

Queensland Health  
Community Health Services Reform Project

# Consultation summary May-July 2007

Smart Health:  
Reforming community health services in Queensland



Queensland  
Government  
Queensland Health

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# 1. Consultation Process

The development of strategic directions for community health services in Queensland for the next five to ten years is being informed by widespread stakeholder consultations.

This paper provides a report on the outcomes of the first round of consultations, which were held between March and August 2007. The information obtained through this phase has contributed to the development of a Discussion Paper *Smart Health: Reforming community health services in Queensland*, which is being released as a basis for further consultation in September 2007.

The first round of consultations was designed to:

- gather information about the strategic and operational issues and gaps for community health services in Queensland,
- prioritise these issues and gaps with stakeholders,
- get an understanding of the perceived level and type of reform needed over the next five years,
- stimulate reflection and discussion amongst stakeholders about what Queensland's demographics and community health sector might look like in ten years time, and
- identify what reforms stakeholders believe are required and what would need to be done to achieve such reforms.

Two methods were used for consultations in this round, face-to-face interviews with individual stakeholders and 13 group forums held in targeted locations across the State. The Project Consultant, Judith Robson, led the consultations with a second Project Team member attending to record the discussion.

The forums were targeted at a broad range of stakeholders including consumers, carers, Queensland Health Community Health managers, non-government service providers, General Practitioners and academics, and designed to capture both strategic state-wide and local issues and gaps, including those for Indigenous health services and rural and remote areas. The organisation of the forums was assisted by Area Health Service officers and on occasion the invitation list was nominated at that level.

Face-to-face consultations were held with all Queensland Health Executive Management Team members, Queensland Health departmental officers from various program and operational areas and related projects and initiatives. In addition, consultations were held with other government agencies (including local government officials), Chief Executive Officers and other relevant staff from the Divisions of General Practice, professional associations and non-government organisations at both state-wide and regional levels.

A second round of consultations will be undertaken between September and early October 2007 on the Discussion Paper, *Smart Health: Reforming community health services in Queensland*, which outlines a proposed vision, key principles, priorities and potential models for reforming community health services to meet future demands on the health system and address the priorities for health.

## 2. List of Key Stakeholders

### ***Community Health Survives Reform Project Advisory Group***

- Aged Care Queensland
- Community Health Agency Group
- Department of Communities
- Commonwealth Department of Health and Ageing
- Ethnic Communities Council of Queensland
- General Practice Queensland
- Local Government Association of Queensland
- Queensland Aboriginal & Torres Strait Islander Health Council
- Queensland Council of Social Service
- Queensland Health representatives
- Queensland Meals on Wheels

### ***Consumers & Carers***

- Queensland Council of Social Services (QCROSS) consultation paper; and
- Individual attendance at various forums.

### ***Queensland Health Stakeholders***

#### *Corporate Office:*

- Executive Management Team
- Policy, Planning & Resourcing Division
- Reform & Development Division
- Office of the Chief Health Officer (Population Health, Mental Health, Alcohol, Tobacco & Other Drugs (ATODs), Aboriginal and Torres Strait Islander Health & Child Health & Safety program areas in particular)
- Chief Information Officer
- Corporate Services Division

#### *Other internal stakeholders:*

- Statewide Health & Community Services Branch
- Area Health Services
- Health Service Districts
- Queensland Health Community Health Services
- Aboriginal & Islander Primary Health Care Services
- Queensland Health Community and Hospital Interface Services
- Queensland Health ambulatory care &/or outreach services (specialist, including paediatric and subacute services)

### ***Non-government Community Health Service Providers - Metropolitan and Regional Services***

- Aboriginal & Islander Medical Services
- Not for profit, non-government domiciliary community health services, including Blue Care, Ozcare, Spiritus & RSL Care & services that target special populations (Aboriginal and Torres Strait Islander & Culturally and Linguistically Diverse)
- Private for profit community health services, including private nursing agencies, allied health practitioners
- HACC service providers

### **Other Government agencies**

- Department of Communities (in particular, the Home & Community Care Program area, Office for Seniors & Disability Services Queensland)
- Department of Child Safety
- Education Queensland
- Department of Emergency Services (in particular, Ambulance Services)
- Department of Health & Ageing & Department of Veterans Affairs
- Local Government Association of Queensland

### **Representatives from Professional and Community Organisations with an interest in Community Health Care**

- Queensland Aboriginal and Islander Health Council
- Divisions of General Practice (State & regional levels)
- Australian Medical Association (Queensland)
- Allied Health Peak Bodies
- Peak bodies representing service providers and consumers, including QCOSS, the Alliance for Mental Illness and Psychiatric Disability Groups Inc.

### **Health Union Representatives**

- Queensland Health Reform Consultative Group
- Queensland Nurses Union

### **Schedule of Round 1 Consultation Forums**

<b>AHS</b>	<b>Location</b>	<b>Date/s Held</b>	<b>Attendees</b>
Southern	Toowoomba	23 May 2007	Queensland Health (QH) Non government organisation service providers (NGOs), State government departments (SG), Division of General Practice (DGP), local General Practitioners (GPs), academics (Ac)
	Gold Coast	24 May 2007	QH, NGO, SG, DGP, District Health Council (DHC), health peak body (PB), Ac, Local Government (LG)
	Roma	31 May 2007	QH, NGO
	Acacia Ridge	28 June 2007	QH only
	Ipswich	27 June 2007	QH only
	Woolloongabba (PAH)	27 June 2007	QH (Princess Alexandra Hospital and Community Health staff).
Central	Maryborough	5 July 2007	QH, Carer organisation (CO), NGO, SG
	Chermside	30 May 2007	QH, Ac, DGP
	Rockhampton	3 July 2007	QH, DGP, NGO
	Marcoola (Sunshine Coast)	14 June 2007	DGP, Aboriginal Community Controlled Health Organisations (ACCHO), Ac, NGO, PB, CO, QH

	Longreach	11 July 2007	QH only
Northern	Cairns	6 & 7 June 2007	QH only
	Townsville	12 & 13 June 2007	Three separate forums – Consumer, NGO, QH

## 3. Summary of Issues and Gaps raised by stakeholders

### 3.1. Issues & Gaps for all community health service in Queensland

#### 3.3.1 Strategic Level Issues & Gaps

##### ***Legislation***

- Privacy legislation/standards are often used by service providers as an excuse not to share information.
- New Zealand has built principles for community health care into their health legislation – should Queensland do this?

##### ***Policy and planning***

- No statewide strategic directions for community health services exist, except at program level.
- Community health sector is 'invisible' in Queensland, except for General Practice.
- Lack of forward planning in response to changing populations.
- Services have not grown in proportion to local populations.
- Lack of consultation and joint planning with the wider health sector (between primary, secondary, tertiary services).

##### ***Culture/ideology***

- High level of cynicism due to 'lack of action' in the past.
- Not a 'whole-of-government' approach to community health.
- Acute-centric culture.
- Rising consumer expectations - consumers more informed by 'internet' but information not always accurate – a challenge for clinicians.
- Not person/client/patient focussed – people and service providers have difficulty navigating the health system.
- Sectors have evolved differently – different cultures / boundaries etc.
- Queensland Health is a large bureaucracy that takes too long to communicate new ideas and to implement changes.

##### ***Core Business & Governance***

- No clearly defined 'core business' for community health services that are funded through or by Queensland Health.
- No clearly defined roles and responsibilities for community health services that are funded through or by Queensland Health.
- No overall governance mechanisms and accountability in place for 'community health' services.
- No idea what the 'core business' of community health services is and who is best placed to deliver them.
- Community health services are the 'poly fillers' of the health system – plug the holes and are often the default provider for all health services.
- Community health versus community support services – current services are a mix of both.
- Commonwealth and State Government don't work together to facilitate flexible service responses.
- Lack of real consumer engagement in planning, design & service delivery.
- Historical lack of integrated planning – planning not population-based.
- Program/government priorities may not always be a priority for local communities.
- Political decisions usually a 'bandaid' solution – not necessarily a good and sustainable solution.

- Lack of vertical and horizontal integration between sectors / services.
- Should we still call it 'Community Health' – is this a misleading and outdated term?

### ***Information management***

- No consistent / accurate data to measure performance and health outcomes.
- No consistent / accurate data to support investment and benchmarking in the sector.
- Little or no IT compatibility between sectors to support integration & coordination.

### ***Funding & Accountability***

- Commonwealth / State divide, e.g. funding & responsibilities – how to work around this barrier?
- Little investment in community sector – new investment required.
- Highly competitive environment – many competing for the same resources.
- Government needs to recognise that funds are required to build the capacity of the sector, as well as for direct service delivery.
- Funding is tied to discrete programs/initiatives/projects, each with eligibility and/or other specified criteria – no overall funding model for community-based services.
- Multiple sources of funding means services have to meet multiple reporting and quality standards – administrative burden.
- NGO and private sectors have to charge fees – Queensland Health services are free – not a level playing field.

### ***Access***

- Diverse and fragmented sector - difficult to navigate - no single point of entry for community health sector.
- Consumers don't know or care how services are funded / organised – they just want a seamless service.
- Referral patterns / pathways are not coordinated with transport a capability, which creates a barrier to access.
- Lack of services for very disadvantaged people (e.g. homeless).
- Poor communication with clients and their families regarding treatment and availability of services.
- Number of forms and assessments can be a barrier to accessing services.
- Need flexible models to suit diverse demographics within Queensland.
- Rural / remote areas – difficulty accessing specialist services.
- Indigenous clients still not accessing mainstream services without assistance – cultural competence issues.

### ***Workforce***

- Ageing, diminishing workforce, recruitment and retention issues.
- Lack of professional development opportunities, flexible learning options and assessment of clinical competencies in community health sector.
- Disparities in industrial awards between sectors – no 'level playing field' contributes to workforce issues (e.g. QH poaching NGO staff).
- Shortage of GPs, especially in rural areas.
- Shortage of specialists, especially in rural areas.
- Need new roles to support health professionals.

## **3.1.2 Operational Level Issues & Gaps**

### ***Policy***

- Queensland Health is seen to be, and tries to be, all things to everyone.
- Lack of clarity about what core business is / should be.

### ***Culture/ideology***

- Highly competitive environment inhibits sharing of information and collaboration, and efficient use of workforce / other resources.
- Lack of trust between sectors / services (within QH and between sectors).
- Lack of knowledge / understanding between sectors / services about what services are provided and their scope (e.g. between acute and community health services).
- Philosophical differences between sectors / services.
- Lack of marketing of community health services – partly because services do not have the resources to manage current demand.
- Cultural divide between sectors, e.g. acute/community, QH/NGO/private.
- Rhetoric about wanting to work in partnerships but it gets 'just too hard'.
- No clinical governance for community – services not necessarily evidence-based.
- Lack of cultural awareness by community health staff.
- Lack of understanding of client advocacy.

### ***Core Business***

- Duplication of assessment services between sectors – inefficient use of scarce resources.
- Lack of service and care coordination across the health continuum for patients, especially those with chronic and complex needs.
- In areas where there is good professional / service networking, it is usually informal and personality driven.
- No business or service planning framework for community health.
- Good local service networking & collaboration is usually 'personality driven' – not built into systems.

### ***Information management***

- Lack of communication between sectors, e.g. discharge planning is generally not done well.
- No capacity to communicate electronically between sectors.

### ***Funding***

- Services driven by opportunistic funding. NGO sector does not get funded 100% of what it costs them to deliver a service – governments cost shift to the 'charitable' sector – and this is not sustainable.
- Short-term funding and different business cycles inhibit sustainability of services, e.g. services must apply for growth HACC funds before they know whether they were successful in their previous years funding application.
- Service providers are increasingly wary of taking on 'pilot' projects as they then have to manage raised client expectations when funding stops – also often not evaluated.
- Funding along program / professional lines results in some people falling through the gaps.
- Funders need to allow sufficient time for newly funded community services to get up and running – don't pull back funds if not fully spent at the end of the financial year – need to fund for infrastructure / training as well as services.
- Services are under funded, i.e. demand for services is greater than the capacity to deliver under current funding arrangements.
- Cost shifting from acute and outpatient services to the community sector.
- Historical funding model does not reflect geographical barriers or demographic influences.

### ***Access***

- Transport issues for clients, especially in rural/remote areas.
- Unmanaged waiting lists in some areas.
- Poor discharge coordination impacts on a patients ability to access community services.

- Difficult for services to discharge high-need patients if there are no other services to provide follow-up health care.
- Patients access Queensland Health and NGO services for the same service (duplication because of poor planning).
- High unit costs for in-home care in rural/remote areas not often recognised – increased distance / time to travel, and associated travel costs.

#### **Workforce**

- Recruitment and retention issues, poor succession planning, lack of professional development and limited / no support for sole practitioners in community (worse in rural/remote areas).
- QH not recognising the value of some health graduates, e.g. exercise physiologists.
- Universities have difficulty securing clinical placements for students.
- Disadvantaged students can't afford to pay for criminal history checks and immunisation requirements prior to clinical placement with QH.
- Mobile workforce – everyone seems to be 'acting' in positions - difficult to develop & sustain relationships / continuity of care.

### **3.2. Issues & Gaps for Queensland Health community health services**

#### **3.2.1 Strategic Level Issues & Gaps - all of the above plus:**

##### ***Culture/ideology***

- Medical model dominates QH acute and community services, as well as General Practice.

##### ***Core Business***

- Acute sector provides services that could be provided by the community sector, e.g. some bowel screening programs are run by the hospital.
- Acute sector is increasingly specialised.
- More acute care is occurring in the community.
- Acute / community interface models should be based on a 'community in-reach' model, not 'hospital outreach', i.e. community health staff working across both acute and community sectors - would also help with upskilling the workforce.
- Program areas work in 'silos', e.g. problems at the interface of community health services and public health and mental health services.

##### ***Information management***

- Lack of a QH IM/IT platform for community health services.
- No capacity to communicate electronically with other services/sectors.
- No consistent performance indicators used, even within some Program areas.
- Lack of ability to communicate and share information across government, non-government, general practice and other health providers.

##### ***Funding***

- No funding model for Queensland Health community health services.
- Lack of adequate infrastructure, e.g. accommodation, IT, vehicles etc.

##### ***Access***

- NGOs receive referrals from QH but do not know who they can refer clients back to QH.

##### ***Workforce***

- Most Health Service Districts have vacant nursing and allied health positions they cannot fill, even in metropolitan areas.
- Limited career structure and training for Indigenous Health Workers – also not enough positions to meet health needs - often used as 'taxi drivers' and welfare workers.

### 3.2.2 Operational Level Issues & Gaps - all of the above plus:

#### ***Culture/ideology***

- Queensland Health staff try to be all things to everyone, and fail.

#### ***Core Business and Governance***

- Services driven by opportunistic funding - competition with NGO sector.
- Services driven by the workforce, e.g. availability of disciplines, the skills and interests of individual staff.
- Duplication of services between sectors – inefficient use of scarce resources.
- Services also crisis driven – don't have the resources to be pro-active.
- Lack of a service capability framework for community health services.
- In spite of NGOs being funded to provide services, QH often ends up having to deliver it, especially in the short term until they can access an NGO service as NGOs can't often respond in a timely manner, e.g. 3 day wait before a client can access community care.
- Gaps are bigger in rural and remote areas.
- Services for children aged 5 – 18 are under resourced in some Districts (services mainly focussed on ageing population – same issues for women's and men's health).
- Many staff believes that QH does not have to always assume the 'case manager' role.
- Lack of clear reporting pathways from community sector to corporate office.

#### ***Information management***

- Continuing problems with accuracy of Lattice<sup>1</sup> reports - don't match actual Full Time Equivalent (FTEs)<sup>2</sup>.
- Many staff are not computer literate or have limited access to computers.
- Districts have many locally developed and supported IT programs -staff often have to enter client information into several databases.
- Currently little or no information to support the development of 'Expanded DRGs<sup>3</sup>' for community-based care, e.g. post acute care.

#### ***Funding***

- Travel budget and unit costs are high for rural/remote areas.
- Inequitable funding of community health services between districts.
- Some QH community health services starting to refuse / give back funding when they do not have capacity to deliver.
- Rural and remote areas problems with Shared Services Provider (SSP) – Locum and relief staff often not getting paid in a timely manner which is a major disincentive for attracting staff to these areas.
- Remote Area Nursing Incentive Package payments differ between hospital and community health services.

#### ***Access***

- Transport and accommodation costs – for staff and clients.
- Indigenous clients and other disadvantaged groups are not accessing mainstream services/programs – need linkage positions.
- Inequitable access to services across the State.
- Different interpretation of business / program rules between districts.
- Some community health staff are acting as 'taxi drivers' for clients.

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<sup>1</sup> Queensland Health payroll system.

<sup>2</sup> Total full-time equivalent units are the sum of the on-the-job hours worked, hours of paid leave (eg. sick, recreation, long-service, workers' compensation leave, etc.) by that staff member (or contract employee where applicable) divided by the number of hours normally worked by a full-time equivalent staff member (or contract employee where applicable) under the relevant award or agreement.

<sup>3</sup> Diagnostic Related Groups - A code which signifies the patient's classification in the hospitals case mix, derived from the ICD-9-CM diagnostic codes for principal and secondary diagnoses, procedures performed, age, sex and discharge status.

### **Workforce**

- Recruitment and retention issues, and problems with succession planning, especially when there is a time delay between when staff finish and start in a role (especially in rural/remote areas).
- Rural / remote areas do not have large applicant pools for positions and often have to recruit staff with limited knowledge and skills for the positions.
- Lack of professional development and limited /no support for sole practitioners in community.
- Staff safety issues – would be worse after hours.
- Lack of staff accommodation in rural areas, including in Indigenous communities.
- Queensland Health's requirement that students pay for Hepatitis B vaccinations and a criminal history check before taking up clinical placement is inhibiting disadvantaged student's access to this as a compulsory course requirement.

## **4. Critical areas for reform in order of priority and proposed strategies for achieving reforms**

### **4.1 Policy**

- Explore whether the Health Services Act 1991 needs to be amended to drive reform of community health sector (e.g. New Zealand).
- Develop statewide policy directions for community health services, and develop a central area for community health policy development and review.
- Need a Whole of Government approach to 'wellness' to address social determinants of health – prevention is everyone's responsibility.
- Queensland Health can't be all things to everyone – need to clarify core business.
- Develop links with universities in order to inform policy and evidence based practice.
- Need to work more closely with the Commonwealth government in developing policies and strategies.
- QH has a social responsibility to provide services for the disadvantaged when there are no other options – usually most at risk groups.
- Develop policies that reward wellness, and address the health inequities between advantaged and disadvantaged Queenslanders, e.g. between Aboriginal and non-Aboriginal peoples.

### **4.2 Culture/ideology**

- Culture change needs to be addressed within all sectors.
- Change ideology so that community health care is the preferred option where possible, not hospitals.
- Admission to hospital should be viewed as a failure of the community health service system to support people in their homes, especially for people living with chronic disease and complex needs.
- Develop a partnership approach to service planning and delivery and build trust and collaboration.
- Establish trust / relationships and define roles and responsibilities of sectors / services, e.g. 'who is doing what'.
- Develop networks for information sharing, which address service needs, client needs and privacy legislation.
- Change culture from medical / illness model to wellness model, e.g. embed the concept of self-management into health services.
- Increase consumer engagement and person-centric philosophy within services.
- GPs well placed to help patients to navigate the system – that's where most people go in the first instance.
- Design health services in line with the health continuum rather than focus on 'community' or 'acute' health services - suggested changing the name from community health' to something else that reflects integrated health service models.

- Need better understanding of the diversity within the community and the health and service needs of culturally and linguistically diverse communities.

#### **4.3 Core Business**

- Definition of core business for community health – QH to focus on subacute / post-acute and hospital substitution care and NGOs focus on health maintenance and support services with close linkages between the sectors.
- Queensland Health should be a lead agency and have care coordination role. QH should be a clearinghouse for data, provide the more specialised services and provide training and quality assurance to the wider community health sector.
- Accountability and transparency of community health services – focus on outcomes, not inputs.
- Clinical governance – development of, or use of existing, standard care / clinical pathways / protocols for the whole health continuum for use across all sectors which is evidence-based and up-to-date. Need to strengthen links with clinical networks and form partnerships with tertiary sector. Possible establishment of a Centre for Excellence
- Build capacity of the community health sector – workforce (use a multidisciplinary team approach), continuity of care, technology, communication, and infrastructure.
- Develop models and systems that support integration, coordination of care & improve access to community care, in particular, after hours access.
- Streamline intake systems – single intake model supported overall.
- Care management approach needed for people with chronic disease and complex needs.
- Linkage positions needed to help disadvantaged groups to access health services across the continuum.
- GP Liaison Officer positions effective at the acute / GP interface – should continue
- GPs allotted Visiting Medical Officer status, especially for frequent and avoidable admissions.
- Core business for QH community health could include health promotion / health education group sessions, plus specialist services for secondary prevention, e.g. Positive Parenting Program, ATODs, diabetes, Chronic Obstructive Pulmonary Disease management etc.
- Need more preventative health services, more services for chronic disease management, more services for young people with acquired brain injury and more services for young people in general.
- Develop some consistent key performance indicators for all community health services and compulsory reporting, e.g. waiting times – build into Memoranda of Understanding & service agreements.
- After hours Medical Benefit Scheme (MBS) items for GPs a positive for clients.
- Shared service coordination tools needed in an electronic environment.
- Develop community health centres – including pharmacy, telemedicine, health promotion, visiting specialists, GPs, dentists, some outpatient services.

#### **4.4 Information management**

- Address gaps in information management and communication between sectors / services as a high priority.
- Utilise 1300 HEALTH as a platform for central intake etc.
- Develop a web-based booking system (e.g. UK system) for clinicians for specialist services.
- Develop capacity for different IT systems to communicate electronically.
- Develop IT platform for QH community health services, including 'hand held' technology for workers.
- Make better use of telemedicine, especially in rural/remote areas.

#### **4.5 Funding**

- Need a funding model for community health and maximum flexibility to provide / procure services that meet person's needs.
- QH position itself to receive MBS payments where possible.
- GPs may be interested in being on 'retainers' to manage chronic disease after hours – use practice nurses to triage.
- QH provide GPs with incentives for co-locating community health staff in GP practices to run group sessions, provide post-acute care with GPs (shared care).
- Invest in infrastructure for community-based health services but don't only focus on building large Community Health Centres - workforce should be out in the community not sitting in buildings, where appropriate workplace is in the vehicle / community.

#### **4.6 Access**

- Rural areas should ensure communities have access to basic health services at a minimum – often not the case.
- Greater use of technology to improve access to specialist services in the bush (e.g. telemedicine) and in the home.
- Need different service models for rural/remote areas and metropolitan and urban areas.
- Services must address community transport issues when planning / designing services, e.g. health services procure / provide patient transport for appointments / group sessions.
- Rural areas need access to mobile services and increased assistance with transport and accommodation to specialist services.
- Need a centralised service entry point for community health services and clear referral pathways from acute sector to the community.

#### **4.7 Workforce**

- Address workforce issues - make 'health' an attractive career choice.
- Address industrial issues - engage unions to help solve problems.
- Work in partnership with universities / vocational education and training colleges - fund scholarships & development of new roles, e.g. allied health assistants, physician assistants, and on-line adult learning options for existing workforce.
- Better utilise post graduate roles in health services, e.g. exercise physiologists etc.
- Develop a 'clinical knowledge base' for community health workers and keep up-to-date.
- Rural areas - recruit and train young people from within the community for 'assistant' type roles as they may be more likely to stay.
- Adopt a multidisciplinary team approach to health care in community with all community-based health professionals having a range of 'core competencies' for assessment and intervention to make better use of workforce, e.g. engaging and communicating with individuals and their families, assessing functional and home environment, e.g. need for grab rails, assistive aids.
- Work closely with Unions to address establishment of new roles and reduce disparity of salaries and conditions between sectors.

## **5. Specific Issues**

### **5.1 Rural specific issues**

- Communities accept that access to specialist services is often more difficult but expect that they will have access to essential health services.
- Lack of support for 'spokes' from 'hub' services which could play a greater role in developing and maintaining clinical skills.
- Funding does not often take into consideration the higher travel and accommodation costs which impact on services' capacity to effectively implement services.
- Some rural districts report that they are starting to refuse new funding as they are don't have the capacity to implement programs effectively (high unit costs, recruitment problems).
- For rural communities, avoidance of hospital admissions is not usually an issue when low bed occupancy rates are low and patients reside out of town.
- However, duplication of services and poor networking are significant issues.
- Services are often forced to recruit health professionals who do not necessarily have the knowledge and skill required for a role due to limited applicant pools. This raises competency and safety issues due to lack of professional development opportunities and lack of supervision.

### **5.2 Indigenous specific issues**

- Continuing reluctance of Indigenous peoples to access health services, in particular mainstream services, is a major concern. There is an ongoing need for service models that include Indigenous 'linkage' positions to facilitate access and care / discharge management.
- Reluctance of Indigenous peoples to access prevention and early intervention health services – tend to only seek help in a crisis.
- Communities that have control over health services seem to have better outcomes.
- Need more Indigenous Health Workers and health professionals and assistance with training.
- Existing Indigenous Health Workers are not often used effectively as they find they have to fill the gaps in community 'support' services, e.g. most patients referred from remote communities to northern centre arrive with no money, identification, Medicare Card, transport, accommodation and insufficient clothing. These issues need to be addressed before their health problems can be met.
- Perceived lack of career structure for Indigenous Health Workers.
- Lack of consultation and engagement with Indigenous communities.