

3. Rural, regional and remote issues, Indigenous communities and community/patient advocates

3.1 Background

The terms of reference require the Review Team to examine the systems issues from the various patient perspectives. To this end the following issues, whilst briefly mentioned in other parts of the report, will be dealt with separately in this chapter.

3.2 Rural, regional and remote issues

An important part of the consultation process has been with the rural and regional communities. It was not possible for the Review Team to visit the more remote parts of Queensland. However, with the establishment of the Regional and Rural Remote Reference Panel, the Review Team has been able to gain some insights into the specific problems of these communities. The following represents some of the themes discussed with the Panel but are in no way a full description of the issues which face these communities.

A major issue facing rural, regional and remote communities is that they do not have the population size or economies of scale required to maintain a highly skilled professional and representative workforce. Staffing problems exist, are slightly managed in some professions by the use of incentive packages but most arrangements are ad hoc, and not strategically designed. Shortages exist in all health professional groups in rural, regional and remote Queensland.

Situations described by people throughout the consultation phase represent what could be called a downwards spiral effect of staffing levels partly reflective of the changing nature of rural communities and partly a cause of that changing nature. We know that people will be attracted to areas that provide an appropriate level of service. The services cannot exist without the infrastructure to support them and infrastructure requires people.

Some of the issues raised include maintaining the workforce through appropriate remuneration, recognition of the need for access to training and professional development, quality and safety issues for rural services, and integration and partnerships.

Remuneration

There are currently incentive packages available to nurses working in those areas defined as “remote” but not to other staff working in those areas. These positions are in the Primary Health Care areas. It is therefore important to note that the packages do not apply to a large number of nurses working in isolated areas. The definition of remote is based on distance and isolation. There are no incentive packages for staff to work in rural and regional centres. The reference panels have made many suggestions in regard to applying flexibility to incentive arrangements based on other descriptors.

Training

Often staff who go to these areas are under prepared, especially where there are fewer staff for support in times of clinical need. This leads to staff having a less than satisfying experience working in areas outside the southeast corner.

There is an argument put that rural and remote medicine and nursing should be recognised as being of a specialist nature and that training programs should reflect this. The perception is that Queensland Health does not value and support the role of the “generalist”, who is seen as the backbone of rural and remote services.

Lack of access to ongoing training is often cited as a deterrent to staff doing a rural, regional or remote term or contract. Staff indicate that they feel “forgotten” and “unsupported” on these placements.

This particularly relates to the International Medical Graduates and those staff who work beside them in very isolated practice. A clear message from the consultations was that “training should not be considered an add on, but is essential to the viability and quality of health services”.

Engagement with the university sector has been “patchy” and based on the premise that if someone else pays, Queensland Health will engage but will not willingly “user pay” for quality education and clinical placement in rural and remote areas.

Quality and safety

The following were identified to ensure quality and safety in areas of varying levels of clinical practice, support and supervision:

- Developing a culture that is comfortable with clinical audit
- Multidisciplinary approaches to care and training
- Adequate relief of all staff and a manageable workload
- Continuing professional education for all clinicians
- Further development of clinical guidelines and standardised care protocols
- Develop models of health care that reflect the primary care nature of rural services, recognising that hub and spoke models are necessary to provide the higher levels of support when needed.

Integration and partnerships

Many people identified that in some non-metropolitan areas, different services were still operating independently of each other. Examples were given of where the public sector had not acted to engage a very active private sector, leading to duplication of services. The private sector (including General Practice) often felt they are in competition with, rather than complimentary to, public health services.

Concern was expressed that there has been rhetoric about integration and partnership but it is not always clear what this means in practice and limited progress has been made.

The workforce turnover in rural, regional and remote health services is high and results in considerable loss of corporate memory. Partnerships between communities and service providers could help to minimise this. (This is even more important for Indigenous communities where clinicians often stay only months and at best a year and, more unusually, longer). Junior doctors describe a situation where they feel unsupported when sent to isolated areas to relieve and feel unprepared to do so. Queensland Health does not recognise and 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. It was suggested that Queensland Health should do more to support and encourage doctors who express a preference for this sort of work.

General practitioners in rural areas particularly feel they are not engaged and recognised by local public health services as having something to offer. They feel they are losing and have lost a large percentage of procedural skills because of the employment and remuneration practices of Queensland Health, but it is also recognised that in some rural communities, local general practice provide no services or support to the public sector.

3.2.1 Principles

- Need to examine, describe and implement the best models of care for our communities based on a principle of engaging the community in those discussions and decisions.
- Ensure that staff are adequately trained and prepared for work in rural, regional and remote Queensland.
- Develop networks of care around primary, secondary and tertiary services and adhere to them.
- Ensure professional relationships are developed based on networks.
- Develop multidisciplinary training and development for teams working in rural and remote areas.
- Engage with other sectors, including the private sector and universities to better enhance integration of services.
- Provide appropriate incentives for staff and their families to provided services in these areas.
- Establish better linkages and support between metropolitan hospitals and small regional hospitals.

3.3 Indigenous health issues

Aboriginal and Torres Strait Islander people comprise approximately 2.2% of Australia's total population. Queensland has the highest percentage of Aboriginal and Torres Strait Islander people representing 3.5% of the Queensland population and 27.5% of the total Indigenous population in Australia. Queensland is the only state that recognises two distinct Indigenous communities, Aboriginal people and Torres Strait Islander people.

Approximately 20% of the Indigenous population live in remote and very remote areas compared to 1% of the total population. 39% of the Indigenous population is under 15

years of age compared with 21% of the total. Only 2.6% of Aboriginal and Torres Strait Islander people were over the age of 65 years, compared with 12.2% of the total. 50% of the Aboriginal and Torres Strait Islander people in Queensland live above the Tropic of Capricorn and 50% below. Many reside in close proximity to urban health services but do not necessarily access them for reasons including access disadvantage and for the lack of cultural safety and sensitivity felt by the community.

Aboriginal and Torres Strait Islander people experience social disadvantages, which is explained in chapter 2 as having a profound adverse impact on the health status of Indigenous people. For example, lower levels of educational qualifications and median incomes in every occupation group, lower home ownership, and are over represented amongst the homeless or those at risk of being homeless. They 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.

Major health issues

Aboriginal and Torres Strait Islander people have significantly poorer health outcomes in areas such as:

Based on death:

- Heart disease (death rate around double that of the non-Indigenous population)
- Diabetes: is 17 times higher than the non-Indigenous population (Type 2 diabetes more common). Aboriginal and Torres Strait Islander people are more likely to develop diabetes at a younger age and die earlier from diabetes.
- Chronic respiratory disease: is 5 times higher than for the non-Indigenous population
- Pneumonia: is 10 times higher than for the non-Indigenous population
- Accidents are 3 times higher than for the non-Indigenous population

Mental Health: The rate of hospitalisation for people with mental health issues is 3 times higher than the non-Indigenous population

Other diseases can also be described in the above terms such as eye disease, self harm and assault, ear disease, oral health and diarrhoeal disease and tuberculosis.

Health risk factors

There are other social and lifestyle factors contributing to the high burden of disease amongst the Indigenous population which include low birth weight, obesity, poor nutrition in pregnancy, substance misuse and higher than average rates of cigarette smoking and illicit drug use.

Consultations

As highlighted in chapter 2, it can be argued that the gaps in the health status of Aboriginal and Torres Strait Islander people are not being bridged. The Review Team were able to speak to many people across the state, either consumers of services or staff working with Indigenous peoples within the various communities. Whilst there were many examples where districts had worked hard with local communities to improve

relationships and services, there were still many examples of the fragmentation of services which occur for Indigenous people and the need for improved service delivery arrangements.

Indigenous health workers describe a system that does not value them or their need for training. They see themselves being expected to be “all things to all aboriginal people” and that other staff often use them inappropriately to help deal with difficult Indigenous staffing issues. There is a perception that there is an insufficiently focussed and resourced commitment by Queensland Health and the government to improving the health of Indigenous people through the coordination of programs, many of which could involve numerous departments.

Indigenous peoples both in the workforce and the community do not believe they have a place at the decision making table at the local level and cite many examples of difficulties with mental health and birthing services. The relationships with other providers of services to Indigenous clients are in some places very good and non-existent in others. There is no systematised approach to networking with other service providers.

The total percentage of Indigenous workers in the Queensland Health workforce is 2.15%. The recruitment, retention and development of a skilled workforce is one key component of health system reform which encompasses new ways of working across the health sector through community capacity building, innovative clinical pathways and models of best practice and regional management

In many discrete rural and remote communities, Queensland Health is the sole provider of health services to Aboriginal and Torres Strait Islander people. In planning the effective delivery of programs and services for Aboriginal and Torres Strait Islander communities, Queensland Health needs to increase investment in and consultation with Aboriginal Controlled Community Health Services and the people themselves. Greater consideration should be given to more flexible governance and funding options, such as pooling of resources within a local community or region.

Aboriginal Controlled Community Health Services could provide Queensland Health with an opportunity to consider better ways of affording access to health services for Aboriginal and Torres Strait Islander people. Consultation indicated that partnerships of this type could move to better offset the economies of scale in providing high quality and culturally safe health services to rural and remote communities, including a better sharing of resources and information. There are other worthwhile partnership approaches as well, including those with tertiary providers.

In 2004-05, \$4 million in recurrent funds was allocated to improve access to health services for Aboriginal and Torres Strait Islander people in Queensland. It allowed Queensland to strengthen the partnerships with the Commonwealth government to enhance primary health care for Indigenous communities and contribute to other Indigenous health initiatives. Added to this is another \$68.8 million over four years as a targeted investment with an emphasis on prevention, early detection and early intervention.

This Review is continuing to assess how best Queensland Health can address this priority but at this point has concluded:

- Significant added resources will be required for programs from prevention, community education and support, through to acute services, with targets for health status inputs over a number of years.
- Targeted programs which incorporate higher levels of recruitment and up skilling of Indigenous health workers must be developed with all Aboriginal and Torres Strait Islander communities.
- The way forward must include the greater resourcing and empowerment of existing community health services.

3.3.1 Principles

- Health service delivery models would become an integral part of community driven social and economic enhancement strategies that would be reflective of Indigenous culture and the need for cultural safety.
- Indigenous peoples should be involved in deciding how their care is delivered.
- Empower Indigenous health services to develop flexible, local delivery models to improve the health status within communities. Queensland Health should support and encourage this model so that all Aboriginal and Torres Strait Islander people are receiving health services relevant to their health needs.
- Health service delivery strategies should reflect the role of Indigenous health workers in helping Indigenous people to access care.
- Partnerships with other key providers should be an integral part of the service delivery model.

3.4 *Issues expressed by community/patient advocates*

The Review has conducted a number of public forums and consulted with a number of patient and community representatives. Some former patients were praiseworthy of their local health service. Others expressed satisfaction with service quality and care. Others were far less complimentary and raised problems relating to systems which include:

- Excessive and unacceptable delays for accessing specialists in outpatient clinics at public hospitals after receiving a referral from a general practitioner, and before being scheduled on an elective surgery waiting list.
- Cancellation of scheduled elective surgery times – often at the last minute, sometimes twice (reportedly due to hospital emergency department use of theatres, decision of specialist to address another more urgent priority, theatre nursing staff unavailable to extend theatre times).
- All patients in some clinics are given the one appointment time, leading to frustration because of length of time patients are kept waiting. This is worsened when doctors arrive late for clinics.
- Poor communication from doctors regarding explanation of cancellation, procedures or implications.
- Do not receive care from the one nurse while in hospital – patients often do not see the same nurse twice, and nurses often appear very inexperienced.

- A desire to explain symptoms and problems to one doctor once.
- Moved from one ward to another, sometimes more than once, due to limited bed numbers.
- Nursing staff too busy to attend to basics, care and hygiene.
- Discharge uncertainty, too early, delayed, sudden.
- Long lapse times before letters from specialists are forwarded to general practitioners about follow up care.
- Lack of support following discharge.
- No or limited mental health facilities or specialised medical support – a frequent complaint.
- If patients or carers wish to complain there is no clear avenue – where it is clear, patient experiences were quite variable – many said it was not a patient friendly experience and not focussed on resolution.
- Subsidised transport arrangements being inflexible, resulting in assignment to locations by air or road when there are no public transport options to return home.
- Lack of integration of services between Queensland Health and the non-government sector which provides the majority of post-acute and community health care services.

These issues were all noted to ascertain how system improvements would help to address such outcomes.

Patients and participants at forums shared their direct experiences and concerns, frustrations, sorrow and anger about poor clinical outcomes for loved ones or from their own experiences.

The Review noted systemic relevance and advised some individuals where to refer their unresolved issues. It can be concluded that service and care in some instances is insufficiently patient focussed. Patients in these cases were being expected to receive service to suit the requirements of an imperfectly performing public system rather than the system being designed in the best interests of the patient.

Others raised uncertainty, doubt and a lack of trust in public sector doctors, especially overseas trained doctors, due to direct experience (Bundaberg) or reported experience of others. In some districts, overseas trained doctors with long experience and of high standing commented that this dynamic was much more noticeable and prevalent and had become a significant problem in the doctor patient relationship.

As indicated above, delays in access to specialists in outpatient clinics has been a source of frustration in the community. As detailed in chapter 5, there is evidence to suggest Queensland faces shortages in a range of specific specialities. A key consequence of these staffing shortages has been high patient workload for specialists in shortage areas.

This has led to significant delays for patients between their general practitioner's referral for a specialist appointment and the time of the appointment. Appointments are determined by specialists in Queensland Health on the basis of urgency, based on information provided in the general practitioner's referral. General practitioners and their patients have asked for a system that provides greater certainty as to likely waiting times for their first appointment.