

Submission

"Delivering Safe and Sustainable Clinical Services"

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Responses to questions raised "Community", p.32 Delivering Safe and Sustainable Clinical Services, Green Paper.

1. Centres of excellence are appropriate, providing they do not delay treatment through greater waiting lists of people attempting to access services all at one site and the resources at that site have not changed to meet the increased demand.
2. **ACCESS and SUSTAINABILITY:** Patients should be offered access to two types of waiting list. One for their local/nearest facility and a state-wide list. The two would operate side by side. The state wide list though would open up greater opportunities to have a procedure undertaken at any site and this should expedite treatment times and assist with wait list times. Patients would need to be fully consulted and educated as to the difference between the two. PTAS, as per comments below, would need to be more supportive of patients undertaking the state wide list option.
3. Access to these sites for consultations should be available, whenever and where ever possible, via teleconference or Skype.
4. **SAFETY and SUSTAINABILITY, inc. cost effectiveness.:** Pre admission clinics, regardless of where the patients procedure is to be undertaken, should be completed at the patients nearest hospital. It would be totally unacceptable in the business or industrial sector, for a person to travel 8-9 hours driving for a one hour meeting. It would be a safety risk (e.g.: driving fatigue) plus economically unsustainable. This, however, does not factor into patients travelling from the North West region to the Royal Hobart for pre admission clinics. With our ageing population the risk is greatly increased. It should be obvious to note patients travelling these distances already bear a risk as they have a medical condition needing surgical treatment. This travel can therefore increase the risks and also increase patient discomfort.
5. **ACCESS TO SERVICES:** Patient Transport Access Services (PTAS) needs a radical overhaul. The current system is unfair, overly bureaucratic and forces financial burden onto those who often can least afford it.
 - Allowing \$46 per night accommodation allowance is insufficient. Given the average rates of hotel/motel accommodation exceeds \$120 per night in both major population centres of Hobart or Launceston, for a patient needing an escort home this can be financially unobtainable. The need for social support in the management of medical condition/s is widely acknowledged within the social model of health.
 - There needs to be approved partner accommodation providers. Pre booking of these and part payment met by PTAS prior to check in needs to be an available option.

5. *Patient Transport Access Services (PTAS) needs a radical overhaul. The current system is unfair and forces financial burden onto those who often can least afford it. (continued)*

- Chronic health patients, who regularly travel for treatment, need to be able to access refunds within 48 hours or pre approval/payment for travel and accommodation. Currently it can be several weeks before refunds are made and this places an enormous financial burden on many. Suggestion to improve; a high user card, no current yearly co contribution, card also contains patients regular providers as part of the data base information management, a simpler medical certificate, completed at consultation time linked to the patients membership/user number that can be presented at Service Tasmania or PTAS for an immediate refund (via EFT to a pre-loaded/nominated bank account). The appointment letters changed to allow for a medical certificate at the bottom to be signed and completed at the time.
 - Patients travelling interstate need taxi vouchers issued for a pre-determined amount or the option of a patient being refunded for the cost of a rental car if they choose. The waiting for refunds is not an option for many patients, myself included. I cannot afford the \$150-\$200 taxi fare burden in Melbourne, then having to wait weeks for a refund. I use a cheaper provider who charges \$50 per day for a car rental but cannot have this refunded to me. The option of finding \$50 for a car rental is still more accessible than the afore mentioned taxi fares.
 - Currently I fund the management of my chronic health conditions and the unavoidable travel through debt. I either have to use a credit card or borrow money as my DSP simply will not meet the financial burdens of everyday living costs and chronic health care management. The refunds from PTAS do not meet all the money borrowed or expense placed on a credit card. I travel on average at least once a month/every 2 months and have no option as services are not available on the North West. This is not to imply I expect all costs met but the current costs that are met rarely exceed 50% of the actual financial costs; so a more equitable system is needed; where financial concerns do not impact on the choice to attend necessary appointments.
6. **SAFETY:** Rescheduling options need to be improved. If a patient is simply not well enough and therefore not safe for them to travel on the day, a new appointment should be far easier and quicker to obtain. Being unable to travel on the day means that there is mostly a significant delay in being able to secure a new appointment time. Being forced to travel when unwell is the only option; as any other available services cannot take short notice bookings and booking just in case is also not an equitable option on the service providers.
7. **QUALITY CARE:** All of a patients primary providers, including GP's, have access to a patient's medical records. The current system, despite Ministerial claims to the contrary of change to be implemented, do not allow GP's access to a patients records from any provider in the north of the state. This matter could and should have been resolved when it was first identified several years ago when the 3 THO's were created but no one, either in public service, THO or government level has chosen to make an immediate change and this has compromised and does compromise patient care. The blame is shifted to the IT system when it would be a simple policy change to enforce the transfer of manual records/results to a patients GP outside of the northern region.