

# Needs Assessment Report

1 July 2019 – 30 June 2022



**Australian Government**

**Department of Health**

**phn**

An Australian Government Initiative

# **Primary Health Network Needs Assessment Report (2019 - 2022)**

# SECTION 1 - NARRATIVE

## Needs Assessment Process and Issues

The overarching design for the Needs Assessment (NA) was the collection and analysis of both quantitative and qualitative data from multiple information sources focussed on identifying the health and service needs of priority areas drawn from:

- (1) our core agreement national headline performance indicators (mental health, cancer screening, avoidable hospitalisations, and immunisation);
- (2) priority areas included within the NA guidelines (Aboriginal and Torres Strait Islander health, population health, health workforce, eHealth and aged care); and
- (3) additional areas reflecting required inclusion, emerging policy interest and/or planned work (alcohol and other drugs, child health and rural health).

The governance and operations of the NA process was led by the organisation's Planning and Evaluation team who perform the organisation's health intelligence function. The Planning and Evaluation team was supported by the organisation's Clinical Advisory Council and Community Advisory Council.

The Clinical Advisory Council reviewed the overall needs assessment process to ensure it was robust, comprehensive, evidence based, systematic and conducted in accordance with the Department of Health Needs Assessment Guide. In addition, the Council reviewed the NA detailed reports for each priority and the data sources accessed for each priority area to ensure relevance, identify gaps, and identify additional sources of information that could inform the needs assessment.

The Community Advisory Council also undertook a similar role in the development process and contributed to the final NA report.

Quantitative data in relation to each of the noted priority areas was obtained from a range of national, state and local sources and, collated, analysed and reviewed with qualitative data sourced from Primary Health Tasmania stakeholder engagement activities undertaken for the period July 2016 – November 2018

The final report was submitted to the Executive team and the Board for discussion and endorsement.

## Additional Data Needs and Gaps

In undertaking the Needs Assessment, Primary Health Tasmania obtained and analysed information from a broad range of sources and prepared a comprehensive stand-alone report describing Tasmania's population health, potentially preventable hospitalisations, mental health, alcohol and other drugs, immunisation, aged care, Aboriginal and Torres Strait Islander health, rural health and cancer screening health needs, service system and corresponding priorities.

The analysis and priorities outlined in this Needs Assessment form the basis for ongoing organisation planning and commissioning activities. The NA also highlights gaps in available data across the spectrum of Primary Health Tasmania priority areas. These gaps will be addressed in future years as part of Primary Health Tasmania's iterative health intelligence activities.

The major identified needs pertaining to improved data capture include:

- Ongoing data collection and analysis to further elucidate the health and service needs of mental health consumers in Tasmania;
- Robust and comprehensive data collection that encompasses the National Immunisation Program Schedule in its entirety to include adult immunisations;
- Improved availability of data pertaining to the health status of Aboriginal and Torres Strait Islanders in Tasmania; and
- Improved cancer screening data at a local level.

### Additional comments or feedback

Primary Health Tasmania is committed to building upon the findings of this Needs Assessment to better understand the health needs of the Tasmanian population with an aim to improve the health of Tasmanians. The NA methodology will be subject to ongoing review and refinement. This will ensure a rigorous process is in place to build on this important work as Primary Health Tasmania embeds its major role as a commissioning organisation.

As part of this quality improvement process Primary Health Tasmania will:

- (1) incorporate information and performance metrics collected from commissioned organisations into future needs assessments;
- (2) systematically incorporate findings from an increasing number and range of stakeholders.

#### Scoping Solutions: The Pillars of Integration

During the NA process across the identified priority areas, a range of complex issues and ideas for solutions emerged. It is not possible to capture the nature and extent of this complexity, nor the long-term nature of the solutions required within a report of this type. These complexities will be considered in more detail as part of the annual planning process.

However, in preparing potential options as part of the NA, it is Primary Health Tasmania's view that these issues require a strategic focus that adequately addresses the issues from a whole of systems approach. Therefore, in working to tackle the identified and prioritised issues, Primary Health Tasmania will seek to identify opportunities within the scope of its mandate as a PHN. This will be achieved by applying a model for improved system integration that considers action from three 'pillars of integration'. These pillars were developed by Primary Health Tasmania on the basis of research conducted by The King's Fund into how best to implement integrated care. The three pillars are (1) system integration, (2) professional provider interactions, and (3) consumer and community engagement across services.

Consideration of these three pillars is reflected as key themes throughout the identified potential options for addressing priority issues. It is important to note that to formally develop and implement solutions that reflect these three pillars, ongoing consultation with a broader range of stakeholders will be required.

From this basis of pillars of integration, we have refined our focus to incorporate the quadruple aim. This has been reflected in the strategic goals of Primary Health Tasmania.

## SECTION 2 - OUTCOMES OF THE HEALTH NEEDS ANALYSIS

*\*Please note: All rates are age standardised unless reported otherwise*

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
<b>1. Population Health</b>		
Health status of Tasmanians	Tasmanians experience poorer health outcomes than Australians as a whole.	<p>The median age of the Tasmanian population is the highest in Australia and continues to increase. In the 2016 Census it was 42 years, four years higher than the Australian average of 38 years<sup>1</sup>. The proportion of the population aged 65 years and over is also higher in Tasmania than other states, with 20% of Tasmanians aged 65 years and over in 2016, compared with 16% for Australia overall.</p> <p>Life expectancy in Tasmania has steadily improved to an average of 82.8 years. Tasmania still has the second lowest life expectancy of all states and territories in Australia and lower than the Australian average of 84.5<sup>2</sup>. Aboriginal and Torres Strait Islander peoples continue to have a lower life expectancy than the general population in Tasmania<sup>3</sup>.</p> <p>Tasmanians have the highest prevalence of chronic disease and multi-morbidity in Australia. Four in five Tasmanians (83%) have a chronic condition and 65% have two or more chronic conditions<sup>4</sup>.</p> <p>The most commonly reported chronic conditions by Tasmanians are long-sightedness, hay fever /allergic rhinitis and mental health or behavioural problems.</p>

<sup>1</sup> Australian Bureau of Statistics, Census of Population and Housing: General Community Profile, Australia, 2016, Cat No 2001.0 (Canberra, Australia: 2017).

<sup>2</sup> Australian Bureau of Statistics, Life Tables, States, Territories and Australia, 2013-2015, Cat No. 3302.0.55.001 (Canberra, Australia: 2016).

<sup>3</sup> Department of Health (Tasmania) , Health Indicators Tasmania 2013 (Population Health Branch: Department of Health (Tasmania) Tasmania, 2013).

<sup>4</sup> National Health Survey: First Results, 2014-15

Outcomes of the health needs analysis		
		<p>Tasmania's mortality rates are higher than the Australian average for all-causes and all of the major causes including cancer, diabetes, ischaemic heart disease, stroke, respiratory diseases, diabetes and suicide<sup>5</sup>.</p> <p>Self-assessed health status declined in the most recent decade, with 76% of Tasmanians reporting either good, very good or excellent health in 2016, down from 80% in 2009. The Tasmanian population aged 65 years and over generally report good health, with three quarters (75%) reporting excellent, very good or good health in 2016<sup>6</sup>.</p> <p>Aboriginal and Torres Strait Islanders are less likely to self-report good health compared to non-Aboriginal Tasmanians, with only 71% reporting excellent, very good or good health in 2016<sup>7</sup>. The proportion of Aboriginal and Torres Strait Islanders in Tasmania with profound or severe activity limitations is 12%, almost three times that of non-Indigenous Tasmanians (5%)<sup>8</sup>.</p> <p>An estimated 22.7% of Tasmanian adults self-reported having a disability, compared with 18.5% of Australians as a whole<sup>9</sup>.</p>
Lifestyle risk factors for chronic disease	Tasmanians have high rates of adverse lifestyle risk factors for chronic disease.	<p>Almost one third (30%) of the burden of disease in Australia is attributable to the five leading risk factors of tobacco use, overweight and obesity, high alcohol use, physical inactivity and high blood pressure and Tasmanians have higher prevalence of all five risk factors than the rest of Australia<sup>10</sup>.</p> <p>Approximately one in six Tasmanians (16%) smoke tobacco, which has declined in line with national trends from 20% in 2009 but Tasmania still has the second highest prevalence of smoking in Australia, behind the Northern Territory. One in five (21%) young Tasmanians aged 18-24 years smoke daily or occasionally<sup>11</sup></p>

<sup>5</sup> Primary Health Information Development Unit, Social Health Atlas of Australia: Local Government Areas; Compiled Based on Data from the 2010 to 2014 Death Unit Record Files Supplied by the Australian Coordinating Registry (2010-14).

<sup>6</sup> Department of Health (Tasmania) Tasmania, Tasmanian Population Health Survey 2016, ed. and trans. Department of Health (Tasmania) Tasmania, 1 ed. (Hobart, Australia: Department of Health (Tasmania) Tasmania, 2017).

<sup>7</sup> Department of Health (Tasmania) , Tasmanian Population Health Survey 2013 (2014).

<sup>8</sup> Ibid.

<sup>9</sup> Department of Health (Tasmania) , Health Indicators Tasmania 2013.

<sup>10</sup> Australian Institute of Health and Welfare, Australian Burden of Disease Study: Impact and Causes of Illness and Death in Australia 2011 (Canberra: AIHW: 2016).

<sup>11</sup> Department of Health (Tasmania) Tasmania.

Outcomes of the health needs analysis		
		<p>Alcohol consumption exceeding the National Health and Medical Research Council (NHMRC) Guidelines for single occasion risk was higher in Tasmania (46%) than at the national level (44%), and higher for younger age groups and males. Alcohol consumption exceeding the NHMRC Guidelines for lifetime risk is also higher among Tasmanians than the Australian average (19% versus 17%). Tasmanian males are more likely to drink at harmful levels than the average Australian male (29% compared with 26%) while Tasmanian women are slightly less likely than the average Australian female (8% compared with 9%) to drink at levels shown to increase the lifetime risk of harm<sup>12</sup>.</p> <p>Physical activity levels remain low with 70% of Tasmanians reporting inadequate levels of muscle strengthening activity and a further 15% reporting inadequate aerobic activity<sup>13</sup>. Similarly, Tasmanian Secondary School students are insufficiently active, with less than 20% reporting adequate levels of physical activity<sup>14</sup>.</p> <p>Two-thirds of Tasmanian adults are overweight or obese (66%), an increase of 6% from 54% in 2009<sup>15</sup>, just above the national average of 63%<sup>16</sup>.</p> <p>Very few Tasmanians consume the recommended five serves of vegetables per day with a reduction from 11% in 2009 to 8% in 2016<sup>17</sup>. Two in five Tasmanians (39%) met the guidelines for fruit consumption in 2016 a reduction from 50% in 2009. Breastfeeding initiation rates have been reasonably stable over time, and iodine status has improved following fortification programs<sup>18</sup>.</p>
Socio-economic disadvantage	People with socio-economic disadvantage experience a disproportionately greater chronic disease burden.	Tasmania has greater socio-economic disadvantage than Australia overall. The median personal income in Tasmania is \$573 (\$662 nationally) and the median

<sup>12</sup> Australian Bureau of Statistics, Australian Health Survey: First Results, 2011–12, Cat No: 4364.0.55.001 (Canberra: 2012).

<sup>13</sup> Department of Health (Tasmania) , "Tasmanian Population Health Survey 2013."

<sup>14</sup> Australian Secondary Students' Alcohol and Drug Survey - Victorian Report 2014, by Department of Health & Human Services (2017).

<sup>15</sup> Department of Health (Tasmania) Tasmania.

<sup>16</sup> Australian Bureau of Statistics., National Health Survey: First Results, 2014-2015, ed. and trans. ABS, 4364.0.55.001 ed., 4364.0.55.001 vols. (Canberra: ABS, 2014-2015).

<sup>17</sup> Department of Health (Tasmania) Tasmania.

<sup>18</sup> Australian Bureau of Statistics, "Australian Health Survey: First Results, 2011–12, Cat No: 4364.0.55.001."

<b>Outcomes of the health needs analysis</b>		
		<p>household income is \$1100 (\$1734 nationally). Almost one third (31%) of Tasmanians have a weekly household income less than \$650<sup>19</sup>.</p> <p>Educational attainment is lower in Tasmania than other jurisdictions with 43% of Tasmanian students completing year 12 in 2015, well below Victoria (78%), South Australia (77%) and New South Wales (72%) and Australia overall (72%) but higher than the Northern Territory (38%)<sup>20</sup></p> <p>Potentially preventable hospitalisations are highest in people in the lowest SEIFA quintile (26 per 1000 population) compared with those in the highest quintile (19 per 1000 population)<sup>21</sup>.</p> <p>Smoking is strongly related to socio-economic status and is 2.5 times more common among people in the most disadvantaged SEIFA quintile at 25% than the least disadvantaged quintile at 10%. Obesity is also associated with socioeconomic disadvantage, with 25% of people in the most disadvantaged SEIFA quintile being obese compared to 18% in the least disadvantaged quintile.</p> <p>Self-assessed health and avoidable mortality are worse in the most disadvantaged communities<sup>22</sup>.</p> <p>Socio-economic disadvantage also adversely affected participation in cancer screening and cancer survival rates<sup>23</sup>.</p> <p>Rates of diabetes and hypertension are higher in the most disadvantaged communities, and five-year cancer survival is lower<sup>24</sup>.</p>
<p><b>2. Potentially Preventable Hospitalisations (PPH)</b> – For the purposes of the Needs Assessment potentially preventable hospitalisations have been defined as health conditions where immunisation is believed to be avoidable if timely and adequate non-hospital (primary) care had been provided.</p> <p>Rates of potentially preventable hospitalisations are used as indicators for monitoring the quality or effectiveness of non-hospital (primary) care in the community.</p>		

<sup>19</sup> Australian Bureau of Statistics, "Census of Population and Housing: General Community Profile, Australia, 2016, Cat No 2001.0."

<sup>20</sup> Australian Government: Productivity Commission, Report on Government Services 2017: School Education (Australian Government: Productivity Commission, 2017).

<sup>21</sup> Department of Health (Tasmania), Health Indicators Tasmania 2013.

<sup>22</sup> Ibid.

<sup>23</sup> Ibid.

<sup>24</sup> Ibid.

<b>Outcomes of the health needs analysis</b>		
Overall, potentially preventable hospitalisations account for 6% of all hospitalisations in Tasmania. There are three categories of potentially preventable hospitalisations: vaccine-preventable, acute and chronic conditions.		
Potentially preventable hospitalisations	Vaccine preventable potentially preventable hospitalisations still occurring in Tasmania	<p>Among potentially preventable hospitalisations, vaccine preventable diseases make up a small but increasing number of total hospital admissions (almost 600 in Tasmanian public hospitals in 2015/16)<sup>25</sup>.</p> <p>Analysis of ACIR data shows <sup>26</sup>variation in the percentage of children fully immunised at across different geographical areas. Low rates of 7immunisation identified in the North East and Cradle Coast areas of Tasmania.</p>
Potentially preventable hospitalisations	Acute conditions contribute to almost half of all potentially preventable hospitalisations in Tasmania.	The main acute medical conditions associated with potentially preventable hospitalisations in Tasmania are pyelonephritis, cellulitis and dental conditions.
Potentially preventable hospitalisations	Chronic conditions contribute to almost half of all potentially preventable hospitalisations in Tasmania.	<p>The main chronic conditions associated with potentially preventable hospitalisations are chronic obstructive pulmonary disease, heart failure and diabetes complications<sup>27</sup>.</p> <p>People with these diagnoses have high levels of co-occurring chronic diseases i.e. multi-morbidity.</p>
Frequent hospital re-admissions	Readmission to hospital of a limited number of Tasmanians comprise almost as many hospitalisations as potentially preventable hospitalisations.	<p>There are people in Tasmania who experience frequent readmissions to hospital (excluding patients with haemodialysis and day chemotherapy care needs). This patient group comprises 6% of all bed days and admissions<sup>28</sup>.</p> <p>Among these patients, chronic obstructive pulmonary disease, heart failure and diabetes are the most frequent chronic conditions. The majority of these patients have multiple comorbid conditions.</p>

<sup>25</sup> Department of Health (Tasmania). Health Central Data Warehouse. Accessed November 2015.

<sup>26</sup> Australian Childhood Immunisation Register. Data accessed November 2016

<sup>27</sup> Ibid

<sup>28</sup> Health Services Innovation Tasmania. Analysis of hospitalisations data. January 2016.

Outcomes of the health needs analysis		
3. Mental Health		
Mental health	Tasmania has a high prevalence of people identifying as socioeconomically disadvantaged, which places large proportions of the population at increased risk of mental and behavioral illness and their associated sequelae.	<p>An estimated 15% of Tasmanian adults self-reported a mental health problem<sup>29</sup>.</p> <p>In Tasmania, rates of self-reported psychological distress and diagnoses of depression/anxiety have increased over time.</p> <p>Approximately 13.7% of Tasmanians report high to very high levels of psychological distress. These rates are not statistically significantly different to any other jurisdiction with the exception of the Northern Territory, where self-reported mental health problems are recorded for 10.6% of the population<sup>30</sup>.</p> <p>Depression and anxiety are the most frequently reported and managed mental health problems.</p> <p>More Tasmanians are seeking professional help for mental health problems over time, with women more likely to seek help than men.</p>
Severe and complex mental illness	Poor physical health of people with severe and complex mental illness	<p>An estimated 2.5% of the Tasmanian population have a severe mental health disorder. This translates to 14,860 Tasmanians living with severe mental health problems.</p> <p>Most people with mental health problems also have chronic diseases. People with severe and persistent mental health disorders die 15 to 20 years earlier than the general population.</p> <p>Severe mental health problems contribute to psychosocial support needs. Just over half of people with psychotic illness receive no or minimal support from any source.</p>
Suicide prevention	Tasmania has more suicide deaths than the Australian average.	<p>Death rates from suicide have increased over time between 2008 and 2017 in Tasmania.</p> <p>Suicide is the leading cause of death among people aged 15 to 44 years.</p>

<sup>29</sup> Australian Bureau of Statistics. Australian Health Survey, 2011/12.

<sup>30</sup> Ibid

Outcomes of the health needs analysis		
Children and adolescents with mental health needs	Poor mental health outcomes for children and adolescents in Tasmania.	<p>Young people aged 18 to 24 years have the highest prevalence of mental illness than any other age group. An estimated 1 in 7 children and adolescents aged 4–17 self-report having had a mental disorder in the previous 12 months.</p> <p>The prevalence of mental health disorders for 4–17 years decreases with increasing severity, with 8.3% having ‘mild’ disorders, 3.5% ‘moderate’ and 2.1% ‘severe’ disorders.</p> <p>The principal diagnoses of children aged 4-17 years with mental health disorders are:</p> <ul style="list-style-type: none"> <li>• Attention deficit / hyperactivity disorder (predominantly males)</li> <li>• Anxiety disorders (predominantly females); and</li> <li>• Depression</li> </ul> <p>Young Tasmanians (aged 18-24) have the highest rate of self-reported psychological distress at high/very high levels compared to other age groups.</p>
Aboriginal and Torres Strait Islander mental health	<p>Data specific to this population is scant.</p> <p>Aboriginal and Torres Strait Islander Tasmanians suffer higher levels of psychological distress than other Tasmanians.</p> <p>Mental and behavioral disorder related hospitalisation profiles mirror those of non-Aboriginal and Torres Strait Islander Tasmanians.</p>	<p>Aboriginal and Torres Strait Islander Tasmanians are 2.8 times as likely to report a high level of psychological distress as non-Indigenous Tasmanians<sup>31</sup>. The majority are from non-remote regions of southern and north-western Tasmania. Factors including history, socioeconomic disadvantage, ongoing perceived discrimination all contribute to this difference, which in turn contributes to high rates of mental health and self-harm.</p>
<b>4. Alcohol and Other Drugs</b>		
Harms associated with substance use disorders	<p>Excess hospitalisations associated with alcohol and other drugs use</p> <p>Prescription drug misuse - a growing problem.</p>	<p>Hospital separations with a drug-related principal diagnosis represent 1% of all hospital separations across Tasmania. Separation rates are higher for people in low socioeconomic status areas<sup>32</sup>.</p>

<sup>31</sup> DHHS Tasmania. Health Central Data Warehouse. Accessed October 2016.

<sup>32</sup> Department of Health (Tasmania). Health central data warehouse. Accessed January 2016.

Outcomes of the health needs analysis		
		<p>Alcohol is the most common reason for hospital separations with a drug-related principal diagnosis (61% of separations).</p> <p>Prescription drug misuse contributes to drug-related harm. Overall, 12% of alcohol and other drug related hospitalisations are for analgesics, with opioids (heroin, opium, morphine and methadone) accounting for half of this group (6% of all drug-related hospitalisations).</p> <p>Stimulants and hallucinogens, including cannabis and cocaine, accounted for 9% of all separations where the principal diagnosis was drug-related.</p>
Care for people with dual alcohol and other drugs/mental health diagnoses	Alcohol and drug use and mental health comorbidity	Mental and behavioural disorders are common comorbidities for people hospitalised with a drug-related principal diagnosis (31% of separations) <sup>33</sup> .
Substance use disorders in Aboriginal and Torres Strait Islander Tasmanians	Tobacco misuse predominates amongst Aboriginal and Torres Strait Islander Tasmanians.	Aboriginal and Torres Strait Islander Tasmanians report higher levels of smoking and greater exposure of children to tobacco smoke in their homes, and a slower rate of decrease of smoking prevalence. Younger age groups experience a slightly higher risk from alcohol related health problems. This trend is increasing amongst Tasmanians of all backgrounds.
<b>5. Child Health</b>		
Children from low socio-economic status communities	Poor health outcomes in low socioeconomic status communities in Tasmania.	Tasmanian children from poorer backgrounds have higher relative mortality rates, more hospital and emergency department separations, and exposure to more adverse health risk factors, the youth justice system and a higher need for or usage of child protection services <sup>34</sup> . Tasmania has higher rates of children in out of home care than other states <sup>35</sup> .

<sup>33</sup> Department of Health (Tasmania). Health central data warehouse. Accessed January 2016.

<sup>34</sup> Commissioner for Children and Young people Tasmania, Health and Wellbeing of Tasmania's Children, Young People and Their Families Report (Hobart: CCYP, 2017), accessed 22/9/17, <http://www.childcomm.tas.gov.au/wp-content/uploads/2017/03/Health-and-Wellbeing-of-Tasmanias-Children-Young-People-and-their-Families-Report.pdf>.

<sup>35</sup> Ibid.

Outcomes of the health needs analysis		
Children and adolescents with mental health needs	Refer to Mental Health section	
Nutrition and obesity in children	The nutritional intake of Tasmanian children remains poor. High portions of children are overweight or obese.	The majority do not eat adequate amounts of fruits and vegetables and eat food with excess added sugars. Increasing numbers of children are being identified as overweight or obese with time <sup>36 37</sup> .
Childhood immunisation	Refer to Immunisation section	
6. Immunisation		
Improving timeliness and coverage of childhood immunisations	The 2-year age category had relatively worse immunisation coverage rates than the 1 or 5-year age categories across SA3 regions; however, these rates were mostly above 90%.	Tasmania compared favourably against Australia, and overall immunisation rates are high and improving across all age groups and local areas over time, with the gaps between local rates decreasing.  The number of children within Tasmanian SA3 regions who are not immunised ranged from 6 to 42, with the 24<27month age group having relatively more children who were not fully immunised within recommended timeframes when compared to the 1 and 5-year old age groups.  Aboriginal and Torres Strait Islander children have marginally lower completed immunisation rates at 1 and 2-years but are comparable to other children at the 5-year immunisation point <sup>38</sup> .
Immunisation amongst refugees	Low completed immunisation rates compared to the National Immunisation Program	Humanitarian entrants on arrival to Australia have very low completed immunisation rates when compared to the National Immunisation Program. Attending a Refugee Health Clinic achieves a higher rate of completed immunisation compared with mainstream general practice <sup>39</sup> .

<sup>36</sup> ABS. Consumption of added sugars, 2011-2012. In: ABS, editor. Australian Health Survey. Canberra: ABS; 2016

<sup>37</sup> 4364.0.55.001 - National Health Survey: First Results, 2014-15. Canberra: Australian Bureau of Statistics; 2015.

<sup>38</sup> Immunise Australia Program, "Current Sa3 Immunisation Coverage Data for All Children," last modified 28/7/17, accessed 24/8/17, 2017.

<http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/current-data-SA3>.

<sup>39</sup> Howes F, Shaw K et al. Adopting novel settings to achieve higher influenza uptake rates in people with homelessness. Population Health Congress, 6-9 Sept, Hobart 2015.

Outcomes of the health needs analysis		
Meningococcus W	Tasmania had the highest rate of invasive meningococcal disease due to MenW.	While cases of invasive MenW infections are more common in adults, there has been an increase in cases in children aged less than 5 years since 2015. Many of the MenW cases were caused by hypervirulent sequence type (ST) 11 which is associated with a higher risk of invasive disease and a higher case fatality rate. <sup>40</sup>
HPV immunisation	HPV vaccination rates (completion of 3 <sup>rd</sup> dose) low across Tasmania for both genders	<p>Tasmania had one of the lowest vaccination completion rates for HPV amongst boys nationally. SA4 breakdowns indicated that the South East had the lowest rates nationally (42.8%). Launceston and the North East had 56.4%, Hobart 62.1% and the West and North West 62.8%.<sup>41</sup></p> <p>The national vaccination rate for girls was 78.6% and Tasmania as a whole achieved 67.2% coverage, the second lowest in the nation. However, the variance between SA4 regions is smaller for girls, and vaccination rates are slowly increasing<sup>42</sup>.</p>
7. Aged Care		
Aged services	High use of hospital services by patients in residential aged services	<p>An estimated 10.5% of all hospital separations in Tasmanians aged 65 years and over are residents of a Residential Aged Care Facility. Approximately 26% of these will be re-admitted within a 28-day period. The most common reasons for hospital admissions are: sub-acute care (8,659 admissions), circulatory system diseases (2,176 admissions), injury (2,082 admissions - 703 of which were for fractured femur) and mental and behavioural disorders (1,829 admissions).</p> <p>Consultation with key stakeholders, including Aged and Community Services Tasmania, the DHHS and NGOs, conducted since the previous Needs Assessment, indicates older people with diabetes are a priority group within</p>

Howes F, McIntyre, Shaw K, Nelson M, Kay M. Retrospective clinical audit of the health of newly arrived refugees to the refugee health clinic in Northern Tasmania. Sustainable Healthcare Transformation Conference, March, Hobart 2015.

<sup>40</sup> Australian Government Department of Health, Invasive Meningococcal Disease National Surveillance Report with a Focus on Menw (2017), <http://www.health.gov.au/internet/main/publishing.nsf/Content/ohp-meningococcal-W.htm>.

<sup>41</sup> Australian Institute of Health and Welfare, Healthy Communities; Hpv Immunisation Rates in 2014-15 (AIHW, 2017), accessed 25/8/17, <http://www.myhealthycommunities.gov.au/our-reports/HPV-rates/march-2017/report/overview>.

<sup>42</sup> Ibid.

Outcomes of the health needs analysis		
		residential aged care facilities. These residents have complex care needs and staff struggle to manage hypoglycaemia, hyperglycaemia and 'sick days', resulting in excess transfers by ambulance to hospital emergency departments.
Mental health burden in aged care	High rates of depression and anxiety in aged care	Older people in RACF are five times more likely to experience mental health problems. About 10% of older people have depression or anxiety – in RACF 50% of people have either or both depression and anxiety.
8. Aboriginal and Torres Strait Islander Health		
Lack of Aboriginal and Torres Strait Islander health data	Poor quality Aboriginal and Torres Strait Islander data with which to quantitatively identify priorities.	<p>Certain mortality statistics including standardised death rates, infant mortality rates, perinatal mortality and median age at death are not reportable for Tasmanian Aboriginal and Torres Strait Islander peoples due to the relatively small population size. Specific causes of death are inaccessible for Tasmanian Aboriginal and Torres Strait Islander peoples. Life expectancy data specific to Aboriginal and Torres Strait Islander Tasmanians is not accessible.</p> <p>Evidence analysis of Aboriginal and Torres Strait Islander data in Tasmania is problematic due to poor identification, low numbers and recording of status within administrative data collections.</p>
Adverse risk factor profiles and ongoing gap in health outcomes	<p>Persistent inequalities in social determinants of health.</p> <p>Ongoing increased incidence of risk factors and poor health outcomes.</p>	<p>A higher proportion of Aboriginal and Torres Strait Islander peoples self-reportedly have fair/poor health (29.5% vs 23.7%). Conversely, fewer report that they are in good health.<sup>43</sup></p> <p>Aboriginal and Torres Strait Islander Tasmanians are 1.6 times as likely to report a high level of psychological distress as were their non-Indigenous Tasmanian counterparts.<sup>44</sup></p>

<sup>43</sup> Department of Health (Tasmania) Tasmania 2016 Epidemiology Unit, Report on the Tasmanian Population Health Survey 2016 (Hobart: DHHS, 2017), [http://www.dhhs.tas.gov.au/publichealth/epidemiology/tasmanian\\_population\\_health\\_survey\\_2016](http://www.dhhs.tas.gov.au/publichealth/epidemiology/tasmanian_population_health_survey_2016).

<sup>44</sup> Ibid.

<b>Outcomes of the health needs analysis</b>		
		<p>Approximately 26% of Aboriginal and Torres Strait Islander Tasmanians smoke tobacco, compared with 16% of non-Indigenous Tasmanians. <sup>45</sup></p> <p>Across all age groups, a higher proportion of Aboriginal and Torres Strait Islander Tasmanians are categorised as overweight or obese, compared with their non-Indigenous counterparts. <sup>46</sup></p> <p>The top five causes of death across Tasmania are chronic cardiovascular conditions, cancers, endocrine disorders (especially diabetes mellitus), chronic respiratory conditions and mental and behavioural disorders. Chronic disease data specific to Aboriginal and Torres Strait Islander Tasmanians is scarce. Available data suggests there is substantial morbidity from chronic conditions across Tasmania<sup>47</sup>.</p> <p>A consultation to inform this needs assessment was conducted with key stakeholders, including Aboriginal Community Controlled Health Organisations, consumers and other stakeholder groups in Tasmania. Stakeholders largely confirm the findings from the quantitative analysis of data regarding chronic disease, mental health and alcohol and other drugs disease burden.</p>
<b>9. Rural Health</b>		
Health outcomes and risk factors	Health outcomes slightly more adverse than in Hobart or Launceston for most rural LGAs	<p>Rurality (i.e. living in a rural or remote area) is an independent risk factor for poor health and rural Tasmanians experience poorer health outcomes than non-rural Tasmanians. Overall, Tasmanians felt more stressed and less healthy in 2016 compared to previous years, with significantly more Tasmanians reporting financial hardship and food insecurity. The proportion of adults with fair or poor health continued to increase, and there were more Tasmanians reporting high levels of psychological distress in 2016 than in 2009, particularly among Aboriginal and Torres Strait Islanders and young people. Most modifiable lifestyle risk factors remained similar to 2013 levels, with fruit consumption being the sole indicator with a statistically significant change. Only smoking and low fruit consumption were</p>

<sup>45</sup> Ibid.

<sup>46</sup> Ibid.

<sup>47</sup> Department of Health (Tasmania) , Health Indicators Tasmania 2013.

Outcomes of the health needs analysis		
		associated with socio-economic disadvantage, with obese BMI no longer linked to socio-economic disadvantage in 2016. There has been limited progress towards healthier lifestyles measured against indicators of key risk factors, including the metabolic risk factor of obesity. <sup>48</sup>
Improve the population health risk factor profile for rural areas	Most modifiable lifestyle risk factors remained similar to 2013 levels (i.e. suboptimal). Only smoking and low fruit consumption were associated with socio-economic disadvantage, with obese BMI no longer linked to socio-economic disadvantage in 2016.	<p>Rural regions generally report higher proportions of daily smokers than greater Hobart and Launceston.<sup>49</sup></p> <p>Rates of obesity are increasing across Tasmania over time and are higher in most rural LGAs when compared to those in the greater Hobart and Launceston regions. The gap between the most advantaged and disadvantaged socioeconomic status areas is closing, with people across both types of areas becoming more obese/overweight and fewer people in the less disadvantaged areas having normal BMIs or being underweight. Indicators for physical activity and nutrition, both closely associated with weight management, have also worsened across Tasmania as a whole.</p> <p>Again, most rural regions compared unfavourably to greater Hobart and Launceston with regards to these indicators. Higher proportions of rural residents did not meet recommended guidelines for fruit and vegetable consumption than their urban counterparts, although Tasmania as a whole did poorly in these indicators. Across Tasmania, soft drink and juice intake significantly declined, falling to 5.1% and 1.5% respectively in 2016. Those with an obese BMI were the most likely to consume sugar sweetened drinks (41.1%). Nearly 2 out of every 5 Tasmanians (39.7%) expressed dissatisfaction with the food available to them, with cost, quality and lack of variety being the top 3 reasons cited<sup>50</sup>.</p>

<sup>48</sup> Department of Health (Tasmania) Tasmania 2016 Epidemiology Unit, Report on the Tasmanian Population Health Survey 2016 (Hobart: DHHS, 2017), [http://www.dhhs.tas.gov.au/publichealth/epidemiology/tasmanian\\_population\\_health\\_survey\\_2016](http://www.dhhs.tas.gov.au/publichealth/epidemiology/tasmanian_population_health_survey_2016).

<sup>49</sup>

<sup>50</sup> Epidemiology Unit.

Outcomes of the health needs analysis		
		Whilst alcohol consumption levels causing occasional harm are higher in greater Hobart and Launceston, rural LGAs generally report worse alcohol consumption causing lifetime harm <sup>51, 52</sup> .
Multi-morbidity	High rates of multi-morbidity mostly due to chronic and/or potentially preventable conditions	Tasmania has higher rates of multi-morbidity (defined here as three or more self-reported chronic conditions) than any other jurisdiction <sup>53</sup> . There are no significant differences in rates of multi-morbidity between regional and rural / remote Tasmania.
Chronic conditions	Chronic conditions require continuity of care, often from multiple services, are related to health risk factors, are amenable to primary, anticipatory & community-based care and are trending upwards across rural regions.	The top 5 causes for PPHs amongst rural Tasmanians are similar to those for people from greater Hobart and Launceston (i.e. COPD, complications of diabetes, CCF, UTIs and angina) <sup>54</sup> . Gangrene, perforated ulcers, CCF, vaccine preventable conditions and COPD were the 5 conditions resulting in the longest average length of stay for rural Tasmanians. <sup>55</sup>
Cater to the needs of an ageing population	Tasmania's ageing population has a significant impact on the primary health care and acute care sectors as older people are more likely to develop chronic diseases and to require the use of health services.	Rural areas in general have higher proportions of residents over the age of 65. Population trends for Tasmania as a whole indicate that the population will continue to age, with the current Tasmanian being older, on average, than other Australians (42 years, compared with the Australian median of 38 years) <sup>56</sup> .
Mortality	Higher relative risk of mortality if a resident in rural Tasmania	Apart from a few exceptions (Glamorgan/ Spring Bay, Kingborough, West Tamar and Meander Valley) most rural Tasmanian LGAs have a higher relative risk of mortality than Australia as a whole. Coronary heart disease is the leading cause of death across Tasmanian rural LGAs with other chronic conditions (including

<sup>51</sup> Department of Health (Tasmania) Tasmania.

<sup>52</sup>

<sup>53</sup> Statistics.

<sup>54</sup> My Healthy Communities, Potentially Preventable Hospitalisations Interactive Data Table (2017).

<sup>55</sup> Department of Health (Tasmania), National Minimum Dataset Admitted Patients Cohort (Hobart: Department of Health (Tasmania), 2017).

<sup>56</sup> Australian Bureau of Statistics, "Census of Population and Housing: General Community Profile, Australia, 2016, Cat No 2001.0."

Outcomes of the health needs analysis		
		dementia and COPD) being common amongst the top 5 causes of death across multiple localities. <sup>57</sup>
<b>10. Cancer screening</b>		
Cancer screening	Most cancers increase in incidence with age, and Tasmania's relatively aged population means cancers constitute a large proportion of the burden of disease health providers across the state manager.	<p>Most Tasmanian SA3 regional rates compare well to the national averages. Only 44% of eligible Tasmanians participate in the National Bowel Cancer Screening Program (NBCSP). 8.6% of Tasmanians who completed their screening test had a positive result. More women return the screening test than men, however, more men are diagnosed with bowel cancer than women.</p> <p>Crude screening participation rates in Tasmania were lowest in the Brighton, Hobart, North West, West Coast and Central Highlands SA3 regions.</p> <p>The age-standardised mortality from bowel cancer was highest in the Northern Territory and Tasmania (state average 19 deaths per 100,000 people) and lowest in Western Australia (14 deaths per 100,000 people). The five-year survival rate for bowel cancer in Tasmania is only 61.6%. This is because of the late stage diagnosis. Compared to other commonly diagnosed cancers in Tasmania such as breast, prostate and melanoma of the skin, bowel cancer has the lowest 5-year survival rate.<sup>58</sup></p> <p>Just over 50% of Tasmanian women participate in BreastScreen. Although Tasmanian participation rates are higher than the national average in multiple SA3 regions, they are below the target of 70%.<sup>59</sup></p> <p>Tasmanian SA3 level cervical screening participation rates are mostly below the national average. Tasmanian screening rates are higher for the younger age groups (20-39 years) than the older age groups (40-69 years).<sup>60</sup></p>

<sup>57</sup> Australian Institute of Health and Welfare, Mortality over Regions and Time (Mort) Books, Local Government Area (Lga) 2010-2014, Mortality Over Regions and Time (MORT) books (Canberra: AIHW, 2010-2014).

<sup>58</sup> Australian Institute of Health and Welfare, Cancer in Australia 2017 (Canberra: AIHW, 2017), accessed 29/8/17, <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129559144>.

<sup>59</sup> Department of Health (Tasmania), "BreastScreen Tasmania," accessed 29/8/17, 2017.

[http://www.dhhs.tas.gov.au/cancerscreening/population\\_screening\\_and\\_cancer\\_prevention/breast\\_screening/breastscreen\\_tasmania](http://www.dhhs.tas.gov.au/cancerscreening/population_screening_and_cancer_prevention/breast_screening/breastscreen_tasmania).

<sup>60</sup> Australian Institute of Health and Welfare, Participation in BreastScreen Australia 2014-2015 (2017).

<b>Outcomes of the health needs analysis</b>		
<b>11. Digital health</b> - It is important to recognise that eHealth is not a “need” in itself; rather it is an enabler to other health needs, by improving quality of health information and its delivery from one point to another.		
Utilisation	Minimal use of digital health technology by health professionals	<p>Although slowly increasing, My Health Record (MHR) usage remains low across Tasmania.</p> <p>Most GPs across Tasmania have a Healthlink installation, and while most receive large amounts of information through this (mainly from hospitals and pathology laboratories) very few utilise it to send more than (potentially automated) acknowledgements of messages received.</p> <p>Pathology providers are the biggest users of secure messaging state-wide.</p> <p>Access to and use of digital health initiatives is low in the allied health sector.</p> <p>Medical Director and Best Practice were the most widely used clinical information systems amongst both General Practitioners and commissioned mental health providers.</p> <p>Commissioned mental health providers indicated there were gaps in the abilities of the clinical information systems they utilised to collect and extract the relevant data required to meet mandatory national reporting.</p> <p>Review of the Personally Controlled Electronic Health Record.</p>
<b>12. Health Workforce</b> - It is important to recognise that health workforce is not a “need” in itself; rather it is an enabler to addressing health needs, by supporting and improving access to quality health workforce skills and expertise in primary health settings.		
Health Workforce	Health workforce shortages	<p>Tasmania has an ageing health workforce.</p> <p>There are shortages in specific professions, particularly dentists.</p> <p>The workforce is concentrated in inner regional areas, making access to health professionals in rural areas problematic.</p>

Outcomes of the health needs analysis		
13. Refugee Health		
Immunisation amongst refugees	See Immunisation section	See Immunisation section
Initial health needs in the first 6 months post resettlement	Different burden of disease amongst refugee cohort	<p>In general, people of refugee background have higher rates of long-term physical and psychological problems than other migrants.</p> <p>Nutritional deficiencies were more prevalent within the refugee population but rates of anaemia amongst women of childbearing age were similar to those seen in Australia.</p>

## SECTION 3 – OUTCOMES OF THE SERVICE NEEDS ANALYSIS

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence
<b>1. Population Health</b>		
Lifestyle risk factors	Tasmanians have high rates of adverse lifestyle risk factors for chronic disease.	<p>Consultation with Department of Health (Tasmania), Tasmanian Health Service, General Practitioners, private allied health providers, University of Tasmania, Chronic Disease Prevention Alliance, local government, Cradle Coast Authority, public health services, Education Department, Neighbourhood Houses, Colony47, Anglicare, Smith Family and local communities demonstrates: ongoing efforts are required to reduce smoking and alcohol consumption and increase physical activity and fruit and vegetable intake. Low health literacy is a significant factor that affects the efficacy of chronic disease management initiatives.</p> <p>Tasmania’s ‘urban fringe areas’ (e.g. Gagebrook, Ravenswood, Somerset) are disproportionately affected by poor lifestyle risk factors and large chronic disease burden than urban or rural areas.</p>
Social and economic disadvantage	People with socio-economic disadvantage experience a disproportionately greater chronic disease burden.	Consultation was undertaken with Department of Health (Tasmania), Tasmanian Health Service, General Practitioners, private allied health providers, University of Tasmania, local government, Cradle Coast Authority, public health services, Education Department, Neighbourhood Houses, Colony47, Anglicare, Smith Family and local communities.
<b>2. Potentially Preventable Hospitalisations</b>		
Reduce avoidable hospital readmissions	<p>Poor transfers of care across health and community providers due to inadequate communication, information sharing and coordination of care.</p> <p>Person-centred care and patient self-management strategies require a greater focus by service providers.</p>	<p>Consultation was undertaken with acute, community and primary health services providers.</p> <p>Analysis was performed of community services, acute hospital, rural hospital and sub-acute services data.</p>

<b>Outcomes of the service needs analysis</b>		
		<p>Key findings:</p> <ul style="list-style-type: none"> <li>• Fragmentation of care results from poor understanding of accountability for communication and information by providers across the boundaries of care;</li> <li>• Patients with complex care needs experience disproportionately more fragmentation of care;</li> <li>• Service supports (including telehealth and integrated IT systems for clinical records) are under utilised;</li> <li>• Significant service gaps statewide in sub-acute services. As a result, the acute and community sector provides generalist sub-acute care services that is not fit for purpose.</li> </ul> <p>A highly successful trial and subsequent evaluation was completed of providing general practitioners with access to the Digital Medical Record. Patient acceptance was high. Information sharing between the hospital and community was improved. General practitioners reduced duplicate pathology and radiology ordering. Loss to follow-up of patients with serious medical problems was reduced. Adverse events decreased.</p>
Potentially preventable hospitalisations – acute and chronic	Lack of easily understood and accessible referral pathways across settings and providers. Rural Tasmanians have a higher rate of hospitalisation for potentially preventable conditions than their urban counterparts.	<p>Consultation was conducted with acute, community and primary health services providers.</p> <p>Focus groups were held in three regions of Tasmania with medical, nursing and allied health stakeholders across public and private hospitals and including aged services providers.</p> <p>Key findings:</p> <p>Tasmania-specific health pathways have been developed across a range of clinical areas, but these are under utilised due to:</p> <ul style="list-style-type: none"> <li>• some reports that the online pathway portal difficult to navigate and time-consuming for providers to access;</li> </ul>

Outcomes of the service needs analysis		
		<ul style="list-style-type: none"> <li>the continuing need to improve general practitioners' awareness and usage of the pathways;</li> <li>significant IT issues in general make access to online resources time-consuming.</li> </ul>
3. Mental Health		
<p>Access to mental health services in Tasmania</p>	<p>Mental health related encounters in general practice are common and increasing.</p> <p>There is significant regional variation in service availability.</p> <p>The rate of growth of inpatient mental health service use is above the national average and is not sustainable.</p> <p>There is no clear pathway through the mental health service system, including entry and exit pathways.</p> <p>Acute sector options require significant improvement e.g. short-stay, assessment, transition services (step-up, step-down).</p> <p>Workforce attraction, retention and burnout issues, variable skill sets.</p>	<p>More Tasmanians are seeking professional help for mental health problems over time, with women more likely to seek help than men.</p> <p>For both men and women, general practitioners (GPs) are the most common service provider (1.2 million services) delivering mental health care, with 7% of all females and 4% of all males accessing a GP for mental health problems. Psychologists are the next most common (4% females compared with 2.4% males)<sup>61</sup>.</p> <p>The local geographical areas with the highest rates of patients accessing public sector mental health services are Hobart (North West, North East and Inner) and Brighton (2010-2015 data).</p> <p>In Tasmanian public hospitals, mental health disorders are a large contributor to admissions and length of stay. Mental health problems account for approximately 5% of all public and private hospital admissions.</p> <p>Age-standardised hospital admission rates for mental health problems have been rising significantly in Tasmania since 2008. Nationally the trends have been stable. Tasmania has fewer inpatient beds per capita but has more residential mental health beds<sup>62</sup>. Tasmania has the lowest use of ambulatory care (day case) models in Australia.</p> <p>The number of recorded mental health-related Emergency Department (ED) occasions has increased over time by 5% per year<sup>63</sup>. The rate of mental health-</p>

<sup>61</sup> MBS data file, 2016.

<sup>62</sup> Shaw et al. Mental health services in Tasmania, 2014. Australian Primary Health Care Research Institute, 2014.

<sup>63</sup> DHHS. Acute hospitals data. As at 12 September 2016.

Outcomes of the service needs analysis		
		related ED occasions of service in Tasmania is similar to the national level of 92 per 10,000 population <sup>64</sup> .
Access to psychosocial support services and stepped care for severe and complex mental illness in Tasmania	Tasmanians with severe and complex mental health problems are under-served for psychosocial support. Not all patients will be eligible for the National Disability Insurance Scheme.	<p>Tasmanians with severe and complex mental health problems are being transitioned from existing programs to the National Disability Insurance Scheme (NDIS). Overall, 73% of services provided are for daily living support. There are a group of people with psychosocial support needs who are not eligible for the NDIS.</p> <p>Access to specialist mental health services is often not timely for people with severe and complex mental illness. Waiting times in emergency departments are long for people in crisis (several days in the ED in some cases).</p> <p>Consultation with mental health consumers, provider organisations and peak bodies, the Department of Health (Tasmania) and Tasmanian Health Service.</p>
Suicide prevention	Tasmania has high rates of suicide compared with national averages	<p>Consultation with local government, community suicide prevention bodies, rural health providers, the Department of Health (Tasmania) and Tasmanian Health Service, consumers and mental health peak bodies demonstrates a complex relationship between social determinants of health and suicidality in Tasmania.</p> <p>Drought is impacting risk of suicide in rural communities.</p> <p>Local communities need increased capacity to identify and respond to people at risk of suicide.</p>
Understanding GP management of mental health conditions	<p>Tasmania has the highest proportion of the population in Australia accessing Pharmaceutical Benefits Scheme (PBS) mental health medications.</p> <p>There is considerable regional variation in prescribing rates.</p> <p>Low rates of uptake of Mental Health Treatment Plans.</p>	<p>GPs are the most commonly accessed health professional for mental health conditions; therefore, GPs has an impact at a population level for the management of mental health illness. The majority of mental health related prescriptions are written by GPs. Tasmania has the highest rate in Australia for people accessing PBS mental health medications. Antidepressant, anxiolytics and medications for ADHD all have high dispensing rates with inter-regional variation.</p>

<sup>64</sup> AIHW. Mental Health Services in Australia, September 2015.

Outcomes of the service needs analysis		
		<p>Mental health treatment plans provide a structured framework for GPs to undertake early intervention, assessment and management of patients with mental disorders, providing referral pathways to other health professionals. Tasmania has markedly lower rates of uptake of mental health treatment plans compared to other jurisdictions.</p>
<p>Child and adolescent mental health service delivery</p>	<p>Insufficient child and adolescent psychiatry services state-wide.</p> <p>Insufficient youth outreach and behaviour management services.</p>	<p>There are no dedicated Child and Adolescent Mental Health inpatient units in Tasmania. When admission is necessary, this either occurs on the paediatric wards or they are 'specialled' in the adult mental health unit<sup>65</sup>.</p> <p>Tasmania has below national average spending on child and adolescent mental health services.</p> <p>Wait time for assessment in the public sector is between 3 and 6 months<sup>66</sup>. In private sector state-wide the waiting time for a private psychiatry appointment is also 3 to 6 months. Lack of group and individual services for children with complex mental health needs.</p>
<p>Aboriginal and Torres Strait Islander Tasmanians</p>	<p>Mental health, social and emotional wellbeing and substance misuse are related, but there are limited services available addressing these holistically.</p>	<p>Consultation with key stakeholders, conducted since the previous needs assessment, indicates that where possible Aboriginal people require access to Aboriginal Community Controlled Health Organisations (ACCHOs) that can arrange and support the delivery of culturally appropriate mental health care.</p> <p>At present, there is a need for such services outside the major population centres.</p> <p>ACCHOs struggle to sustain and develop steady Aboriginal health workforce to meet current mental health service needs.</p> <p>Very few Aboriginal and Torres Strait Islander people are employed in or receiving training for mental health related positions.</p>

<sup>65</sup> DHHS Tasmania. Report of the Chief Psychiatrist, 2015.

<sup>66</sup> Tasmanian Health Service. iPM (Department of Health (Tasmania) patient database). Waiting list statistics. Accessed January 2016.

Outcomes of the service needs analysis		
4. Alcohol and Other Drugs		
Service provision alignment with health needs	Insufficient knowledge and intelligence in relation to alignment of overall system configuration in meeting community needs.	Representatives from Primary Health Tasmania and the Department of Health (Tasmania) are undergoing training in a nationally-funded framework to determine alcohol and other drugs service needs as part of a mental health resource allocation framework.
Access to alcohol and other drugs services	Reduced engagement with and access to alcohol and other drugs services by people with highest need for assistance, including for people with dual alcohol and other drugs and mental health diagnoses.	<p>Evaluation of social determinants of health projects conducted by Primary Health Tasmania under the Tasmanian Health Assistance Package:</p> <ul style="list-style-type: none"> <li>• People in low socioeconomic status communities with known alcohol and other drug problems are reluctant to engage with alcohol and other drugs or mental health services</li> <li>• Local communities and local government identified to have skills and level of engagement that would support community-based initiatives</li> </ul> <p>Rethink Mental Health Tasmania – Stakeholder consultation:</p> <ul style="list-style-type: none"> <li>• People with dual alcohol and other drugs and mental health diagnoses reluctant to engage with services due to perceived stigma of being identified as having alcohol and other drugs and / or mental health needs</li> </ul>
Access to specialist drug and alcohol services	<p>Limited access to specialist alcohol and drug services due to reduced number of specialist providers.</p> <p>Limited capacity for specialist services to meet current and future demands.</p>	Stakeholder feedback obtained from the DHHS and THS indicates that specialist alcohol and other drugs services have been scaled back significantly due to the amalgamation of these services with mental health services. The number of addiction medicine specialists does not currently meet the demand for services.
Access to a competent and skilled primary care workforce	Limited opportunities to improve/maintain the knowledge and skills of the primary care workforce.	The primary care and generalist workforce in Tasmania (e.g. community nursing, general counselling, mental health professionals) receives limited professional development in the alcohol and other drugs area. This is the result of specialist addiction medicine workforce shortages. These specialists would normally provide education and professional development to support generalist providers. Tasmania has not, to date, explored the opportunity to partner with interstate specialist providers such as Turning Point to have a holistic and more effective professional development approach.

Outcomes of the service needs analysis		
		<ul style="list-style-type: none"> <li>• GPs need improved skills to manage patients with complex substance misuse issues</li> <li>• Doctor shopping is reported as prevalent in the Tasmanian community</li> <li>• Community alcohol and other drugs workforce requires increased professional development opportunities</li> </ul>
Access to inpatient beds for alcohol and other drugs detoxification and rehabilitation	There is a significant shortfall in inpatient and residential beds for alcohol and other drugs detoxification and rehabilitation.	Increasing referrals into specialist services where inpatient care is required is problematic as there is limited capacity within the system to treat additional patients as inpatients.
5. Child Health		
Health services catering to children and adolescents	<p>Unclear transitions between paediatric and adult health services, and unclear demand and waiting times for specialist services frequented by children (allergy, ENT).</p> <p>Poor health, social and justice outcomes for children in out of home care.</p> <p>Service planning and provision needs better access to relevant data, especially in mental health, drugs and alcohol spaces.</p>	<p>Tasmania has higher proportions of children receiving child protection services than other states and territories.</p> <p>A large proportion of children who grow up with chronic conditions fail to successfully transition to adult services<sup>67, 68</sup>.</p> <p>Tasmania is the only Australian state that has not had a framework to guide the transition from paediatric to adult health care services<sup>69</sup>.</p>
Children and adolescents with mental health needs	Paucity of data available to assess children and adolescent mental health, alcohol and other drug related needs.	Refer to Mental Health section
Childhood immunisation	Refer to Immunisation section	Refer to Immunisation section

<sup>67</sup> Pacaud P, Yale J. Exploring a black hole: transition from paediatric to adult care services for youth with diabetes. Paediatric Child Health. 2005;10:31–4.

<sup>68</sup> Reid G, Irvine M, McGrindle B, Sananes R, Ritvo P, Siu S, et al. Prevalence and correlates of successful transfer from pediatric to adult health care among a cohort of young adults with complex congenital heart defects. Pediatrics 2004;113:197–205.

<sup>69</sup> Moving on UP. A Practical Framework to Support Tasmanian Children with Chronic Conditions Transition to Adult Care. Primary Health Tasmania, Department of Health (Tasmania).

Outcomes of the service needs analysis		
<b>6. Immunisation</b>		
Immunisation	Services need better support to deliver immunisations (for children and adults) as per the National Immunisation Program Schedule.	<p>Consultation was undertaken with Public Health Services, Department of Health (Tasmania). The National Immunisation Strategy for Australia 2013-2018 was reviewed<sup>70</sup>. Evidence shows:</p> <ul style="list-style-type: none"> <li>• Low levels of awareness among consumers regarding the requirements of the schedule;</li> <li>• Inability to monitor uptake of priority vaccines in high risk populations.</li> </ul>
Influenza immunisation for homeless and vulnerable populations	Only 34% of targeted population immunised in 2017.	Commissioned services to provide influenza vaccination to the homeless and vulnerable vaccinated 161 people during 2017 (34% of the identified target population). <sup>71</sup>
<b>7. Aged Care</b>		
Inappropriate use of hospital services by aged services	Frequent presentation and re-presentation to hospitals of residents who could otherwise be managed within the aged care facility or community	<p>In-depth consultation has completed with Aged and Community Services Tasmania (ACSA), members of the Transformations in Aged Services forum groups, intensive consultation with rural aged services providers, including in the Derwent Valley, Huon Valley, Flinders Island, pharmacies, community nurses, Aged Care Assessment teams, Home and Community Care service providers, ambulance services, the Department of Health (Tasmania), and the Tasmanian Health Service.</p> <p>Thematic analyses of findings from these consultations show:</p> <ul style="list-style-type: none"> <li>• A lack of availability of sub-acute services statewide;</li> <li>• Poor availability of health services providers within the residential aged services facility particularly to respond to acute health care needs of residents;</li> </ul>

<sup>70</sup> Australian Government Department of Health. National Immunisation Strategy 2013-2018.

<sup>71</sup> All Round Health and Community Care, *Providing Access to Influenza Immunisation for People at Risk of Homelessness 2017: Evaluation Report 31st August 2017* (All Round Health and Community Care, 2017).

Outcomes of the service needs analysis		
		<ul style="list-style-type: none"> <li>• Poor provider skills in chronic disease management, particularly in the acute management of diabetes, by staff in residential aged services. Personal care workers statewide have a high need for additional skills;</li> <li>• Poor communication and information sharing between aged services, acute hospital, community nursing and primary health providers;</li> <li>• Poor integration between hospitals, General Practitioners and aged care facilities and poor understanding of other services;</li> <li>• Consumers on the waiting list for packages or higher-level packages are often admitted to hospital.</li> </ul>
<p>Identification and management of mental health problems in residential aged care (RACFs)</p>	<p>The aged care sector requires support to identify and respond to the mental health needs of residents.</p>	<p>In-depth consultation has completed with Aged and Community Services Tasmania (ACSA), members of the Transformations in Aged Services forum groups, intensive consultation with rural aged services providers, including in the Derwent Valley, Huon Valley, Flinders Island, pharmacies, community nurses, Aged Care Assessment teams, Home and Community Care service providers, ambulance services, the Department of Health (Tasmania) and the Tasmanian Health Service</p> <p>Mental health providers generally do not provide in-reach services for mental health care into RACFs.</p> <p>Care staff lack resources and skills to identify residents with mental health problems.</p> <p>GPs tend to prescribe medication where mental health problems are identified, rather than cognitive therapies or evidence-based non-medication alternatives.</p>
<p>Improved communication</p>	<p>The aged care sector requires better communication channels with the acute sector, including better information and communication technology connectivity.</p>	<p>Stakeholder consultation conducted as part of the Streamlined Care Pathways program remains current.</p>

<b>Outcomes of the service needs analysis</b>		
<b>8. Aboriginal and Torres Strait Islander Health</b>		
Ongoing focus on Aboriginal and Torres Strait Islander health priorities	Lack of coherent strategic plan and plan for action to identify and address Aboriginal and Torres Strait Islander health priorities.	<p>To build on the stakeholder consultation basis for our needs assessment, individual and group consultations were conducted with Aboriginal and Torres Strait Islander people and a state-wide workshop was convened with Aboriginal Community Controlled Health Organisations (ACCHOs), Aboriginal people and health providers for Aboriginal and Torres Strait Islander people. This was followed by a later integrated team care provider forum to ensure Primary Health Tasmania’s understanding of health needs and priorities remains current.</p> <p>A network analysis was performed of patient journeys of Aboriginal and Torres Strait Islander people accessing primary, community and acute services in regional and rural areas. An analysis of the cultural appropriateness and quality of communication, coordination and information sharing between providers and with the patient and carers was conducted for the North and South of Tasmania.</p> <p>Opportunities were identified to improve access to care through the delivery of patient centred, integrated, comprehensive care to Aboriginal people with complex, chronic care needs. Continuity of care across ACCHOs and mainstream services, sharing of information and communication were identified as areas for improvement.</p> <p>Poor access to culturally safe care and culturally appropriate care were identified as barriers for Aboriginal people to access mainstream services.</p> <p>The availability of specialist Aboriginal health workers, including in mental health and alcohol and other drugs, requires improvement.</p>
<b>9. Rural Health</b>		
Poor integration of existing rural health services	Poor integration of existing rural health services	<p>Consultations were originally held in Queenstown, Burnie, Launceston, Bicheno and Brighton, and on Flinders Island and King Island. An additional 38 stakeholders completed an online survey.</p> <p>The major themes emerging from the consultations were to improve the coordination of care for people in rural areas with complex care needs, the</p>

Outcomes of the service needs analysis		
		<p>delivery of team-based care with a focus on strong local provider networks and the delivery of person-centred care.</p> <p>More recently, commissioned provider forums have been conducted that confirm the major themes emerging from the initial consultation remain current.</p>
Commissioned RPHS providers	<p>Patient patterns demonstrate multiple complex comorbidities being managed</p> <p>Underutilisation of digital health initiatives meant to improve integration of care</p> <p>Poor clinical data quality across most providers</p> <p>Low/unmeasurable levels of integration of care between commissioned providers</p>	<p>Commissioned Rural Primary Health Services provide services to a mostly middle aged to older population with complex multi-morbidity.</p> <p>Chronic cardiovascular, diabetes and chronic respiratory conditions are quite prevalent, however commissioned organisations offer a variety of services for a very wide range of conditions, including chronic musculoskeletal and mental health conditions.</p> <p>Prescribing patterns might be a potential area to focus on for future clinical quality improvement activity. Underutilisation of secure messaging, low levels of recording health risk factor, diagnosis and clinical measure data, and improved integration of care between commissioned RPHS services remain challenging.</p>
Access to dentists and specialists	<p>Whilst access to GPs across Tasmania remains good (comparable to national rates) access to dentists and specialists is poor in rural LGAs.</p>	<p>Attendance to specialists is lower across rural Tasmania<sup>72</sup>.</p> <p>The dental workforce is concentrated in Hobart and Launceston.<sup>73</sup></p>
Access to mental health services	<p>Numbers of people accessing public mental health services is increasing.</p>	<p>Across all remoteness areas in Tasmania, the number of people accessing public mental health services is increasing, with the highest proportion being in very remote areas and the lowest in remote regions, according to the latest available figures<sup>74</sup>.</p> <p>Tasmanians from rural regions constituted 3 out of every 10 community mental health care service contacts<sup>75</sup>.</p>

<sup>72</sup> Australian Institute of Health and Welfare, *Number of Specialist Attendances and Medicare Benefits Expenditure on Specialist Attendances, Per Person, by Statistical Area Level 3 (Sa3) (2015-2016)*.

<sup>73</sup> HealthDirect Australia, *Healthmap* (HDA, 2017).

<sup>74</sup> Australian Institute of Health and Welfare, *Key Performance Indicators for Australian Public Mental Health Services* (AIHW, 2016).

<sup>75</sup> Ibid.

Outcomes of the service needs analysis		
<p>Demand for hospital services continues to increase and rural Tasmanians spend longer in hospital once admitted.</p>	<p>A likely impact of rural Tasmania's ageing population and high rates of chronic diseases, particularly of individuals experiencing multiple chronic illnesses simultaneously, is that demand for hospitalisation in Tasmania will continue to increase.</p>	<p>Acute care hospital separations are the number of episodes of acute hospital care received by people, including same-day hospital admissions (i.e. that last less than 24 hours in total).</p> <p>For very remote areas, the Launceston General Hospital (LGH) and 'other Tasmanian public hospitals' (i.e. rural hospitals) accounted for the largest number of hospital separations, whilst for outer regional areas the LGH was the hospital most separations were recorded at, and for remote regions this was the Royal Hobart<sup>76</sup>. Patients from very remote areas presenting to the 4 major public hospitals had longer average lengths of stay than those from other areas.</p> <p>Across regions, patients utilising statewide mental health services had significantly longer length of stays than those utilising other hospitals.</p> <p>Tasmania has the highest rates of separations for falls resulting in patient harm in hospital of any Australian state or territory, with people from outer regional areas having the highest rates (4.2/1000 separations for people from inner regional Tasmania, 4.9/1000 separations for people from outer regional Tasmania.<sup>77</sup></p>
<b>10. Cancer screening</b>		
<p>Post positive screen follow up</p>	<p>There is a need to improve colonoscopy waiting times across the state.</p> <p>Breast screening rates are relatively good but could be improved across Tasmania.</p> <p>Across Australia participants who self-identified as Indigenous, participants who lived in very remote areas and</p>	<p>Guidelines recommend that people with a positive Faecal Occult Blood Test (FOBT) are referred for colonoscopy within 30 days<sup>78</sup>. Screening positivity rates indicate the proportions of people who have been screened who qualify for</p>

<sup>76</sup> Department of Health (Tasmania) , "National Minimum Dataset Admitted Patients Cohort."

<sup>77</sup> Australian Institute of Health and Welfare, *Admitted Patient Care 2015-16: Australian Hospital Statistics* (2017), accessed 13/9/2017, <https://www.aihw.gov.au/getmedia/3e1d7d7e-26d9-44fb-8549-aa30ccff100a/20742.pdf.aspx?inline=true>.

<sup>78</sup> Royal Australian College of General Practitioners, "Clinical Guidelines," in *Guidelines for Preventative Activities in General Practice 9th Edition*, ed. RACGP (RACGP).

Outcomes of the service needs analysis		
	<p>participants who lived in lower socioeconomic areas had higher screening positivity rates yet had a lower follow-up.</p>	<p>further investigation, and Tasmania has one of the higher screening positivity rates in Australia<sup>79 80 81 82</sup>.</p> <p>The National Cervical Screening Program (NCSP) reports the following planned changes to cervical cancer screening from 1 December 2017:</p> <ol style="list-style-type: none"> <li>1. The two-yearly Pap test for women aged 18 to 69 will change to a five-yearly human papillomavirus (HPV) test for <b>women aged 25 to 74</b>. Women will be due for the first Cervical Screening Test two years after their last Pap test.</li> <li>2. The time between tests will change from two to five years.</li> <li>3. The age at which screening starts will increase from 18 years to 25 years.</li> <li>4. Women aged 70 to 74 years will be invited to have an exit test before leaving the NCSP.</li> </ol>
<b>11. Digital Health</b>		
<p>Sub-optimal utilisation of digital health technology</p>	<p>Sub-optimal utilisation of digital health technology across the board by health care providers.</p>	<p>Although slowly increasing, MHR usage remains low.</p> <p>Most GPs across Tasmania have a Healthlink installation, and while most receive large amounts of information through this (mainly from hospitals and pathology laboratories) very few utilise it to send more than (potentially automated) acknowledgements of messages received.</p> <p>Pathology providers are the biggest users of secure messaging state-wide.</p> <p>Access to and use of digital health initiatives is low in the allied health sector.</p>

<sup>79</sup> Department of Health (Tasmania) , *Health Indicators Tasmania 2013*.

<sup>80</sup> Natalie Whiting, "Bowel Cancer: Doctors Concerned Growing Waiting Lists for Colonoscopies Could Prove Fatal," accessed 29/8/2017, 2017. <http://www.abc.net.au/news/2017-01-18/growing-waiting-lists-for-colonosopies-test-could-prove-fatal/8192048>.

<sup>81</sup> Martyn Goddard, "Urgent Patients Waiting Months or Years for Care," *Tasmanian Times*, 4 November 2015, 6 November 2015, <http://www.tasmaniantimes.com.au/index.php/article/urgent-patients-waiting-months-or-years-for-care>.

<sup>82</sup> "One-Year Colonoscopy Delays Raise Concerns," *Australian Doctor*, 25 August 2016.

Outcomes of the service needs analysis		
		<p>Medical Director and Best Practice were the most widely used clinical information systems amongst both General Practitioners and commissioned mental health providers.</p> <p>Commissioned mental health providers indicated there were gaps in the abilities of the clinical information systems they utilised to collect and extract the relevant data required to meet mandatory national reporting.</p>
<b>12. Health Workforce</b>		
Health Workforce	Retention and workforce distribution.	<p>Tasmania has an ageing health workforce and a maldistribution of the workforce – supply in regional areas greater than supply in rural and remote areas.</p> <p>Ongoing difficulties recruiting and retaining GPs in rural locations.<sup>83 84</sup></p>
<b>13. Refugee Health</b>		
Immunisation amongst refugees	See Immunisation section (Health Needs Analysis)	See Immunisation section (Health Needs Analysis)
Initial 6 months post resettlement	Completion of initial clinical assessments and preparation to transition into mainstream care.	<p>Infectious disease profiles are related to the refugee’s country of origin or any country in which they spent a significant transit time. Further screening conducted post-arrival includes a full blood count, screening for nutritional deficiencies, hepatitis, syphilis and schistosomiasis. Tasmanian screening rates were universally high. Tasmanian refugee screening results indicate lower positive schistosomiasis, malaria and syphilis tests when compared to other jurisdictions.</p> <p>Nutritional deficiencies were more prevalent within the refugee population but rates of anaemia amongst women of childbearing age were similar to those seen in Australia. Afghani women and girls over the age of 15 were significantly more likely to be vitamin D deficient than other population subgroups. The majority had mild to moderate vitamin D deficiency. Approximately 12% of Tasmanian</p>

<sup>83</sup> Strategic Framework for Health Workforce 2013–2018, Department of Health (Tasmania)

<sup>84</sup> 2016 Primary Health Tasmania General Practice and Allied Health Needs Surveys

Outcomes of the service needs analysis		
		<p>refugees were vitamin B12 deficient, most of them from Bhutan or Afghanistan and 70% over the age of 15.</p> <p>In terms of risk factors, male refugees over 18 were more likely to smoke than male Australians (approximately 27% vs 20%). Mean systolic blood pressure, overweight and obesity rates were all lower among the refugee population as compared to Australia in general regardless of gender (and Tasmania in particular); this may be partially due to the younger nature of the refugee cohort. The prevalence of diabetes amongst the Tasmanian refugee cohort was low (1.9%). Data specific to rates of other chronic conditions among the refugee population (including mental health conditions) was not available.</p>
<p>Over 6 months post resettlement</p>	<p>Mainstream GPs and other health services equipped to manage specific health problems which are more common in the refugee population than the general population.</p>	<p>Some of the particular challenges refugees face in accessing and managing their health care needs, are outlined below;</p> <p>1. Challenges in accessing health care</p> <p>Some refugees have to overcome different, often adverse, past experiences associated with accessing health services. Cultural norms might dictate how individuals access or seek health care (e.g. ask friends or family before seeking professional care). Time is required to build trust with unfamiliar health professionals. Actual information around where to go for help has been identified as a barrier in some instances, as is getting past gatekeepers in the health care system due to language or a lack of familiarity and confidence in how appointment systems work. Physically getting to appointments is challenging without familiarity with, and the ability to navigate, transport systems in a time efficient manner.</p> <p>2. Challenges during the receipt of health care</p> <p>Language and fluency is an often-cited barrier to refugees accessing health care. Whilst interpreter services are available, trust in interpretation skills needs to be established for both the client and health care provider. Most refugees and practitioners still utilise family or friends as primary interpreters; this can pose particular challenges to women and youth accessing reproductive or sexual health services. Mismatched expectations and understanding between clients and health practitioners can lead to misunderstandings and frustration for both</p>

Outcomes of the service needs analysis		
		<p>parties; these can be due not just to language, but culturally differing modes of expression (e.g. primarily mental or behavioural problems may be expressed primarily via multiple somatic complaints, expressions of pain differ, expectations for treatment may be skewed towards medication).</p> <p>3. Challenges managing health care needs longer term</p> <p>Attending referrals or follow up appointments is mediated by understanding the importance of appointments; if clients do not realise how waiting lists work, or that certain practices have policies around non-attendance, they may prioritise other activity over attending these appointments. Cost is a challenge (seemingly minor costs take on extra significance when the person has limited financial means and unknown employment prospects, clients may prioritise other family essentials before purchasing health care). Language levels, health and computer literacy mediate the ability to adhere to treatment plans, access health care resources and self-manage.</p>

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