25 May 2015

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To the Research Director

By email ipnrc@parliament.qld.gov.au

Thank you for providing AMA Queensland with the opportunity to provide a submission to the Infrastructure, Planning and Natural Resources Committee's inquiry into fly in, fly out and other long distance commuting practices in Queensland.

AMA Queensland is the state's peak medical advocacy group, representing over 6000 medical practitioners across Queensland and throughout all levels of the health system. Many of our members treat and work with fly in, fly out (FIFO) and drive in, drive out (DIDO) workers on a regular basis. We have consulted confidentially with our members including general practitioners, general practice nurses and staff. We also consulted via e-mail with over 100 doctors and medical practices who work with FIFO employees.

Although FIFO is not a practice exclusive to the mining and energy sector, it is the area in which it is most prevalent and most relevant to Queensland. AMA Queensland's submission to this inquiry will confine itself to the use of this form of commuting in the resources and energy sectors.

AMA Queensland's submission will examine the impacts FIFO and DIDO work practices can have on the mental and physical health of workers and their families. While we recognise FIFO has a place in a modern employment context, there is evidence that organisational management is causing stress, isolation, alienation, insecurity and powerlessness among FIFO workers and their families.

FIFO in Queensland and Nationwide

Queensland's FIFO workers operate primarily in the Bowen and Galilee Basins, which together make up Queensland's largest coal mining regions. They incorporate four regions of the state; namely Whitsunday, Isaac, Central Highlands, Banana and Barcaldine[1]. The Queensland Treasury has analysed the non-resident populations of these areas and attempted to project their population statistics from 2015 through to 2021. It has found the following key statistics.

- The non-resident population of the Bowen Basin was 16,360 persons in June 2014, down from a peak of 25,040 in June 2012. Factors contributing to this fall include completion of construction for new mines, expansion projects and coal seam gas (CSG) projects, as well as mine closures and workforce restructuring. [2]
- Four projection series expect the Bowen Basin's non-resident population to reach between 14,230 and 14,640 persons by June 2015[3]
- Development of large greenfield mining projects, rail and power infrastructure in the Galilee Basin would see the non-resident population of Barcaldine (R) increase substantially to a peak of between 3,260 and 3,270 persons by 2021[4]

[1] Barker, R., (2011) Resource Communities Research, Office of Economic and Statistical Research, Queensland Treasury, July 2011
[2] Queensland Treasury (2014), *Bowen and Galilee Basins non–resident population projections 2015 to 2021*, http://bit.ly/1zw4CD8
[3] *ibid*
[4] *ibid*

Outside of mining activity in Queensland, it is estimated up to 200,000 workers are not residents in the areas where they live nationwide[5], with many Queensland workers flying to other mining operations in Western Australian and the Northern Territory. Indeed, FIFO is most prevalent in Western Australia, where it was estimated that by 2015 the WA resources industry would employ 110,000 people with 57% of these, or approximately 63,000 workers employed on FIFO rosters.[6]

FIFO Rostering and Fatigue

FIFO and DIDO workers work long shifts, often of 12 hours or more. A typical roster (known in the industry as a "swing") is 14 days on, seven days off (14/7) but rosters of seven on, seven off are beginning to be introduced. Rosters of 21/7 and 10/4 are also common and, according to the CFMEU, are considered by many to strike the right balance between earning capacity and lifestyle balance.[7]

Studies conducted on job satisfaction indicate that employee churn rates were influenced by a number of factors including roster length, whether the environment was positive and commitment by management to training and skill development.[8]

Depending on an employee's particular roster, FIFO workers have reported feeling elements of fatigue and also stress, the latter usually as a result of missing important events like Christmas and birthdays.[9] This can have a potential flow on impact on mental health. However, many FIFO employees have also noted the positive aspects of the roster system, such as the ability to spend extended periods at home with family.

In our own consultation with AMA Queensland members, we found it was clear that the doctors and nurses/receptionists working in mining towns where FIFO is voluntary reported that the practice of FIFO under the circumstances of shift arrangements which were acceptable to the FIFO miners generally was harmonious. There was however a strong observation that the people who do live locally in townships where the mine accepts voluntary FIFO are experiencing high levels of social stress and misery.

We also noted that the process of travelling involved with FIFO and other long distance commuting practices can add to issues of fatigue, with the long hours of travelling before and after shifts resulting in significant extra fatigue on top of the fatigue caused by 12 hour shifts. This was especially the case where the timing of shifts is irregular.

How FIFO Impacts on Mental Illness and Mental Health

The World Health Organisation explains that mental illness is often manifested by incidents of self harm and, in particular, suicide, whereas mental health is defined as a "state of wellbeing in which the individual realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to their community." [10] It is important to make this distinction because as AMA (WA) stated in their submission on FIFO;

> *"Whilst it is essential that issues relating to mental illness are addressed, it is also necessary to highlight the contributing and overarching effect of FIFO work on mental health and wellbeing. Recognising that, even in the absence of mental illness, maintaining mental health is essential to personal wellbeing and is something that should be a parallel focus of this Inquiry."*[11]

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[5] Naidoo, V, *The Human face of FIFO,* Sunshine Coast Daily, http://bit.ly/1HDZM9S, 30th September, 2012

[6] AMA (WA) Submission on Mental Health Impacts of FIFO Work Arrangements

[7] CFMEU FIFO/DIDO Policy: http://qld.cfmeu.asn.au/index.php/about-work/fifodido-policy

[8] Beach, R., Brereton, D., Cliff, D., (2003); *Workforce Turnover in FIFO Mining Operations in Australia: An Exploratory Study*, Centre for Social Responsibility In Mining, Sustainable Minerals Institute, University of Queensland

[9] Clifford, S, *The Effects of Fly-in/Fly-out Commute Arrangements and Extended Working Hours on the Stress, Lifestyle, Relationship and Health Characteristics of Western Australian Mining Employees and the Partners,* University of Western Australia, 2009

[10] World Health Organisation, *Mental Health: A State of Wellbeing*, http://bit.ly/1d0EFej, August 2014

[11] AMA (WA) Submission on Mental Health Impacts of FIFO Work Arrangements

The reason that FIFO workers appear to have poorer mental health outcomes than others, seems to be primarily related to extended absences from their families. In a document created by the Queensland Resources Council (QRC) called *Guidance for Long-Distance Commuting Workers*, which presents a largely positive outlook on FIFO, the QRC explains that depression can be a challenge for workers in the industry.

> *If not managed properly, stressful situations like family crises or work pressures can trigger feelings of loneliness and depression.*[12]

The QRC argues that the incidence of mental health issues does not "appear to be any higher among FIFO and DIDO workers than in the general Australian population." However, a footnote to this claim acknowledges that "some researchers have found strong evidence that FIFO does have a negative impact on the mental health of workers and their families" which makes the initial statement seem highly disingenuous. Despite the largely positive view of FIFO presented in this document, the fact that it acknowledges that depression and relationship stresses can be challenges associated with the FIFO lifestyle would suggest that the mental health of FIFO workers is an issue that requires serious attention and acknowledgement.

AMA Queensland members have advised us that many of their FIFO workers who suffer from depression and anxiety are worried about relationship problems, and are worried that their partners back home may leave the relationship. Many partners of FIFO workers have indicated to our members that they feel isolated, which leads to mental health issues of their own.

There is also evidence that families of FIFO also experience poorer mental health outcomes, particularly children. Increased behavioural problems and negative emotions can be the result of a FIFO parents extended absences, and this is especially the case among boys. FIFO children also reportedly experience greater instances of bullying at school, and feel an increased pressure to succeed academically.[13]

The worst problems both for miners and townspeople are seen where compulsory FIFO is the norm. AMA Queensland has found general agreement that we are witnessing major psycho-social disruption of families with detrimental effects on miners, their partners and children where relevant and associated other family members. In parallel, we witness major psycho-social disruption of other groups including small business and service industry personnel who set themselves up to supply goods and services to the mining industry and its miners only to be cast aside when compulsory FIFO became the rule. We also understand that FIFO miners living camps are actually contracted to not visit local towns even if they have family there.

In 2010, the Australasian Centre for Rural and Remote Mental Health reported that the rate of suicide of male miners is 4 times greater than that of the general male population[14]. Despite a reluctance from the mining sector to acknowledge the mental health concerns associated with the FIFO lifestyle, this sobering statistic (when viewed in concert with other presented evidence) should make it abundantly clear that addressing this aspect of the FIFO lifestyle needs urgent attention from all stakeholders involved in this industry.

How FIFO Impacts on Physical and Sexual Health

A Federal Parliamentary inquiry into FIFO work practices revealed many claims around alcohol and substance misuse as a result of FIFO work. It cited poor diet and physical inactivity, increased sexually transmitted and blood borne infections and fatigue related injuries as just some of the health outcomes FIFO workers can experience.[15]

The New South Wales Governments' submission to the inquiry highlighted how substance and alcohol abuse related to the FIFO lifestyle has resulted in impacts not only upon FIFO workers but their families, also.

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[12] Queensland Resources Council, *Guidance for Long-Distance Commuting (FIFO/DIDO) Workers,* http://bit.ly/1IlyS0L, Accessed May 2015
[13] The Australian, *10 Things to know about fly-in, fly-out families,* http://bit.ly/1FK3b4B, February 19, 2014
[14] Ashby, N, *FIFO Families Submission to the Federal Inquiry into FIFO,* October 2011
[15] House of Representatives Standing Committee on Regional Australia, *Cancer of the bush or salvation of our cities? Fly-in fly-out and drive-in drive-out workforce practices in Regional Australia*, http://bit.ly/1EUlEGM, February 2013

> *Social service providers in NSW also indicate that there are negative social impacts associated with the large gender imbalance of FIFO/DIDO workforces, and that isolation from family and other supports can lead to increased use of alcohol, drugs and prostitution. Sudden increases in population in regional centres have also been observed to coincide with an increase in alcohol-related violence (including domestic violence).*[16]

Several submissions to the inquiry raised concerns about the rise in sexually transmitted infections (STIs) amongst FIFO workers.

> *AMA WA claimed that, particularly in Western Australia, doctors are seeing an increasing number of FIFO patients and that cheap South-East Asia holidays combined with 'young blokes who are cashed up' is leading not only to a high rate of STIs, but also the introduction of South-East Asian strains of disease, exposing the wider community to significant risks. It was also argued that current health strategies are not appropriately addressing this risk.*[17]

Physical health is also an issue that requires consideration. A University of Western Australia (UWA) study into the health of FIFO workers found that most of the over 200 participants were overweight or obese. The spread of overweight participants was 75.4 per cent of the males and 62.6% of females, with no underweight individuals.[18] The QRC also acknowledges that FIFO workers have the potential to gain weight, referring to "Smorgasboard Syndrome" as a challenge of living in worker accommodation villages (WAV)[19].

Despite this, the UWA study found that most FIFO workers were in similar or sometimes better health than direct contract employees (DCE). However they do note that this did not necessarily translate into better health outcomes, with many participants reporting similar high levels of obesity and fatigue. [20]

In discussions with our members, AMA Queensland found there was a view that the rapid boom of the coal mining industry in the Bowen Basin brought with it an influx of unskilled labour to the region. These workers found themselves in a dynamic where they suddenly had buying power for which they had no experience. Members reported widespread abuse of drugs and alcohol, obesity and a general increase in a number of other factors known to be detrimental to health. These factors were already well entrenched before the advent of FIFO and indeed the mining companies may well say that they do not warrant an opinion that FIFO is deleterious as there appear to be few if any metrics.

However there has been a telling observation in the area of pharmacy. Pharmacists keep a very tight tally on the types and dosages of medications which are dispensed. AMA Queensland has been advised that the already considerable flow of anxiolytics and anti-depressants has increased in a measurable way and the strengths of dosages dispensed have also increased in parallel with the practice of compulsory FIFO.

In 2015, AMA Queensland released the first part of our *Health Vision*, a document that will guide our advocacy and policy goals over the course of the next five years. The *Health Vision* outlined a target for a whole of government public health plan that would bring together any and all stakeholders who have a part to play in the public health of Queenslanders. It is hoped that such a public health plan would, if implemented, solve some of the state's biggest public health concerns such as obesity, alcohol abuse, mental health concerns and more.

AMA Queensland has attached a copy of the *Health Vision* to this submission and suggests to the committee that if it is considering how it might mitigate some of the negative impacts of the FIFO lifestyle, a whole of government public health plan would be an important step in doing this. We look forward to working with the Government to advise them on how this might be achieved.

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[16] New South Wales Government, *Fly-in Fly-out and Drive-in drive-out workforces in NSW Mining*, 2011, p.18

[17] House of Representatives Standing Committee on Regional Australia, *Cancer of the bush or salvation of our cities? Fly-in fly-out and drive-in drive-out workforce practices in Regional Australia*, http://bit.ly/1EUlEGM, February 2013

[18] Clifford, S, *The Effects of Fly-in/Fly-out Commute Arrangements and Extended Working Hours on the Stress, Lifestyle, Relationship and Health Characteristics of Western Australian Mining Employees and the Partners,* University of Western Australia, 2009

[19] Queensland Resources Council, *Guidance for Long-Distance Commuting (FIFO/DIDO) Workers,* http://bit.ly/1IlyS0L, Accessed May 2015

[20] Clifford, S, *The Effects of Fly-in/Fly-out Commute Arrangements and Extended Working Hours on the Stress, Lifestyle, Relationship and Health Characteristics of Western Australian Mining Employees and the Partners,* University of Western Australia, 2009

Conclusion

It seems clear that the policy of compulsory FIFO is detrimental to the physical and mental wellbeing of miners and their families and to the mental wellbeing of the residents of the several small towns which have been directly affected by the policy of compulsory FIFO. Voluntary FIFO seems to be acceptable in that it allows those who wish to come from outside to do so and those who prefer to live close to the mine to do so.

AMA Queensland wishes to make it clear that it is not inherently opposed to FIFO. We believe it has a place as a form of recruitment to meet workforce needs. We also recognise that despite the oft-mentioned negative aspects of a FIFO lifestyle, some people appear to enjoy and genuinely thrive within it. The suitability and capability to adapt to this lifestyle appears to depend on the individual themselves and, more importantly, whether the worker is away from family and missing out on important life events.

AMA Queensland is concerned about the mental and physical impacts that the FIFO lifestyle has on many people who work within the industry, as well as the wider impacts it has on workers families. Through the *Health Vision*, which was developed with the expert advice of our members, AMA Queensland has provided a number of recommendations which could assist in remedying these issues. We look forward to working with Government in making the *Health Vision* a reality.

If you require further information in regards to this matter, please do not hesitate to contact Mr Leif Bremermann, Policy Advisor, AMA Queensland on 3872 2203.

Yours sincerely

Dr Shaun Rudd
President
Australian Medical Association Queensland

AMA QUEENSLAND

AMA QUEENSLAND'S

HEALTH VISION

PART ONE: PUBLIC HEALTH AND GENERATIONAL DISADVANTAGE

EXECUTIVE SUMMARY

AMA Queensland is proud to launch Part One of its Health Vision, the first of five documents that will guide our advocacy and policy efforts over the course of the next five years.

This first chapter examines the topic of public health, but future sections will focus on other topics such as; workforce and training issues affecting our medical workforce; end of life care; reprioritising care in response to changing demand and; unifying the health system.

It is appropriate that the Health Vision begins by examining the topic of Public Health, an issue of vital importance in ensuring Queenslanders live healthy, productive lives. Sadly, growing health inequality and unhealthy lifestyles in both Queensland and Australia, especially in children, and an ageing population are increasing problems that are jeopardising the ability of our health care system to provide adequate care for Queenslanders.

Children make up 19 percent of Australia's total population [1], but they are 100 per cent of Australia's future. This is why the Health Vision aims to ensure that in five years time a child who was born today will be healthier and be best placed to live longer than a child born earlier. We believe this can be done by implementing the following initiatives.

› **A Whole of Government Public Health Plan:** By 2020, Queensland will have a whole of Government public health plan that will oversee all of the Government's efforts to combat obesity, smoking, alcohol, mental health and more

› **Escalating the fight against Obesity:** Queensland Health estimates that three million Queenslanders are expected to be overweight or obese[2] Like a flood or bushfire, obesity is a state emergency and should be treated as such. By implementing a series of escalating responses to help Queenslanders lose weight, from fresh food initiatives to publicly funding bariatric surgery, we believe it is possible that overweight and obese Queenslanders will be, on average, five percent slimmer by 2020

› **Recommit to Closing the Gap:** Queensland's commitment to Closing the Gap has faltered in recent years. AMA Queensland will convene a working group as part of the development of the Public Health Plan to help advise the Queensland Government on what is needed to help Queensland meet its targets.

› **Extra Measures to Improve Vaccination Rates:** AMA Queensland recognises the effort that has been put into achieving Queensland's high vaccination levels and commends the release of the Queensland Immunisation Strategy 2014-17, which contains a number of positive solutions to increase immunization rates and combat misinformation. But more needs to be done to increase immunisation rates in areas with low herd immunity. AMA Queensland is advocating for funding for a mobile immunisation van in areas of low herd immunity and a targeted patient transport plan to assist patients in travelling to and from their appointments.

AMA Queensland's Health Vision draws on the experience of our members and existing research in developing its recommendations. We believe that these targets are achievable and affordable and in many cases will help deliver savings to health resources.

We hope to work collaboratively with Government and other stakeholders on the implementation of the AMA Queensland Health Vision over the next five years and we commend this report to all who read it.

1 Australian Bureau of Statistics, Population by Age and Sex, Regions of Australia, 2013, http://www.abs.gov.au/Ausstats/abs@.nsf/mf/3235.0

2 Queensland Health. The health of Queenslanders 2014. Fifth report of the Chief Health Officer Queensland. Queensland Government. Brisbane 2014.

> Public health requires an organised response to minimise illness, injury and disability, and to protect and promote health.

PUBLIC HEALTH

THE PROBLEM:

For too long now, Queensland has lacked a dedicated public health policy. Although there have been policies that cover individual public health issues, such as smoking or obesity, there has been a distinct lack of a coordinated, overarching, whole-of-government policy that tackles the best way to manage public health in a state as large and decentralised as ours. This has resulted in some significant wins, such as Queensland's higher than average vaccination rates, as well as some significant losses, such as our state's growing obesity epidemic.

Whereas there has been a large and commendable investment in health infrastructure and hospitals and attempts at addressing the health workforce crisis, the previous term of Government in Queensland saw significant cuts to public health funding programs which made the task of treating public health problems all the more difficult.

As defined by AMA's public health position statement, public health[3] requires an organised response to minimise illness, injury and disability, and to protect and promote health. A strong public health policy is predicated on the measurement and analysis of the burden of disease. In a resource scarce environment, this analysis informs the decisions that are made regarding which health activities/services are cost-effective for the population's health.

AMA Queensland believes the following areas of public health are of particular concern, and require special attention from Government when developing future public health policy.

3 AMA Public Health Position Statement, https://ama.com.au/position-statement/public-health-2006

ABORIGINAL AND TORRES STRAIT ISLANDER PUBLIC HEALTH:

Aboriginal and Torres Strait Islander health outcomes are among the worst in the developed world. It is for this reason that the Closing the Gap program was initiated.

The Close the Gap program has been a rare example of bipartisanship in Australia, which is to be commended. It is because of this bipartisanship, and because of the dedication of many hard working medical professionals around the country, that the Close the Gap initiative has managed to achieve some important successes since it began in 2009, particularly in the health sphere such as the notable improvements in infant mortality rates.

However, it has also had some worrying failures. In the most recent Closing the Gap report, delivered by Prime Minister Tony Abbott in 2015, it was revealed the Aboriginal and Torres Strait Islander men and women still die, on average, around a decade younger than non-Aboriginal and Torres Strait Islander Australians.[4] There are still 15 years to go until 2030. Policy continuity and transparent reporting is critical for the achievement of health equality over that span of time.

In recent years we have started to see a shift away from bipartisan support of Closing the Gap toward implementing austerity measures. For example, in 2013 the Queensland Government has cut a number of health services that were assisting to improve health outcomes in Cape York and the Torres Strait, such as smoking cessation programs and women's health. And in the 2014 Federal Budget, $165 million over five years will be cut from Indigenous Health programs and redirected to the Medical Research Future Fund.[5] Further, the Budget did not mention any further funding for a National Partnership Agreement on Indigenous Health or investment for the National Aboriginal and Torres Strait Islander Health Plan.[6] The 2015 Queensland election also all but ignored Close the Gap and Aboriginal and Torres Strait Islander health policy. When this is all considered together it paints a worrying picture, given that the Close the Gap initiative requires continued momentum to turn around Aboriginal and Torres Strait Islander health outcomes.

VACCINATION RATES:

Vaccinating against preventable disease is a proven method of reducing the incidence of and deaths from diseases such as measles, tetanus, diphtheria, and Haemophilus influenza type B. Australia's comprehensive vaccination program means that the occurrence of vaccine-preventable diseases (VPD) is now very rare[7]. This, coupled with substantially improved vaccination rates in the last 20 years[8], means Australia has an excellent record of achievement in the prevention of disease through immunisation.

Unfortunately there are some sections of society who believe, wrongly, that immunisation is dangerous. Organisations that continue to peddle incorrect information about the safety and efficacy of vaccines are threatening the herd immunity[9] that vaccination rates require to be effective. This is particularly the case in more affluent areas, such as the Sunshine Coast which reports an 89.9% immunization rate, but is also true in other parts of Queensland, such as the Torres Strait which reports a worryingly low 85.7% rate.[10] In an effort to turn this around, April 2014 saw Queensland Health introduce a $3 million incentive to help local Hospital and Health Services (HHS) boost immunization rates. Any HHS that improves vaccination rates will be able to share in the funding.[11] There is currently no data to test the effectiveness of this plan.

Queensland Health, particularly its Chief Health Officer, deserve credit for providing material to counter this claim and debunk the views put forth by vaccination skeptics. However, Queensland Health has also begun a trial of a scheme which allows pharmacists to administer injections. AMA Queensland believes the Queensland Pharmacy Immunisation Program (QPIP) is a poor and possibly dangerous substitute to vaccinations provided via a qualified medical practitioner. While immunisations are safe, there is always the possibility of an adverse reaction. Pharmacists lack the training and medical expertise to handle adverse reactions, which could lead to potentially disastrous results. Further, AMA Queensland believes that the QPIP fractures care, which is not an ideal situation. To help maintain Australia's impressive record in vaccination schedules and to help combat the misinformation being peddled by skeptics' networks, the community must be confident in the safety and quality of immunisation services.

AMA Queensland welcomes the release of the Queensland Immunisation Strategy 2014-17, released in July 2014, which contains a number of positive proposals to try and counter incorrect information and increase vaccination rates[12]. However, the Strategy plans to expand the QPIP, which AMA Queensland sees as a significant step backwards in improving consumer confidence in the safety of the vaccination process.

4 Department of Prime Minister and Cabinet. Closing the Gap: Prime Ministers Report 2015. Commonwealth Government. Canberra 2015.

5 Federal Budget Papers No.2, p.185

6 Reconciliation Australia. 2014-15 Federal Budget Summary, https://www.reconciliation.org.au/news/2014-15-federal-budget-summary/, 2014.

7 The Australian Immunisation Handbook, 9th edition, Department of Health and Ageing, 2008

8 Australia's Health, Australian Institute of Health and Welfare, 2010

9 Herd immunity is a form of immunity that occurs when the vaccination of a significant portion of a population (or herd) provides a measure of protection for individuals who have not developed immunity

10 Springborg, L. $3 million incentive to boost vaccination rates. Queensland Government. Brisbane. 2014

11 ibid

12 Queensland Health. Queensland Immunisation Strategy 2014-17. Queensland Government. Brisbane. 2014

OVERWEIGHT AND OBESITY:

Rates of overweight and obesity are reaching pandemic levels in Australia and Queensland. While this is a condition that can affect anyone, research shows that where you live can put you at greater risk of becoming overweight or obese. Households in low socio-economic areas have a greater prevalence of overweight or obese people. This can be due to a number of factors, including the cost of fresh and healthy food (which is often more expensive than less healthy options). This is a significant concern as part of Generational Disadvantage, which will be discussed in greater detail later in this chapter.

SMOKING:

Queensland has recently enacted tough new smoking laws which ban smoking in indoor and outdoor public areas, as well as restrictions on the promotion, sale and display of tobacco products. This is to be commended. Further, smoking rates appear to be decreasing by around 4 per cent every year. And yet Queensland's smoking rates are comparatively still relatively high, with the third highest proportion of smokers (17%) behind the Northern Territory (24%) and Tasmania (22%)[13]. The latest Australian Health Survey reveals diseases of the respiratory system, such as lung cancer, are the most prevalent form of disease in Queensland.[14]

ALCOHOL RELATED HARMS:

Currently Queensland lacks a focused policy on the responsible consumption of alcohol. It is also spread out across at least two portfolios with no obvious cooperation between them. Queensland Health has the "Young Women and Alcohol" campaign, whereas the Office of Liquor and Gaming Regulation (OLGR) handles laws around the sale of alcohol, including the "Safe Night Out Strategy." The OLGR also regulates the sale of alcohol in several Aboriginal and Torres Strait Islander communities, a responsibility it shares with the Department of Aboriginal and Torres Strait Islander Partnerships and Multicultural Affairs. Focus is needed to strengthen this area of public health concern.

This lack of focus is arguably contributing to a sharp increase in dangerous levels of alcohol consumption in Queensland. In 2009, 10.6% of persons, 11.9% of males and 9.2% of females, reported consuming alcohol in quantities that placed them in risky or high risk categories for harm in the long term.[15] By 2011, this had increased to 22.7% of all adult Queenslanders drinking at dangerous levels, with 35.0% of males and 10.6% of females respectively.[16] This trend needs to be curtailed, not least because drink driving is the number one contributor as a factor in approximately 30 per cent of crashes in Queensland.[17]

It is also a danger for unborn children. When a pregnant woman consumes alcohol during pregnancy, the unborn child can develop Foetal Alcohol Spectrum Disorder (FASD). This can lead to problems including low birth weight, distinctive facial features, heart defects, behavioural problems and intellectual disabilities.[18]

During the 2015 Queensland election, the Labor Party agreed to support the Queensland Coalition for Action on Alcohol (of which AMAQ is a member) plan[19] to change the culture of alcohol consumption in Queensland. With the subsequent election of the Palaszczuk Government, AMA Queensland will keep a watching brief on this issue so as to ensure action on alcohol fuelled violence is taken.

MENTAL HEALTH:

Mental Health already constitutes a greater burden of disease than it attracts in budget spending – nation-wide it attracts only five per cent of the budget while causing 13 per cent of the overall disease burden.[20] The most recent data indicates Queensland continues to fall significantly behind all other States including Western Australia, South Australia and Tasmania in per capita expenditure on mental health. [21]

13 Australian Bureau of Statistics, Australian Health Survey: First Results, 2011-12, http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4364.0.55.0012011-12?OpenDocument

14 ibid

15. Queensland Health. Alcohol Consumption in Queensland 2009, http://www.health.qld.gov.au/atod/documents/2009_alcoconsumpqld.pdf

16. Queensland Health. Alcohol Consumption in Queensland 2011, http://www.health.qld.gov.au/epidemiology/documents/alcohol-2011-fs.pdf

17. Centre for Accident Research and Road Safety. State of the Road: Drink Driving Factsheet, https://www.police.qld.gov.au/EventsandAlerts/campaigns/Documents/drink_driving_fs.pdf. 2012.

18. Better Health Channel. Fetal Alcohol Spectrum Disorder (FASD), http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Fetal_alcohol_spectrum_disorder?open, Victorian Government.

19. Queensland Coalition for Action on Alcohol, Election Platform, http://www.qcaa.org.au/2015-election-platform/, 2015

20. Well meant or well spent? Accountability for $8 billion of mental health reform. Sebastian P Rosenberg, John Mendoza and Lesley Russell. Med J Aust 2012; 196 (3): 159-161

21. *SCRGSP (Steering Committee for the Review of Government Service Provision) 2013, Report on Government Services 2013, Productivity Commission, Canberra, figure 12.3*

GENERATIONAL DISADVANTAGE:

A related issue to these concerns is that of generational disadvantage. Generational disadvantage refers to the situation in which multiple generations of the same family experience high and persisting levels of social exclusion, material and human capital impoverishment, and restrictions on the opportunities and expectations that would otherwise widen their capability to make choices. [22]

There are considerable inequalities in health outcomes within Queensland's population. This is particularly the case for Aboriginal and Torres Strait Islanders, whose children are almost twice as likely to die between the ages of 0-4 as non-Indigenous children. [23] But even outside of these communities, around the fringes of the Brisbane local government area, there exist whole suburbs where anywhere between two and four generations of children have grown up without a working parent. [24]

It is likely that this is one of the many reasons that obesity is more prevalent in low income areas. Research indicates that a healthy start in life is vitally important, with obese or overweight children often growing to become obese or overweight adults.[25] If entrenched poverty makes it difficult to purchase healthy food and participate in healthy activities, it is understandable that this would be a contributing factor to Australia's obesity epidemic.

Research shows that smoking and poor mental health is also more prevalent in areas where there are generally lower levels of income. It also shows alcohol consumption which exceeds the lifetime risk of harm (more than two standard drinks on any day) is more prevalent in areas of higher income. This is true of both Aboriginal and Torres Strait Islander communities and non-Aboriginal and Torres Strait Islander communities. Young Australians growing up in disadvantage are more likely to take a number of health (e.g. smoking, drinking, illicit drug use) or social risks (e.g. running away, coming into contact with police/courts) and to have health problems as they enter adulthood (e.g. asthma, depression).[26]

Generational disadvantage is also having a long term negative effect on the health system and public health in general. Lack of affordable oral health care services in disadvantaged areas and remote areas of Queensland is leading to higher hospitalisation rates for dental decay. This is a problem that should be prevented from occurring in the first place, or if treatment is needed it should be affordable and accessible in the primary care setting.

There is relatively little evidence that Queensland's disjointed approach to public health policy over successive governments has taken into account the well established fact that the socio-economic status of a given area can have an impact upon public health.

22. Hancock, K. Edwards, B. Zubrick, S.R. Echoes of disadvantage across the generations? The influence of long-term joblessness and separation of grandparents on grandchildren, Longitudinal Study of Australian Children Annual statistical report, 2012

23. Queensland Council of Social Services, Addressing Poverty and Disadvantage in Queensland, http://bit.ly/1EX28iu, March 2013

24. Tanton, R. Gong, H. Harding, A. Multiple Generation Disadvantage. http://www.natsem.canberra.edu.au/storage/Multiple%20Generation%20Disadvantage.pdf, National Centre for Social and Economic Modelling. July 2011

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26. Cobb-Clark, D. Disadvantage Across the Generations. http://insights.unimelb.edu.au/vol8/07_Cobb-Clark.html, University of Melbourne, Faculty of Business and Economics, 2010

> AMA Queensland wants to ensure that a child born today will grow up in a Queensland that has a public health regime that ensures he or she will have the best possible start in life...

AMA QUEENSLAND'S HEALTH VISION FOR PUBLIC HEALTH

AMA Queensland wants to ensure that a child born today will grow up in a Queensland that has a public health regime that ensures he or she will have not only the best possible start in life, but also the best chance of living a longer and healthier life. This means not only creating a public health policy that benefits the child, but his or her parents, too.

A child born today will be five years old in 2020, and to achieve our vision, AMA Queensland believes the following targets must be actively worked towards during the next five years.

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TARGET ONE

A WHOLE OF GOVERNMENT PUBLIC HEALTH PLAN

By 2020, Queensland must have a whole of government public health plan. It will be a coordinated plan to tackle some of Queensland's biggest health challenges, such as smoking, obesity, diabetes, alcohol abuse and mental health. Addressing Queensland's obesity emergency and changing Queensland's drinking culture should be given a particularly high priority in this plan.

AMA Queensland believes the ideal model for a Queensland Public Health plan is the South Australian State Public Health plan. The development of the SA plan began in 2000 and has had cross-party support since that time, with successive Health Ministers from both sides of politics continuing the development of the plan. This kind of bipartisan support that transcends the three year electoral cycle is not only rare, it is highly commendable, and AMA Queensland believes that if South Australia can do it, there is no reason Queensland can't do the same.

The SA plan coordinates the actions of all State Departments involved in the health and well being of South Australians. Further, it brings stakeholders from outside the State Government into the picture, allowing for "the development of sustainable relationships and more robust coordination mechanisms, particularly between State and Local Governments."[27]

To get Queensland moving on the road to this plan, AMA Queensland will spearhead a Public Health Improvement Partnership (PHIP) group which will draw upon the expertise of its members to develop a blueprint for what a public health plan in Queensland should look like. As part of the PHIP, we will also partner with other health advocacy organizations interested in contributing their knowledge, experience and expertise to the Health Vision. In addition, local councils, community organisations, and Queensland Health will also be invited to join the PHIP.

Within one year of the establishment of the PHIP, AMA Queensland expects to be able to deliver a Public Health plan which it will formally deliver to the Queensland Government for its consideration and further development and implementation. We will also deliver this plan to the Queensland Opposition, as it is important that any public health plan be implemented and delivered in a bipartisan manner, to ensure that it survives the three year electoral cycle.

AMA Queensland believes that a Public Health Plan for Queensland is vitally important. It will be a coordinated plan to tackle some of Queensland's biggest health challenges, such as smoking, obesity, diabetes, alcohol abuse and mental health. It will also get the ball rolling on the monumental challenge of reversing generational disadvantage so that by 2020 Queensland will be taking the right steps toward turning around generational disadvantage in some of its most needy communities.

27. Department of Health and Ageing, South Australian Public Health Plan, http://bit.ly/1GfRH6H, Government of South Australia, Adelaide. 2013

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TARGET TWO

OVERWEIGHT AND OBESE QUEENSLANDERS WILL BE 5% SLIMMER BY 2020

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. To this end, AMA Queensland is advocating a series of escalating responses to help Queenslanders on the road to a slimmer waistline.

- **Ban fast-food outlets opening within 1km of schools:** In cooperation with local government and the food industry, the Queensland Government should use its development powers to ensure that new fast food outlets[28] do not open within 1km of schools. This won't stem the tide of existing fast-food outlets close to schools, but will be an important line in the sand for new schools and future planning
- **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
- **Expand the use of telehealth to fight obesity:** Queensland Health should establish a multidisciplinary team comprised of dieticians, exercise physiologists and specialist bariatric services whose primary purpose is to consult on chronically obese patients. Based in Brisbane, this team would be available to consult on patients who need help losing weight.
- **Publicly fund bariatric surgery:** To be seen and used as 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 for 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.[29]

28 The definition of a "fast food outlet" would not apply to small businesses; a threshold and/or activity test should be developed as part of this policy so as to ensure that small and rural communities are not economically disadvantaged.

29. 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.

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TARGET THREE

BY 2020, QUEENSLAND WILL BE CLOSING IN ON THE GAP

AMA Queensland believes that although Aboriginal and Torres Strait Islander Health policy requires a special focus due to centuries of neglect, it is fundamentally no different from mainstream public health policy.

We believe Aboriginal and Torres Strait Islanders along with all other Australians have the right to good health as defined by the World Health Organisation's Declaration of Alma Ata which states that health is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity.

Aboriginal peoples and Torres Strait Islanders will not achieve equal health outcomes until their economic, educational and social disadvantages have been eliminated. Nevertheless, while social disadvantage continues, Aboriginal people and Torres Strait Islanders should not be doubly disadvantaged by the neglect of potential medical solutions arising from health sector inequities.

AMA Queensland will aim to improve Aboriginal and Torres Strait Islander health in Queensland by first establishing a committee of experts in Indigenous health, led by a trusted and respected member of the Aboriginal and Torres Strait Islander community. Their work will feed into the work being undertaken as part of the PHIP's whole of government Public Health Plan and will advise what the Government should be doing to improve Aboriginal and Torres Strait Islander health outcomes in Queensland.

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TARGET FOUR

A BOOSTER SHOT FOR QUEENSLAND'S VACCINATION RATES

AMA Queensland recognises the effort that has been put into achieving Queensland's high vaccination levels, and commends the Queensland Chief Health Officer for confirming the safety of immunisation in the face of opposition from misguided anti-vaccination groups[30]. We are cautiously supportive of the monetary incentive being used to try and increase Queensland's vaccination levels[31]. We look forward to the public release of information in the future which would allow evaluation of the plan. We also welcome the release of the Queensland Immunisation Strategy 2014-17, which contains a number of positive solutions to increase immunization rates and combat misinformation.

However, there are a number of Queensland communities that are currently experiencing pockets of low herd immunity. This must be addressed as a matter of priority. AMA Queensland believes that the safest way to do so is through immunisations delivered by a medical practitioner. While vaccines are safe, there is always a risk of an adverse reaction and only a qualified medical practitioner has the training required to manage such an event.

Strategies that increase the opportunity to vaccinate have been shown to be the most effective. Improving access, awareness and affordability could potentially boost coverage rates by as much as three to four percent.[32] To achieve the goals of increasing affordable opportunities to improve herd immunity, delivered by a medical practitioner while not fracturing continuity of care, AMA Queensland advocates for the Queensland Government to implement the following initiatives in areas of low herd immunity;

- Fund a mobile immunisation clinic, staffed by doctors, with a private area in which patients can rest should they need to do so. Records of immunisations provided should be sent to the patients regular GP.
- Consider a targeted patient transport plan that would assist patients who require vaccinations to travel to and from their appointments.
- Consider ways in which Queensland Health can assist GP practices to review their patient data and identify and contact those patients who need to have their immunisation updated. This can be achieved by either outlining the process or actually visiting the practices to provide hands on assistance.outcomes in Queensland.

30. Queensland Health, Immunisation not up for Debate, http://www.health.qld.gov.au/news/stories/140515-expo.asp, Queensland Government, Brisbane. 2014

31. Springborg, L. $3 million incentive to boost vaccination rates. Queensland Government. Brisbane. 2014

32. Ward, K., Chow, M. Y. K., King, C. and Leask, J. (2012), Strategies to improve vaccination uptake in Australia, a systematic review of types and effectiveness. Australian and New Zealand Journal of Public Health, 36: 369–377. doi: 10.1111/j.1753-6405.2012.00897

FUTURE VISION

THERE ARE FOUR MORE SECTIONS OF AMA QUEENSLAND'S HEALTH VISION TO COME, WHICH WILL BE DELIVERED PROGRESSIVELY OVER THE COURSE OF 2015.

Part Two: Workforce and Training

An engaged, well-trained and appropriately planned medical workforce is vital to the success, efficiency and effectiveness of Queensland's health system into the future. But with workforce shortages already placing pressure on our health system's capacity to provide the services Queenslanders have come to expect, action is needed now. This part of the Health Vision will offer Government ways in which they can address medical workforce and training issues while ensuring that our junior doctors, general practitioners and clinicians are happier and more effective while doing their jobs.

Part Three: Reprioritising Health Funding

All too often we hear that the Australian health system is in crisis. We are told by Government and other policy makers that the Australian health system needs to be sustainable, and that if action isn't taken to make our system sustainable now, the entire system generations of Australians have come to rely on to deliver quality health care will collapse. this chapter of the AMA Queensland Health Vision will consider how to reprioritise care in response to changing demand. Rather than suggesting quick fix policy solutions to complex problems, we have consulted with our members and drawn on international research to propose a number of targets that will help eliminate waste and inefficiency within our health care system.

Part Four: Unifying the Health System

Australia currently has, in effect, eight different state and territory health systems. 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. Unifying the health system would help to alleviate this problem, but this is easier said than done. There is a complex division of responsibility for health care services in Australia, with many types of providers and a range of funding and regulatory mechanisms. With the help of our members, AMA Queensland will propose a series of targets that could help end the blame game and make our patients journey through the health system less complex and practically seamless.

Part Five: End of Life Care

Our society is ageing and this means more Queensland families face heartbreaking choices about how their loved ones spend their dying days. People want to honour the wishes of the dying person, but the low numbers of people who have a formal 'advance care plan' mean doctors often face frustration and confusion about the level of care to provide. AMA Queensland wants to see Queensland become a world leader in end-of-life care. In this chapter of the Health Vision, we will examine what Queensland needs to do to make this happen.

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