised service systems.
- Primary Health Care service redesign efforts within the Tasmanian Healthcare System need to be based upon a commonly understood and defined set of health pathways.
- Undertake workforce redesign based upon agreed and established health pathways occurs as a subsequent process in the system redesign program.
- Invest in continuous evaluation and monitoring of integrated preventative health strategies to enable long term measurement of health outcomes.

4.0 Term of Reference 4: Experience and expertise

It is difficult for TML to comment on the extent to which experience and expertise in the social determinants of health is appropriately represented on whole of government committees or advisory groups, however overall we feel that collectively we need to develop a deeper understanding of the social determinants of health in Tasmania and the best ways forward. There is a significant body of literature that can assist the Tasmanian Government to move forward on this agenda, such as that undertaken by the WHO, as mentioned earlier.

Importantly, collectively the relevance of such recommendations within the Tasmanian context must be recognised. TML refers the Committee to Tasmania's experiences with Tasmania *Together* as a model for comprehensive engagement with our citizens on a broad range of issues.

Whilst the Tasmania *Together* experience may be judged as unsuccessful by some this is more likely attributable to the fact that some priorities and targets were not adequately addressed, prioritised or resourced.

TML recognises the broad spectrum of stakeholders that should be involved in making decisions about health and wellbeing outcomes for Tasmanians, including its citizens. TML believes that it is important to develop the knowledge of our citizens and refer to the value of citizen's juries (in point 5 below), which aim to develop a critical awareness among participants, while at the same time engaging them in making decisions about their health needs.

Lastly TML recognises that given the implications of this matter – in terms of the health and wellbeing of Tasmanians, social justice, as well as the economic sustainability of our State – that it is imperative that the Government engage health economics expertise to provide some guidance on ways forward.

> *'Health economics brings the economist's way of thinking to how health is "produced" in populations and how it can be produced better and distributed more fairly. It involves the study of healthcare systems, payment mechanisms for clinicians, and factors outside the health system that affect health as well (such as employment, taxation and education).*
>
> *If you have ever heard that hospital A or country Y gets better recovery rates from coronary bypass surgery at less cost than hospital B or country Z, then you are learning from health economists. If you read that building more footpaths increases quality of life and reduces healthcare costs then that is health economic research also.'*[26]

[26] Shiel A, 2013, 'The founding father of health economics', *The Age,* 7 January 2013.

Recommendations:

The Government:

- Utilise the sound body of work that has been carried out to guide action on the Social Determinants of Health, such as reports and recommendations published by the WHO
- Implement strategies to raise awareness of the social determinants of health across State Government departments, as well as in partnership with the non-government sector and the wider community
- Invest in health economics expertise to guide action in Tasmania.

5.0 Term of Reference 5: Research

An area of investment typically lacking and often cut in times of crisis is that of health research. Working closely with academic institutions both within and external to Tasmania and investing in research and evaluation will build a more robust and responsive system, a system focussed and based on evidence and outcome, and one less susceptible to the vagaries of political influence or inheritance.

Sound research and deepening our understanding of integrated primary health care models and the social determinants of health and health inequities is always welcomed, however it must not take place instead of *action*.

Overall, Tasmania does not have a strong track record when it comes to gathering data on the social determinants of health. This has resulted in ill-informed decisions and lack of long-term vision for health and wellbeing in Tasmania.

One area of 'research' that TML is passionate about is growing and listening to the voice of our citizens.

A citizen's jury takes a random selection of citizens, provides them with information about a topic and gives them the opportunity to have their say about the issue. TML became the first Medicare Local to consult its community through a citizens' jury when it convened its after hours jury in April 2012.

The after hours citizens' jury was held in Launceston on 20 to 21 April 2012 and facilitated by the late Professor Gavin Mooney, a health economist of 35 years' standing and, more recently, pioneer of citizens' juries in health in Australia. The jury consisted of 14 randomly selected people from around Tasmania. The jury members were provided with information on TML and on after-hours care, deliberated on what they had heard, then made recommendations on the principles on which they, as Tasmanian citizens, wanted after-hours care to be based and what aspects of after-hours care they saw as priorities.

The key priorities identified included equity, information about availability and appropriate use of after-hours services, and making best use of resources. Jury participants saw improving community awareness of after-hours services as a key priority, with more resources dedicated to vulnerable population groups. The citizens' jury recommendations – along with advice from health professional stakeholders – are guiding TML's plan to improve access to after-hours care.

Recommendations

The Government in partnership with the non-government and private sectors to engage with Tasmanian citizens to deepening our collective understanding about new and more efficient models of primary health care and on the factors influencing their health by implementing citizen's juries, consumer panels or other community planning methods to engage citizens in decision making processes related to their health.

That future investment in and reform to the Tasmanian health system – in particular in respect of integrated primary health systems – be based upon and contribute to the growing local, national and international evidence base.

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