AMA QUEENSLAND

AMA Queensland

Advocacy Priorities 2024-26

Supporting Queensland Doctors
Creating Better Health

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Introduction

From its beginnings as the Queensland Branch of the British Medical Association in 1894, AMA Queensland has grown into the state's peak medical representative body, supporting approximately 8,000 Queensland doctors and medical students across all specialties and career stages.

We have evolved from a group of doctors largely concerned about the latest medical advances to an effective advocacy group and a trusted voice for the profession, our patients and the community.

Our *Advocacy Priorities 2024-26* builds on our *Strategic Plan 2021-23* and has been developed by the AMA Queensland secretariat, Council and Board to guide our work, priorities and actions over the next three years.

Our vision is to be Queensland's most trusted, influential and engaged medical professional body.

Our mission is to deliver strong medical leadership through health advocacy that supports the medical profession and achieves better health outcomes for all Queenslanders.

The way we lead, work and behave is driven by our core values. We are committed to nurturing respectful relationships with our valued members, employees and stakeholders that harness our unique and collective strengths. Our business activities are underpinned by excellent governance, environmental and sustainable practices. We have a long history of supporting the profession and our leadership is driven by a bold and influential approach that encompasses high ethical standards.

Our advocacy priorities are in three main areas:

- Advocacy for doctors – workforce, training, leadership, wellbeing and primary-tertiary integration;
- Advocacy for patients – prevention, collaborative evidence-based practice, digital integration, First Nations health and women's health; and
- Advocacy for our community – climate and sustainability, LGBTQIA+SB community, aged and end-of-life care, and substance-related harm.

We will work hard to advance these priorities with all levels of government and all sides of politics for the good of the Queensland community.

1. Advocacy for doctors

1.1. Workforce

Queensland's health workforce crisis has deepened on the back of the COVID-19 pandemic. Medical practitioner shortages across all specialties and seniorities are now not only chronic in rural, remote and First Nations communities, but even large regional and some metropolitan areas are struggling to attract and retain doctors.

Evidence is emerging that these shortages are no longer solely the result of maldistribution but also an inadequate supply of medical practitioners globally. Factors contributing to this situation are complex and include decreases in satisfaction and wellbeing amongst medical graduates and doctors-in-training; inadequate leadership, particularly in hospital settings; and insufficient workforce incentives to attract and retain doctors in all specialties.

Investment is urgently needed to address a range of workforce issues, as set out below:

- Broader workforce incentives are required to both attract and retain the medical workforce in our regional, rural and remote communities, particularly our First Nations doctors. Incentives should enable these doctors to maintain their skills in and/or train in crucial fields such as obstetrics, anaesthetics, paediatrics, general practice and mental health.
- Excessive workloads and inadequate resources are contributing to moral injury and burnout. Staff must have access to sufficient resources for safe supervision of patient care. Whilst AMA Queensland recognises innovations in models of care are part of the workforce solution, these must be evidence-based and grounded in reality. The simple fact is that most admitted patients require hospital treatment and cannot be managed via virtual models. We need more doctors and they must only be expected to work at sustainable levels so we are not losing them faster than they can be replaced.
- Pathways for career development are required for all professions, including medicine. They must be needs-based and drawn from accurate data projections about the number of doctors required and requisite college training place availability. Queensland Health must undertake holistic stakeholder engagement to develop and implement these pathways, particularly for regional, rural, remote and First Nations health practitioners.
- Hospital upgrades or builds must produce the physical infrastructure necessary for staff to work effectively. Doctors report that basic facilities such as offices, workstations, IT systems and adjunct transport infrastructure are often lacking, directly reducing their ability to treat patients well. Sufficient high-quality, safe and affordable staff accommodation must also exist to support health workers moving to regional, rural and remote areas.

1.2. Training pathways

We cannot grow our medical workforce if recent domestic and international medical graduates (IMGs) cannot access the training pathways needed to further their careers. Insufficient training places or resources and guidance once on a program are amongst the leading causes of distress and poor wellbeing amongst early-career and IMG doctors.

These issues cause many practitioners to resign from hospital positions to accept locum roles instead or leave medicine altogether. We cannot afford to lose the graduates our medical schools produce.

Productive training pathways must be developed for recent medical graduates and IMGs that meet the needs of both doctors and the community. Pathways must be needs-based and drawn from accurate data projections about the numbers of doctors required and the requisite training places available through specialist medical colleges.

This will require a holistic approach and greater engagement by Queensland Health with medical stakeholders, especially the Medical Board, colleges and tertiary institutions to guide course curriculum in line with community needs. In addition, Queensland Health must implement elements of successful workplace-based education including:

- adequate availability of supervision and education resources;
- sufficient clinical opportunities for genuine learning (eg. doctors report 20-person ward rounds are not uncommon in metropolitan hospitals);
- quality supervisor/educator training; and
- adequate time for student assessments.

AMA Queensland is also aware the Indigenous Interns Pathway, currently in place at Townsville Hospital and Health Service, has had high rates of success and intern satisfaction. The program provides culturally appropriate support and mentorship for First Nations doctors and, given we know 30% of these doctors leave the profession, we advocate for its implementation in all Hospital and Health Services (HHSs) as a priority.

1.3. Leadership

Doctors consistently report that they are not adequately consulted or involved in critical healthcare decisions made by HHSs or Queensland Health. Many doctors are leaving medicine because of cultural problems and poor wellbeing and this workforce crisis is only set to worsen, with global shortages of doctors predicted in the short- and medium-term.

Medical practitioners must be embedded in decision-making processes and leadership at senior levels if we are to turn the decline around. Whilst health professionals are highly skilled in delivering clinical care, they are not trained in leadership, human resources, recruitment and staff wellbeing. Equipping our health leaders with the skills they need will require Queensland Health to fund mandatory leadership training for hospital executives in all 16 HHSs. This will ensure they have the training needed for their senior roles and can set the hospital culture necessary to attract and retain our valuable medical workforce.

Doctors remain extremely concerned about the ramifications of speaking up about issues affecting patient safety or staff wellbeing including bullying and harassment. HHS executives must understand their obligations to staff, including under whistleblower protection legislation. We also submit that all recommendations arising from the Wilson Review regarding the Public Interest Disclosure Act 2010 must be implemented in full and in a timely manner.

1.4. Wellbeing

AMA Queensland is alarmed by recent research documenting health practitioner suicides and poor wellbeing. Levels of distress reported amongst DiTs, First Nations doctors and IMGs are chronic and unacceptable.

Reform is urgently needed to many aspects of the health system with regulatory processes amongst the most urgent. All health practitioners report extreme distress at being the subject of a complaint, notification or investigation by the various regulatory bodies including the Australian Health Practitioner Regulation Agency, Queensland Office of the Health Ombudsman and Professional Services Review. Assessments and investigations are often complex, time-consuming, and handled in an adversarial manner. Overwhelmingly, doctors report they lack adequate education and knowledge about regulatory processes which leads to unnecessary and costly delays and hinders efficient resolution of matters.

Unique personal and professional challenges are also experienced by DiTs, First Nations doctors and IMGs. DITs regularly report excessive workloads and inadequate resources, both in treating patients and in trying to meet their training requirements. Queensland Health must commit to reducing those pressures for both patient and staff safety.

It is also disgraceful that First Nations people continue to experience unacceptable differences in health outcomes compared to the general population. First Nations doctors are an essential component in eliminating this gap. Despite this, reports suggest approximately 30% of these doctors leave the profession altogether, a rate far higher than that of their non-Indigenous colleagues. AMA Queensland urges the Government and Queensland Health to implement programs such as Townsville HHS' Indigenous Interns Pathway as a priority. Our First Nations communities must receive the culturally appropriate, best practice health care they deserve.

Likewise, our IMGs are amongst the most at-risk doctors for poor mental health outcomes. AMA Queensland's survey of IMGs identified three main areas that cause stress and directly reduce overall wellbeing and clinical performance for these doctors, including:

- orientation issues, both in adjusting to personal life in Australia and the health system generally;
- workplace issues, such as obtaining advice on employment contracts, entitlements and support services; and
- training issues, including identifying, accessing and navigating training programs and pathways.

AMA Queensland has raised these issues with Queensland Health and recommended actions the Department can take to provide increased support for IMGs. We will continue to call on the Government to provide the requisite funding that Queensland Health needs to implement them as a priority.

Finally, doctors have advised that exit interviews upon staff separation are not routinely undertaken at all HHSs. We cannot stem the flow of medical practitioners to locums or out of the profession if HHS executives are uninformed of the reasons their staff leave. This is essential and must be implemented in all HHSs.

1.5. Primary-tertiary integration

Greater collaboration and integration of tertiary and primary care services, particularly general practice, has been a consistent feature of AMA Queensland advocacy for some time. Improvements in patient health and care cannot be achieved without greater coordination between general practice and our public hospitals.

Basic processes such as discharge summaries are still inadequate and require reform to ensure important records and information are available to a patient's entire treating team, especially their general practitioner. This would also reduce costs to Queensland Health by reducing emergency department presentations and increased prevention of illness and disease.

AMA Queensland will continue to advocate for:

- formal collaboration mechanisms between Queensland Health and the general practice sector to improve continuity of care for all Queenslanders;
- establishment of a dedicated governance role for general practice within Queensland Health, being a 0.5 FTE GP liaison role within senior executive to embed and represent general practice at a senior level and advise on:
  - the most appropriate methods to integrate tertiary care, particularly public hospitals, with general practice that will ensure continuity of care and reduce public health costs;
  - the impact of legislative amendments and policies on general practice, including unintended consequences; and
  - funding to establish mechanisms and support for patients to see their GP within 7 days of discharge, such as the current Queensland Health-funded trial of Patient Care Facilitators in Logan and Ipswich, reducing readmissions and adverse events and helping patients recover.

2. Advocacy for patients

2.1. Prevention

The burden of disease is increasing at the same time as our population is aging. Preventative health must be the prime focus for all governments to ensure our people live longer and healthier lives and our public health systems remain sustainable. The more patients who can be empowered to protect their health and obtain the prevention and early intervention care they need, the less it will cost governments in delivering health resources and services. This is particularly crucial for First Nations Queenslanders.

AMA Queensland will continue to advocate for greater investment in what we know works in preventing disease – high quality primary care, particularly general practice. In addition, governments must address the underlying causes of poor outcomes including the following key social determinants of health:

- poverty;
- lack of safe and affordable housing;
- low rates of access to and consumption of nutritious diets;
- exposure to and experience of domestic and family violence;
- inconsistent or low access to education;
- unemployment; and
- increasing cost of living pressures.

Effective policy in these key areas, particularly for First Nations communities, will require a comprehensive approach that incorporates all levels of government and multiple portfolios. We will urge Queensland Health to take a leading role in promoting and driving such reforms.

2.2. Collaborative, evidence-based practice

AMA Queensland supports new models of care that are collaborative, evidence-based and proven to be safe for patients. We reject any proposals and models that prioritise convenience or clinician satisfaction over patient safety or that result in increased costs to our public health system.

Changes in scope must not undermine institutional processes designed to protect patients, including the Therapeutic Good Administration, Australian Health Practitioner Regulation Agency, the 16 national boards, training colleges and state boards. These organisations are rightfully placed to determine practitioner scope since they base such decisions on robust evidence and ensure vital safety controls accompany any such changes.

State and territory governments must not be able to unilaterally undermine these processes and place patients at risk.

Evidence also suggests non-medical prescribing leads to over- and inappropriate prescribing and antimicrobial resistance, designated by the World Health Organisation as one of the top 10 public health threats facing humanity. It is imperative that the integrity of the prescribing-dispensing separation is not compromised and financial conflicts of interest permitted to dominate over patient safety.

AMA Queensland recognises, however, that new ways of working are needed to meet community expectations and relieve pressures on our health system. Our 2023-24 pre-Budget submission included a proposal for a joint Queensland Health-AMA Queensland PhD research project analysing medical practitioners' scope of practice, including a detailed job analysis. This project would identify tasks currently undertaken by medical practitioners that could be safely performed by other health professionals (eg. administrative activities), improving patient flow and care by having doctors spend maximal time working at the top of their scope.

Likewise, it is a common misconception that doctors are not hindered in practicing to their full scope when, in reality, this occurs in many settings. This project could also identify areas where changes in scope for certain medical practitioners are both safe and cost-effective and relieve other medical practitioners from unnecessary tasks. For example, general practitioners report that certain administrative activities currently requiring a doctor's input could be completed by other health practitioners (or completed by them more often) including:

- Patient Travel Subsidy Scheme applications;
- driving assessments;
- permits for disability parking;
- Centrelink forms;
- medical certificates; and
- insurance requests.

AMA Queensland will also continue to call for more doctor-led, collaborative, holistic and team-based care in certain areas, particularly mental health. We will advocate for increased use of allied health practitioners including mental health nurses, social workers and psychologists and for funding to ensure patients have ready access to their services. This must also be developed in collaboration with both primary and tertiary care services.

Finally, we reiterate our call for Queensland Health to implement the outstanding recommendations of our Ramping Roundtable Action Plan to relieve pressure on the public hospital system. This is likely to be far safer, effective and cost-efficient at relieving current hospital pressures than recklessly expanding scopes of practice without evidence or adequate safeguards.

2.3. Digital integration

Technological advances can improve patient care and reduce workload on our health practitioners. This can only occur, however, where digital systems are seamlessly integrated with each other and between sectors (eg. general practice and aged care).

Government must invest in integrating our primary care and tertiary systems to promote necessary information-sharing and continuity of care and increase the use of platforms such as MyHealth Record. Ongoing issues with many systems must also be urgently rectified, including ieMR and QScript, which continue to compromise patient safety and unnecessarily waste health professionals' valuable time. AMA Queensland will continue to call for:

- publication of past reviews of ieMR and Communicare;
- rectification of technical issues delaying the expansion of ieMR (again noting spending must be conditional on and guided by a robust and transparent external review);
- clear and consistent information for doctors about QScript, noting these problems have continued to plague the program since its beginning; and

- implementation of the submissions made by AMA Queensland on Queensland Health's 'Mandatory checking of QScript Legislative review consultation paper' submitted 15 February 2023.

The above said, doctors report concern that the Government is focusing significant effort on digital models of care such as hospital-in-the-home without sufficient evidence that they are cost-effective, provide appropriate standards of care and do not result in unintended consequences, including medico-legal risks. Such issues have historically been overlooked by the Department.

Many doctors also state that Queensland Health's current enthusiasm for these technologies belies a false assumption that significant numbers of admitted patients did not require hospitalisation. We know the pressures within our hospitals are the result of inadequate workforce and bed block by patients who are not suitable for hospital-in-the-home models. Many patients who are hospitalised simply need to be in hospital and cannot be managed through virtual models, no matter how sophisticated.

AMA Queensland will continue to urge Queensland Health to take a more balanced and realistic view of the opportunities presented by digital technologies. All changes in models of care must be evidence-based, in line with best practice and cost-effective.

2.4. First Nations health

Queensland's First Nations community continues to experience a disproportionate burden of disease in comparison to the rest of the community. Gaps in health outcomes and life expectancy persist and are widening in some areas.

AMA Queensland recognises that First Nations people and organisations must lead policy development and decision-making at the local and regional level to address these gaps. They must also be supported to do so by health allies in the non-Indigenous sector through joint advocacy and partnerships.

As such, AMA Queensland's priorities will be informed by those of First Nations health organisations, including the Institute for Urban Indigenous Health (IUIH) and the Queensland Aboriginal and Islander Health Council (QAIHC). In addition, AMA Queensland will continue to advocate for all investments to be needs- and evidence-based, focusing on addressing health inequity, rather than funded via ad-hoc processes that have historically lacked adequate transparency and accountability.

To that end, AMA Queensland recognises the success of programs that are supported by IUIH and QAIHC, including:

- Mob Link;
- Birthing in our Community (BiOC);
- Surgery Pathways; and
- Deadly Choices.

Advocacy efforts will focus on partnering with First Nations organisations to ensure such programs remain viable, accountable and empirically robust.

Improving the health of our Indigenous Queenslanders remains heavily dependent on laying a strong foundation for better preventative and mental health. The Government must start with investment in the social determinants of health as set out under section 2.1, especially those that adversely impact Indigenous communities the most such as poverty, inadequate housing, unemployment, poor diet and domestic and family violence. AMA Queensland's advocacy will focus on improving these determinants across the state, whether in urban or non-metropolitan regions.

First Nations patients also experience significant difficulty in accessing palliative and end-of-life care services that are culturally appropriate and enable community members to die with dignity on country. Whilst the $171 million investment in palliative care services in the 2022-23 Queensland Budget was welcome, it is unclear what programs have been supported as a result and how much remaining funding is yet to be allocated. As a priority, AMA Queensland will advocate for all unallocated funds to be reinvested in end-of-life care with a focus on expanding service provision in First Nations communities.

The Minister for Health has also stated that First Nations health practitioners make up just 2% of the Queensland Health workforce and the Government forecasts that it will need 2000 more Indigenous health workers within the next 10 years. As stated already, we know 30% of First Nations doctors leave the profession yet are essential to improving health outcomes for our First Nations communities. We will reiterate our call for the implementation of the Townsville Indigenous Interns Pathway in all HHSs as a priority to address retention and attraction of these critical staff.

Finally, we commend the Department on its establishment of the Aboriginal and Torres Strait Islander Health Division and Chief Aboriginal and Torres Strait Islander Health Officer and each HHS for appointing directors of their respective Aboriginal and Torres Strait Islander Health Units. Our First Nations health workforce must have the leadership needed if it is to grow and prosper. AMA Queensland will continue to advocate for adequate investment in our First Nations workforce and leadership.

2.5. Women's health

AMA Queensland is supportive of the Government's focus on aspects of women's health that have historically been neglected, including that to be provided via its Queensland Women and Girls Health Strategy. The prioritisation of First Nations and Culturally and Linguistically Diverse women's health and the disproportionate impacts on women from chronic disease, disability and domestic and family violence is long overdue.

Similarly, prioritisation and increased investment is urgently needed in key areas of women's health including:

- maternity care, especially for regional, rural and remote communities;
- termination of pregnancy services; and
- alcohol and other drug treatment services.

The Queensland Government must also provide women with increased choice of health services that are holistic and appropriately and sensitively include women's partners, family and social networks in care planning. General practice and maternity services are best-placed to provide such care and must receive increased investment so they can deliver the collaborative, team-based care necessary for women's health needs, including for GP shared-care antenatal models.

3. Advocacy for our community

3.1. Climate and sustainability

Climate change is increasingly recognised as a global health emergency and one of the greatest emerging threats to human health. It presents a daunting and unpredictable challenge to our public and private health systems. Our hospitals and health services are also a significant source of carbon emissions and waste production, particularly via single-use items, biohazardous waste and high use of non-renewable energy.

The Queensland Government must do more to reduce the impacts of climate change on our community and environment and ensure health care services are sustainable. AMA Queensland will continue to advocate for action in the following key areas:

- reduction of carbon emissions, including running pilot programs in broader areas beyond just health – eg. transport;
- mitigation of health impacts by increasing current investment in preventative health through general practice, particularly to reduce obesity and address the mental health impacts of climate events;
- pandemic planning and disaster medicine and treatment;
- mitigations of environmental risks; and
- provision of adequate resources for Queensland Health's Office of Sustainable Healthcare so it can advise the Government on broader sustainability and climate change policy including:
  - best practice initiatives within Queensland Health to improve sustainability and meet climate change objectives;
  - key benchmarks and targets to achieve sustainability in health services;
  - development of a sustainable hospitals' infrastructure investment plan;
  - suitable terms of reference for a review of procurement policies and practice;
  - an engagement strategy for clinicians, managers and other staff; and
  - appropriate funding for:
    - an online climate change clearinghouse for best practice evidence; and
    - the implementation of pilot programs in environmental sustainability in:
      - 6 hospitals (3 metro and 3 regional/rural); and
      - 10 GP clinics (5 metro and 6 rural/remote).

3.2. LGBTQIA+SB community

Members of the lesbian, gay, bisexual, transgender, queer, intersex, asexual, sistergirl and brotherboy (LGBTQIA+SB) community face unique barriers and challenges in accessing health care that is culturally sensitive and appropriate for their needs. Ongoing discrimination within health care settings by all practitioner groups and the broader public, along with outdated institutional processes, contributes to poorer health outcomes within this community.

AMA Queensland will advocate for considered and sensitive government and media responses to reports and policy proposals concerning the LGBTQIA+SB community. Our key short- and medium-term goals include:

- establishing a voluntary suicide register for surviving partners, family, friends and clinicians to notify LGBTQIA+SB suicides held by a suitable body (eg. university or Australian Institute of Health and Welfare) for liaison with the Coroners Court of Queensland and legislative amendments to permit the flow of information from clinicians;
- seeking LGBTQIA+SB representation on key research and health bodies including the National Health and Medical Research Council (NHMRC) and Australian Health Ethics Committee (AHEC) and inclusion in Chapter 4 of the NHMRC's Ethics Statement;
- ensuring LGBTQIA+SB academic and consumer representation on the Australian Medical Council, including the establishment of a Committee for People of Diverse Gender, Sex Characteristics and Sexuality to advise on relevant curricula and accreditation standards; and
- encouraging adequate consultation with and inclusion of LGBTQIA+SB people by all health organisations and other peak medical bodies.

3.3. Aged and end-of-life care

It is clear that investment in aged and end-of-life care is urgently needed. All people deserve the dignity and comfort of high-quality health services as they age and reach the end of their lives.

Culturally appropriate services must also be provided to First Nations Queenslanders as a priority given the inequity of access for these communities relative to non-Indigenous Queenslanders. This means palliative and end-of-life care for First Nations patients must not only be culturally safe but enable community members to die with dignity on country.

As stated, whilst the $171 million investment in palliative care services in the 2022-23 Queensland Budget was welcome, it is unclear what programs have been supported and how much remaining funding is yet to be allocated. As a priority, AMA Queensland will advocate for all unallocated funds to be reinvested in end-of-life care with a focus on expanding service provision in First Nations communities.

We will also continue to advocate for increased investment in aged care, particularly to support general practitioners and other doctors who continue to dedicate themselves to these patients despite woefully inadequate funding by both the Queensland and Australian Governments. Likewise, we will reiterate our calls for increased palliative care funding and policy reforms including:

- an increase in the palliative care eligibility access period for all services from 3 months to 12 months;
- an independent review of the rural and remote community-based palliative care services awarded by tender under the *Palliative and End-of-Life Care Strategy* in May 2022;
- permanent funding of the Specialist Palliative Care in Aged Care (SPACE) Project;
- expansion of the Medical Aids Subsidy Scheme (MASS) to include the last 12 months of life (not 6 months);
- removal of the requirement for a palliative care specialist to confirm prognoses to improve access to MASS; and
- more support and investment in our community-based workforce to reduce demand on overburdened public hospital specialist palliative care services.

End-of-life care must also include supply of Voluntary Assisted Dying (VAD) services that meet demand. Currently, both private and public services are reporting a significant shortfall in services, particularly for regional, rural and remote and First Nations communities.

Medical practitioners and health services need VAD-specific funding, particularly for community-based services, longer GP consultations and for practitioners to travel to outer-area patients. VAD must be given its own, separate funding stream that does not reduce that available for other end-of-life care services.

3.4. Substance-related harm

AMA Queensland welcomes recent legislative reforms that adopt a health approach to drug use, including for prescription medicines. This is a sensible first step in reducing the stigma and negative effects of a drug charge, encouraging early users to seek help and diverting people to the treatments they need. We urge the Queensland Government to ensure the supporting regulations are developed in close consultation with alcohol and other drug (AOD) services and people with lived and living experience.

Further, dedicated and additional funding must be provided for health services to treat the anticipated 17,000 people who will access the scheme, separate from the $1.6B allocated from 2023 to 2027 for mental health. Drug diversion is a valuable reform but must not come at the expense of services for the many Queenslanders who need treatment for non-drug related mental illness. We will continue to call on the Queensland Government to allocate a requisite proportion of the savings generated to our criminal justice agencies to Queensland Health, general practice and community AOD treatment services that deliver drug diversion programs to support this vital reform.

We note these organisations also require additional support to continue services aimed at reducing alcohol-related harms and will urge the Government to consider their inclusion in such budget reallocation. To that end, we will reiterate our submission to the Government's recent proposed regulatory framework for online alcohol sales and deliveries and the broad reforms advocated by the Foundation for Alcohol Research and Education.

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