AMA QUEENSLAND

AMA QUEENSLAND'S

HEALTH VISION

PART FIVE: CARE AT THE END OF LIFE

EXECUTIVE SUMMARY

It is a fact of life that everyone will die. Most of us will not die suddenly, but will have our death unfold over a period of time. This is true regardless of our socioeconomic status or how healthy or unhealthy we are. Despite this, compared to other factors that influence health outcomes, such as obesity and smoking, dealing with death and the care of the dying person attracts far less attention and funding in our health system.

AMA Queensland believes this needs to change. We know Australia has an aging population[1]. People are living longer but with multiple and more complex conditions requiring more complex health care. This reality affects the care that is provided at the end of a person's life.

Evidence shows most people who need palliative care services in Queensland will be treated not by a specialist service, but by their family general practitioner (GP). Others will be treated by a doctor working in our public hospital system. The latter is making death and dying in Australia "institutionalised" which is a very poor result considering 70 per cent of Australians want to die at home but only about 14 per cent actually do[2]. We believe compassionate change must be enacted to ensure our doctors and clinicians are able to effectively care for their patients, and that, where possible, the wishes of patients and their loved ones are respected.

Like all other Australians, Queensland patients and their families face difficult choices about how they will spend their dying days. If a patient loses the capacity to make their own decisions, families and health practitioners will want to honour the wishes of the dying person; however, the low numbers of people who have a documented Advance Health Directive (AHD) mean doctors and families may face confusion and a lack of direction about the level of care to provide, including what care the patient would or would not want to receive at the end of their life.

The reasons for this are many and varied. It is often difficult to identify patients who are at the end of life and there may be cultural reasons that prevent doctors from discussing end-of-life care with patients, and vice versa. There can often be confusion as to the end-of-life decision-making process and who should initiate conversations on the topic. Some patients may simply be unaware that end-of-life care options, such as palliative care, are available.

For practical and compassionate reasons, AMA Queensland believes Queensland should become a leader in end-of-life care in Australia. Evidence from our members and others working within the sector indicates Queensland's spending on palliative care is inadequate. To this end, we believe the first step is to **ensure planning commences now to ensure that palliative care funding, staff and infrastructure is meeting the needs of patients by 2022**. This will require greater funding for specialist palliative care services and a focus on multidisciplinary palliative care training for all providers of palliative care within the medical, nursing and allied health professions, as well as within the community and social care.

There are number of steps that should be taken to improve the care of those approaching the end of their life:

Step 1: Doctors should be supported to recognise when patients are approaching the end of their life and to learn how better to communicate this to their patients so as to avoid futile or burdensome treatments.

Step 2: Access to, and use of, advanced care planning must be improved. This can be achieved through the following actions:

i. Develop and deliver an educational campaign aimed at doctors and the public on the benefits of advance care planning.

ii. Work with Queensland Health to help implement Queensland's strategy for end-of-life care, particularly in the development of potential guidelines that prepare doctors to become "conversation ready" to have end-of-life planning discussions with patients and their families.

iii. Use the My Health Record and Queensland Health's Integrated Electronic Medical Record (iEMR) system to improve access to care plans within and external to the public hospital system, subject to all appropriate privacy requirements. Such a system would keep only the true and final record of the patient's wishes, giving clinicians confidence that the document they access via the record is their patient's most recent care plan.

Step 3: Ensure health practitioners, particularly doctors, in all fields of health care delivery, develop the skills to provide appropriate care to those at the end of their life. Much of this care can and should be provided by non-specialists, particularly general practitioners. However, for complex problems and to support non-specialist care, specialist palliative care services should be developed to match demand across the state.

AMA Queensland recognises the important work that many other organisations have contributed to this important area of health care, many of whom we have worked and consulted with to refine and strengthen this part of the *Health Vision*. We thank them all for the assistance and contributions they have made.

CARE AT THE END OF LIFE IN QUEENSLAND TODAY

Care at the end-of-life in Queensland is in urgent need of review and improvement. Evidence provided to a Queensland Parliamentary committee in 2013 indicated there was significant unmet need for palliative care in Queensland and this gap was continuing to grow. Access to palliative care services was deemed to be largely based on factors such as the patient's age, location and diagnosis. Cultural background and the level of education of the treating health care professional were also factors determining the type and level of care accessed.[3] The report, presented by the parliamentary committee, concluded specialist services in Queensland are "understaffed, under-resourced, mostly have insufficient beds, and do not have the capacity to provide adequate community care and after-hours cover."[4]

Reliable data on the use and uptake of palliative care is difficult to come by, given a lack of data on funding and expenditure on palliative care at a state level[5]. However, Palliative Care Queensland estimated the total amount of funding available to specialist palliative care services was $77.81M, including $8.1M of Commonwealth funding in 2012. In that year, Queensland's population was estimated to be 4,610,932[6], with 28,300 registered deaths[7]. Queensland's population is estimated to reach 5,488,667 by 2020, with expected deaths to reach 32,932. Our specialist palliative care services are already stretched, with referrals to services increasing annually by 20 per cent while funding is only expected to increase by an annual 12.9 per cent.[8] Despite this, the quality of palliative care services has been maintained, but this has come about through rationing of services, such as limiting palliative care to only the predicted last three months of life as opposed to the recommended six months[9]. A strategic injection of funds is urgently required to help our palliative care services meet demand and give our most vulnerable Queenslanders the care they need at the end of their life.

On top of the low rate of funding for palliative care services, as in other states, laws that guide advance care plans and advance health directives within Queensland and across the country are inconsistent and confusing. Every state has different laws using different terminology to create or recognise different types of advance care directives or medical powers of attorney, which take effect under different clinical conditions.

This situation is undesirable for the following reasons:

- The current state of the law may cause confusion for health workers, patients and families, particularly when there is interstate movement
- The current jurisdictional differences make a national database impractical

In Queensland, advance care planning may be manifest through one or more of the following distinct documents, namely:

- **Enduring Power of Attorney (EPOA) :** To appoint a substitute decision maker (for health and/or financial matters) for when the patient loses capacity.
- **Advance Health Directive (AHD):** A document that records wishes regarding future medical treatments that comes into effect when the patient loses capacity.
- **Statement of Choices:** A document that records a person's wishes to assist the substitute decision maker and doctor in making appropriate treatment decisions when capacity is lost.
- **Acute Resuscitation Plan (ARP):** an ARP is a medical order that describes the nature of the treatment that will and will not be provided for a patient. It is the product of a direct discussion between the doctor and their patient (or the substitute decision-maker in the event that the patients lacks capacity). It records the agreed treatment plan as expressed at the time, or as recorded in an AHD, as required by an appointed public guardian, as expressed by their EPOA(s) acting in their interests or, last in priority, by their statutory health attorney also acting in their interests.

An enduring power of attorney enables a person to appoint a third party to decisions on their behalf in the event that they lose the capacity to do so themselves.

An advance health directive allows an adult to give directions, about health matters and special health matters, for his or her future health care.[10] It only operates while the person has impaired capacity for the matter covered by the direction and has the same effect as if the person, with full capacity, had made the same decision.[11] Medical practitioners are generally protected for having followed an advanced health directive to the same extent as if the principal had consented to the treatment.[12]

OBSTACLES TO EFFECTIVE ADVANCE CARE PLANNING

Advance care planning (ACP) is a vital tool in ensuring the wishes of Queenslanders can be met at one of their most vulnerable stages in life. Despite the importance of this planning and the concept having existed since the early 1970s, there is low awareness of the value of ACP in the community. This is likely due to a variety of barriers such as;

- **Avoidance of acknowledging death and dying:** The predominant barrier to effective advance care planning is the societal and cultural stigma attached to discussions around death and dying. Despite the inevitability of death, many of us avoid thinking about our own mortality, or serious illness, until it is too late. Most individuals, including clinicians, prefer to avoid thinking and talking about death and dying,[13] however many patients report feeling relieved once their doctor has raised the issue. There can also be cultural factors, where clinicians are unsure of how to raise the topic for fear of touching on cultural taboos.
- **Uncertainty about when to initiate ACP discussions:** Clinicians can be unsure of when to start discussing advance care planning with patients. If the discussion is held too early, it can undermine the patient's coping strategies or deter them from participating in self-management activities.[14] Compounding this, clinical uncertainty about the progression of the illness can blur the timelines within which advanced care planning can, or should, occur.[15] These factors can delay vital conversations about advance care planning between clinicians and patients until it's too late.
- **Uncertainty about who should initiate ACP discussions:** The question of who should initiate the advance care planning discussion remains. Where there are complex co-morbidities, several members of the treating team may be capable of initiating the conversation, however, they may reasonably expect that another team member will take on this role. The general practitioner, who in many cases has known the patient for the longest period, could be waiting for the specialist to raise the issue. The specialist, who is managing the condition that requires AHDs, may feel it is inappropriate to raise it given their comparatively limited engagement with the patient. Both clinicians may be waiting for the patient and their family to raise the issue. The end result is that the treating team can miss the opportunity to have this vital discussion of advance care planning until it is too late. [16]
- **Access to a copy of the most recent AHD:** Even where a person has made a legally valid AHD there may be difficulties in providing the relevant clinicians with a copy. Advance health directives need to be immediately accessible to health care staff, hence, storage and access must be proactively addressed with the person at the time of drafting and also within health care organisations. Plans that are outdated or inaccessible can erode clinicians' trust to rely on the AHD as a valid expression of the patient's wishes. Hence, easy access to a current, valid AHD is critical in empowering clinicians to support a patient wishes at the end of their life.
- **Cultural considerations:** Cultural considerations present another possible barrier to greater rates of advance care planning. As a multicultural society, health care organisations and staff must respect and accommodate cultural diversity. For instance, in a small descriptive study of Aboriginal people living in the Northern Territory, researchers found if information was not communicated in the "right way" through the "right story" to the "right people," the sick person could be left frightened and anxious. In East Asian cultures it is widely regarded as inappropriate and wrong to talk about diagnoses of end-stage illnesses, such as cancer.[17]

Research has also shown patients of minority cultural and language backgrounds are fearful that if they complete advance care plans and advance directives in a mainstream health care context, they may be left to die in instances where further medical intervention could improve their health outcomes. Thus, they hold fears that not only might they not benefit from policies on advance care planning and advance directives but that these might actually work to their detriment.[18] Such concerns may be held by other members of the community as well.

The under-resourcing of palliative care, and the confusion and inconsistency that surrounds planning and decision making at the end-of-life, is leading to poor care for Queenslanders and their families. AMA Queensland members confirm that too many people are entering 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 failure to plan appropriately is leading to the institutionalisation of death and dying in Australia.[19]

Community and medical attitudes plus a lack of funds for formal community care mean that about half of Australians die in hospital, and about a third in residential care. Often they have impersonal, lingering and lonely deaths; many feel disempowered. Seventy per cent of people want to die at home, yet only about 14 per cent do so. People are twice as likely to die at home in countries such as New Zealand, the United States, Ireland and France.[20]

Although we acknowledge a 2015 BMJ article which disputes the claim 70 per cent of people wish to die at home[21], the fact remains that almost one quarter of intensive care beds are being occupied by patients receiving potentially inappropriate care[22]. 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[23]. Dying outside an intensive care unit is less costly, less painful and more desired by patients[24]. Additionally, in some instances, cancer patients managed palliatively may out-survive those treated more aggressively[25], thus, demonstrating that people's choices with respect to end-of-life care can bring psychological and financial benefits.

AMA Queensland believes the next five years provide the Queensland Government with an opportunity to leave an indelible mark on the face of our society. Supporting best practice in end-of-life care and empowering Queenslanders to have a good death are issues that are gaining mainstream traction. A government which recognises this and makes itself a leader in insisting on a humane approach to support people at end-of-life is one that will cement its legacy as a compassionate, connected and reform-driven administration.

AMA QUEENSLAND'S VISION FOR CARE AT THE END-OF-LIFE

AMA Queensland's core value of compassion compels us to become national leaders in care at the end-of-life. Queenslanders can and should expect compassionate care at the end of their (or a family member's) life. The wishes of some our most vulnerable Queenslanders should be respected and valued. Doctors and other health workers should be supported to enhance their skills, knowledge and confidence when working with patients approaching the end of their life. The stress and the grief felt by patients and their families can be lessened when conversations about death and dying have been facilitated early in the course of an illness by experienced and skilled practitioners.26

AMA Queensland wants to ensure Queensland becomes a compassionate state that respects and honours the wishes of Queenslanders about the end of their life. To this end, we offer the following two targets:

TARGET ONE

BY 2022, PALLIATIVE CARE IN QUEENSLAND IS MEETING PATIENT NEED

AMA Queensland believes that planning must start now to ensure planning commences now to ensure that palliative care funding, staff and infrastructure is meeting the needs of patients by 2022. As part of this a strategic injection of funding will be required to help ensure Queensland's struggling palliative care sector is meeting demand. This funding should be targeted at the following initiatives:

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

Funding: AMA Queensland believes the State and Federal Governments should be responsible for ensuring the provision of comprehensive palliative care services to all Queenslanders, within a coordinated, strategic framework. Emphasis should be placed upon the need for the provision of adequate long-term and recurrent funding to enable the implementation of a sustainable, equitable palliative care policy for Queensland. We call upon the Queensland Government to establish as a priority the infrastructure necessary to enable health care providers to efficiently and compassionately address the growing need for palliative care services in Queensland. We also call upon the Federal Government to increase its funding of the National Palliative Care scheme as part of an expected 2017 review. [27]

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

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

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

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

Care should be provided in the location of choice wherever possible. Within that environment, there is a place for inpatient palliative care units which generally attached to hospitals due to the complexity of medical management and the need to involve a variety of clinicians in order to attain effective symptom management.

Each major training hospital should be resourced to set up a specialist palliative care team within a dedicated Palliative Care Unit according to the interconnected requirements of existing Clinical Service Capability Frameworks. Although hospital-based, these teams should support and work within the framework of the community-based palliative care model.

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

AMA Queensland supports training a number of general practitioners to take a leading and informed role in facilitating a greater palliative care participation and commitment of their GP colleagues. This can be undertaken through specialised short courses and, for those wishing to develop their skills further, as the Clinical Diploma in Palliative Medicine of the RACP. The diploma was developed through the cooperation of the Royal Australasian College of Physicians, the Royal Australian College of General Practitioners, the Australian College of Rural and Remote Medicine and others. These practitioners would provide an interface between other general practitioners, domiciliary nursing and specialised palliative care services, as well as hospitals, nursing homes and other groups involved in professional care. While all GPs are expected to hold basic skills in the delivery in palliative care as a result of their specialty training, we believe as many GPs as possible should receive sufficient further basic palliative care training to enable them to provide high-quality and effective care to palliative patients. Again, this could and should ideally be delivered by QMETI.

AMA QUEENSLAND

TARGET TWO

BY 2022,FIFTY PERCENT OF QUEENSLANDERS OVER 50 YEARS OF AGE HAVE AN ADVANCE CARE PLAN

AMA Queensland recognises and acknowledges the hard work of other stakeholders in the space, including the Queensland Clinical Senate, in identifying the barriers to an effective end-of-life care sector. However, despite the welcome introduction of the Queensland Government's Statewide Strategy for end-of-life care in 2015, the low uptake of AHDs in Australia remains concerning.

AMA Queensland advocates for a "Fifty over Fifty" target, where at least fifty percent of Queenslanders over the age of fifty have a documented Statement of Choices or AHD registered in the My Health Record or iEMR systems by 2022. We believe the following measures, in broad consultation with other relevant stakeholders, are necessary to achieve this plan.

Confidence for clinicians: If clinicians are to effectively utilise advanced health directive, they must have complete confidence that the document in front of them is a true and final record of their patient's wishes. There can be no ambiguity or fluidity in their confidence, it must be absolute or the document is substantively weakened. AMA Queensland proposes the following steps to improve clinician confidence in advanced care planning.

1. Convene a stakeholder roundtable to determine the place of common law advanced health directives and establish confidence in advanced health directives

AMA Queensland recommends the Queensland Government convene a stakeholder roundtable with the view to removing section 39 of the Powers of Attorney Act 1998 (Qld), that provides:

> *"This Act does not affect common law recognition of instructions about health care given by an adult that are not given in an advance health directive."*

This provision causes considerable ambiguity as common law advanced health directives are not recognised under the Guardianship and Administration Act 2000 (Qld) in the hierarchy of priorities for dealing with health matters.[28] Such ambiguity reduces the confidence in these documents and lends itself to unnecessarily legalistic argument at a time when families should be focused on the patient.

AMA Queensland urges the Queensland Government to establish a stakeholder roundtable, comprising of peak representative bodies and leading medical and legal practitioners to discuss whether section 39 can be removed from the legislation. They should also be empowered to explore the best mechanism for this to occur.

2. Make the forms more user friendly for patients and practitioners

In its current form, the Queensland advanced health directive form is complex, long and clinically limited. While we appreciate that this comes from a desire to ensure the form is comprehensive it is not fit for purpose and must be amended if utilisation rates are to increase.

AMA Queensland commends the work of Metro South Hospital and Health Service in the establishment of their Statement of Choices form for advanced care planning.[29] These forms are excellent in that that are user friendly and easy to complete. However, the Statement of Choices is not a statutory document. However, AMA Queensland believes that the Statement of Choices is a good stepping stone in trying to achieve an easier to use document.. Exploring ways in which Queensland can adopt a more straight-forward advanced health directive will allow more principals to complete it, while still retaining the capacity for patients to outline what they want in their care at the end-of-life, and drive utilisation rates up to better inform patient care.

3. Provide wider access to advanced health directives on the iEMR or My Health Record

While clinicians are protected from liability in those circumstances where they cannot access the latest copy of the principal's advance care plan (or there is no document), the treatment team must be confident they can access the final copy of the document whenever necessary. AMA Queensland believes this confidence could be achieved through the use of the My Health Record, which would ensure a nationally consistent approach. However, it is recognised that most doctors working in the Queensland system primarily use the Viewer system. For this reason, until the My Health record is a more widely used system, it is important that AHDs be uploaded to the iEMR at the very least.

This approach is complicated, however, for while Queensland Health has recently opened the Viewer to the GP sector, it has only provided read-only access. If GPs are to be able to upload a new Statement of Choices or AHD to the Viewer, upload access must also be given. AMA Queensland appreciates the privacy concerns around this suggestion, so we recommend Queensland adopt or develop a new Queensland standard for uploading such documents to the Viewer until such time as a national standard is developed.

Improved education: To address the cultural and societal taboos with regards to discussion and acceptance around death and dying, the Queensland Government must invest in a public education campaign to improve community literacy and knowledge about the issue. This program should endeavour to normalise discussions about advance care planning among a variety of cultural and societal groups. This should include, but not be limited to:

- An education campaign targeted directly at residents of aged and retirement homes;
- A tailored education campaign, delivered in partnership with peak representative bodies, targeted at distinct cultural groups such as the Aboriginal and Torres Strait Islander populations; and
- An education campaign to help people generally to feel more comfortable talking about death and dying. Sometimes the difficulty comes from the obstacles arising from reluctance of clinicians to use words like “death” and “dying,” or to talk openly about the fact that a patient’s life expectancy is limited.

To help equip clinicians with the skills and training to have these discussions, the Queensland Government, in consultation with AMA Queensland and other stakeholders such as Decision Assist, should invest in the design, piloting and roll-out of an integrated multi-disciplinary education program for clinicians on advance care planning. This program should be designed by clinicians and ensure that they are conversation ready.

Improved multidisciplinary guidelines: The Queensland Government should work with AMA Queensland and other health sector stakeholders to implement as fast as possible the initiatives outlined in Service Direction 1 of its “Strategy for End-of-Life care,” specifically around supporting and encouraging health care professionals to have conversations around end-of-life care with patients and their families. Where any roadblocks exist in delivering on this goal, the Queensland Government should identify and work with stakeholder organisations to remove these obstacles.

The Queensland Government should also commit to discussing, with the Federal Government, the establishment of dedicated MBS rebates to properly remunerate clinicians for taking the time to engage in advanced care planning with their patients. While AMA Queensland does not believe clinicians are currently neglecting such planning for financial reasons, it is important they are appropriately compensated for having difficult and time-consuming conversations. Such conversations may greatly enhance the quality of the remainder of the life of their patients, with the secondary consequence of potentially reducing the overall burden on the general health system.

REFERENCES

1. The Commonwealth of Australia, 2015 Intergenerational Report Australia in 2055, Australian Government, Canberra, March 2015
2. Swerissen, H and Duckett, S., 2014, Dying Well. Grattan Institute
3. Health and Community Services Committee, Palliative and Community Care in Queensland: towards person-centred care, Queensland Parliament, May 2013
4. ibid
5. Australian Senate Committee Inquiry, Palliative care in Australia, 50–53
6. Queensland Statistician, Population Growth, Queensland, December Quarter 2012, http://bit.ly/1hGDYiV, Queensland Government, June 2013
7. Queensland Statistician, Deaths, Queensland 2012, http://bit.ly/1EwuoFP, Queensland Government, November 2013
8. Health and Community Services Committee, Palliative and Community Care in Queensland: towards person-centred care, Queensland Parliament, May 2013
9. ibid
10. Section 35(1)(a) Powers of Attorney Act 1998 (Qld)
11. Section 36(1)b) Powers of Attorney Act 1998 (Qld)
12. Section 101 Powers of Attorney Act 1998 (Qld)
13. Scott, I, Mitchell, G, Reymond, E, Daly, M, Difficult but necessary conversations – the case for advance care planning, Med J Aust, 2013
14. ibid 1031
15. Scott, I, Mitchell, G, Reymond, E, Daly, M, Difficult but necessary conversations – the case for advance care planning, Med J Aust, 2013
16. ibid
17. Journal of Transcultural Nursing , Ethics and Advance Care Planning in a Culturally Diverse Society, Megan-Jane Johnstone and Olga Kanitsaki , 13 July 2009, http://goo.gl/6CGWDK
18. ibid
19. Swerissen, H and Duckett, S., 2014, Dying Well. Grattan Institute
20. ibid
21. BMJ 2015;351:h4855
22. Scott, I, Mitchell, G, Reymond, E, Daly, M, Difficult but necessary conversations – the case for advance care planning, Med J Aust, 2013
23. Van Weel C, Michels J. Dying, not old age, to blame for costs of health care. Lancet 1997; 350: 1159-1160
24. Saul, P, A Conversation That Promises Savings Worth Dying For, The Conversation, April 2013
25. Temel et al. Early palliative care for patients with metastatic non-small-cell lung cancer. N Engl J Med 2010;363:733-42
26. 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
27. http://www.health.gov.au/palliativecare
28. Guardianship and Administration Act 2000 (Qld) s66
29. Statement of Choices Form, http://bit.ly/1Qjat2r, Department of Health, Queensland Government, September 2015

THE COMPLETE VISION

The release of Health Vision Part 5 marks the completion of our Health Vision concept. But the vision isn't fully realised yet. The Health Vision is a five year advocacy plan and AMA Queensland will continue to advocate for the ideas contained within the vision until it is complete in 2021.

We have already had some success with the previous parts of the Health Vision. Below is a recap of the Health Vision and our advocacy efforts to date.

To earlier parts of the Health Vision, please visit www.amaq.com.au

PART ONE: PUBLIC HEALTH AND GENERATIONAL DISADVANTAGE:

AMA Queensland called for a whole of government public health plan, initiatives to tackle obesity and improve immunisation rates and recommitting to Closing the Gap. We did this because we are all patients and we believe Queenslanders deserve to live happy, health lives.

Achievements to date (2017): In its 2015-16 Budget, the Queensland Government committed $7.5 million dollars to the establishment of a whole-of-government Health Promotion Commission. AMA Queensland provided advice and input into the development of the Commission, which is expected to commence operations in 2017.

PART TWO: WORKFORCE AND TRAINING:

AMA Queensland believes passionately in supporting our medical workforce at all stages in their career. This is why in the second part of the Health Vision we called for improvements to the way Queensland trains and treats its medical workforce. For the junior membership, AMA Queensland called for a Queensland Medical Education Training Institute (QMETI) to improve medical training for junior doctors in Queensland. And we suggested initiatives that would improve both the health of both junior doctors and SMOs, including changes to mandatory reporting and the culture of our medical workplaces.

Achievements to date (2017): In late 2015, AMA Queensland was invited to participate in a Junior Doctor Roundtable where the concept of QMETI was discussed. AMA Queensland has continued to advocate for the QMETI concept and mandatory reporting exemptions through submissions to the Queensland Governments Medical Workforce Review and our 2016-17 Budget Submission.

PART THREE: REPRIORITISING CARE IN RESPONSE TO DEMAND:

AMA Queensland values and believes in the work that our doctors do. We know that our general practice sector are achieving excellent results and delivering real value for money for our health system. But general practice is under pressure and with increasing rates of chronic disease, we believed it was important to add our voice to the call for a trial of health care homes. By reprioritising our health system into one that stops you from getting sick before you need to go to hospital, AMA Queensland believes we can empower the general practice sector and reduce preventable admissions to hospital.

Achievements to date (2017): Prime Minister Malcolm Turnbull announced a trial of health care homes in various locations across Australia in March 2016. AMA Queensland will continue to work with the Queensland Government to implement measures which will reduce preventable admissions to hospital.

PART FOUR: UNIFYING THE HEALTH SYSTEM:

In the penultimate part of the Health Vision, AMA Queensland outlined ways in which the different parts of our health system could work more closely together, and proposed an initiative which would allow doctors and patients to track their referral through the health system.

Achievements to date (2017): This part of the Health Vision was released in mid 2016 so at time of writing there is not much progress to report. AMA Queensland will continue to discuss the concepts proposed in the Health Vision with the Queensland Government as part of our continuing efforts to improve the patient experience for all Queenslanders.

AMA QUEENSLAND

PO Box 123,
Red Hill, Queensland 4059

Phone: (07) 3872 2222
Fax: (07) 3856 4727
Email: amaq@amaq.com.au

www.amaq.com.au