

7. Improving patient care and health services

Improving patient care and access to health services is the key challenge facing Queensland Health today. Common concerns expressed to the Review from patients and the community related to:

- access to acute health services including waiting times for outpatient services and elective surgery, and in emergency departments
- the need for improved coordination between Queensland Health and other providers including general practitioners and non-government organisations
- accessing services in rural and remote areas
- health inequities between Indigenous and non-Indigenous Queenslanders
- access and care options for those with mental health conditions including community based mental health services
- access to oral health services.

A range of strategies are recommended below to improve the systematic approach to addressing these issues.

7.1 Improving patient centred care and patient flows

Patients treated in Queensland public hospitals generally indicate they are satisfied with the treatment they receive and are complementary of the professionalism and dedication of staff (89 percent based on patient satisfaction surveys). However, there are also a number of issues which cause frustration and distress to patients and staff, limit hospital efficiency and pose risks to patient safety including:

- patients being placed on a long referral list to see a specialist, especially when there is no clarity of waiting time and when treatment other than surgery may be required
- cancellation of scheduled elective surgery times – often at the last minute, sometimes twice (reportedly due to emergency surgery, decision of specialist to address another more urgent priority, theatre nursing staff being unavailable to extend theatre times, etc)
- all patients in some clinics being given the one appointment time on a specific day, leading to frustration because of length of time patients are kept waiting. This is worsened when doctors arrive late for clinics because of other priorities
- receiving care from multiple doctors and nurses while in hospital – patients indicated a desire to explain symptoms and problems to one doctor once and expressed concern that they often do not see the same nurse twice
- being moved from one ward to another, sometimes more than once in some cases, due to overall congestion and limited bed numbers
- discharge uncertainty - either too early, delayed or sudden and difficulty arranging transportation home
- long lapse times before letters from specialists are forwarded to general practitioners about follow up care
- lack of home or community support following discharge from an acute hospital.

Staff working in these environments also feel pressured and concerned they are not providing the best possible care. Some of these issues are due to capacity constraints within the public hospital system. Providing more doctors, more nurses and more beds is an obvious and important part of the solution. However, in a time of workforce shortage, it may not be feasible to increase clinician numbers significantly in the short term.

The Review gathered clear evidence from Queensland and other jurisdictions that there is significant potential, particularly within acute hospitals, for business process redesign to improve the responsiveness of services. This includes better models of referral from the general practitioner to the specialist, pre and post acute care in local settings, and facilitating teams involving patients and clinicians working at the local level to improve service from a patient perspective. Examples of work practice review and better integration of technology were observed in some of the districts visited including hospital wards and emergency departments. However, the approach was not as well developed or universally applied as one would have expected, based on experience with other industries.

While patient flow redesign is often achieved through simple arrangements, it is not always easy to change in busy workplaces where clinicians are under continued pressure to meet patient needs. Throughout the district visits, clinicians identified potential changes which could improve patient flows and care, but felt they were too busy or insufficiently resourced to design and implement these changes properly.

The Review had the opportunity to visit hospitals in New South Wales and Victoria which have been actively supporting patient flow improvement programs with their clinicians. Examples are provided below.

The Maggie's Journey: An approach to patient centred care in the New South Wales Hunter New England Area Health Service

The Maggie program has been a major reform with the objective of walking "Maggie" (a hypothetical patient) through standard entry points to healthcare and investigating the patient experience.

John Hunter Emergency Department

The Emergency Department (ED) Project began in May 2002 with a 14 week diagnostic and solution design process. During this time, a range of analysis activities were undertaken to understand the issues affecting emergency department patients and staff. These activities included interviews with staff and patients, process mapping sessions, patient tag-alongs, data analysis, and review of external reports and internal reports and surveys.

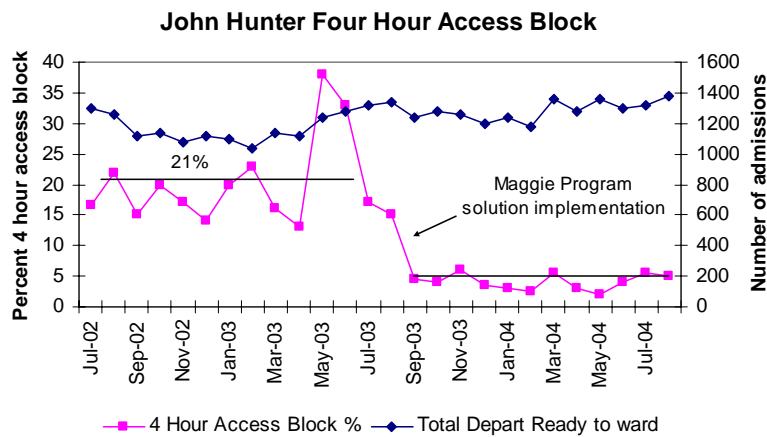
The problems:

- "Time to treatment" varied throughout the day. 6 percent to 10 percent left the ED in frustration. A number of attendances at the ED could have been treated elsewhere.
- Staff were under pressure and clearly frustrated with current working conditions. Staff rostering and staffing levels were not always aligned with peak patient demand. Acts of aggression toward staff seemed to occur during the 'waiting' phase of a patients stay.
- Delays in the availability of imaging and pathology services impeded patient diagnoses.
- Separate and complex work processes inhibited staff coordination and teamwork.
- IT and communications systems were often ineffective or inefficient.
- Access block and slow processing added to workloads and adversely affected patient care.
- Limited availability of transport led to delays in patient departure.

The solutions:

- Triage as the first point of contact and improved communication within the waiting environment reduced patient confusion and anxiety.
- A Rapid Emergency Assessment Team was formed to assess and stream patients quickly with a “Fast track Zone” to treat ambulatory patients, with treatment and testing commenced earlier.
- Patient care teams and zones were developed to improve medical-nursing-allied health teamwork within the ED and reduce fragmentation of care. Nursing roles were expanded to include nurse initiated tests and treatment.
- Telephone call handling/communication was handled by a designated communications clerk and bedside clerical and associated technology was introduced.
- A Nurse Unit Manager assumed responsibility for managing patient flow through the department and patient referrals - traditionally the responsibility of the staff specialist.
- ED samples sent to the pathology laboratory were clearly identified to improve test turn around times. Education was provided regarding pathology testing to reduce the volume of inappropriate tests.
- The admission process from ED was streamlined to ensure patients were admitted to the appropriate inpatient team in a timely manner.

The results:



With the implementation of the Maggie Program, triage performance improved in all categories, particularly categories 3 and 4 where there was a 42 percent to 48 percent improvement in meeting treatment times. There was an 80 percent reduction in four hour access block, despite a 10 percent increase in admissions and eight hour access block reduced from 41 percent to 31 percent.

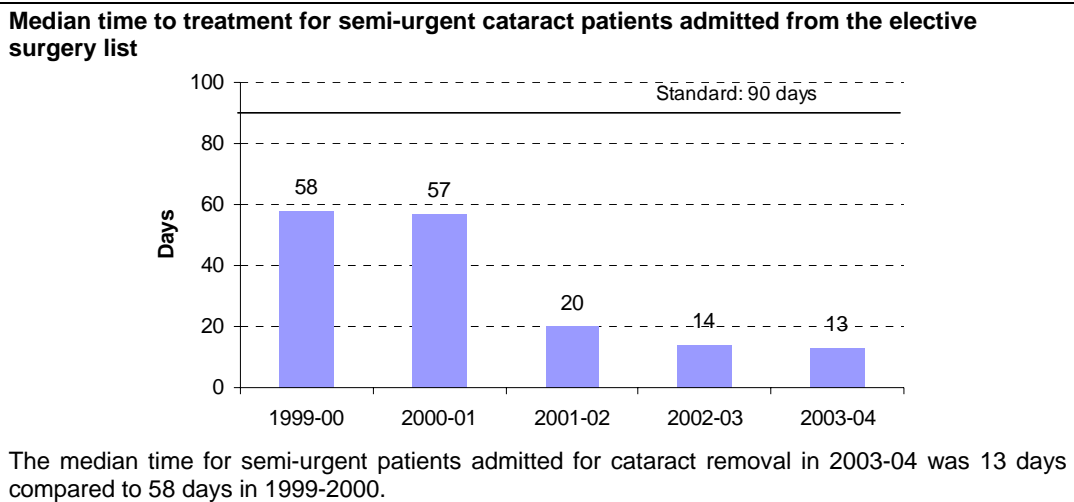
Source: Printed with the permission of Hunter New England Area Health Service NSW

Cataract surgery – Cranbourne Eye Service Victoria

In 2002, Victoria began focusing on the need to reduce the time to treat patients needing cataract surgery in metropolitan and rural Victoria, drawing on international research to devise the best model of care. This has comprised several different components including:

- Treating long-wait cataract patients in rural areas and on the Royal Victorian Eye and Ear Hospital’s waiting list
- Focusing on improving the day surgery rate for cataract surgery statewide
- Funding a regional eye service – Cranbourne Eye Service

Victoria’s Elective Surgery Access Service worked with the Cranbourne Eye Service to streamline the model of care for cataract patients. This included reducing the number of visits for cataract patients by combining the initial consultation and pre-admission visit and referring patients to their own optometrists at an earlier stage. The service operates in the local community but provides access to regional areas, with a “Cranbourne Eye Bus” provided to transport more remote patients to and from surgery



Source: *Your Hospitals, Department of Human Services, Victoria June 2005*

Improving flow process design will require investment and support including:

- a period of some months for most projects which will require regular clinical input sessions
- sufficient resources locally to allow clinicians as multi-disciplinary teams to step back from their clinical load, including funding to backfill shifts
- leadership support at senior levels to support the review and subsequent change process
- business process redesign expertise including the capacity to map patient journeys and facilitate clinicians in designing local solutions
- identifying patients willing to be involved in the redesign process and work with a team to ensure services are patient focused and to bring new perspectives to the design process
- an ongoing review process.

Victoria and New South Wales have formed Patient Flow Collaboratives to support clinicians and hospitals to redesign their patient flow functions. The collaboratives have focused on access to emergency departments, access to elective surgery, discharge planning and prevention of adverse events. The collaboratives have provided support for multi-disciplinary teams to assist local clinicians identify and implement best practice across multiple sites. This includes providing support to access international best practice models which can be adopted locally.

Recommendation 7.1

That support be provided to clinicians in local areas to redesign patient flows for acute hospital services. Priority areas are to include emergency departments, elective and emergency surgery and outpatient services and links to respective hospital wards. District change facilitators will establish and assist local implementation of reforms and liaise with a Patient Flow Collaborative to guide system redesign.

7.2 Partnerships to improve health services for Queenslanders

7.2.1 Issues and challenges

Effective partnerships require a willingness to negotiate and compromise in order to forge shared interests and a common purpose.⁵⁶ The Review heard that Queensland Health has not demonstrated a strong commitment to the concept of partnering, despite a willingness by other providers to deliver care through innovative partnership models. Queensland Health is perceived in some cases to be in competition with other providers rather than working cooperatively.

There is all this rhetoric about integration and partnerships but it is not clear what this means in practice and limited progress has been made.

Source: Submission to Queensland Health Systems Review, July 2005

Queensland Health only wants partnerships where they are in control.

Source: Submission to Queensland Health Systems Review, July 2005

In an environment of constrained public resources and workforce shortages, there is a tendency to be “risk averse” and avoid partnerships requiring resource pooling. However, these very resource and workforce constraints make it essential that Queensland Health works more effectively with other organisations to maximise available health resources. This is in line with public expectations that different health sectors and levels of government should work together to provide the very best of patient care and share information between services.

Building genuine partnerships may be challenging for Queensland Health as some partnerships may be most effective if funds are pooled or devolved to another sector altogether. Whilst it remains important that potential partnerships be subject to risk assessment and management, they should be primarily assessed on the potential to add value to service delivery and patient care rather than concern about who holds the dollars.

7.2.2 Partnership opportunities

Health sector partnerships

The most obvious partnership opportunities for Queensland Health involve improved coordination and cooperation between the public, private and non-government health sectors and across the continuum of care. In particular, it is important that Queensland Health focus on improving coordination within the primary care sector, particularly with general practitioners.

Queensland Health provides primary health care services in community health settings. In areas where it is not viable for general practitioners to operate a practice, such as rural and remote settings, Queensland Health is the sole primary care provider. Additionally, Queensland Health delivers primary care from inappropriate settings such as emergency

⁵⁶ Borys and Jemison in Keast 2003,p.46

departments in large hospitals, due to non-urgent patients being unable to access after hours general practitioners or being unsure of the urgency of their condition.

Further opportunities could be identified to ensure the right service is provided in the most appropriate setting. This may include Queensland Health outsourcing some of its primary care services to the non-government sector or general practice or re-orienting the roles of some community based workers to be “service coordinators.”

This will require significant cultural change within Queensland Health and improved relationships at all levels within the organisation. There are examples across the State where Queensland Health and general practice work together, including:

- Aboriginal and Torres Strait Islander controlled health services
- use of GPs to assess non-urgent patients in emergency departments
- outsourcing hospital services to a local general practice in a rural community
- colocated Queensland Health and general practice clinics.

A vehicle for improving collaboration between sectors is inclusion of primary care practitioners – including general practitioners and allied health professionals - in Queensland Health’s clinical collaboratives, which have been established for clinicians to come together for the purposes of improving patient care through data sharing and evaluation.

The case study below led to improved patient outcomes and continuity of care through successful partnership, service coordination and funds pooling. It also demonstrates that Commonwealth/State funding arrangements should not be seen as a barrier to working across health sectors.

Team Care model

The Team Care Health II research study aimed to improve the care of people with chronic disease by focussing on collaboration among health care providers including general practitioners, Queensland Health hospital and community based clinical staff and non-government organisations. The initiative is sponsored by the Brisbane North Division of General Practice and is stage two of the Coordinated Care Trials funded by the Commonwealth and Queensland Governments.

Over 2500 patients participated in the study. Patients found that the health care provided through the collaborative approach exceeded their expectations. While formal evaluation is currently underway, patients, GPs, and community nurses have all praised the model in its ability to improve efficiency in the health system, improve patient access to services and improve patient health outcomes. However, it will be important to assess the formal evaluation findings, including assessment of the model’s sustainability, before the model is considered for wider implementation.

Improved service coordination was achieved through community nurses working as ‘service coordinators’. Service coordinators worked closely with general practice and brought their knowledge of community resources and services to the practice. They assisted GPs in care planning and arranged services for patients. Workforce shortages and time constraints limit GPs’ ability to routinely implement prevention strategies with patients. The Team Care model overcame this issue and positively impacted on patient’s health and reduced unnecessary hospital admissions. The Service Coordinator also liaised with hospital staff to prevent readmission by arranging community services once patients were discharged.

The availability of brokerage funds appears to have been a successful strategy. GPs and service coordinators had access to funds made available from Queensland Health and Home and Community Care Services (HACC) to purchase services from the private sector for patients to address risk factors or prevent hospital admission. This brokerage model improved the timeliness of patient access to allied health and HACC services particularly where there were long waits in the public system and also minimised patient’s admission to hospital.

Universities

The university sector is a critical partner both as an educator of the clinical workforce and in maintaining a quality health system able to adapt to the rapidly changing health environment. Key academic clinicians such as professors of medicine, surgery, obstetrics, psychiatry and paediatrics as well as academics in nursing and allied health areas should assume key roles, along with Queensland Health clinical and administrative leaders, in quality, safety and innovation within health institutions and across health districts. Clinical academics have a significant role in designing, sustaining and monitoring local systems of clinical audit, innovation planning, near-miss incident reporting and analysis of routine health outcome data.

Through their research capability, universities can also make a major contribution in researching models of care, alternative workforce roles and better use of technology in health care. The Centre for On-line Health is an example of a successful collaboration between a university and Queensland Health.

Local government and community services sectors

There should not only be a focus on partnerships within the health and education sectors, but the department should also look to opportunities with local government and the community services sector to improve public health and outcomes for patients with complex or special needs. Regional Managers' Coordination Networks provide one vehicle for Queensland Health to work cooperatively at the local level with other Queensland Government agencies and local government, businesses and communities. Availability of discretionary funding to progress joint initiatives would assist in this regard (see discussion under Implementation which discusses this further).

Currently, Queensland Health has effective partnerships with a range of community services providers. In some cases, this relationship is cemented by a formal working agreement, including:

- Joint Work Plan with Education Queensland, which has a focus on the priority areas of healthy weight in children, skin cancer, alcohol, tobacco and other drugs, sexual and reproductive health, mental health promotion and partnership development.
- A Public Health Partnership Protocol between Public Health Services – Queensland Health, Local Governments of Queensland and the Local Government Association of Queensland Inc. (2000). The Protocol includes details of the working relationship between Queensland Health and Local Governments and action plans for: public health planning, communication and consultation, marketing, mosquito control, fluoridation and sharps disposal. It will be reviewed in the context of the broader relationship with local government, and mechanisms developed to improve these relationships at a state, regional and local level.
- Partnership agreements between the Departments of Housing and Health, which aim to support people with a diagnosed mental illness to sustain public housing tenancies and provide a stable, long-term accommodation option.

- In Logan, transitional supported accommodation is provided for people with mental illnesses through a partnership between a community housing provider, non-government disability support provider and mental health services. The integrated service provides short-term stable accommodation for people discharged from hospital with no housing or those who would be hospitalised without the supported housing option. This type of “step-down” model helps stabilise mental illness and assists people to transition into longer term, independent housing.

Responding to the needs of a multicultural community

Another area for focus is the growing cultural diversity within the community. Approximately one in five Queenslanders were born overseas (17.2 percent) and over one in twenty speak a language other than English at home⁵⁷ (7.1 percent). Despite the relatively high number of Queenslanders born overseas, there is little information available on the health of overseas-born people in Queensland. Of the little available information, it is clear that people born overseas have been shown to be less likely to rate their health as excellent or very good, compared with other Australians and, for those not proficient in English, more likely to report a disability or long term health condition. It is well recognised that refugees are a highly vulnerable group, with many having experienced torture or trauma. Recent refugee arrivals have been from refugee camps in Africa and have arrived with significant communicable and chronic conditions requiring urgent treatment.

Following community concern about ethnic communities’ access to services and their experience of health services, Queensland Health recently conducted a review of the implementation of its multicultural health policies. The review identified a number of areas of concern including the limited use of interpreting services and limitations in routine data collection on the health of ethnic communities and their use and experience of health services. This lack of information is a significant barrier to effective health service planning for these communities.

Queensland Health recently launched an initiative in response to the review findings, the key elements of which include the establishment of a statewide interpreter service to assist clients with language difficulties to talk to their doctors and specialists, and to better understand the medical process. Better data will be collected and a statewide cross cultural training program will also be conducted. Implementation and evaluation of this initiative must involve culturally and linguistically diverse communities to ensure that the health concerns of these communities are effectively addressed, particularly vulnerable sub-groups such as newly arrived refugees.

Implementation

As outlined in Chapter 5, an Innovation Fund is proposed to enable Area Health Services to provide seed funding for innovative projects or pilots. A major priority of the Innovation Fund will be development of partnerships to improve service delivery and health outcomes. Allocation of funding would be contingent upon development of a partnership plan and evidence that all parties have agreed on a partnership model, including roles and responsibilities.

⁵⁷ Queensland Health 2003 Culturally and Linguistically Diverse Population Profile 2001 Public Health Services.

There should be an expectation that Queensland Health will actively seek to enter into partnerships. To build this into core business and service planning, building effective partnerships should be monitored in performance agreements for key positions such as Area Health Service general managers and district managers.

Recommendation 7.2

Partnerships should focus on the health, university, community services and local government sectors to improve health promotion and service delivery, drawing on examples of good practice such as funds pooling, service devolution and service delivery service coordination.

Area Health Services should use the Innovation Fund to encourage and assist health service districts to develop appropriate partnerships which could be established to improve health promotion or service delivery.

Building partnerships will be an expectation of key roles in the organisation including Area Health Service general managers and district managers and will be included in performance agreements for these positions.

Primary care practitioners within Queensland Health, general practice and allied health services should be included in clinical collaboratives to improve coordination between sectors in provision of primary health care.

The recommendations from the Queensland Health review of multicultural health policies, in collaboration with community representatives, should be implemented.

7.3 Surgical access

Elective surgery waiting times and waiting lists have caused much anxiety for patients. There is much concern about the inordinate waiting times to see a surgical specialist which is then followed by a wait for surgery.

The current community and media focus on elective surgery waiting lists whilst understandable at one level, is not the best overall indicator of health service performance nor is it necessarily in the best interests of all patients. Waiting lists are an imprecise indicator of the level of access to public hospital services and place undue focus on certain kinds of surgical activity sometimes to the detriment of medical services. Due to budget and workforce constraints the community's need is not being met which is resulting in less than optimal patient outcomes.

Surgical waiting lists reflect Queensland Health's attempts to manage finite resources where demand for services exceed supply. Waiting lists are not limited to the public sector as there are quite lengthy waiting times in the private sector reported for some specialties. This indicates the impact that workforce shortages in some specialties is having on both the public and private sector.

There are many limitations of the surgical system that need to be addressed, including:

- people waiting longer than clinically appropriate
- inconsistent processes between public hospitals particularly for emergency surgery
- surgical cancellations
- lack of access to specialist outpatient services
- capacity to provide surgical services in regional and remote areas
- lack of transparency in the management of the waiting lists.

7.3.1 Specialist outpatient services

Specialist outpatient services are a key element in the process of accessing public surgical services. There is significant variation between Queensland public hospitals in the way that specialist outpatient referral information is managed and collected with scant information relating to specialist outpatient services reported publicly. Therefore, it is difficult for patients and health care providers to make informed clinical decisions.

Based on the most recent survey of Queensland's public hospitals undertaken by Queensland Health in July 2004, it was estimated that 108,571 people were waiting to see a public surgical or medical specialist. Of these, 65 percent had not yet received an outpatient appointment with the remaining 35 percent booked for a consultation. Data was not collected on the length of time these patients had waited to receive an appointment or the length of time between getting an appointment and being seen. This indicates there is a significant access block to specialist outpatient services in public hospitals.

Up to 30 percent of surgical specialist outpatient appointments result in the patient being assessed as having a need for surgery. Of the 108,571 people waiting to see a public specialist in outpatients as at July 2004 (both surgical and medical specialist services), 83,240 (76 percent) were for surgical specialists. Based on the estimated conversion rate above, up to 25,000 would likely require surgery and would be placed on the public surgical waiting list.

Anecdotally, a large proportion of the 70 percent assessed by a surgical specialist as not requiring surgery are referred back to a GP for ongoing management of their condition.

As part of any reasonable health care system, patients and health care providers should have access to information on the availability of services at their local hospital, the expected waiting time for assessment in outpatients and the expected waiting time for treatment. Currently patients and health care providers do not have any access to information on the availability and waiting times for specialist outpatient services nor waiting times for surgery at the individual hospital and specialty level, both of which are imperative to patients and health care providers being empowered to make informed health care decisions.

In many cases patients are waiting excessive periods until being able to access specialist services, during which time they are not getting the required treatment. An important benefit of providing improved information at the District level on the availability and waiting times for specialist services would be for primary health care providers being able to consider interim treatments while the patient waits for access to specialist services.

Currently, Queensland is the only State or Territory in Australia that uses a 5 percent target for the proportion of elective surgery patients not treated within a clinically appropriate time. This benchmark was arbitrarily set and creates a disincentive to treat patients in order of clinical urgency.

Recommendation 7.3

Specialist outpatient and surgical waiting times should be made available publicly in such a way that it help patients and their health care providers make informed choices about their individual care options.

Recommendation 7.4

As part of the performance framework, report and monitor activity (weighted for complexity) and waiting times for elective, emergency and other surgery.

Recommendation 7.5

Consistent with the national approach to reporting elective surgery waiting times, the 5 percent long wait performance benchmark should be abolished consistent with the objective of prioritising patients according to clinical need.

7.3.2 Strategies to improve access to outpatient services

Queensland has a history of providing free outpatient services which began with the free hospital system. Twenty years ago, medical outpatient services were provided across the spectrum from general practice to specialist services. These services were free at all interfaces including the doctor, the prescription medicine and any other service. The major changes over time to this arrangement have been around the cost of prescription drugs which have been aligned to the Commonwealth's Pharmaceutical Benefit Scheme and the range of outpatient services provided.

Under the current Australian Health Care Agreement, states and territories are required to provide at least the same range and volume of outpatient services as they did on 1 July 1998. This requirement was in response to some states reducing the range of outpatient services available publicly thereby shifting the cost of these services to the Medicare funded private sector. States (Queensland in particular) that did not reduce access to outpatient services prior to 1 July 1998 are therefore unfairly impacted by this provision. It also suggests that Queensland should not expand such services as it is not required to do so under the Australian Health Care Agreement.

A practical strategy would include:

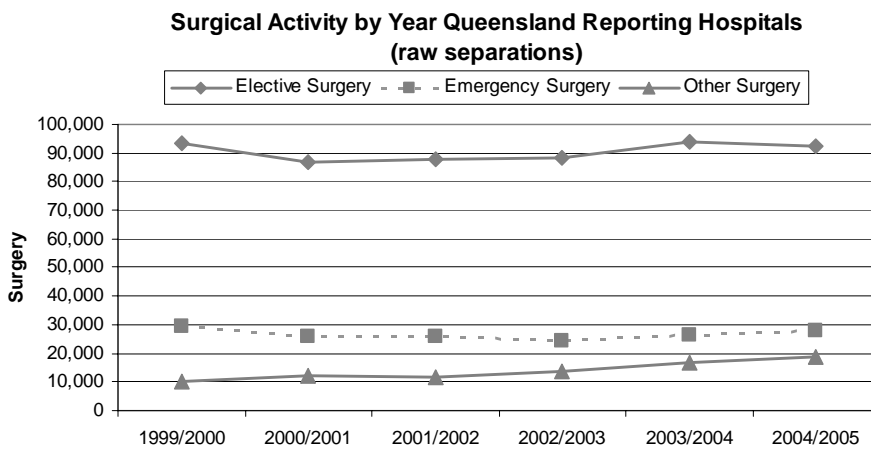
1. Maintain the current level and range of outpatient services.
2. Implement and support processes to improve productivity, eg.
 - new patient versus review patient ratios be piloted and benchmarked between specialty groups
 - appropriate clerical support for timely written communication with GPs
 - good discharge processes from outpatients to GPs
 - funding for GPs to continue to manage complex cases.
 - good support for GPs to manage complex cases with telephone and urgent consultation support for GPs who are managing complex patients
 - ensuring clinic time is appropriately booked and organised (eg. ringing patients the day before to remind them of appointments, ensuring medical records and test results are available).
3. Subsequent to these processes being implemented, the Queensland should advise the Commonwealth that outpatient services will not be expanded.
4. At a patient level, all patients who will wait greater than three months for an appointment should be advised so that they, with their doctor, can discuss other options, including accessing a private specialist.
5. For public patients who, after seeing a private specialist, require public inpatient care (eg. surgery) should follow a process that allows direct access to hospital care without an intermediate step of reprocessing through public outpatients.

Recommendation 7.6
 Increase access to specialist outpatients by examining opportunities, including those detailed in the report, for specialist outpatient services (surgical and medical) to be provided privately as is done in other States and Territories.

7.3.3 Surgical activity

In 2004-05, 139,009 surgical separations were provided in Queensland public hospitals representing around 20 percent of total hospital inpatient activity. It is estimated that surgery accounts for around \$1.1 billion of Queensland Health’s \$5.3 billion budget. Of the 139,009 surgical separations in 2004-05, 70 percent were elective procedures, 20 percent were emergency procedures and 10 percent were categorised as other procedures which includes diagnostic scopes such as endoscopies.

The level of surgical activity is largely driven by the demand for surgery and the availability of resources, specifically the availability of the clinical workforce and funding. Since 1999-00, surgical activity (raw) has remained relatively stable despite spikes in activity in 1999-00 and 2003-04 which can be explained by increases in resources allocated to elective surgery in those years. While elective surgery and emergency type surgery has remained relatively stable, there has been considerable growth of (82 percent between 1999-00 and 2004-05) in what is categorised as ‘other surgery’. The graph below shows the number of surgical separations provided between 1999-00 and 2004-05 split between the three categories of surgery which are emergency, elective and other surgery.



Source: Queensland Health Admitted Patient Data Collection (2005)

While the number of surgical patients treated has increased by an average annual rate of 1 percent since 1999-00, the complexity of cases has grown considerably. The number of weighted surgical separations, which is adjusted for complexity, grew by 8 percent in 2003-04 and 5 percent in 2004-05.

7.3.4 Surgical waiting times and performance

As noted in Chapter 2 of the report, national data indicates Queensland has the second highest rate of elective surgery in Australia and has the second highest rate of elective cases treated on time⁵⁸. Despite this, Queensland patients still wait longer than is clinically appropriate for many procedures, particularly for less urgent surgery and there is a significant access block issue for specialist outpatient services.

Based on preliminary 2004-05 data, 90.4 percent or 100,890 elective surgery patients were treated within clinically appropriate timeframes with around 10 percent or 10,691 patients waiting longer than clinically appropriate. Waiting time performance is reported across three categories of elective surgery which include Category 1, Category 2 and Category 3 and are shown in the table below.

2004-05 Elective surgery activity and 1 July 2005 waiting times

	Activity in time		Activity long waits		TOTAL activity Number	Waiting List	
	Number	%	Number	%		In time	Long waits
Category 1 (< 30 days)	35,155	89.6	4,102	10.4	39,257	2,255	128
Category 2 (<90 days)	44,895	90.6	4,644	9.4	49,539	10,114	1,290
Category 3 (< 365 days)	20,840	91.5	1,945	8.5	22,785	13,806	6,063
Total	100,890	90.4%	10,691	9.6%	111,581	26,175	7,481
Category 1: Admission within 30 days desirable for a condition that has the potential to deteriorate quickly, to the point where it may become an emergency							
Category 2: Admission within 90 days acceptable for a condition causing some pain, dysfunction or disability, but which is not likely to deteriorate quickly or become an emergency.							
Category 3: Admission at some time in the future acceptable for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency.							
Long waits: Patients waiting longer than clinically appropriate							

Based on data at 1 July 2005, there were 33,656 people waiting for surgery with 7,481 or 22 percent waiting longer than clinically appropriate. This figure reflects only the number of patients that have been assessed as requiring surgery through specialist outpatients. As noted in Section 7.3.1, it is estimated there are an additional 25,000 people waiting to get on the surgical waiting list. Recommendations to meet this excess demand are provided as part of the Section 7.3.7.

The total number of patients waiting for surgery declined from the peak of around 40,000 in 2000 to the lowest level of 31,478 in 2004 from which time the number waiting has since increased to the current level.

Little focus is given to the performance and waiting times for emergency and other surgery. The review has observed a lack of consistent processes in place for patients who require emergency surgery resulting in sub optimal outcomes. There is also significant variation between public hospitals in the way emergency surgery cases are managed and prioritised. Strategies targeted at improving the management of emergency surgery in particular are provided at Recommendation 7.8.

⁵⁸ State of Hospitals Report, 2005, Australian Government.

7.3.5 Funding surgical services

An issue brought to the attention of the Review is the different way that the categories of surgical services are funded. Elective surgery is funded on an activity basis with the level of funding allocated to a district dependent on the quantity and complexity of surgical activity within agreed targets. In contrast, emergency and other types of surgery are funded from the existing district base budget.

This inconsistency in funding arrangements has created incentives for health service districts to place a greater emphasis on elective procedures which may provide disincentives to treat patients in terms of general clinical priority. The funding arrangements for surgery must support good clinical practice and not differentiate between the provision of elective, emergency and other surgery or medical services.

The recurrent base elective surgery funding is \$83.7 million which has specific activity targets. Hospital activity targets associated with this recurrent funding have been maintained each year despite increasing costs of surgery. This means that the same amount of activity has been expected from the same pool of funds. This situation has resulted in cross subsidisation of elective surgery from other clinical areas within hospitals. This has meant that some districts have made decisions that have compromised clinical services to ensure that elective surgery targets are met. The Government has committed extra funding to elective surgery as part of election commitments and other initiatives.

Recommendation 7.7

Integrate the management and funding of all surgical activity including emergency, elective and other surgery with a view to prioritise patients on the basis of clinical need. This is consistent with recommendations in Chapter 6 where all acute services are proposed to be funded using a casemix funding model.

7.3.6 Principles of an optimal surgical access system

The Review has observed much dysfunction in the way surgical services are managed and provided by Queensland Health. Much of this could be attributed to the absence of an explicit goal for public surgical services. A reasonable goal would be to ensure that no person waits longer than is clinically appropriate for public surgical services including emergency cases. However, due to the high demand for public surgical services and the capped budget environment, articulation of a clear goal is challenging.

Given the interrelationship between the public and private health sector, it may be necessary to explore measures to ensure those least able to afford care are provided timely access to safe hospital services. Those with the capacity to pay should be encouraged to use the private sector with a view to restore a responsive public system for those least able to afford care.

A goal and a number of principles for improving access to safe and timely surgical services form the basis of the following recommendations.

Recommendation 7.8

That the following principles be adopted to guide implementation of recommendations to improve timely access to public surgical services:

- Access to both specialist outpatient and surgery services are prioritised based on clinical need.
- All patients requiring trauma surgery receive treatment within 24 hours if clinically appropriate.
- Encourage all patients with private health insurance to use it as private patients in public hospitals or in the private hospital system.
- Any planned increases in surgical activity needs to be considered in the context of bed capacity and the likely impact on medical patients.
- Additional non-emergency surgery should not adversely affect the provision of care for emergency (surgical and medical) cases.
- Patients and their primary health care providers (GPs) should be empowered to make informed decisions about their care which would include access to accurate and timely information about waiting times and costs.

Further development of these principles needs to be considered by the relevant clinical networks to guide a Government position on public surgical services in Queensland.

Potential measures to reduce the reliance on the public hospital system to provide non-urgent surgical services by those able to afford private care include:

- actively encourage the community to retain and use their private health insurance
- means test access to non-urgent public surgical services
- introducing a means tested co-payment for non urgent public surgical services to stop a shift from the private to the public sector.

As outlined in Chapter 3, there are some significant barriers to implementing these options including financial penalties based on current Commonwealth policy.

Recommendation 7.9

Explore the introduction of means tested measures for non-urgent surgical services to improve the safety and timeliness of public surgical services for those least able to afford care.

7.3.7 Strategies to increase surgical activity

An estimate of the level of additional surgical activity on top of that provided in 2004-05 is provided below based on the following elements:

- *Long Waits* - 7,481 elective surgery patients were waiting longer than clinically appropriate at 1 July 2005 which broadly equates to 12,122 cases weighted for complexity.
- *Unmet demand* - It is estimated there are an additional 25,000 patients waiting to get on the surgical waiting list. Given that the rate of growth in the number of people waiting for access to specialist outpatients is unknown due to no periodic data collected on these services, it is difficult to estimate what additional surgical activity needs to be provided to meet this demand. However, should the recommendations to increase access to outpatient services be successful, it may be necessary to increase surgical activity by 5,000 weighted separations per year until the excess demand has been met.

- *Natural Growth* - Emergency surgery has grown by an average of 5 percent per year since 2002-03. Applying this rate of growth to the 2004-05 level it is estimated that an additional 4,347 weighted surgical separations will present in 2005-06. Other surgery has grown by an average of 20 percent per year since 2002-03. Applying this rate of growth to the 2004-05 level, it is estimated that an additional 7,653 weighted surgical separations will present in 2005-06.

The following table shows an additional 31,195 weighted surgical separations would need to be provided to meet forecast growth across the three categories of surgery, estimated unmet demand and eliminate the number of people waiting longer than clinically appropriate. Based on the average cost per weighted separation of \$3,230, the estimated cost of this surgical activity on top of that provided in 2004-05 would be \$100.8 million.

	Elective Surgery	Emergency Surgery	Other Surgery	Total Surgery
2004-05	149,873	90,388	36,303	276,564
2005-06 Estimate				
- Long Waits	12,122			12,122
- Natural Growth	2,073	4,347	7,653	14,073
- Unmet demand	5,000			5,000
2005-06 TOTAL	169,068	94,734	43,957	307,759
Growth	19,195	4,347	7,653	31,195

Further modelling would need to be done to determine how this additional activity will focus on long wait specialities, continue to prioritise patients based on clinical need and meet the needs of communities outside of metropolitan areas.

The level of surgical services provided publicly is dependent on many factors including funding, infrastructure and workforce constraints and capacity in the private sector. Recommendations targeting an increase to public surgical services are provided below. While many of these strategies require additional funding, others relate to redesigning the workflow around surgery and creating more flexible working arrangements.

Recommendation 7.10

Increase surgical throughput by 31,195 surgical separations weighted for complexity at an estimated cost of \$100.8 million (\$61.6 million of which is ongoing).

Recommendation 7.11

Expansion of surgical activity, with a view to reducing excess demand, over and above existing targets should involve offering the opportunity to provide extra surgical services to the following (in order of priority):

1. existing staff specialists at overtime rates
2. Visiting Medical Officers currently operating in the public system (at sessional rates)
3. other specialists to operate as Visiting Medical Specialists (at sessional rates)
4. Where services are unable to be provided in the public system, activity at an appropriate type and volume should be offered to syndicated private specialists, private hospitals and other interested parties who operate outside the public system (contracted arrangements based on a specific performance agreement).

Recommendation 7.12

Investigate and pursue the following clinical quality and improvement practices with a view to improve surgical capacity and patient outcomes:

- Pre-admission clinics
- Day of surgery admission procedures
- Discharge planning processes
- Outpatient and surgical waiting list booking processes
- Peri-operative management guidelines and procedures
- Theatre management and utilisation strategies
- Integrated bed management procedures
- Flexible rostering of staff (including 10 hour shifts)
- Post-acute and transitional care services
- Hospital in the home services
- After hours theatre utilisation
- Dedicated trauma / emergency surgery sessions
- Dedicated hospitals for elective surgery
- Expand the 'Fit for Surgery' scheme
- Regular administrative and clinical audits of the surgical access waiting list.

Recommendation 7.13

That as clinical networks become established, they be given responsibility for the implementation of strategies to improve surgical access in Queensland public hospitals. This would involve providing advice and recommendations to the sponsoring Area Health Service General Manager on surgical access issues for implementation.

7.4 Rural and remote health services

Rural communities have a right to expect safe and timely access to health services. Approaches that look at preventing avoidable illnesses, promoting good health, managing chronic disease and coordinating care across the lifespan are critical to the longer term well being and health of rural communities.

However, geographic isolation and smaller populations necessitate different models of care from metropolitan areas. Workforce requirements are also different in rural and remote areas with a greater need for a flexible workforce of “generalists.” Workforce availability is a key issue, with some services reported to be at risk of closure due to staff shortages. The isolation of remote workers who often work without peer support or supervision can also lead to “burn out” and the loss of valuable skills for communities.

7.4.1 Service models

Working with the Commonwealth Government

The Commonwealth Government is a key partner in this regard and has played a significant role in funding and coordinating rural and remote health services and funding structures such as the Divisions of General Practice and Health Workforce Queensland. Additionally, the Commonwealth Government has worked in partnership with Queensland Health and local communities to improve services in rural and remote areas. Examples include:

- combining Commonwealth funded aged care facilities and Queensland Health acute services into Multi-Purpose Health Centres in some rural and remote communities
- supporting telehealth services through the Commonwealth Medical Specialist Outreach Assistance program (see boxed text below)
- development of integrated outreach services through the North West Queensland Allied Health Service (see boxed text below).

Notwithstanding these efforts, major Commonwealth programs such as Medicare are currently failing to provide universal access to health care in rural and remote communities where general or specialist medical practices are not viable. In these instances, Queensland Health is often the sole provider and carries a disproportionate burden in providing health care.

The Commonwealth Government has previously responded to a similar market failure in respect of access to medical services by Indigenous people. In this instance, the Commonwealth recognised Indigenous people were not accessing their per capita share of Medicare funded services and “cashed out” what would have been spent. This funding was used to establish alternative medical services provided by Aboriginal and Torres Strait Islander controlled health services (see separate section on Indigenous health for further discussion of these services).

A similar approach could be taken in the area of rural and remote health services. That is, the Commonwealth Government could “cash out” the per capita share of Medicare services to which rural and remote communities are entitled. In partnership with Queensland Health, alternative service models could then be explored, including fund pooling between the Commonwealth and State Governments and/or devolving health services in rural and remote communities to another provider.

Alternatively, the Commonwealth Government could adjust Medicare rebates to create additional incentives for doctors to work in areas of need, including rural and remote communities. This could be done within existing global Medicare funding by reducing Medicare rebates across the board and redirecting the savings to create bonus schemes that reward doctors with a commitment to working in areas of need. Current Medicare rebates could remain unchanged and additional funds could be used to create bonus schemes. This approach would be in line with previous initiatives by the Commonwealth to influence private medical practice through incentive schemes.

The Queensland Government should explore these options with the Commonwealth to improve access to Medicare funded health services in rural and remote areas and explore new service models that could be jointly funded by both levels of government.

Improving access to services through technology: Telehealth

Telehealth enables the medical workforce to provide “outreach” support to regional or remote facilities experiencing workforce shortages or with insufficient service volume to warrant a local specialist. To date, Queensland Health has developed telehealth initiatives to facilitate consultations via videoconferencing (eg a Brisbane based psychiatrist providing consultations to patients in a regional or remote centre) and transmission and reading of medical images (eg a radiologist in Brisbane reading images from a remote centre).

The Commonwealth has provided funds via the Medical Specialist Outreach Assistance program for the establishment of e-Health initiatives in TeleDermatology and, in 2005, for Teleradiology. These services are provided via the Australian College of Rural and Remote Medicine’s web platform Rural and Remote Medical Education Online

The Telederm service has operated since 2003 and was again funded in 2005. This service is available to all doctors in Queensland - both private and public. Over 600 doctors access this service to improve access to specialist advice to over 150 patients in areas where specialist services are not available. The service will extend to teleradiology from October 2005.

Queensland Health has invested significantly in telehealth, with 300 sites currently operating. Telehealth should be more widely integrated into service delivery to enable patients to be treated as close as possible to where they live.

Based on experience to date, telehealth programs should be developed in consultation with the providers expected to use them and a suitable clinical champion should be identified to encourage clinicians to participate in telehealth initiatives

One of the barriers to wider use of telehealth is the absence of Medicare Benefits Scheme recognition of private telehealth consultations in disciplines other than Psychiatry. This is a matter which should be pursued with the Commonwealth to recognise the legitimate role of telehealth/e-health in medical service delivery.

**Providing integrated outreach services to rural and remote communities:
North West Queensland Allied Health Service**

This integrated service model was developed to improve access to allied health services in north west Queensland. Before the service was developed, allied health services in this area were provided by a range of agencies with little coordination, short visits to communities, high staff turnover and service gaps in some disciplines.

Services are delivered using a hub and spoke model, with allied health professionals based in Mt Isa. Features of the service include:

- Allied health professionals travelling in teams
- Therapy assistants in each community to support follow up care and develop skills of local people
- Development of a six month calendar of service delivery to avoid clashes with other visiting services
- Each community is visited on a six-weekly basis
- A centralised booking number for referrals
- Use of videoconferencing to support therapy assistants, clients and carers
- Case conferencing with local health professionals at each visit
- Maximising clinical time and enabling service provision during the wet season by using charter aircraft to the Gulf and Highway precincts

The North West Queensland Allied Health Service is auspiced and managed by North and West Queensland Primary Health Care (formerly the Northern Queensland Rural Division of General Practice) and funded under the Commonwealth Government's Regional Health Strategy.

Directions for Queensland Health

Queensland Health's role in improving the health and well being of rural communities may involve directly providing services, coordinating provision in partnership with other providers or funders or completely integrating services.

All rural and remote districts should explore opportunities to replicate successful models such as these and develop innovative arrangements that maximise local services and resources. Sustainable service models must be:

- developed in direct consultation with communities, other providers and, where appropriate, the Commonwealth Government
- informed by the needs of the community based on its demography and service use patterns
- considered in the context of the changing nature of rural communities
- able to span the continuum of primary, secondary and tertiary care.

Consultation is required with rural and remote communities about the types of services which can and cannot be provided locally. It is easy to criticise Queensland Health for trying to scale down services in the bush when in some instances, this may be in the interests of patient safety.

For example, irrespective of workforce availability, it may not be safe to provide a service locally if there is insufficient volume of patients to maintain a practitioner's skills and credentials. Alternative models of care such as visiting specialists, assisted transport to larger centres, high quality aero-medical retrieval services and/or employment of an appropriately skilled generalist practitioner may need to be considered. These are difficult issues that should be considered and addressed locally.

Health service planning in rural and remote communities must take account of transport issues. On average, Queensland Health commits \$64 million annually to patient transport. This scheme is largely uncoordinated, resulting in a fragmented model of supply throughout Queensland⁵⁹.

The Review heard the travel subsidy scheme is not user friendly, does not reflect the true costs of living away from home for patients and/or their families and does not always take account of public transport routes which enable family and carers to join patients. Additionally, the Review heard that Queensland Health focused on the least expensive travel options without adequately considering the personal and health costs of some travel options. Bus travel, for example, can be uncomfortable over long distances at the best of times let alone when a person is injured or ill.⁶⁰

Queensland Health has commissioned a report "Access to Health Services (Transport is the Key)". This report should form the basis of decision making around changes and improvements to patient transport, particularly in rural, remote and regional Queensland.

Health services in rural and remote areas must be built on open and transparent communication and effective partnerships between local governments, Queensland Health and other government agencies. There is no place for intra-agency silos where

⁵⁹ Eustace G, Access to Health Care 2005

⁶⁰ RAPAD. Review of Health and Human Services p73. 2005

agencies see their activities as distinct from other government agencies.⁶¹ Local government has an important role to play as the representative voice of the community and should be involved in Queensland Health planning and decision-making, especially at local levels. Improved communication and the development of feedback channels and regular dialogue would support this increased involvement.⁶²

7.4.2 Building the rural and remote workforce

Service planning in rural and remote communities must be accompanied by analysis of existing and potential staff resources and the development of a workforce strategy. There are several dimensions to effective workforce management in rural and remote areas, including education, training and the development of incentives and professional support. This section outlines specific initiatives for the rural and remote workforce. Broader clinical workforce strategies are canvassed in Chapter 10 and apply equally to the rural and remote workforce.

Education and Training

In the 1990s, the Commonwealth and State Governments established Rural Health Training Units. In Queensland, three units were established (one in each zone) to increase the recruitment and retention of clinical staff in rural Queensland. The units have undertaken a range of initiatives including cultural awareness programs, programs for allied health skills enhancement and facilitation of recruitment to some allied health positions in rural and remote areas. However, each training unit has evolved differently.

Several reviews have identified that the roles and responsibilities of the Southern and Central Zone training units are unclear. Northern Zone has successfully adapted the training unit to play a workforce planning and development role which is well regarded within the organisation. The Southern and Central Zone training units should similarly be realigned and all three units should play a lead role in workforce planning for the three Area Health Services.

It will be important for these units to work closely with the university and training sectors at the regional level to ensure the health workforce is well trained and prepared for rural practice. Additionally, there is an opportunity to build on the benefits of recruiting rural students into health professional courses and teaching in rural, remote and Indigenous communities. Evidence suggests that students are more likely to choose rural clinical practice as a career if:

- they or their partner has a rural background
- they attended rural high schools
- they have repeated undergraduate rural clinical exposures and
- they have opportunities to work rurally during the early post-graduate period.

Intensive efforts must therefore be made to attract and assist students from rural and remote communities to study health professional courses and to provide rural and remote clinical placements for students.

⁶¹ RAPAD. Review of Health and Human Services p60. 2005

⁶² RAPAD. Review of Health and Human Services p 59. 2005

Additionally, Queensland Health should work with education and training providers to ensure availability of workforce roles that best meet the needs of rural and remote communities. As specialist services are generally unsustainable in rural and remote Queensland, there is a range of “generalist” roles which could be better used in these communities. These include the medical generalist, advanced rural and remote nurses, nurse practitioners and paramedic primary care practitioners. These roles need to be developed in very close consultation with communities and other partners. Given the immediate and long-term medical workforce shortages, the policy priority for government should be investment in generalist training (in primary care and specialist areas).

Building the Medical Generalist role

There is evidence that medical generalists produce comparable outcomes in a number of areas of specialist and sub-specialist medical practice (eg: birthing outcomes in small rural hospitals⁶³). The Review therefore supports the proposal put forward by the Queensland Government to create Rural General Medicine as a specialty with a broad scope of independent practice (in procedural areas as well as internal medicine and paediatrics). This should create a career path and increase the attractiveness of medical practice in rural and remote communities, at a time when numbers of rural generalists are decreasing. This role is distinct from a general practitioner or traditional specialist as it requires a broad understanding of diagnosis, treatment and management from the perspective of a number of medical and surgical disciplines and applies these along the continuum of care from primary to tertiary.

The Australian College of Rural and Remote Medicine is currently awaiting Australian Medical Council approval of this new medical specialty. It would be helpful for the Queensland Government to engage with the Australian Medical Council and the Commonwealth Minister for Health and Ageing to advocate for recognition of this specialty, which would significantly benefit existing and potential rural doctors employed by Queensland Health.

The Australian College of Rural and Remote Medicine has indicated its interest in working with Queensland Health to implement training towards the Fellowship of the Australian College of Rural and Remote Medicine. It is suggested that Queensland Health explore partnership opportunities with the College, including facilitation of registrar training placements in rural and remote settings that offer a wide range of health services across the continuum of care – for example, a mix of primary and hospital based training.

In small centres lacking a sufficient population base to support a full time salaried medical generalist, there is an opportunity for Queensland Health to help train procedural general practitioners. The Commonwealth Government has contracted the Australian College of Rural and Remote Medicine to administer key components of the MedicarePlus Training for Rural and Remote Procedural GPs program. This program supports procedural rural doctors for skills maintenance and upskilling in anaesthetics, obstetrics and surgery covering both formal (courses) and informal (clinical attachments) delivery modes. It is in the form of a grant of \$15,000 per doctor per financial year based on 10 days training at \$1500 per day. This funding is also available for procedural medical officers undertaking only rural hospital based work.

⁶³ Tracy M, The safety of small maternity unit in Australia- a population based study.2005

Queensland Health could partner with the College in facilitating procedural training for rural generalists, and promoting the Commonwealth funded procedural medicine grants to improve access to professional development for skills maintenance and upskilling for generalist proceduralists. This would increase availability of suitably skilled rural generalists. Additionally, this could be used as an avenue to recruit additional private procedural GPs into public service. For example, Queensland Health could offer training for GPs in return for providing services in the public system either through sessional work or innovative arrangements such as the Longreach group practice model.

Outsourcing hospital services: the Longreach model

The district visit to Longreach identified an innovative outsourcing model used to service the town's hospital. Under this model, the local general practice is contracted to provide a range of services to the hospital including having a doctor present from Monday to Friday during certain hours, undertaking ward rounds, providing cover to the emergency department, performing the duties of a medical superintendent and covering all other medical on call.

The general practice includes procedural GPs with anaesthetic, minor surgery and obstetrics privileging to enable some procedural work to be performed in town, with more complex cases referred to larger hospitals as appropriate. The practice is paid a set annual sum to provide this total service. This means that the general practice rather than the hospital is responsible for arranging annual leave, rostering, professional development etc.

This model maximises the skills and expertise of local doctors, enables a mixed model of public and private practice for the doctors involved and avoids over servicing or duplication of efforts between the public and private sectors.

Advanced nursing and nurse practitioner roles

These workforce roles are discussed in depth in Chapter 10. Advanced nursing roles enable nurses to take on some of the tasks currently performed by doctors, under medical supervision. Rural and isolated advanced nursing roles are already successfully used in Queensland Health and should continue to be developed and expanded. To this end, Queensland Health should increase places in the Rural and Remote Isolated Practice Nurses Program to meet increasing demand. The nurse practitioner role is still in the development stages and enables suitably qualified nurses to practice independently within their scope of practice. Both these roles have the potential to increase availability of safe, quality health services to rural and remote communities in the context of medical workforce pressures.

Paramedic primary care providers

There is interest in Australia and overseas in extending the role of ambulance paramedics, recognising that they are often the "first line" primary health care providers in small rural communities with limited or no local health services. An extended role could include professional responsibilities throughout the cycle of care, such as in the prevention of injury and illness, responding to emergencies, facilitating recovery, and planning future strategies for a healthy community.⁶⁴

James Cook University and the Queensland Ambulance Service have entered into a partnership investigating the extended role of paramedics in rural and remote areas, including assisting rural doctors and nurses to deliver primary health care.⁶⁵ Any future implementation of such a role will need to occur in close consultation with health providers and local communities and ensure that the emergency response function is not compromised in taking on this wider role.

⁶⁴ O'Meara, P, individual submission to the Productivity Commission health workforce study, August 2005.

⁶⁵ Queensland Government submission to the Productivity Commission health workforce study, July 2005

Attracting health professionals to rural and remote areas

The Review heard that clinicians feel isolated and unsupported in rural and remote areas. Measures to attract and support the health workforce in these areas are essential in order to ensure provision of sustainable health services.

Queensland Health does not value junior doctors, where they are left unsupported when sent to isolated areas to relieve and feel unprepared to do so.

Source: Submission to Queensland Health Systems Review, July 2005

Queensland Health does not support, recognise or value the role of the Generalist Practitioner, a doctor who is not a specialist of one procedural type, but someone who can provide a level of practice across many procedures.

Source: Submission to Queensland Health Systems Review, July 2005

I am a remote area nurse, I have a critical care certificate, am RIPRN endorsed an immunisation and women's health nurse and midwife. I am the only registered nurse and am on call 24/7. It is impossible to try and carry the burden of these workloads and keep your head above water ... we all enjoy remote area nursing but burn out/fatigue is a factor of our everyday life. We have no regular contact with our line manager (nurse).

Source: Submission to Queensland Health Systems Review, July 2005

Fair remuneration, conditions and support

Difficulties attracting and retaining health professionals to rural and remote areas are well known. The workforce profile in Chapter 10 highlights the maldistribution of doctors, with an oversupply in south east Queensland at the expense of regional and remote areas.

The Review heard of remuneration anomalies which frustrated and angered clinicians in rural and remote areas. Transparent and consistent "rural and remote packages" should be designed for professional groups working in designated rural and remote health districts.

Whilst transparent remuneration packages should be developed, district health services must also be allowed flexibility to negotiate any other assistance required to attract professionals to the bush. Districts must work with local governments, business and community organisations to facilitate the necessary support for clinicians moving to rural and remote areas – for example, assistance in finding accommodation or support for a spouse in finding employment.

As a retention incentive, consideration could be given to offering a service bonus. For example, clinicians could receive a lump sum bonus or additional recreation leave upon completion of a certain term of service, conditional upon a commitment to a further term of rural and remote service.

In considering such measures, Queensland Health should investigate incentives offered by other Queensland Government agencies to ensure some parity. During consultations, clinical staff indicated that they were aware of more generous remuneration and incentive packages in other government departments.

Training programs appropriate for isolated practitioners must also be established and delivered, before commencement of work in these areas. Ongoing support should also be provided, given that isolated workers often have limited professional supervision and support. Peer support networks could be formed, based around professional groupings

(eg sexual health nurses, isolated practice nurses, allied health professionals, medical generalists) or around streams of care (eg mental health, birthing services). To this end, Area Health Services should create peer networks to provide an avenue to problem solve, share good practice and build collegiate networks.

All rural and remote health services should be linked to tertiary hospitals through “networked services” within an Area Health Service. This would require tertiary hospitals to provide outreach services. A certain level of country service could be included as a condition of employment in key tertiary hospital positions, particularly in specialty or senior positions.

Country service register and incentive package

The Review identified difficulties in relieving rural and remote vacancies and staff leave. The current practice of sending junior doctors to the bush without adequate support and supervision is a major cause for concern.

Some districts have developed a register of metropolitan clinicians willing to perform country service on a short or longer term basis to assist in relieving vacancies and staff leave. A number of doctors, nurses and allied health professionals expressed interest in performing short term rural and remote service on a rotational basis and this goodwill should be used to assist smaller districts. This would provide a means of sending experienced clinicians to provide relief, resulting in a safer service to those communities and reduced risk associated with sending junior doctors to the bush.

Each Area Health Service should establish a register of interested clinicians and develop an incentive package to make the rotations attractive, this would include accommodation, meals, living allowances and travel. Other benefits might include offering additional recreation leave in return for a certain amount of country service, enabling the package to be promoted as a working holiday.

Increased use of GPs

In smaller centres without a sufficient population to support a full-time salaried medical officer, Queensland Health should consider employing procedural GPs on a sessional basis or through outsourcing of medical services under contractual arrangements, in line with the model successfully used in Longreach.

Potentially, this model could be extended to allow doctors to conduct their private practice clinics in public hospital facilities. This type of approach has been used in some areas by providing areas separate from the hospital for private practice, to enable Medicare billing. This approach has been found to work best in communities where there is only one general practitioner or general practice in the community, to avoid perceptions of unfair advantage.

Queensland Health has an existing policy allowing rural and remote allied health professionals in eligible districts to use public facilities for private practice. This entitlement should be well marketed during recruitment of allied health staff and all eligible districts should ensure existing staff are aware of this initiative and supported to take advantage of the opportunity.

7.4.3 Implementation

The above initiatives should be driven at the district level with coordination and assistance from Area Health Services. At the same time, a rural and remote clinical network should be established and funded to stimulate clinician led initiatives for rural and remote communities and assist in planning networks of services. Once established, some of the roles undertaken by districts or Area Health Services might then be devolved to this clinical network.

Strong community engagement is also essential in working through the complex issues around delivery of health services to rural and remote communities. Consultation, working together and seeking advice from community people, their leaders, other service providers and Queensland Health's own staff will significantly improve the feeling of ownership of decisions and empowerment of local providers.

Recommendation 7.14

The Queensland Government to encourage the Commonwealth Government to explore alternative funding or service models that would increase access to Commonwealth funded health services in rural and remote communities.

Safe, sustainable service models should be developed in partnership with rural and remote communities, the Commonwealth Government and other service providers. Suggestions should be drawn from innovative service models already in practice.

The report "Access to Services (Transport is the Key)", should be used as the basis for reforms to patient transport, particularly in rural, remote and regional areas.

Education and training providers will be engaged to assist with increasing workforce supply in rural and remote areas and better develop "generalist" roles including rural generalist doctors, advanced rural and remote nurses, nurse practitioners and paramedic primary care providers.

The Queensland Government to engage with the Australian Medical Council and the Commonwealth Government to advocate for recognition of rural general medicine as a new specialty.

Queensland Health will partner with the Australian College of Rural and Remote Medicine to facilitate procedural training for rural generalist doctors.

Remuneration and incentive packages, including better access to professional development should be improved, to attract clinicians to rural and remote areas.

Peer support networks should be established at Area Health Service level, for isolated workers, based around professional groups or streams of care.

All rural and remote services will need to be networked with larger centres, including a tertiary metropolitan hospital. The purpose will be to provide outreach services and some staffing relief.

Area Health Services will establish a register of clinicians willing to perform short or long term country service.

7.5 Indigenous health

7.5.1 Overview

Queensland has the highest percentage of Aboriginal and Torres Strait Islander peoples in Australia. In 2001, the estimated Indigenous population in Queensland was 125,910, representing 3.5 percent of the Queensland population and 27.5 percent of the total Indigenous population in Australia.

There are key demographic differences between the Indigenous and general populations in Queensland, including a higher proportion of Indigenous people in remote and very remote areas and a younger population profile. However, approximately half of Indigenous people live in urban areas. The types and models of services provided to Indigenous people must take these demographic issues into account.

Aboriginal and Torres Strait Islander people are amongst the most disadvantaged people in Australia, with lower levels of educational qualifications and median incomes in every occupation group, lower home ownership rates and over representation amongst the homeless population or those at risk of being homeless. Indigenous people are also imprisoned at a rate 14 times higher than the non Indigenous population and Indigenous children are over represented in the juvenile justice system.

The health inequities between Indigenous and non-Indigenous people are well documented and have persisted despite efforts by all levels of government to improve Indigenous health. The Interim Report showed that, on average, Indigenous Queenslanders die 20 years earlier than their non-Indigenous counterparts and experience a much higher burden of disease, including chronic diseases, injury and many infectious diseases.

Clearly, new approaches must urgently be developed to address the tragic and unacceptable health inequities facing Aboriginal and Torres Strait Islander people in Queensland today. This includes working with other sectors to try and better address the social and economic determinants of health, many of which are outside the direct influence of Queensland Health.

7.5.2 Addressing the social and economic determinants of health

Queensland Health should trial better ways to work closely with Indigenous communities, government departments and the private and non-government sectors to contribute to efforts to reduce Indigenous disadvantage in both urban and remote settings.

In 2002, the Meeting Challenges, Making Choices (MCMC) initiative was introduced with the intent of making concerted efforts to reduce violence and alcohol abuse in 19 discrete Indigenous communities. Strategies to address alcohol abuse were undertaken together with a range of social, resource management, governance, criminal justice and economic development initiatives. However, early indications are not showing the hoped for improvements in quality of life for people living in these communities.

The intended approach to alcohol management involved supply reduction (eg liquor restrictions) and demand reduction (including rehabilitation, treatment and diversion). Only the supply reduction strategies have been implemented in the past three years, through introduction of liquor restrictions in the communities involved. Given the high rates of alcohol abuse and related violence in the 19 Indigenous communities this is disappointing. Queensland Health must take some responsibility for this failure given its policy role in the area of alcohol abuse and its service roles in rehabilitation and treatment.

There are promising indications that Queensland Health is playing more of a leadership role in Indigenous health. It recently led the development of whole of Government initiatives to improve health in Indigenous communities, including initiatives to improve environmental health and housing quality. This package attracted new funding in the recent 2005-06 Budget and should complement boosted funding for Indigenous health services and the prevention and management of chronic disease.

These initiatives must be subject to rigorous and timely evaluation to identify and build on successful approaches, given the clear failure of many past initiatives to improve social and economic outcomes for Indigenous people.

7.5.3 Health promotion

Queensland Health has a role not only in health service delivery but also in promoting healthy living given the many preventable factors contributing to the high burden of disease amongst the Indigenous population including: low birth weight, obesity, poor nutrition in pregnancy, substance misuse and higher than average rates of cigarette smoking and illicit drug use.

Queensland Health should ensure that Indigenous people have access to information about healthy lifestyles that is culturally relevant. Availability of resources to help Indigenous people make healthy choices are also essential such as aids to help people quit smoking.

Queensland Health should also work with other agencies to make it easier for Indigenous people to make healthy choices. For example, Indigenous people should have access to affordable fruit and vegetables, regardless of where they live and town planning should enable safe and easy use of public spaces and facilities to improve physical activity.

7.5.4 Models of service delivery

There are a number of Aboriginal and Torres Strait Islander controlled health services in Queensland. In keeping with the philosophy of self-determination, these are community controlled health services. The Review visited a number of these which are performing very well but lacking resources.

Aboriginal and Torres Strait Islander controlled health services were introduced nationally in recognition that Indigenous people do not access as many Medicare funded health services as other Australians. Given that they offer an alternative to Medicare funded services, Aboriginal and Torres Strait Islander controlled health services are funded primarily by the Commonwealth Government. Queensland Health provides a much smaller funding contribution (reported to be less than ten per cent), which is lower than the contribution of some other States.

Most Aboriginal and Torres Strait Islander controlled health services are direct service providers, ranging from large multi-functional services employing several medical practitioners and providing a wide range of services, to small services without medical practitioners, relying on Aboriginal health workers and/or nurses to provide the bulk of

primary care services, often with a preventive, health education focus.⁶⁶ However, in one urban area, the Review identified an innovative service coordination model (see boxed text, below). This model may have wider applicability in urban areas where there are a range of locally available health services.

Purchaser/coordinator model for urban Indigenous health services

Under this model, the Aboriginal Medical Service (AMS) acts as a service coordinator by managing referrals and arranging prompt access by Indigenous clients to local primary health care providers (based on a list of approved providers). The model appeared to be well used, with 2,800 of the 3,100 resident Indigenous people registered with the AMS (based on Census data). Key features of this model are:

- using existing, local medical and allied health providers rather than designing a new, Indigenous specific service
- providers treat people with respect
- consumers have a choice of provider and enjoy increased confidentiality as they are not visibly accessing an Indigenous service
- only one referral is required for GP services, with new referrals required for each occasion of service for allied health and dental services
- consumers can access local health service providers rather than face the potential inconvenience of travelling longer distances to a single Indigenous service provider
- providers receive payment in return for collecting information for AMS

In addition to Aboriginal and Torres Strait Islander controlled health services, new models of Indigenous health services could also be considered including fund pooling, where funds from different sources are pooled and managed by an agreed service. Queensland Health has previously resisted the concept of fund pooling, even where it has been demonstrated that there are other providers more able to deliver programs, particularly in the areas of primary care and health promotion. However, there are promising signs that this may be changing. The Cape York Institute for Policy and Leadership is developing a new devolved model of budget holding involving a non-government organisation. Queensland Health is working closely with the Institute with a view to implementing this service model in northern Queensland, including remote Indigenous communities.

The private sector also has a potential role to play in developing new approaches to Indigenous health. The Rio Tinto Child Health Partnership is an example of the private sector, communities, governments, researchers and service providers working together to improve Indigenous health.

In rethinking service models, paternalistic approaches to services such as birthing should be addressed. There is strong international evidence suggesting that birthing can occur in very remote locations safely and with improved outcomes for the Indigenous families living in these areas. Indigenous women generally prefer to birth close to their home, community and extended family. In the absence of local services, some women opt for no care, rather than leave their community, potentially placing both the women and their babies at risk.

Dr Cherrell Hirst AO examined this issue in her March 2005 report of the Review of Maternity Services in Queensland and identified improvements for Indigenous women as a priority. It is understood Queensland Health is progressing the reforms and developing an implementation plan for consideration by the Queensland Government. For this reason, the Review has not developed specific recommendations in this area.

⁶⁶ National Aboriginal Community Controlled Health Organisation website

Given the persistent and unacceptable health inequities facing Indigenous Queenslanders, Queensland Health should increase investment in Indigenous health services with an overriding commitment to the principle of self-determination and community control. This could include:

- a greater emphasis on health promotion
- (whilst recognising that these services were initiated and primarily funded by the Commonwealth) increasing the Queensland Government's investment in Aboriginal and Torres Strait Islander controlled health services
- working collaboratively with Aboriginal and Torres Strait Islander controlled health services to build their capacity and share skills
- developing new service models including fund pooling and/or service coordination in collaboration with Indigenous communities, the Commonwealth Government, and the non-government and private sectors
- reviewing paternalistic approaches to services such as birthing
- prioritising essential services in areas of greatest health inequity and working with other providers to ensure approaches reflect best practice for Indigenous communities in urban or remote settings – for example, mothers and babies services draw on the successful Townsville program as noted in Dr Hirst's report
- together with the Commonwealth Government, increasing investment in the Queensland Aboriginal and Islander Council to build its capacity as the peak body for Indigenous health services in Queensland.

7.5.5 Building the Aboriginal health workforce

Just over one per cent of Indigenous school students attend university.⁶⁷ This relates to a range of factors impacting on Indigenous educational disadvantage including poverty, remoteness and negative experiences in schools.⁶⁹ Furthermore, Indigenous students who relocate from their community to attend university have poor completion rates, given difficulties in living alone and being away from family support. This compounds the social and economic disadvantage experienced by Indigenous people and limits the potential supply of Indigenous health professionals.

To redress this issue, recruitment from, and teaching in Indigenous communities should be a major policy priority for all levels of government. In particular, efforts should be made to:

- provide support and mentoring for Indigenous people throughout their studies.
- develop health professional education and training which involve less travel away from communities (eg by using technology) or, ideally developing training based in Indigenous communities. Queensland Health has developed a registered nurse training program that enables Indigenous people to complete training while remaining in their community.

⁶⁷ Smith Family website

⁶⁹ James Cook University submission to the Productivity Commission Health Workforce Study, 2005

- provide income support during training. Mature age Indigenous students with dependents are in particular need of programs to assist with moving to a distant population centre.

As the Commonwealth Government is responsible for income support and funding public universities, it has a responsibility to fund universities to integrate such initiatives into their learning support and equity programs. Equally, Queensland Health as an employer has a role to play in supporting the development of the Indigenous health workforce and should build on existing initiatives such as community based nurse training.

In terms of the Queensland Health workforce, the roles of Indigenous health workers should be better developed as some districts are experiencing shortages in this role. Indigenous Health Workers must be better remunerated and recognised as professionals, with the capacity to screen for disease, offer some treatments and be engaged in the development and management of services. Too often they are relegated to the role of ancillary worker or case manager, with no real autonomy in their roles. Better funded training programs (particularly in the area of mental health), staff mentoring and career development should all be features of an improved service delivery model.

As a principle, Queensland Health should aim to recruit local workers to local positions. The Review has heard anecdotally of situations where local applicants have been overlooked for positions in favour of outsiders. While applicants must demonstrate appropriate skills and capabilities, local appointments are more likely to result in staff retention. Where outside applicants are appointed, they should be supported to build effective relationships within the community.

I agree that more staff are needed, in particular female, but the key to effective communication with Indigenous people is to know how to link with appropriate community people. I have only been here for 9 months, and have developed a healthy relationship and liaison with the elders and I feel this should be continued as an integral part of strong formalised community links between health and the people.

Source: Submission to Queensland Health Systems Review, July 2005

Recommendation 7.15

Better ways will be trialled, to work closely with Indigenous communities, government departments and the non-government sectors to contribute to efforts to reduce Indigenous disadvantage in both urban and remote settings. In particular, Queensland Health will urgently lead the development of alcohol demand management strategies in the nineteen Indigenous communities where Meeting Challenges Making Choices is implemented.

There should be a stronger emphasis on health promotion so that Indigenous people have the skills, knowledge and resources to make healthy choices.

A more flexible approach to Indigenous health services should be established to support existing and new service models including fund pooling and service coordination models, with an overriding commitment to the principle of self-determination and community control.

Partnerships with universities and other providers should be developed to increase Indigenous entry and retention into health professional education and training.

The role of Indigenous Health Workers should be further developed, through access to funded training and skills enhancement programs and will aim to recruit local workers to local positions to improve staff retention.

7.6 Mental health

Since the early 1990s, Queensland Health has undertaken significant mental health reforms including:

- increased expenditure on mental health initiatives from \$240 million in 1997-98 to \$418.7 million in 2003-04 – an increase of 74 percent⁷⁰
- more equitable distribution of inpatient mental health services across the State - by 2002, Queensland Health had completed a process of decentralising inpatient beds from large psychiatric institutions to 18 districts, enabling more treatment of patients closer to their home
- development of community mental health services, particularly in regional, rural and remote areas where no services had previously existed. Community staffing numbers increased by an estimated 350 percent between 1993-94 and 2004-05.⁷¹
- an expanded range of adult community health services
- increased involvement of consumers and carers in the planning, operation and evaluation of services
- implemented quality management systems including minimum service standards
- improved intersectoral links, particularly with housing and disability support agencies eg through implementation of Project 300
- released a position paper supporting consumer designed, recovery-oriented service models which emphasise that even people seriously affected by mental illness can and do recover to live productive lives in their community.

These reforms have made a significant improvement to the quality of life of many Queenslanders with mental illness and were acknowledged by consumers and clinicians who met with the Review. In particular, the recent release of a position paper on recovery service models has met with universal stakeholder support and should guide future reform in mental health.

Despite these reforms, the most significant concerns expressed to the Review were the lack of access to, and quality of, Queensland Health mental health services. There were numerous tragic accounts of systemic failure within the community and acute settings. As noted in the Interim Report, Queensland has alarming suicide rates, particularly for Indigenous people. Overall, Queensland has the second highest suicide rate of the Australian states, approximately 30 percent above the rates in New South Wales and Victoria. This is an important indirect indicator of the mental health system given that 88 percent of people who die from suicide suffer from a diagnosable mental disorder at the time of their death⁷².

Consumers and consumer advocates believe they should have a much stronger voice in planning, delivery and evaluation of mental health services. Whilst in some services, gains have been made in engaging consumers in management teams, clients and advocates have indicated this is sometimes a token gesture, with many decisions in relation to the service made outside the executive committee.

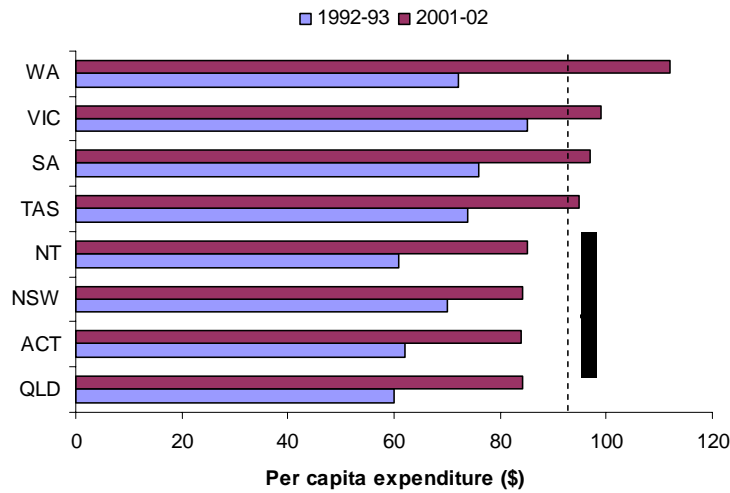
⁷⁰ Queensland Government submission to Senate Select Committee on Mental Health, 2005

⁷¹ *ibid*

⁷² Australian Bureau of Statistics, Mental health and well being: profile of adults, Australia 1997, 1998

The graph below shows that between 1992-93 and 2001-02, Queensland significantly increased mental health funding. Queensland’s per capita expenditure is comparable to NSW, ACT and NT.

Per capita expenditure on specialised mental health services by states and territories, 1992–93 and 2001–02



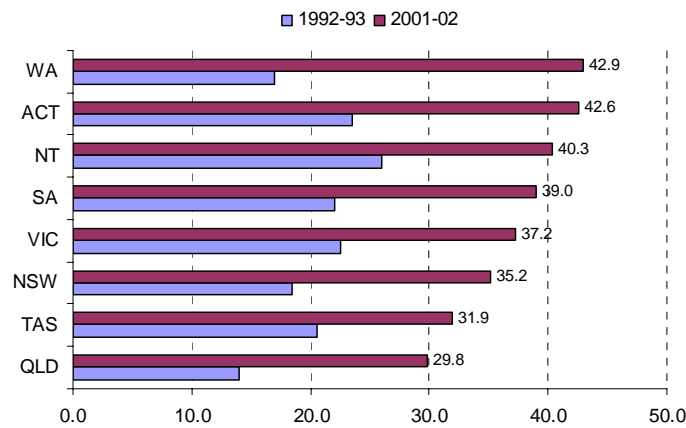
Source: Australian Government Department of Health and Ageing, 2004

Nonetheless, funding for mental health remains comparatively low, despite real funding increases. This is because mental health has had an historically low funding base and funding increases have occurred during a time when population growth in Queensland was twice the national average. In addition to concern about Queensland’s comparative low funding for mental health, there is concern that funding does not reflect the burden of mental illness in Queensland.

This needs to be redressed and, in particular, funding should be directed to enable Queensland Health to meet staffing targets for community mental health services.⁷³ The graph below shows that, despite significant increases in community mental health staff, Queensland has the lowest number of clinical staff employed in non-acute mental health settings. Consideration should be given to updating and providing flexibility in the community health staffing formula to reflect better the particular issues faced by some communities eg levels of drug abuse, socio-economic factors, family breakdown, lack of other support services, lack of alternative care and levels of unemployment.

⁷³ In 1996, planning targets were established at 30 per 100,000 total population for adult mental health services, 25 per 100,000 for the under 19 years population, 10 per 100,000 of the 65+ population, whilst targets set for Indigenous workers are at 5 and 6 per 10,000 for child and youth and adult services respectively.

Clinical staff employed in ambulatory mental health services per 100,000 population



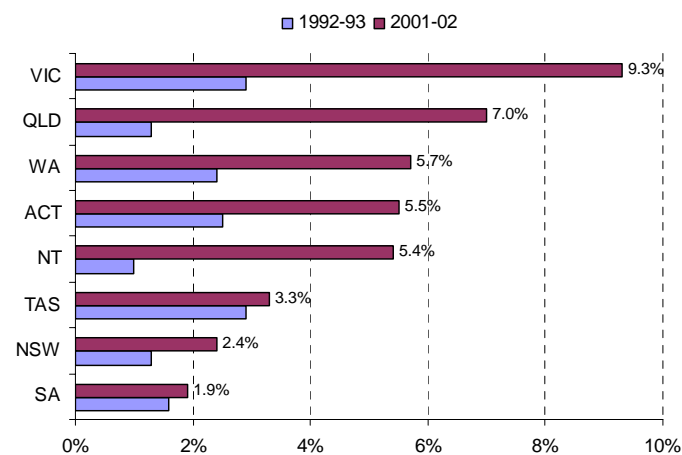
Source: National Mental Health Report 2004

There is a lack of transparency around so called “quarantined” mental health funding and that in some areas, dedicated funding is used for other services or to balance budgets.

Source: Submission to Queensland Health Systems Review, July 2005

Only \$6.9 million is directed to non-government organisations to provide community based social support and non-clinical mental health services.⁷⁴ However, the table below shows that Queensland spends comparatively more in the non-government sector as a proportion of overall mental health expenditure and has significantly increased investment in non-government organisations since the early 1990s. The Review heard directly from mental health consumers about the importance of non-government social support services in their recovery. The role of this sector should be significantly expanded, including stronger partnerships with the non-government psychiatric disability sector.

Funding to non government organisations as a percent of total spending on mental health services



Source: National Mental Health Report 2004

⁷⁴ Queensland Government submission to Senate Select Committee on Mental Health, 2005

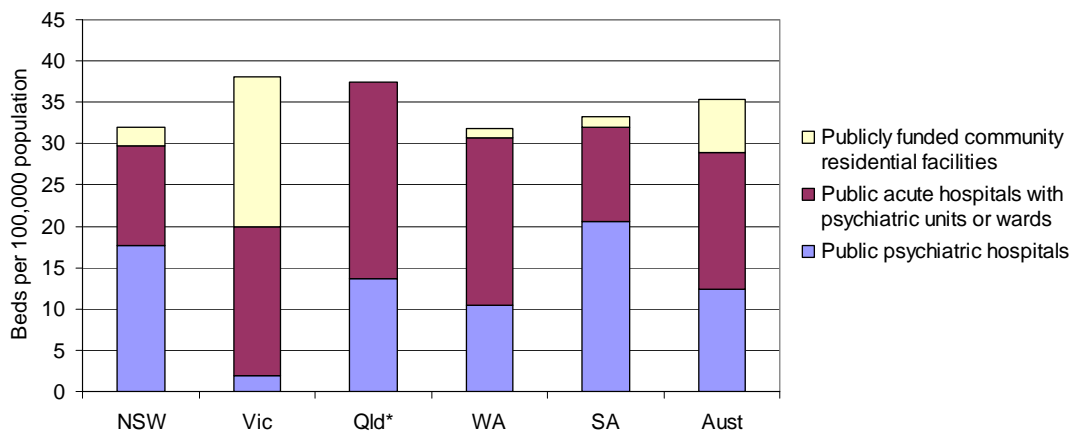
Development of a broader range of care models should take account of the potential contribution that non-government organisations and the private sector can make. Other jurisdictions have adopted models with increased use of private mental health services.

Whilst some links with the housing and disability sectors have been established, these arrangements are immature and there is scope for much improvement. In this respect, reform must be driven at the policy and strategic level as well as at the operational level, to improve alignment between departmental priorities.

Evidence shows that inappropriate discharge and lack of support often leads to adverse outcomes for patients. Tragic first hand accounts were revealed during public consultation sessions. As the graph below illustrates, there is need for improved housing and support for people with mental illnesses, including step down facilities for patients released from acute care. In the absence of a community residential sector, people with mental illnesses are living in inappropriate settings such as private boarding houses.

The non-government sector has a significant role to play in building this sector, given its experience and expertise in managing clients in the community and providing alternative types of supported accommodation. Their contribution cannot be enhanced without funding support. The Logan partnership model noted earlier in this Chapter provides a basis for further work.

Specialised mental health services, number of beds as at 30 June 2003



Source: *Mental Health Services in Australia 2002-03, AIHW 2005*

* Queensland does not fund community residential services, however, it funds a number of campus based and non-campus based extended treatment services. These services are reported either as wards of public acute hospitals or beds in public psychiatric hospitals.

Post-discharge support should also focus on broader issues including employment, rehabilitation and optimising the response to treatment, again through partnership with a range of other sectors. Queensland Health should work with the employment and training sector to develop targeted assistance for people with mental illnesses. Based on international evidence, there is room for much improvement in this area. In Australia, five per cent to nine per cent of public patients are within the workforce compared to other jurisdictions adopting a more holistic model of care which demonstrates 35 percent to 45 percent of patients undertaking some form of employment.⁷⁵

⁷⁵ Cochrane Collaboration, volume 3, 2005

Queensland Health also has a major contribution to make in efforts to reduce homelessness given high rates of homelessness in Queensland and the high prevalence of homeless people with serious mental illness, estimated in some international studies to be as high as 50-80 percent.⁷⁶ It is critical that Queensland Health work across government to implement and evaluate the new initiatives funded in the 2005-06 Budget to establish specialist mental health, general health and drug and alcohol services for people who are sleeping in public places.

Mental health service models must be developed in tandem with alcohol, tobacco and other drug services given the increasing numbers of dual diagnosis (mental illness and drug and alcohol problems) presentations to Queensland Health facilities. In particular, mental health services report increased demand and violence due to use of illicit drugs, consistent with other jurisdictions.⁷⁷ More integrated policy and service planning should be aided by the proposed collocation under the Chief Health Officer of the mental health and alcohol, tobacco and other drugs units in corporate office.

Providing a continuum of care for a widely dispersed population is challenging, particularly in rural and remote communities where local inpatient care is not viable. In these communities, the Review heard of particular difficulties given the lack of after hours care, necessitating travel, sometimes over long distances, to access after hours inpatient care. Queensland Health should provide outreach to rural and remote communities, explore community based alternatives to acute inpatient care and extended hours for community health services, and increase use of telehealth to address this issue.

The Review has also heard of a need for increased and improved services for children and young people, in particular early detection, prevention and intervention for child and adolescent mental health problems. Services catering to young people with dual diagnosis are also required, with services reporting an increase in illicit drug use and increased presentations with first episode psychosis in younger populations.

Indigenous people are over represented in the mental health services. During the Review's consultations, it was repeatedly reported that mental health services offered to Indigenous people were often culturally inappropriate, could not be accessed locally and that staff were very inexperienced in dealing with Indigenous people. This highlights a need for improved models of care developed with the involvement of Indigenous consumers.

There is also a high presentation of mental health clients in the prison system. According to the South East Queensland Prison Mental Health Service, there are 500 to 600 open cases at any one time out of a prison population of 3,500. This is not a stable population as patients come and go from the system with approximately 50 new cases each month. This service is provided by 2.2 psychiatrists and 1.5 allied health practitioners. The discharge and referral process to community mental health is complex and, whilst staff try to follow up they are not always able to trace the client. Additionally, the court liaison service is under-resourced, representing a missed opportunity to provide early intervention and treatment to patients in custodial settings, before they become involved in the criminal justice system.

In line with Queensland Health's increased focus on prevention, there is a need for more investment in preventative measures including mental wellness promotion, early

⁷⁶ "Homelessness and Accommodation", Schizophrenia Fellowship of NSW website

⁷⁷ *ibid*

intervention and relapse prevention. This could include increased “mainstreaming” of primary mental health services including an expanded role for allied health workers in community health settings. This should also involve whole of Government mental health promotion.

Mental health services face significant workforce pressures, including difficulty recruiting specialist nursing, allied health and medical staff. Existing staff report high levels of stress related to dealing with increasingly difficult clients and client aggression. Chapter 10 outlines a program of workforce reform including measures to increase workforce supply, improve recruitment and retention of our clinical staff and provide immediate relief for our stressed and overworked clinical staff.

There is also a perception that mental health is a marginalised issue within Queensland Health. Submissions to the Review highlighted the high turnover in corporate office mental health leadership positions and the need for stability in this regard.

Further mental health reforms will require strong leadership, continued and increased investment and strong involvement of consumers and clinicians. Whilst a mental health clinical network should be used to drive service and workforce planning, it will be essential that consumers, advocates and the non-government sector also participate in this work. As an immediate first step, it is suggested that Area Health Services coordinate a mapping exercise within districts to assess service needs, benchmark service levels and models with other jurisdictions, and identify partnership opportunities with other agencies and the non-government sector. This could inform a renewed reform agenda for mental health.

Recommendation 7.16

A review of the current funding arrangements for mental health should occur, and Area Health Services will undertake an immediate mapping exercise to inform further mental health reforms with a view to:

- Continuing to increase investment in the community health sector
- Increasing provision of supported accommodation including “step up” and “step down” facilities
- Developing new models of care with the private and non-government sectors and continuing to increase investment in non-government mental health services
- Increasing participation of consumers and carers in decision making
- Improving linkages and partnerships with other sectors to improve post-discharge support, improve services for population groups with multiple and complex needs and increase efforts around mental health promotion and prevention
- Improving mental health services for people in correctional facilities and custodial settings
- Increasing integration of mental health and alcohol, tobacco and other drugs services
- Strengthening organisational leadership around mental health including stabilising turnover in key central leadership positions
- Addressing workforce pressures as recommended in Chapter 10.

7.7 Community health services

District visits and consultation identified that many services are offered in Queensland Health community health centres ranging from primary and secondary interventions, particularly in the areas of child and family health, aged care services (Home and Community Care services), some rehabilitation services, such as stroke and cardiac, some health promotion and chronic disease management and some post-acute services. In the districts visited, there was significant variation in the types of services and programs offered in community health centres and in the degree of service growth that had occurred in recent years.

Across Queensland Health, it is not possible to define clearly the scope of community health services. A Community Health Position Statement was developed but there is general agreement it was too broad and has not guided service development or scope definition. There is no person in the organisation, either centrally or in the current zonal structure responsible for community health services. This has made service planning difficult.

There is no information system to record and report collective activity or performance and locally compiled information is not reported above the district level. This prevents any strategic assessment or planning of Queensland Health's community health services, particularly with private health service providers and hinders efforts to drive State-wide programs or reforms through the network of community health services. The paucity of information also prevents effective comparison with other States in terms of expenditure, activity and service models.

In the absence of clear scope definition, community health services are expected to be "all things to all people." The range of roles currently being offered is outlined below.

Promotion, prevention and primary care

Community health services provide health promotion, prevention and primary care services, including alcohol and drug education and counselling, sexual health service, parenting programs and, in some, patient education around disease prevention and chronic disease management. The promotion and prevention role is being expanded through placement of nutrition and physical activity workers in community health centres to address rising childhood obesity. Community health services accept self-referrals, creating potentially unlimited demand from individuals in the community.

Coordination with the acute care sector

Within Queensland Health, there is an expectation that community health services work with public hospitals to ensure that transition to community is facilitated and those services which do not have to be provided in an in-patient service can occur in the ambulatory setting. Some community health services provide post-acute care. However, district visits suggested that this service coordination is not working effectively in all sites. Given the pressure on Queensland Health's acute services this should be an area of priority for community health services and better service planning needs to occur across the hospital and community health settings. A good practice model in Victoria involving community health services is highlighted below. A similar approach in Queensland has been funded in the 2005-06 budget for chronic disease management, building on existing successful models in some Queensland Health service districts.

Victorian model to reduce hospital readmissions through community health services

The Victoria Hospital Admission Risk Program aims to reduce unnecessary hospitalisations for patients with certain conditions who don't always require the medically intensive services that hospitals provide. These people are activity assisted and supported in the community to manage their health conditions. The Program has successfully reduced the need for hospitalisations for the two targeted conditions of chronic obstructive pulmonary disease (COPD) and congestive heart failure. This includes reducing admissions for COPD from over 1,800 to under 400 per year over four years.

Interaction with general practice

As a GP, I am much more concerned about the lack of access to allied health services, services for people with chronic pain, assessment and interventions for children with learning difficulties and behaviour difficulties, parenting support for families, family therapy for those not functioning well, support for families with young disabled people, particularly access to respite and residential care.

Source: Submission to Queensland Health Systems Review, July 2005

The lack of a defined scope for what services are provided by community health means that general practitioners and other private providers have no clear idea of possible duplication or opportunities for collaboration and coordination. Even when GPs are aware of some of the services providers, there is potential for inefficiencies.

For example, some GPs make referrals to community health services to provide nursing and allied health services for patients on low incomes who cannot afford to purchase these services privately. However, some people are able to access Medicare subsidised private allied health services under a treatment plan developed by a general practitioner. As a principle, Queensland Health should not be duplicating allied health service provision where Medicare subsidy is available and should be working with GPs to encourage the development of treatment plans. The boxed text below highlights a good practice example of shared service planning and delivery in south east Queensland.

Shared planning and service provision

The development of the North Lakes and Surrounds Health Precinct is an example of the new way in which services should be planned. The Precinct has been planned through collaboration with local public and private health service providers and is taking a proactive approach to improving the health of the local community, with a focus on reducing avoidable hospital admissions and redirecting services where possible from an acute to community setting.

Local health service providers are collaboratively working towards changing the health care experience of local community members. The aim is for the local community to be screened for lifestyle risk factors as a part of their usual care, to prevent the onset of chronic disease and. The local community will experience greater coordination of their health care across providers. As their care will be based on agreed protocols, local community members will experience less unnecessary intervention and receive more consistent messages about what they can do to be healthier. Their communication with health care providers will be broader than doctor's visits and include telephone contact, email contact and home visiting.

Given limited public resources, there needs to be clarity about the role and scope of community health services and identification of which services are more appropriately offered by other providers. Queensland Health should consider whether it is feasible for community health services to play all of the roles outlined above.

Through district visits, community health services expressed a view that, proportionally, they do not receive as much growth funding as the acute sector. This is attributed to the greater political attention directed towards acute services. Chapter 3 noted there has been higher growth in community health services than the acute sector but consultation findings would suggest that this growth has not been adequate. Future expenditure on community health services should be determined by better scope definition and service planning.

Services also reported that their ability to perform effectively was limited by a lack of computers and other communication tools, vehicles to allow movement in and around communities, and general patient education information. In the districts visited, the Review verified this resource shortfall.

Directions for change

Other Australian jurisdictions use community health services more strategically to:

- provide health promotion
- provide interventions to reduce risk factors for chronic disease
- prevent unnecessary hospitalisations through alternative service provision
- provide post-acute care for those at risk of readmission.

Queensland should similarly adopt a clear, strategic approach to community health service provision. Given the issues identified above, this should involve:

- identifying positions which are accountable for community health services in each Area Health Service
- auditing community health services to identify what services are provided, examples of good practice and service gaps or challenges
- implementing an information system to assess activity, investment and outcomes
- defining the scope of community health centres across the continuum of care and lifespan and clearly delineating the roles of community health services and the population health function in Area Health Services
- aligning new health initiatives announced in the 2005-06 budget with the defined scope for community health services (particularly for the \$151 million over four years for chronic disease management) – this will include a focus on the provision of post-acute care, particularly for those at risk of re-admission
- developing services in collaboration with general practice, non government organisations and community groups, including opportunities for partnerships, outsourcing, service coordination or fund pooling.

Recommendation 7.17

Within 12 months, a clear, strategic approach to community health service provision in line with the directions for change outlined in section 7.7.1. will be adopted.

7.8 Health services for Queenslanders in correctional institutions

The Review has been made aware that the Department of Corrective Services is responsible for the provision of health services to prison populations. These populations have vastly worst health status and outcomes than the average population, and have a much higher representation of Aboriginal and Torres Strait Islander people and people suffering from mental health problems than relative components in the general population. It is also significant that prison populations, on average, turnover in less than six monthly periods when this cohort of people are again part of the general community.

There is need to ensure that health service provision within the correctional system is adequate, and that people although incarcerated are receiving services that will address current needs and most importantly prevent escalating problems once released into the broader community.

There are limitations with the current arrangements in that health services are not considered to be the core business of correctional service management, and there is evidence that health priorities are not being adequately addressed. There is also information to suggest that political and managerial decisions are made about matters that should probably be decided by clinicians.

Whilst it would be imprudent to transfer the responsibility for correctional services population health to Queensland Health at the present time when it is experiencing such service delivery difficulties, it would be reasonable for existing arrangements within correctional facilities to be properly funded and resourced, and for clinicians to make appropriate decisions about the best types of medication regimes that should be provided to these people. Failure to do this will only exacerbate health service problems in the broader community. The Department of Corrective Services and Queensland Health should undertake discussions to ascertain the best model for the delivery of health services to correctional institutions and, if a change is warranted, to ensure this occurs in a timely and appropriate way given all of the other priorities outlined in this report.

Recommendation 7.18

Health care in correctional institutions be resourced adequately and Queensland Health and Department of Corrective Services seek agreement on the best future delivery options.

7.9 Oral health services

Queensland has the worst dental health in Australia and is one of the few States which continued the provision of a free dental health service for eligible adults following the Commonwealth government's withdrawal from providing subsidised access to dental health services nationally.

Approximately 25 percent of the Queensland population is eligible for free dental health services in Queensland, including school aged children and adults with health care cards or pension cards. Despite recent increases in the oral health budget, Queensland Health is unable to meet the demand for oral health services, with emergency rather than routine dental services representing a significant proportion of adult health services provided.

Dentist positions within Queensland Health number around 300. Queensland Health is attracting less graduate dentists and has problems recruiting and particularly retaining its dentists, placing the long term viability of public oral health services at risk. Contributing factors are significantly higher private sector incomes and the less challenging nature of the work performed in the public sector.

An innovative approach to retaining dentists in the public system is a trial being conducted in the Hervey Bay region, using a mixed public/private service model. Public sector dentists are given the opportunity to work one day per week on private patients in Queensland Health facilities. An additional dentist was employed to ensure the public service levels were maintained while the dentists themselves paid the oral health service an hourly fee that covered the use of the facility, staff and materials. This fee represented total cost recovery for Queensland Health.

The benefits to Queensland Health, dentists and patients were seen as very positive, including:

- stabilised staffing as dentists had greater work satisfaction, practiced skills they did not have the opportunity to use in the public sector and enjoyed better remuneration
- increased throughput of public occasions of service by 5 percent
- patients, both public and private, received the initiative very positively
- private dentists and the Australian Dental Association endorsed the trial as it provided them an opportunity to refer patients they could not see due to excessive demands.

To improve provision of equitable, timely and sustainable oral health services, it is proposed that:

- school dental services be continued
- eligibility criteria for adult services be reviewed, to target them to individuals of greatest need in the community
- increased interaction with the private sector be considered including outsourcing and mixed public/private models such as that being trialled in Hervey Bay
- alternative workforce roles be considered, eg enhanced roles for dental therapists.

In respect to outsourcing, persuasive submissions were received from practicing professionals which confirmed that a higher participation by private dentists would be very beneficial, but would require flexible arrangements and fee rates based on each professional's local circumstances.

This is exactly the level of decision authority clinical networks and district health services need to have to ensure highest value use of scarce oral health resources.

Recommendation 7.19

Options to improve provision of oral health services be explored including continuation of school dental services, review of eligibility criteria for adult services, alternative workforce roles and mixed models of public/private practice. There should be an informed public debate about widespread fluoridation of Queensland's water supply.

The involvement of private sector oral health practitioners in delivering public services be encouraged through local fees and arrangements that flexibly address the merits of each case.

7.10 Child and youth

Children and young people have distinctive health needs and priorities that differ from the adult population. Queensland Health provides many services and programs for children, young people and their families across the continuum of care. Key services or programs provided include:

- early childhood health services
- early intervention and parenting support programs including the highly regarded Positive Parenting Program (Triple P)
- school or child care based services such as school nurses and oral health services;
- hospital based paediatric medical and surgical services and associated developmental, allied health and rehabilitation services
- information and support services
- child and youth mental health services.

However, Queensland Health does not have a comprehensive plan for children and young people across the continuum of health, despite children and young people aged 0 to 14 years comprising 20 percent of the population. A child and youth clinical network is suggested to undertake dedicated planning for children and young people's health. This could be informed by reviewing and benchmarking existing initiatives and identifying gaps or opportunities for further focus. Suggested areas for attention are identified below.

One opportunity would be to implement a key recommendation in the March 2005 report by Dr Cherrell Hirst AO on maternity services in Queensland to create "bub-hubs" to provide more seamless transition from maternity services to child health services for families with newborn babies. This would build on the existing integrated maternity, child and youth health services that have been developed in some health districts. There is also an opportunity to develop further the network model in paediatric services, particularly through clinical education and telehealth.

Queensland Health has recently undertaken a mapping exercise and identified a need for investment in:

- increased community based early intervention services for children, in line with international evidence of the benefits of investment in early childhood;
- community based paediatric services for children with chronic conditions, developmental delays and developmental and learning disabilities; and
- health promotion in early childhood and school settings targeting areas of highest need including communities with high Indigenous populations.

In line with discussion throughout this chapter, it is important that Queensland Health works with other providers and organisations in developing new or enhanced children's services. In particular, Queensland Health should continue working with other agencies to build on the Queensland Government's major priorities of education reform and child safety. Continued efforts to identify and assist "at risk" families are required to reduce the risk of child abuse and neglect.

Whilst efforts should be focused on prevention and early intervention for children, there clearly remains a need for high quality acute paediatric services. The duplication of expensive tertiary paediatric sub-specialty services at both the Royal Children's Hospital and the Mater Children's Hospital does not appear to be a sustainable model. Rationalisation is recommended to improve service sustainability, maximise available resources and reduce pressure on staff currently experiencing onerous on-call arrangements.

Recommendation 7.20

A state wide network should be developed for child and youth health across the health continuum involving other major providers and partners. Further expansion of telehealth services should occur where appropriate to maximise availability of paediatric services and clinical education. The development of tertiary paediatric sub-specialty services should be reviewed.