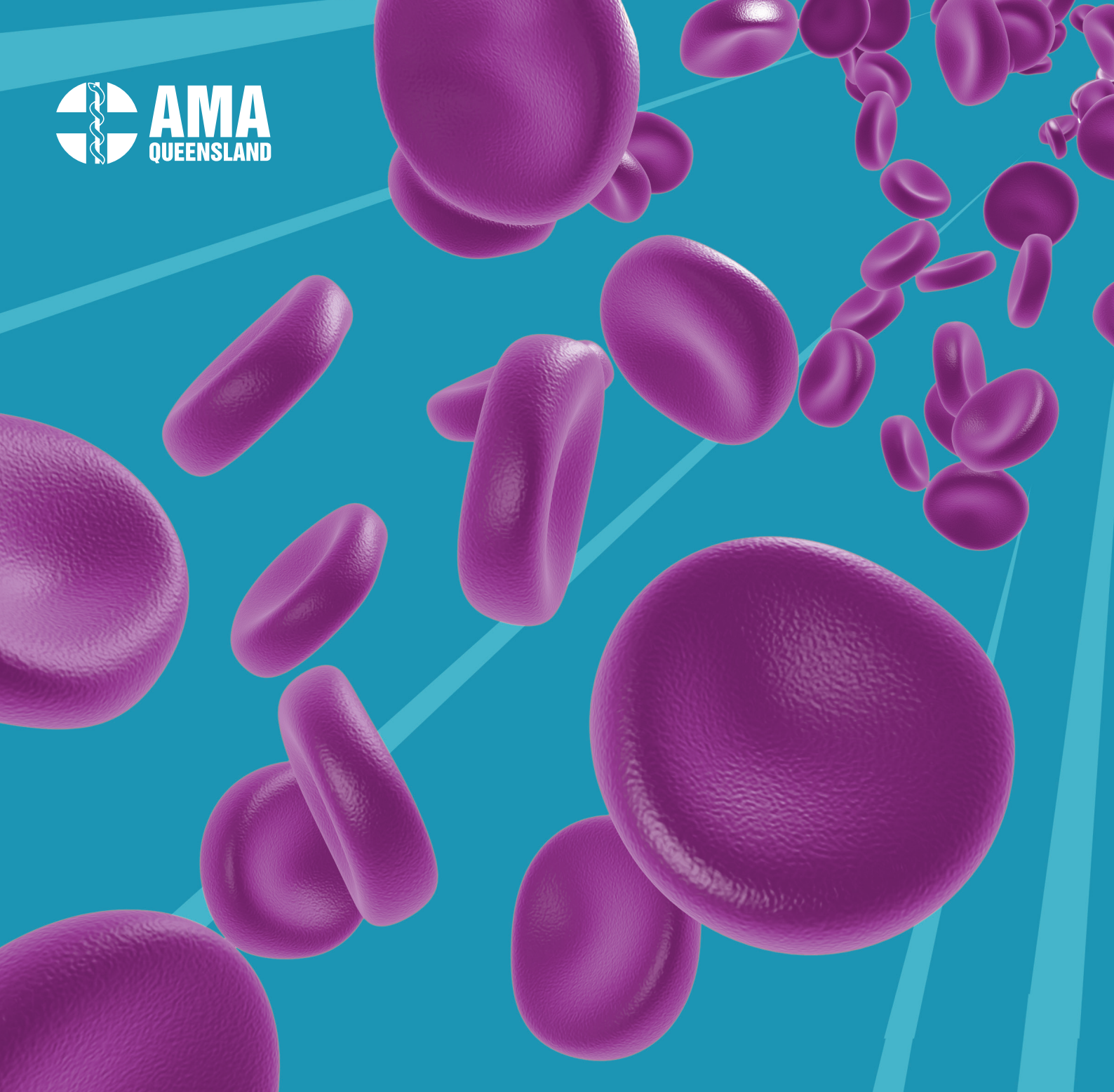
AMA QUEENSLAND



2014 AMA QUEENSLAND BUDGET SUBMISSION

CONTENTS

AN INTRODUCTION

The 2013-2014 Queensland Budget was something of a mixed bag for the Health Sector. On the one hand, the health and hospitals budget was boosted to a total of $12.3 billion, making it the biggest health budget in Queensland's history. However, this extra funding did not keep up with CPI or population growth and was not an across the board increase. Overall, there was much to welcome but there was also a lot of room for improvement to ensure essential surgical and public health services are maintained across the state.

Since the Budget was handed down, we have continued to see Hospital and Health Boards make budgetary decisions which appear to have austerity in mind, such as decisions around the cutting of administrative staff. These decisions have left doctors and nurses to perform paperwork and follow up calls which would ordinarily have been performed by dedicated administration officers. This is an unacceptable use of these skilled professionals time and is having a detrimental impact on patient waiting times and their health outcomes. AMA Queensland accepts the Queensland Government is keen to find efficiencies wherever it can, but we repeat our call that budget decisions must be open and consultative in funding decisions. Any further proposed changes to resource allocations must be supported by a comprehensive business case that encourages local dialogue and ensures greater accountability to the local community.

Many budget submissions ask Governments to commit to a series of spending initiatives, and in that respect at least, AMA Queensland's 2014-15 budget submission is no different. However, our submission also suggests a number of areas in which the Queensland Government can responsibly save money, with the savings generated being used to help fund some of the suggested new initiatives. These forward thinking savings measures have been identified by our Health Vision, and AMA Queensland strongly urges the Queensland Government to consider implementing them as a means toward delivering a more efficient and effective health care system for Queensland.

Later this year, AMA Queensland will launch its *Health Vision*, which is framed around the underlying values of compassion, trust and knowledge. This budget submission is informed by the work we have done in preparing the Health Vision, which was itself informed by the knowledge, dedication and feedback of AMA Queensland's strongest asset; its members. For this reason we are highly confident that the initiatives outlined in this submission will, if adopted by the Queensland Government, help bring about a health system which engenders the values of *AMA Queensland's Health Vision*.

END-OF-LIFE CARE

Doctors report that too many people enter hospitals at the end of their lives without having planned the type of care they would like to receive or discussed their preferences for quality of life with their families. This is problematic as almost a quarter of intensive care beds are occupied by patients receiving potentially inappropriate care, while up to a quarter of total health budgets are spent on inpatient care during the last 18 months of life without extending overall survival or impacting on quality of life.

This situation results in patients receiving care which does not benefit them and in some cases is harmful. This treatment is given often at great cost to the health system and may add to the stress of the patient and their families.

AMA Queensland's core value of compassion directs us to advocate that Queensland should commit to becoming a world leader in advance care planning. It could do this by providing training to its medical workforce on to ensure they are "conversation ready" and are committed to systematically talking with patients about their care preferences, documenting and enacting those wishes.

LOW UPTAKE OF FORMAL AND INFORMAL PRE-PLANNING FOR END-OF-LIFE CARE

Last year the *Medical Journal of Australia* (MJA) reported that there are grave deficiencies in the way that the Australian health system discusses, records and implements the wishes of patients who die in our hospitals. Studies suggest that up to 50% of patients may be "denied adequate opportunity to discuss end-of-life care wishes or have them fully enacted."[1]

Rates of take-up of legal instruments like advance care directives and enduring powers of attorney, and informal mechanisms like advance care planning are low. A 2011 Palliative Care Australia survey has found that just 32 per cent of respondents had discussed their preferences for end-of-life care and the quality of life that is acceptable to them with their families.[2] Greater education and awareness of the importance of planning for end-of-life care is needed, especially among high risk groups.

- Funding should be provided to ensure that all doctors are conversation ready. They should be able to recognise when palliative care is appropriate and start the conversation with patients and their families about whether they wish to receive it. This should be supported by appropriate outreach and training within hospitals.
- Funding should be provided to ensure that all people residing in Queensland nursing homes or receiving palliation should have an Advanced Care Plan (ACP) which can be readily accessed by their treating physician:
- Funding should be allocated to a statewide awareness campaign to educate Queenslanders about the benefits of advance care planning and how to start your advance care plan.

DOCTORS CANNOT EASILY ACCESS ADVANCE CARE PLANS WHEN THEY ARE NEEDED

Even when patients have expressed their wishes in an advance care plan or appointed a friend or family member as their decision maker, the system can fail often because doctors cannot access the patient's wishes or contact the appropriate decision-maker in a timely way. In the meantime, patients are receiving care which they do not want - which in some cases is of no benefit, and in others does more harm than good.

The way to solve this problem is to increase the uptake of advance care planning and make it easier for doctors to access the advance care plans of dying and incapacitated patients – so that patients can receive they care they would like at the end of their lives.

- AMA Queensland calls for a scoping study to establish a registry of advance care plans, advance care directives and powers of attorney. Plans should be easily uploadable by clinicians inside and outside Queensland Health, especially GPs. These plans should be flagged on the patient record and should be easily retrieved by the treating clinician.
- AMA Queensland strongly supports efforts by the Queensland Clinical Senate to produce a standardised Advance Care Plan. AMA Queensland advocates that funding should be allocated to ensure that the template is simple, patient friendly and easily accessible by all Queensland medical practitioners, including General Practitioners and those in private practice.
- AMA Queensland advocates that a regular audit of ACP processes should be undertaken and reported on. It should measure the level of congruence between expressed patient wishes and the care actually received.

1 Ian A Scott, Geoffrey K Mitchell, Elizabeth J Reymond and Michael P Daly. Difficult but necessary conversations — the case for advance care planning. *Med J Aust* 2013; 199 (10): 662-666.

2 Media Release: We need to talk about dying – survey. Palliative Care Australia May 2011. <http://www.palliativecare.org.au/Portals/46/National%20Palliative%20Care%20Week%20Media%20release.pdf> Accessed 20 March 2014.

INCREASE FUNDING FOR PALLIATIVE CARE IN AND OUT OF HOSPITAL

Once this has been done, additional resources will be needed to support the choices that patients make. Studies have shown that most Australians would prefer to die at home, yet most will die in acute care hospitals.[3] [4] Patients who wish to die at home now require a strong network of carers along with appropriately trained and funded medical practitioners and nursing staff. Those that do not have strong informal networks do not have the option to choose.

- AMA Queensland welcomes the government's initiative to provide Hospital in the Home Services in Brisbane, the Sunshine Coast and Townsville – we call on the government to expand these services to palliative care statewide.

Making ACP mainstream within Queensland is undoubtedly a big change but above all it is a *compassionate* change, with many overall benefits. By fostering a culture where doctors talk to their patients and families about their wishes for treatment, the Queensland Government will be ensuring the wishes of patients will be supported and carried through. It has also been shown that the stress and the grief felt by patients and their families who have had this conversation is lessened when conversations about death and dying have occurred in advance.[5] Furthermore, there is also evidence that dying outside an intensive care unit is cheaper and less painful. One study has found that cancer patients managed palliatively may out-survive those treated more aggressively, and that talking about death in advance is associated with both lower cost of dying and a better death.[6]

3 Media Release: We need to talk about dying – survey. Palliative Care Australia May 2011. <http://www.palliativecare.org.au/Portals/46/National%20Palliative%20Care%20Week%20Media%20release.pdf> Accessed 20 March 2014.

4 Lorna K Rosenwax, Beverley A McNamara, Kevin Murray, Rebecca J McCabe, Samar M Aoun and David C Currow. Hospital and emergency department use in the last year of life: a baseline for future modifications to end-of-life care. *Med J Aust* 2011; 194 (11): 570-573.

5 Detering, Hancock, Reade and Silvester. The impact of advance care planning on end of life care in elderly patients: randomised controlled trial. *BMJ* 2010; 340.

6 Temel et al. Early palliative care for patients with metastatic non-small-cell lung cancer. *N Engl J Med* 2010;363:733-42

REPRIORITISING CARE IN RESPONSE TO CHANGING DEMANDS

The evolving challenges to the health system in Queensland are well understood. An ageing population, increasing rates of chronic disease, increased demand for medical services and advances in medical research all point to the success of the medical system at keeping Queenslanders alive and healthier for longer. However, these factors also pose a threat to the system – its success means that use of the system is consuming more community resources and its cost is outpacing the growth of the economy.

Facing this challenge will involve a reprioritising of the care that the health system provides. This reorientation must occur in open consultation with clinicians and the public, reflecting the real values and needs of our community.

Decisions relating to the planning and resourcing of health services are currently left to Hospital and Health Boards which have tight budgets and short-term accountabilities with much emphasis placed on end-level outcomes like elective surgery and emergency department waiting times.

AMA Queensland applauds Queensland Health for its significant progress in these two areas, progress which was achieved by consulting with clinicians on the ground. We also welcome the move toward actively monitoring hospital outputs. However, these indicators by themselves will not tell us if the work of hospitals and the health sector is providing benefit to the community. A more nuanced approach is needed, one which measures the benefit provided to the community and ensures that the most vulnerable are not left behind in the rush for the best average.

Clearly, the way that services are provided and funding allocated has to change. AMA Queensland believes that the medical profession's values of trust and knowledge should guide this process. Decisions taken should be made with access to appropriate data and research, with effective guidelines (dictated by community values) to outline which are the areas of care that will provide the highest value to the community and to patients. This should be done through a transparent and independent process.

COMMUNICATE EFFECTIVELY WITH CLINICIANS AND THE COMMUNITY ABOUT WHAT HEALTH CARE CAN BE AFFORDED AND START AN HONEST DISCUSSION ABOUT WHERE THE FUNDING SHOULD BE DIRECTED.

AMA Queensland believes that decisions about what health care is provided and planned in Queensland should be made in consultation with clinicians and the community and should be made with regard to the values that guide us. Honest and detailed information should be made available to all Queenslanders about the current and future costs of healthcare and its ongoing affordability.

TRANSPARENT DECISION-MAKING

Funding should be allocated to research the development of clinical groups to systematically monitor the cost, health benefits and outcomes of services and procedures carried out in the public system. These groups should consider the value provided by each service and should make recommendations on which services should be funded. Treatments which are of poor value or ineffective should be discontinued.

BETTER PRIORITISE HEALTH FUNDING

AMA Queensland welcomes the government's *Queensland Plan* initiative and notes that Queenslanders want a greater focus on public and population health and on Closing the Gap. AMA Queensland also welcomes the excellent work of the Queensland Clinical Senate in promoting the best use of health resources in Queensland. It is an excellent example of the value of clinical leadership within the system. More can be done to ensure that health funding meets the needs and values of the community.

- Better prioritise the provision of existing services by continuing to accelerate the development of criteria-led referrals for specialist outpatient services. Introduce assessment criteria for prioritising elective surgery that are inclusive of social and economic cost of delayed treatment.
- Ensure that paediatric care is not left behind as failures of health care can affect child development with lifelong consequences. Increase investment in specialist outpatient and elective surgery services for children especially in the areas of ENT, neurology and neurosurgery.
- Place greater importance on Close the Gap targets by including them as Tier One KPIs of Hospital and Health Services (HHS) and link them with bonus funding if targets are met.
- In light of the *Vicious Lawless Association Disestablishment Act 2013*, which will likely see Queensland incarcerate more prisoners over a longer period of time, and recent news that Queensland is holding more prisoners than ever before, AMA Queensland recommends the Government increase funding to pay for more doctors and nurses in prisons – especially in the area of mental health as solitary confinement has been found to have lasting impacts on the mental health of prisoners.

BETTER DATA SHOULD BE AVAILABLE TO ALL

AMA Queensland believes that clinicians are the best asset of the health system and that they should be given the information to allow them to reflect on and adjust their work practices to provide the greatest value to the Queensland community. The health system should also report on the value it provides to the community, not just the number of services it provides.

- Better data should be available to the public so that they can monitor the benefit delivered by the health system. The Queensland Government should create procedures which analyse and report on the quality adjusted life year yield of medical services. Report annually on the number of QALY's created by each HHS (adjusted for age and population).
- The Queensland Government should commission new research and economic modeling that contrasts the key demographic, social and environmental factors driving up the cost of healthcare with the Government's ability to pay for these services over the next 30-years.
- Provide data internally to doctors, clinicians and other managers on the comparative performance of their units –relative to other Queensland Hospitals, both in terms of budget and patient outcomes

UNIFYING THE HEALTH SYSTEM

Queensland's health system is fractured along the fault lines of different funding agreements and mechanisms from the Queensland and Federal governments, lack of connection between General Practice, private specialists and hospital care, and public and private providers.

While AMA Queensland welcomes the significant improvements to these areas brought about by the National Healthcare Reform Agreement, the General Practice Liaison Officer Program and greater connection with private enterprise encouraged by the government, there are still vast gaps in Queensland's health system which patients, sick, vulnerable and often without strong support networks, often fall through.

These gaps and missed connections in the health care system create duplication, inefficiency, over and under servicing of different groups, and it erodes respect and collegiality within the medical and clinical workforce.

As the health system faces the challenges of a changing demographic – an ageing population, increasing rates of chronic disease and greater demand for health care – it must take full advantage of the synergies that exist. All parts of the health system should operate together, like a team aiming for the same goal, rather than a football match where the patient is the football.

CREATE COHESION IN HEALTH CARE BY ENSURING THAT EVERY PERSON HAS THEIR OWN GP

One of the best ways to create a cohesive health system for the patient is to ensure that every person has their own GP. GPs form lasting and effective therapeutic relationships with their patients. They coordinate care and act as the patient's advocate and health manager at the same time as providing primary health care and preventative health care advice.

Their role in coordinating care and keeping patients healthy, communicating with hospitals and specialists and supporting families provides great value to the Queensland health system.

- The Queensland Government should improve health literacy by ensuring every Queenslander has their own GP. A targeted media campaign should be developed to educate the community on finding a General Practitioner who is right for them and making them their own GP. The campaign would emphasise the health benefits of having your own GP such as a life-long approach to your health care and the benefits of health literacy.
- 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, Toowoomba. The trial involved visits by physicians and psychiatrists into rural general practices to provide specialist care to patients and upskill 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 statewide.
- Good relationships and communication between general practice and the hospital sector is an important factor in creating a seamless health system and reducing unnecessary referrals, and duplication of services. Hospital and Health Services should be required to effectively engage with GPs in their area and should develop an annual survey to measure their success. This GP engagement survey should be used as a KPI for measuring the performance of Hospital and Health Services. AMA Queensland recommends the General Practice Liaison Officer (GPLO) program be funded past the original two year mark and extended beyond the current number of 20 positions.
- 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. Queensland Health should investigate the development of a statewide, standardised, online pathway for GPs and patients which would allow them to track their position on the waiting list and the length of time to be waited. This will allow patients to make an informed choice about the type of care they access.

A WELL-TRAINED, ENGAGED HEALTH WORKFORCE FOR ALL QUEENSLAND

Australia is suffering both from both health workforce shortage and maldistribution. Without change, the level of care Australians can expect will be limited. In particular there are concerns about the availability of high quality health services as a result of a predicted workforce shortage of 2,700 doctors,[7] maldistribution of the medical workforce resulting in less accessible services for rural, remote and outer metropolitan areas, and, bottlenecks, inefficiency and insufficient capacity in the training system, especially for doctors.

A huge increase in medical student graduates over the past decade means that training programs, both vocational and pre-vocational, are under-resourced to meet the required training needs. The way Queensland trains and recruits doctors must adapt by tapping into the unrealised potential of the private sector to teach and train graduates and increase the number of generalist practitioners to provide cost-effective primary and secondary care to the community. AMA Queensland recognises the success the Queensland Government has had in placing all domestic interns in 2013. However we remain concerned that Queensland is losing talent in second and fourth year doctors who move interstate and overseas for work or training. It is important to ensure job opportunities are available in Queensland to retain this talent.

There is also an urgent need to redistribute the health workforce to rural and regional areas and Aboriginal and Torres Strait Islander and other underserved communities where there is, according to the Mason Review, an "inadequate or non-existent service provision in some rural and remote areas, and to populations of extreme disadvantage."[8]

However, in Queensland, providing an adequate health workforce to meet the needs of the community may be particularly challenging because of the recent dispute over doctors' contracts. This conflict has the potential to drive many doctors away from the public health system and make recruitment and retention even harder. AMA Queensland advocates for the introduction of fair and equitable contracts which recognise the contribution of doctors to Queensland Health and Queensland communities, especially rural and remote communities.

INCREASE TRAINING, SUPPORT AND RECOGNITION FOR DOCTORS WHO UNDERTAKE RURAL SERVICE

Rural and remote areas do not have access to the same level of medical care as their metropolitan counterparts. In 2011, major cities had 433 doctors per 100,000, while outer regional areas had only 247.[9] Lower rates of medical practitioners combined with long distances between health services means that access to medical care is significantly reduced in regional and rural areas.

Evidence presented to the Mason Review suggests that students who come from rural backgrounds or spend well-supported time training in a rural setting will be more likely to pursue a rural career on graduating.[10] While the Queensland Rural Generalist Program has done much to improve this situation, more can be done, especially in the area of attracting and training community GPs.

While the Queensland Rural Generalist Program has done much to improve this situation, more can be done, especially in the area of attracting and training community GPs.

- Put structures in place to provide formalised recognition for rural service, including increased career opportunities for those junior doctors who undertake rural and remote service. These initiatives should include a mentoring program to support junior doctors who are often isolated, recognition of prior service in a rural area when making applications for employment in metro areas at a later date and, easy access to improved training and support delivered through Telehealth.

- Provide funds to investigate how the "Easy Entry, Gracious Exit" model established by the Rural and Remote Medical Services in New South Wales[11] could be adopted and established in Queensland in partnership with local councils. This program aims to make general practice in these difficult areas more attractive by enabling GPs to work as clinicians without having to be small business owners and managers. This model has been successful in maintaining a continuous medical practice in several remote areas of North West NSW. The Assistant Minister for

7 Health Workforce Australia 2012: Health Workforce 2025 – Doctors, Nurses and Midwives – Volume 1.

8 Review of Australian Government Health Workforce Programs (Mason Review). 2013. Australian Government: Canberra.

9 AIHW 2013. Medical workforce 2011. National health workforce series. Cat. no. HWL 49. Canberra: AIHW, at 29.

10 Review of Australian Government Health Workforce Programs (Mason Review). Australian Government 2013

11 Website of the Rural and Remote Medical Services <http://www.rarms.com.au/site/index.cfm?display=132253> 20 March 2014

Health, as Champion for Rural Health, would lead this process and initiate discussions with other State Government departments as necessary.

- Increase regionally based training for students and doctors-in-training – especially longer placements. Queensland Health should work with the Federal Government and the private sector to deliver more private, rural based training for doctors. As recommended by the Mason Review, this engagement should be planned and should include consideration as to how providers of professional development training funded through Rural Health Continuing Education can be linked with similar organisations, like the University Departments of Rural Health, to benefit from shared approaches and economies of scale.

INVEST IN THE WELLBEING OF DOCTORS WHO EXPERIENCE HIGH RATES OF STRESS AND BURNOUT

Doctors suffer from higher than normal rates of stress, depression and burnout than other members of the community. A recent *Beyond Blue* survey of doctors and medical students has shown that doctors suffer from more than twice the level of very high psychological distress than the general population and more than ten times the level of other professionals.[12] Doctors also reported higher levels of general depression and anxiety than the general population.[13]

Young doctors were especially susceptible to mental health difficulties, with young doctors exhibiting higher levels of burnout, emotional exhaustion and cynicism – suggesting the transition into the workforce may need additional support.

AMA Queensland recommends the Queensland Government invests in the following initiatives to help improve the overall health of doctors within Queensland.

- Improve the coping skills of the medical cohort through evidence-based training. Studies have shown that "mindful listening" (the ability to be fully present and attentive in the moment) is a useful remedy in treating burnout amongst doctors.[14] Mindfulness training can help doctors become more focused, more empathetic and less emotionally exhausted. This resulted in better outcomes for patients and greater efficiency gains. The training is time intensive and can take up to six weeks to complete. The Queensland Government should ensure that evidence-based training of this type is available and heavily promoted to all doctors and that any doctor wishing to undertake the training be given the time to attend and fully complete the course.

- It has been estimated that up to 40 per cent of GPs do not have their own identifiable GP, with many doctors preferring to consult their spouse or practice partner. Therefore, as part of the campaign to ensure every Queenslander has their own GP (see the Public Health section of this submission), the Queensland Government should commit to a sub-campaign specifically targeting doctors themselves.

- Better utilise the Clinician Engagement requirement in the legislation – better monitor the implementation of the clinician engagement strategies and utilise a clinician engagement survey to evaluate the health and wellbeing of the health workforce..

12 National Mental Health Survey of Doctors and Medical Students. October 2013. Beyond Blue..

13 Ibid

14 Beach et al. A Multicenter Study of Physician Mindfulness and Health Care Quality. Ann Fam Med September/October 2013 vol. 11 no 5. 421-428.

PUBLIC HEALTH AND GENERATIONAL DISADVANTAGE

Both the state and federal governments have dropped the ball on population level health. Funding has been cut for important programs delivering education and preventive health care. Important data-gathering and research institutions, like the Queensland Trauma Registry and the National Preventive Health Agency, have had funding cut or are under threat. Without good health at a population level, and good information to guide the provision of services, the health system will not be able to keep pace with the treatments needed to ensure that Queenslanders have the best change to live healthily into old age.

Of greatest concern is that Queensland is not on track to *Close the Gap* in health and life expectancy by 2030.[15]

AMA Queensland notes that the focus of the health targets in the draft *Queensland Plan* is on public and preventive health, and, closing the gap. Queenslanders clearly support the role of government in supporting good lifestyle choices which will make it easier for them to live longer, healthier and more productive lives.

The government must invest in public health institutions and services with long term value for the health system, including statewide reporting, coordination and data analysis, early intervention services which improve health over the lifetime, especially pre-natal and early childhood health, and, reductions in harmful practices including smoking, drinking excessive amounts of alcohol. Care should also be given to including promoting good mental health and coping skills to the population, to assist in creating and maintaining a health outlook.

INVEST IN PUBLIC HEALTH INITIATIVES

The Queensland Government should invest in preventative health programs that have a proven track record in improving health and well-being and reducing demand for hospital services. This investment will pay dividends in the future, easing pressure on future Budgets and allowing further investments to be made.

For example, the Queensland Government could refund the Queensland Trauma Registry, which maximised the benefits of care provided by the Public Health System to people hospitalised in Queensland for serious injury by fostering best practice in data collection, clinical review and scientific research. The decision to close the QTR is a danger to the safety of Queenslanders and their long term health outcomes.

CLOSING THE GAP

In AMA Queensland's 2013 Budget submission, we signaled our belief that Queensland's *Close the Gap Statement of Intent* required increased investment into Aboriginal and Torres Strait Islander health in Queensland.

Instead, we have seen the Queensland Government actively reduce its role in delivering health services to Aboriginal and Torres Strait Islander Queenslanders, particularly in Far North Queensland which is home to almost 26 per cent of Queensland's Aboriginal and Torres Strait Islander population.

AMA Queensland has received advice that the cuts in the Cape York HHS and Torres Strait HHS have reduced the service quality of a number of services to the region's largely Aboriginal and Torres Strait Islander population, including smoking cessation services and PAP smears. Reversing cuts to staff and programs in these regions is of the utmost importance. The government should;

- Renew commitment to funding the *Closing the Gap in Indigenous Health Outcomes* National Partnership Agreement for a further five-years.
- Formalise communication protocols between Hospital and Health Services and local Aboriginal and Torres Strait Islander community-controlled health services to ensure that, following a stay in hospital, each patient's clinical information is accurately reported back to their medical home.
- Place greater importance on Close the Gap targets by including them as Tier One KPIs of Hospital and Health Services (HHS) and link them with bonus funding if targets are met.

IMPROVE SERVICES FOR 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.[16] The most recent data indicates Queensland continues to fall significantly behind other States including Western Australia, South Australia and Tasmania in per capita expenditure on mental health.[17] The establishment of the Mental Health Commission is a good first step but the Government must ensure it has appropriate funding equivalent to the disease burden so it can hit the ground running.

15 Closing the Gap Prime Minister's Report2014. Australian Government: Canberra.

16 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.

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

- Provide the Mental Health Commission with powers to report on the distribution of mental health funds to hospital and health services, including on adequacy of funding.
- Invest in step-down facilities to support those leaving hospitals following acute episodes and free up acute hospital beds.

RURAL HEALTH

Queensland has the most decentralised population in Australia with nearly 25 per cent of its population in outer regional and rural centres; more than double that of any other state.[18] This places Queenslanders at greater health risk, as living in rural areas is associated with poorer health outcomes.

The five year survival of people diagnosed with cancer decreases as their remoteness increases; survival is lowest for people living in remote and very remote areas.[19] Overall, life expectancy in rural and remote areas is, on average, one to two years less than the city.[20] Lower numbers of medical practitioners combined with long distances between health services means that access to medical care is significantly reduced in regional and rural areas.[21]

Rural and remote populations deserve access to quality medical and health care so they can achieve their health potential.

- Designate the Assistant Minister for Health as the Champion for Rural Health. In this role he would be responsible for creating partnerships with other State Government agencies as well as meeting with other levels of Government and NGOs to coordinate efforts and deliver better targeted and more integrated services for improving Rural Health outcomes. This will help to overcome any administrative barriers that impede constructive responses to rural health needs.
- Task the Assistant Minister (in cooperation with the state-wide Clinical Networks) with responsibility for developing strategies to redress the current disadvantage rural Queenslanders experience in key priority areas such as diabetes, cancer, heart disease, and mental health.
- Provide rural infrastructure grants to general practices to expand access to telehealth and acute primary care services in small rural communities.

PROMOTE GOOD NUTRITION AND LIFESTYLE DECISIONS, TO PREVENT HEART DISEASE, CANCER, OBESITY AND DIABETES

AMA Queensland welcomes the government's moves toward a greater emphasis on preventive and public health, including the 'Mums and Bubs' program, recent indications that the government will get tough on tobacco and increased awareness campaigns on HIV and other sexually transmitted diseases.

These initiatives must be supported by appropriate clinical services to assist in the maintenance of healthy life choices and provide early intervention to keep Queenslanders healthy.

The Queensland Government must work with other levels of government, non-government organisations, the health and food industries, the media, employers, schools and community organisations and commit to;

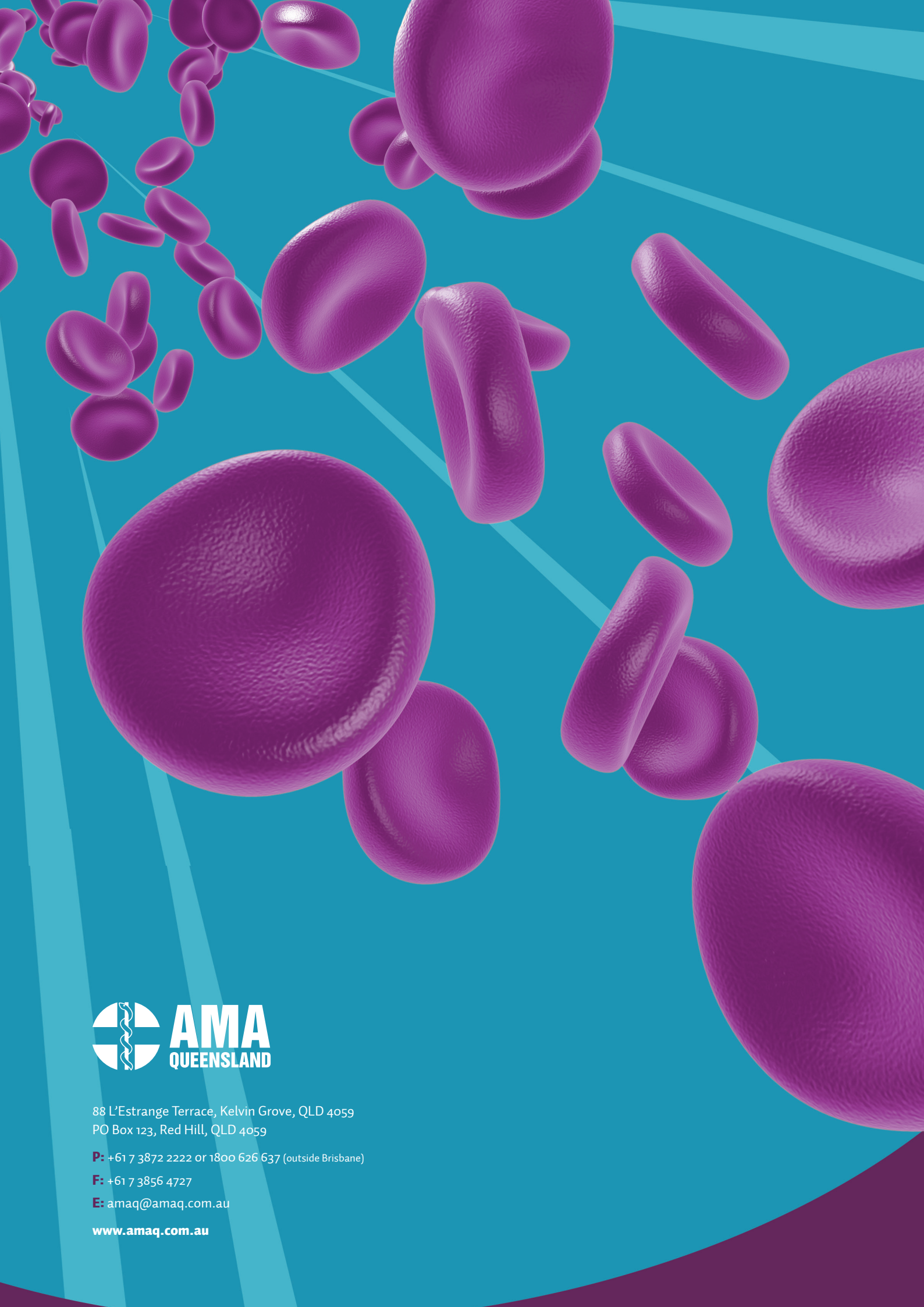
- Whole of school curriculum programs around nutrition with the provision of only healthy food choices in the school context, should be promoted so that children have a greater capacity for nutritional literacy, and for making healthy choices later in life.
- Advocate positively in COAG for;
  - banning junk food advertising to children as well as a simple and uniform 'front of pack' system of nutritional labelling for packaged food
  - subsidising healthy foods like fruit and vegetables to ensure their prices become and remain very low, particularly in remote areas
- Work with local councils to ensure urban planning regulations for new housing developments make provision for local access to retail outlets for fruit and vegetables (eg. local grocery stores or supermarkets)
- Target high-risk or vulnerable groups under the Queensland Government's "Healthier. Happier" plan, such as Aboriginal and Torres Strait Islander peoples and people from lower income groups.
- Establish an online clearinghouse for which interventions work in tackling obesity, for the collection and sharing of information about their successes and challenges.

18 Andrew Wilson. 2012. *Queensland's top five health priorities this election*. The Conversation <http://theconversation.edu.au/queenslands-top-five-health-priorities-this-election-5923> at 18 February 2013.

19 AIHW 2012. *Australia's health 2012*. Australia's health no. 13. Cat. no. AUS 156. Canberra: AIHW, p 263.

20 AIHW 2008. Rural, regional and remote health: indicators of health status and determinants of health. Cat. no. PHE 97. Canberra: AIHW, p 51

21 AIHW 2013. Medical workforce 2011. National health workforce series. Cat. no. HWL 49. Canberra: AIHW, at 29.



AMA QUEENSLAND

88 L'Estrange Terrace, Kelvin Grove, QLD 4059
PO Box 123, Red Hill, QLD 4059

P: +61 7 3872 2222 or 1800 626 637 (outside Brisbane)

F: +61 7 3856 4727

E: amaq@amaq.com.au

www.amaq.com.au