AMA QUEENSLAND

2016 PRE-BUDGET SUBMISSION

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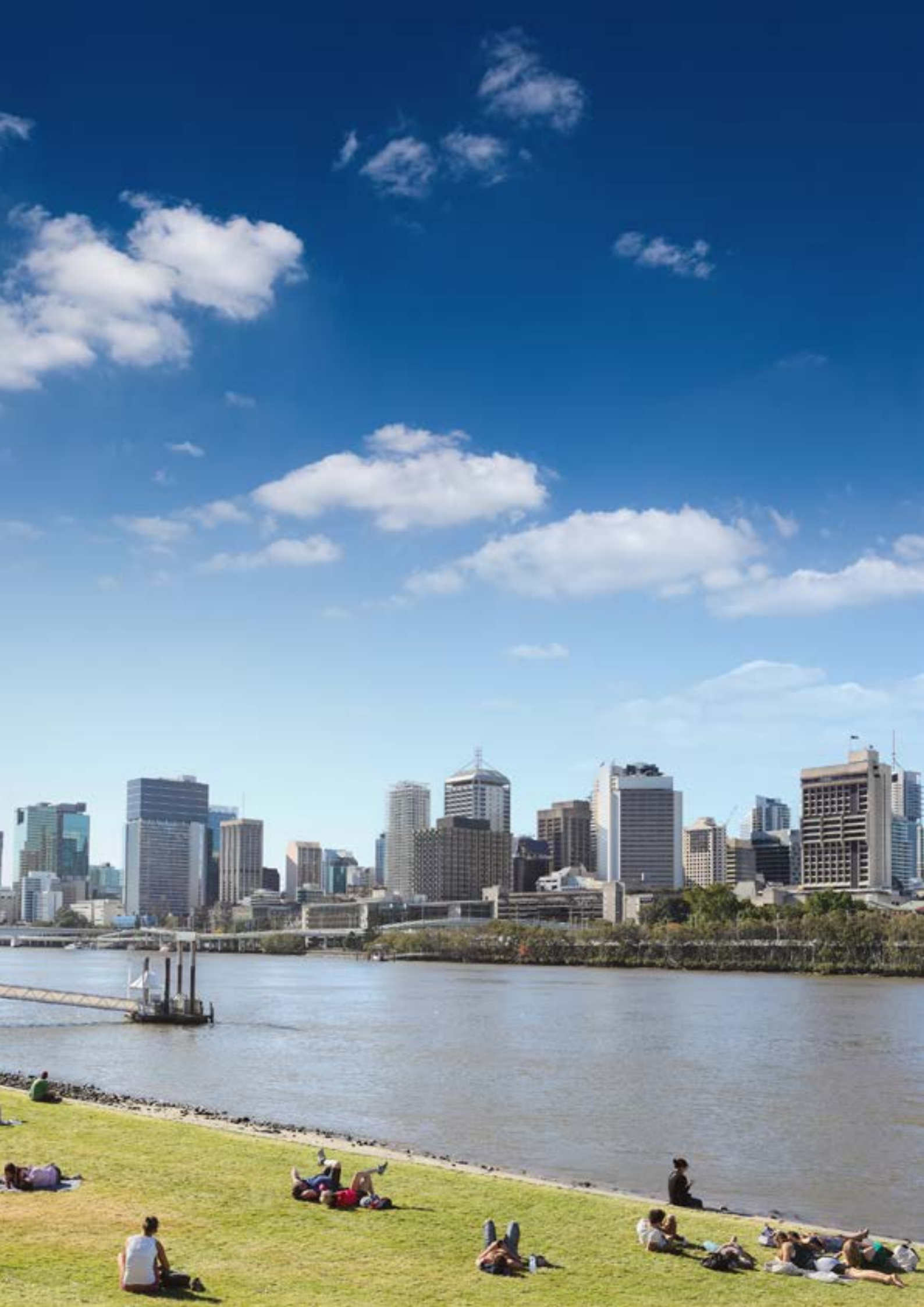

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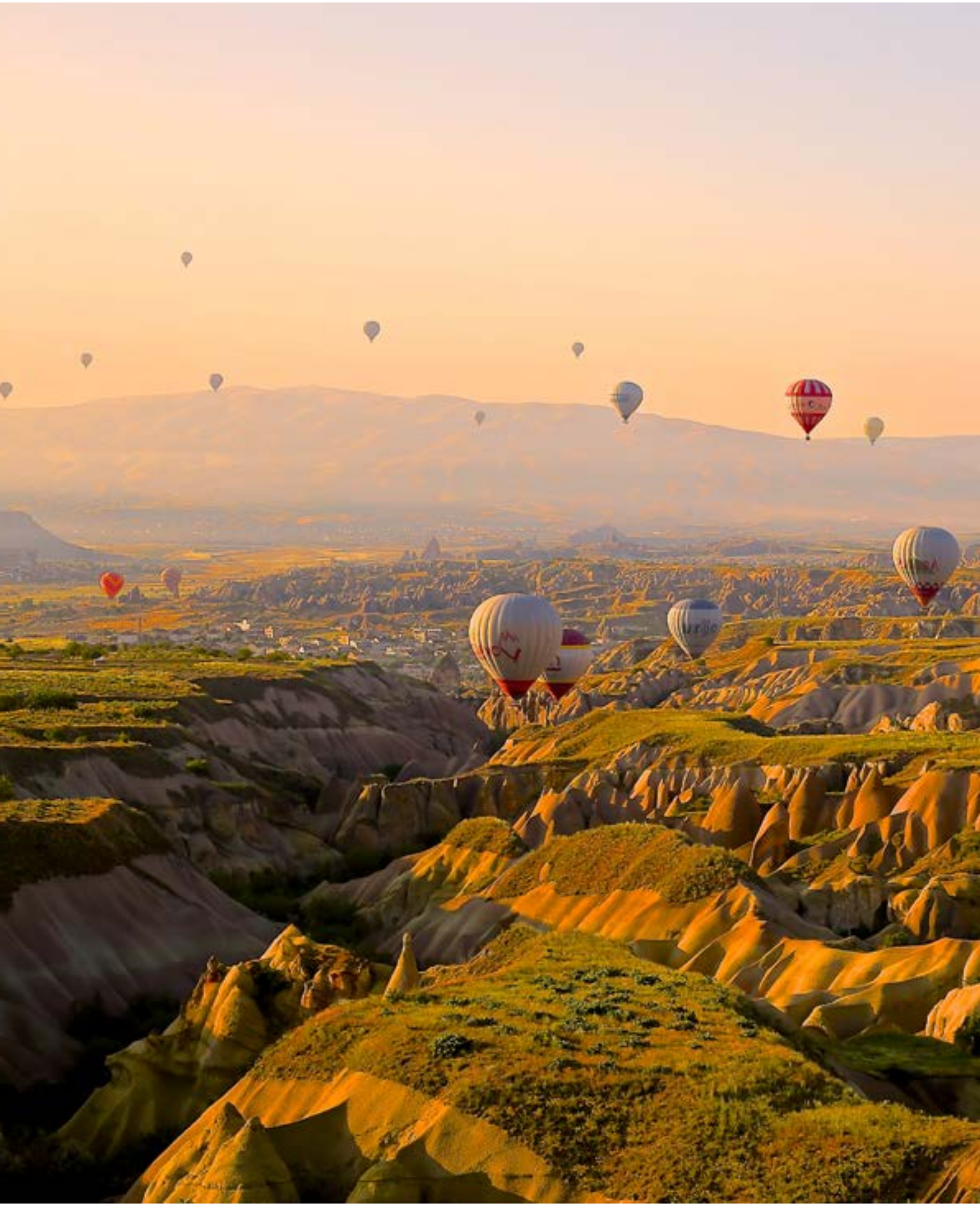


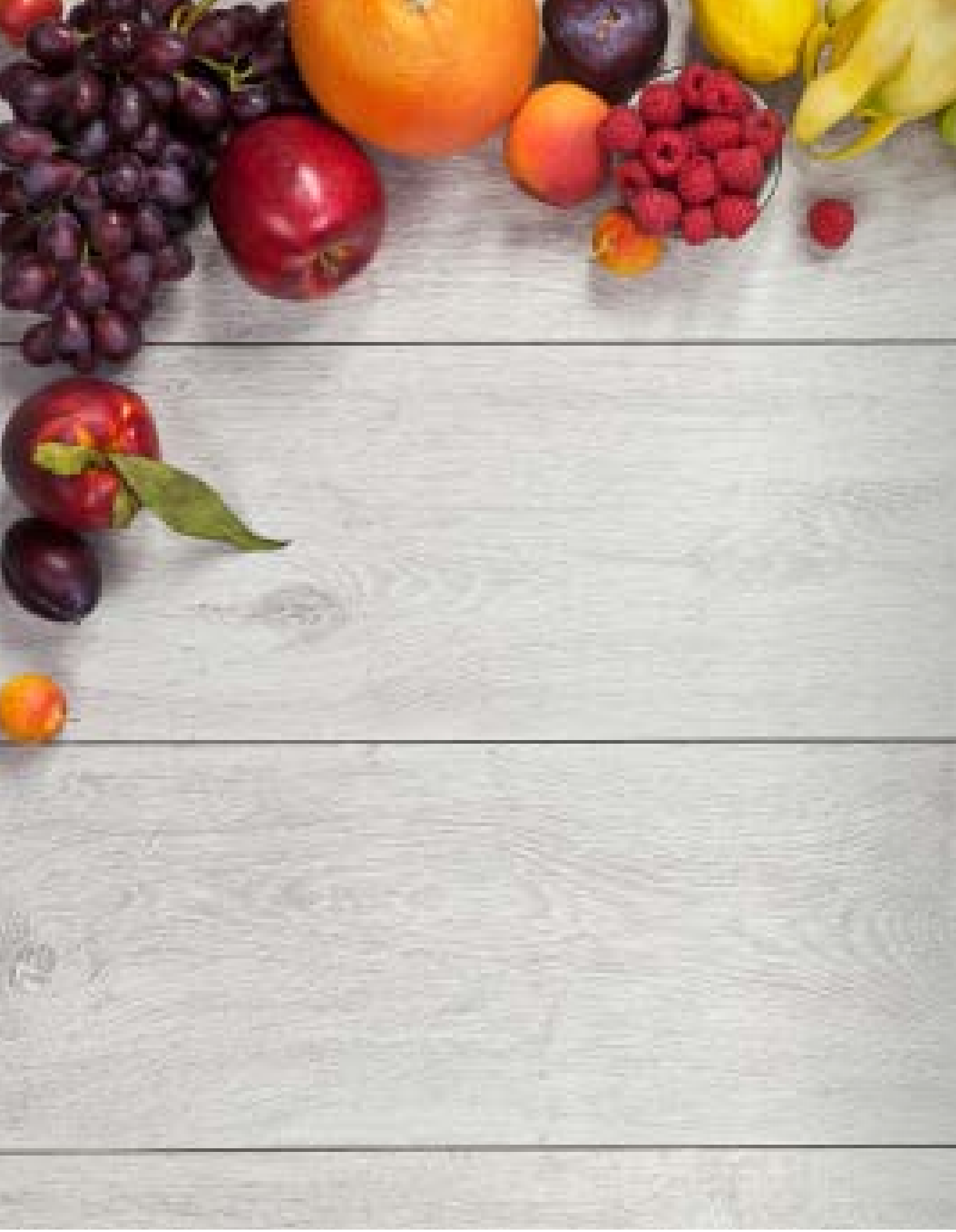
EXECUTIVE SUMMARY

The 2015-16 Queensland Budget was the first Budget of the new State Government and in that sense it represented an entirely new direction for Queensland. AMA Queensland's determined at the time the Budget was handed down that it delivered for the health sector on a number of fronts and we largely supported its initiatives.

We were particularly pleased to see the Government had listened to a number of the proposals we had raised in the AMA Queensland *Health Vision*, which we launched last year. For example, the Budget allocated $7.5 million over four years to establish a state-wide Health Promotion Commission, which would provide strategic leadership for whole-of-government initiatives aimed at maintaining and improving the health and wellbeing of Queenslanders by preventing and slowing the increase of chronic illness. AMA Queensland advocated for a whole-of-government public health plan in *Health Vision Part One*, and we advised the Queensland Government to make the development of such a plan a priority for the Commission.

Since the 2015-16 Budget was handed down, AMA Queensland has released three more parts of the *Health Vision* and their initiatives form the basis for much of our submission to the 2016-17 Budget.

- **Public Health:** AMA Queensland is pleased with the progress made on public health to date, but we want to see the Queensland Health Promotion Commission be developed as soon as possible and to develop a whole-of-government plan. In the interim, AMA Queensland wants to see the Government fund a number of initiatives which could help combat our state's obesity epidemic.
- **Medical Workforce and Training:** AMA Queensland calls on the Queensland Government to fund the Queensland Medical Education Training Institute to improve the quality and consistency of the junior doctor training experience in Queensland, and to improve the resilience of our medical workforce.
- **Health Hubs:** As outlined in *Health Vision Part Three*, AMA Queensland calls on the Queensland Government to fund a trial of the patient-centred medical home. This will help reprioritise our health care funding so our health system is refocused on patients' needs while striving for greater equity and sustainability.
- **Unifying the Health System:** AMA Queensland welcomes the Integrated Care Innovation Fund set up by the Queensland Government, and we will keep watch on the successful tenders to ensure the success of their projects. However, there is more that can be done. We call on the Queensland Government to fund a scoping study that would introduce an online referral and appointment tracking system.
- **End-of-life Care:** There is an acknowledged unmet need for palliative care services in Queensland at the moment, but it appears as though no one is certain where the greatest need exists. AMA Queensland believes the Queensland Government should undertake a state-wide assessment of palliative care needs. After this, it should make it a priority to fund the infrastructure necessary to enable health care providers to efficiently and compassionately address the growing need for palliative care services in Queensland.



1: PUBLIC HEALTH

The first chapter of AMA Queensland's *Health Vision* outlined the crisis facing public health in Queensland. Poor coordination of service and training has contributed to the development of an obesity epidemic, an increase in alcohol consumption, a lack of focus on our health related Close the Gap targets and left Queensland with the third highest smoking rate in Australia.

In our 2015 Budget Submission, we outlined how this crisis necessitated focussing Queensland's public health efforts into a single vision and purpose, and that this response should involve everyone in the community. We felt this could be achieved by funding the development of a whole-of-government public health plan.

AMA Queensland was therefore highly supportive of the Queensland Government providing $7.5 million over four years in its 2015 Budget for the development of a Queensland Health Promotion Commission (QHPC) to "provide strategic leadership for whole-of-government initiatives aimed at maintaining and improving the health and wellbeing of Queenslanders by preventing and slowing the increase of chronic illness." The QHPC could strengthen Queensland's efforts to improve public health by coordinating collaboration and partnerships between Government Departments and external stakeholders. Where such inter-departmental partnerships already exist, the QHPC could strengthen these linkages and help normalise them, making them an intrinsic part of how Government does public health policy development.

While consultation and development of the QHPC continues, AMA Queensland believes the Queensland Government should not overlook some other important public health policy objectives, such as:

- **Continuing the fight against obesity:** Instead of being known as the "Smart State", Queensland is now known as the "Fat State." We are facing an obesity epidemic and urgent action on par with a state emergency is needed to tackle the problem. While obesity would be an important component of the work of the QHPC and the whole-of-government public health plan, AMA Queensland believes the epidemic facing our state requires a series of escalating responses to help Queenslanders on the road to a slimmer waistline and better overall health. The 2016 Budget presents an important opportunity to fund some of the long-term strategies which will begin to make this difference.
- **A pilot program to subsidise fruit and vegetables for 'at-risk' communities**, especially in remote areas. The pilot would run in communities where obesity is the biggest problem and target those on low incomes who have difficulty affording fresh fruit and vegetables for their families. We also call on the Government to further investigate the structural and regulatory changes necessary to improve the availability of healthy foods and to evaluate the economic interventions necessary.
- **Expand the use of telehealth to fight obesity:** Queensland Health should establish a multidisciplinary team comprising dieticians, exercise physiologists and specialist bariatric services whose primary purpose is to consult chronically obese patients. Based in Brisbane, this team would be available to consult patients who need help losing weight.
- **Publicly fund bariatric surgery:** To be considered a last resort only, AMA Queensland recommends that Queensland follows the lead of other jurisdictions, such as the ACT and New Zealand, and increase funding to allow more bariatric surgeries to be performed. As a last resort and a targeted investment, this would allow patients who have tried and failed to lose weight to achieve a healthy weight and would likely result in significant cost savings to the health system in the longer term. [1]

1. Natalie Lukas, Janet Franklin, Crystal M Y Lee, Craig J Taylor, David J Martin, Nic Kormas, Ian D Caterson and Tania P Markovic. The efficacy of bariatric surgery performed in the public sector for obese patients with comorbid conditions. Med J Aust 2014; 201 (4): 218-222

II: MEDICAL WORKFORCE AND TRAINING

AMA Queensland and its members know that a healthy, well planned and engaged medical workforce is fundamental to the success of Queensland's health system. Without these three elements being appropriately addressed, the health system will not be able to deliver the care that Queenslanders expect and deserve. We congratulate the Queensland Government for the significant strides it has made in this area since its election, but there is always room for more to be done. In particular, AMA Queensland believes the health of our medical workforce is a continuing cause for concern and offer the following proposals for a strategic injection of funds.

Healthy medical workforce

In 2015, AMA Queensland piloted our *Resilience on the Run* program with a cohort of interns at Rockhampton Base Hospital. The program was developed following a *beyondblue* report into the mental health and wellbeing of junior doctors that found they suffered from alarmingly high rates of anxiety and burnout. *Resilience on the Run* was designed in direct response, to provide early career doctors with the resilience and coping skills needed to survive and thrive in the field of medicine.

Resilience on the Run, delivered by resilience expert Dr Ira van der Steenstraten, focused on skills such as resilience and mindfulness, managing interpersonal relationships, navigating difficult scenarios on the job and practical steps for asking for help. Since the successful pilot, AMA Queensland has had interest in the program from medical education units around Queensland and interstate.

AMA Queensland calls on the Queensland Government to commit $350,000 to AMA Queensland to fund the *Resilience on the Run* program across all hospitals that accept interns through the state ballot process. This should be seen as an investment in both the individuals, to reduce the risk of anxiety, and the broader system in ensuring that talented young doctors do not burn. Queensland patients would be the ultimate beneficiaries through healthier treating physicians.

Well planned medical workforce

AMA Queensland congratulates the Queensland Government on listening to the medical profession and consulting with them through high level workforce planning exercises such as the Workforce Planning Whitepaper. We further congratulate them on establishing a working group dedicated to examining prevocational medical training in Queensland. We would like to see this working group build on the principles outlined in the AMA Queensland *Health Vision Part II*, namely the establishment of the Queensland Medical Education and Training Institute (QMETI), a dedicated medical workforce organisation to work across hospital and health services to develop Queensland's medical workforce. AMA Queensland began advocating for the establishment of QMETI to ensure that all early career doctors, no matter where they are in Queensland, receive the education and training necessary to effectively serve their patients.

QMETI would improve the medical workforce in Queensland through developing linkages between pre-existing resources, standardising those resources, such as the excellent medical education units across the state, and developing services where gaps may exist. It could also work closely with the Office of the Chief Medical Officer in workforce planning and development to ensure that there is a cohesive strategy for every medical officer in Queensland to practise as effectively as

possible, set training standards and monitor professional development.

The benefits of such an organisation are manifold. Firstly, it would ensure that the best and brightest are attracted to Queensland by the high quality training and opportunities provided. Secondly, it would ensure all doctors have a clear path to develop their skills, so as to provide the highest quality health service to Queenslanders. Finally, Queensland patients would benefit from having a highly motivated, well trained and focused workforce available to treat them, no matter where they live.

Engaged medical workforce

AMA Queensland is extremely supportive of programs that develop the leadership capabilities and competencies of medical practitioners. These programs should combine structured, academic learning, coaching, mentorship and evaluation. We commend the work of the Health care Leadership Unit within Queensland Health for establishing these programs. However, we believe they must be expanded, with funding to match, to ensure all Queensland clinicians can access the programs.

AMA Queensland believes that by making a prudent investment in these areas, the public can enjoy the dividends for years to come through a healthier, better planned, and more engaged medical workforce providing a higher standard of care to Queenslanders.

Culture

Healthy workplaces are needed to ensure we have healthy medical professionals. AMA Queensland believes that the Tristan Jepson Guidelines, developed by the Tristan Jepson Memorial Foundation (TJMF) may be the catalyst needed to start positive cultural change at Queensland Health.

The Guidelines were developed following the death of Tristan Jepson, an Australian law graduate who committed suicide at the age of 26. Although the Guidelines were initially developed with the legal profession in mind, they are applicable to any workplace, with organisations such as Telstra and Westpac as signatories.

They promote physiologically healthy workplaces and promote working environments that emphasise values such as trust, honesty, fairness and respect. Signatories to the Guidelines are encouraged to implement them at their own pace. Over time, they assist cultural change and this, in turn, changes the way employees think, speak and act in addressing psychological health and safety. In Queensland Health's case, becoming a signatory to the Guidelines will allow each HHS to lock in their own projects under this framework.

We note the Queensland Government is in the process of undertaking its annual whole-of-government survey to measure the way its workplaces are operating. The survey provides a timely opportunity to introduce the Tristan Jepson guidelines as a framework under which the individual HHS's can develop their own projects based on needs identified in the survey. We encourage the Queensland Government to commit necessary funding to begin this process.

By becoming a signatory to and fostering the adoption of the Guidelines, the Queensland Government would be delivering a watershed moment not only for the health and well being of its medical workforce, but for the patients they treat each and every day.

III: HEALTH HUBS

AMA Queensland knows our state is facing an epidemic of lifestyle related chronic disease. We know these diseases are largely affecting our most disadvantaged citizens, including the unemployed, Aboriginal and Torres Strait Islanders and refugees. Areas where generational disadvantage has become entrenched suffer high rates of type 2 diabetes, heart disease, stroke and chronic lung disease. Evidence also shows that our most disadvantaged citizens are experiencing higher rates of mental illness. [2]

Our doctors and clinicians are doing amazing work in regard to managing this deficiency, but clearly more needs to be done. AMA Queensland believes that Queensland must reprioritise its health care funding so our health system is refocused on patients' needs and strives for greater equity and sustainability.

To achieve this goal, AMA Queensland believes the Queensland Government should invest in a trial of a "Health Hub" which would demonstrate the clear advantages of reprioritising our health system into a patient-centred, coordinated care model.

Health Hubs are based on the patient-centred medical home (PCMH) model and are designed to better coordinate the care of patients in the community; to improve the quality of health care in Queensland and to reduce future potential costs by reducing demand on hospital services. The medical home has been used extensively overseas, dating back to 1967, and trials of a PCMH are now underway in the *CarePoint* trials occurring in Western Australia and Victoria. This provides us with a growing body of evidence demonstrating the effectiveness and efficiency of the model.

Health Hubs in Queensland should:

- Be GP led;
- Encourage patients with (or at risk of) chronic diseases within the trial area to voluntarily enrol in the Health Hub and educate them on the benefits of having their own GP, with provisions made to allow them to opt out or reverse their decision;
- Utilise the patient's usual general practice and GP as their Health Hub (assuming they have elected to participate in the trial);
- Support shared care with GPs through improved communication and education;
- Work with primary care networks to support the development of 24 hour community care;
- Work with primary care networks and AMA Queensland to develop community based emergency care centres that work collaboratively with local GPs to reduce the burden on hospital EDs;
- Develop integrated approaches to telephone advisory services and emergency dispatch centres to ensure patients have access to the correct type of service;
- Upgrade IT systems to allow better access to information by shared providers; and
- Be subject to independent evaluation after the trial is completed.

Conducting a trial of the Health Hub model before rolling it out across Queensland is a necessary first step to ensure we develop the model optimal for Queensland. It will allow the Government time to ensure the IT and funding solutions needed to support the trial can be properly developed and implemented.

We understand the cost of the *CarePoint* trial in Victoria is approximately $8 million over two years, with the costs divided equally between the Victorian Government and Medibank Private. AMA Queensland believes that, given the costs of the Health Hub trial in Queensland would be comparable to the Victorian *Carepoint* model, the Queensland Government should consider implementation without the involvement of a private health insurer. This would help alleviate any concerns within the primary care sector around managed care and the prioritisation of privately insured patients, and help encourage more GPs to participate.

The *CarePoint* trial showed the costs of moving to a PCMH model could put a significant strain on some GP practices. A review of the challenges associated with properly implementing a medical home model in Australia demonstrates some general practices would encounter difficulties with moving to a new patient-centred system, adopting electronic health records and adapting their payment models to suit[3]. Also, the United Kingdom's decision to move the provision of care out

of hospitals and into the community put significant strain on general practice in that country. To avoid this, we believe the Queensland Government should examine a pragmatic range of solutions to ensure Queensland's Health Hubs can function effectively. At the outset, this would involve reprioritising funding to appropriately resource any practices which require extra support to transition to the new model.

However, it is important to note that any extra investment is likely to be cost neutral overall. Patients whose care is well managed and coordinated by their usual GP are likely to have a much better quality of life and make a positive contribution to the economy through improved workforce participation. In a PCMH, patients and their families have a continuing relationship with a particular GP, who is supported by a practice team and clinical services within the area. The medical home coordinates patients' care and acts as a gateway to the wider health system.

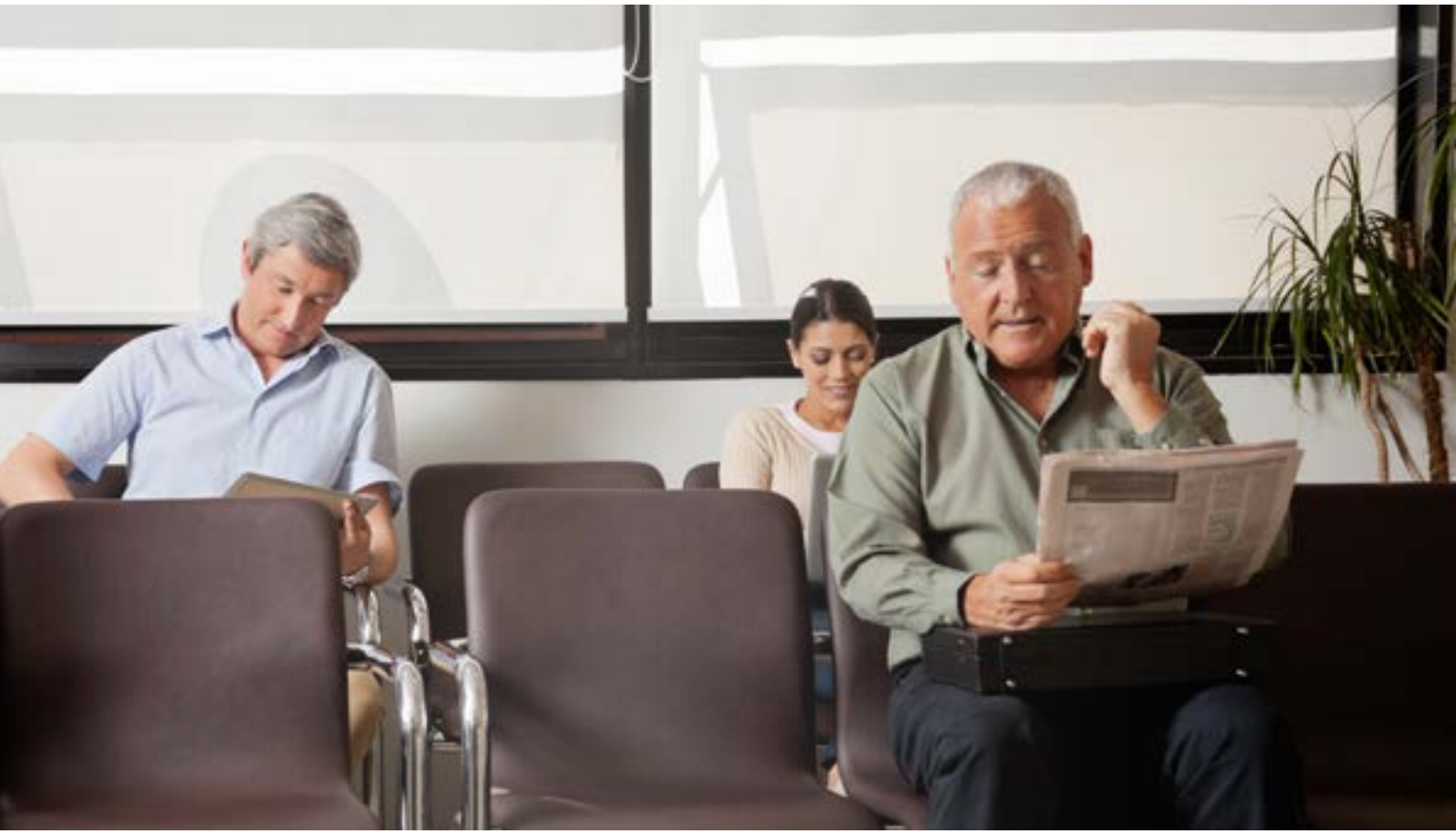
Some would argue general practices in Australia are already doing all of this, which is absolutely true. Many Queenslanders are already receiving high quality care through their GP and other providers. As the Australian Centre for the Medical Home explains, all medical homes in Australia are general practices but not all general practices are medical homes.[4] Making Health Hubs a reality in Queensland empowers our GPs to deliver an even greater service to their patients and gives patients a greater understanding of their own health care needs, leading to greater health literacy, better health outcomes and lower instances of chronic disease. This would be particularly useful in areas with high Aboriginal and Torres Strait Islander populations, especially when there seems to be slow progress towards Closing the Gap health targets.

There is an international basis for the development of the PCMH as an alternative approach to providing comprehensive patient care through a stable and ongoing relationship with a general practice. The model, originally trialled in US Paediatric Care in 1967, has produced significant measurable benefits in providing improved patient-centred care.[5] Notably, this can result in a reduction in avoidable hospital presentations (32-40 per cent drop), hospital admissions (16-24 per cent drop), and length of hospital stay (36 per cent drop) in patients suffering from a chronic disease.[6]

The *CarePoint* trials demonstrate many GPs would be willing to rise to the challenge of this change. In the trial location, 85 per cent of GPs signed on to participate in the trial. Those practices that declined to be involved usually did so because they had computer systems that were not up to the standard required of the trial.

There is an appetite and a need for a PCMH in Queensland. In the absence of any move by the Commonwealth to reform the primary care sector, the Queensland Government must consider ways in which it can drive its own positive change.

2. Australian Bureau of Statistics, National Survey of Mental Health and Wellbeing, Australian Government, 2007
3. Janamian, T, Jackson, C.L, Glasson, N, Nicholson, C, A systematic review of the challenges to implementation of the patient-centred medical home: lessons for Australia, Med J Aust 2014; 201 (3 Suppl): S69-S73.
4. Australian Centre for the Medical Home, The Medical Home – FAQs, http://medicalhome.org.au/faqs/
5. RACGP, RACGP Submission to the Minister for Health, 2013-14 http://bit.ly/1SLIObW
6. ibid



IV: UNIFYING THE HEALTH SYSTEM

Australia's health system is too complex, resulting in confusion for professionals working within the system and their patients. The distribution of responsibilities for health between different levels of government is blurred and unclear, resulting in duplication, cost-shifting and blame-shifting. The relative financial contributions of different levels of government to hospital services are fiercely disputed, especially when hospital funding arrangements are negotiated.

AMA Queensland believes Queenslanders are tired of the blame game. We believe there is something more important than how these services are paid for patients and their health outcomes. It must always be remembered that a single patient is at the centre of this debate, and that person may be someone's mother or father or son or daughter. This is why it is vitally important that the Queensland Government looks at ways it can unify the health system as much as possible. In this, the penultimate chapter of the AMA Queensland *Health Vision*, we will examine how this can be achieved.

AMA Queensland and its members believe the answer can be found through improving connections between the primary, secondary and tertiary care sectors. Until one level of government takes responsibility for funding the health system, improving connections is the only practical way to ensure patients can seamlessly navigate the three sectors and improve health outcomes.

The Queensland Government has already taken some positive steps in this direction through its recent announcement of the $35 million Integrated Care Innovation Fund, which tasks Queensland Hospitals with partnering with GPs and PHNs to develop a coordinated approach to treatment. However, we believe there are other opportunities worthy of exploration.

As part of a suite of measures, AMA Queensland believes the Queensland Government should implement the following actions to help unify the health system.

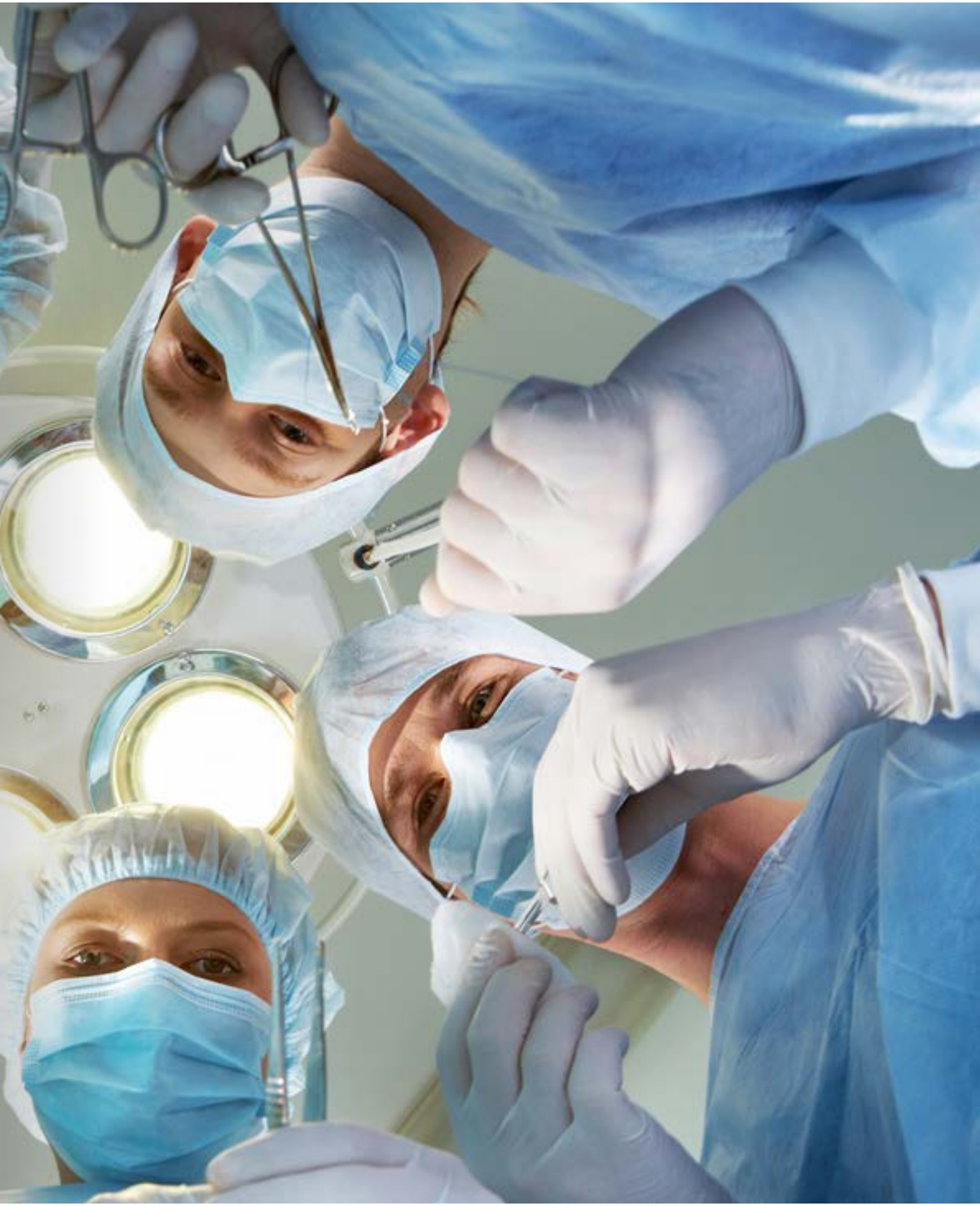
Develop a state-wide, standardised, online pathway for GPs and patients which would allow them to track their position on waiting lists and the length of time to be waited.

Patients and GPs in Queensland continue to experience difficulty in accessing outpatient appointments because a named referral is required for many clinics and there is no accurate way to predict waiting times. To remedy this, AMA Queensland believes the Queensland Government should begin a scoping study that would introduce an online referral and appointment tracking system.

The development of a state-wide, standardised online pathway for GPs and patients would allow them to track their position on the waiting list and the length of time to be waited and would help patients make an informed choice about the type of care they access.

Create connections and training opportunities between general practice and hospital care by implementing a further trial of the Physician/Psychiatrist in the Practice model.

A trial of this model was run by GP Connections in Toowoomba. The trial involved visits by physicians and psychiatrists to rural general practices to provide specialist care to patients and up-skill GPs. The evaluation of this study outlined educational gains for GPs and specialists, improved relationships and improved patient satisfaction. AMA Queensland believes further study should be undertaken into this program with a view to possibly expanding it state-wide.



V: END-OF-LIFE CARE

It is a fact of life that every person will go through the process of dying. This is true regardless of people's socioeconomic status or how healthy or unhealthy they are. But compared to other factors that can influence health outcomes, such as obesity and smoking, death and dying attract far less attention and funding in our health system.

AMA Queensland believes this needs to change[7]. We know Australia has an ageing population . People are living longer but with multiple conditions requiring more complex health care. This reality affects the care that is provided at end-of-life. Queensland families face difficult choices about how their loved ones spend their dying days. In general, families and health practitioners want to honour the wishes of the dying person, however, the low numbers of people who have a documented advance care plan means that doctors and families may face confusion and lack of direction about the level of care to provide, including what care the patient would or would not want to receive at end-of-life.

Evidence shows most people who need palliative care services in Queensland will be treated not by a specialist service, but by their family GP. Others will be treated by a doctor working in our public hospital system. This is making death and dying in Australia "institutionalised" which is a very poor result when considered against the fact that 70 per cent of Australians want to die at home but only about 14 per cent actually do[8]. We believe compassionate change must be enacted to ensure doctors and health care workers are able to effectively care for their patients, and that the wishes of patients and their loved ones are respected.

Reliable data on the use and uptake of palliative care is difficult to come by given a lack of data on funding and expenditure on palliative care at a state level[9]. However, Palliative Care Queensland estimated the total amount of funding available to specialist palliative care services was $77.81 million[10], including $8.1 million of Commonwealth funding in 2012. In that year, Queensland's population was estimated to be 4,610,932[11], with 28,300 registered deaths[12]. Queensland's population is estimated to reach 5,488,667 by 2020, with expected deaths to reach 32,932. Our specialist palliative care services are already stretched, with referrals to services increasing annually by 20 per cent while funding is only expected to increase by an annual 12.9 per cent.[13] Quality of palliative care services has been maintained, but this has come about through rationing of services, such as limiting palliative care to only the last three months of life as opposed to the recommended six months[14]. A strategic injection of funds is urgently required to help our palliative care services meet demand and give our most vulnerable Queenslanders the care they need at the end of their life.

AMA Queensland believes a strategic injection of funding is required to help ensure Queensland's struggling palliative care sector is meeting demand. This funding should be targeted at the following initiatives.

Benchmark data

To ensure that funding is targeted to areas where there is the most need, AMA Queensland recommends the Queensland Government first undertakes a state-wide assessment of palliative care needs. This was a recommendation of the Queensland Parliament's Health and Community Services Committee in 2013. This information should be reported and available publicly to help provide a benchmark on how Queensland is managing and meeting demand.

Increase funding to palliative care services

AMA Queensland believes the State and Federal Governments should be responsible for ensuring the provision of comprehensive palliative care services to all Queenslanders, within a coordinated,

strategic framework. Emphasis should be placed upon the need for the provision of adequate long-term and recurrent funding to enable the implementation of a sustainable, equitable palliative care policy for Queensland. We call upon the Queensland Government to establish as a priority the infrastructure necessary to enable health care providers to efficiently and compassionately address the growing need for palliative care services in Queensland. We also call upon the Federal Government to increase its funding of the National Palliative Care scheme over and above the $52 million over three years it committed in 2014.[15]

Diversity of services

AMA Queensland advocates the provision of a variety of palliative care services to allow maximum flexibility with regard to care options, and maintains that continuity of care is pivotal to the effective management of palliative care patients. AMA Queensland upholds the need for a culturally sensitive approach to the provision of palliative care to Aboriginal and Torres Strait Islander communities and people from culturally and linguistically diverse backgrounds.

Within the framework set out under the whole-of-government public health plan we advocated for in *Health Vision Part One*, AMA Queensland believes the coordination and resourcing of palliative care services in Queensland should and would be best performed by designated multi-disciplinary specialist palliative care service units. Each unit should be responsible for a specific geographic region and should coordinate and resource palliative care services within that region, based on evident need, ideally determined by means of targeted research.

These units should facilitate the implementation of community-based palliative care models, providing education and training, consultation and respite resources for community and other hospital-based palliative carers within designated geographic regions, as well as each providing a domiciliary visiting team to support GPs and domiciliary nurses within their designated community.

Community care should be provided by integrated teams of community-based carers, led by a well-trained, palliative care medical officer and comprising appropriately trained and experienced nursing, allied health and volunteer staff with access to specialist palliative care.

Care should be provided in the location of choice wherever possible. Within that environment, there is a place for inpatient hospice units which could be freestanding or attached to other hospital and/or community services.

Each major training hospital should be resourced to set up a highly skilled palliative care team within a specialised, dedicated Palliative Care Unit. Although hospital-based, these teams should support and work within the framework of the community-based palliative care model.

Training and education

AMA Queensland recognises the need for and strongly promotes specialist palliative care training and education. Access to this training and education should exist for all providers of palliative care within the medical, nursing and allied health professions, as well as within the community generally. The special training needs of volunteer palliative carers should also be taken into account. This training and education should be consistent across Queensland and would be best delivered by the Queensland Medical Education and Training Institute (QMETI) body we advocated for in *Health Vision Part Two*.

AMA Queensland supports the training of a number of GPs to take a leading and informed role in facilitating and greater palliative care participation and commitment of their GP colleagues. These practitioners would provide an interface between other GPs, domiciliary nursing and specialised palliative care services, as well as hospitals, nursing homes and other groups involved in professional care. Further, we believe as many GPs as possible should receive sufficient basic palliative care training to enable them to provide high-quality and effective care to palliative patients. Again, this could and should ideally be delivered by QMETI.

7. The Commonwealth of Australia, 2015 Intergenerational Report Australia in 2055, Australian Government, Canberra, March 2015
8. Swerissen, H and Duckett, S., 2014, Dying Well. Grattan Institute
9. Australian Senate Committee Inquiry, Palliative Care in Australia, 50–53
10. Palliative Care Queensland's Submission to the Queensland Parliament's Health and Committee Services Committee Inquiry into Palliative Care and Home and Community Care Services, Palliative Care Queensland, August 2012
11. Queensland Statistician, Population Growth, Queensland, December Quarter 2012, http://bit.ly/1hGDYiV, Queensland Government, June 2013
12. Queensland Statistician, Deaths, Queensland 2012, http://bit.ly/1EwuoFP, Queensland Government, November 2013
13. Health and Community Services Committee, Palliative and Community Care in Queensland: towards person-centred care, Queensland Parliament, May 2013
14. ibid
15. Nash, F, $52 Million to Improve Palliative Care Services and Training, http://bit.ly/1MwDMzD, Australian Government, 2014

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