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An Australian Government Initiative

IMPACT STATEMENT

Health and Wellbeing Queensland Bill 2019

Submitted by Western Queensland PHN

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IMPACT STATEMENT

Health and Wellbeing Queensland Bill 2019

The link between social and economic conditions and health inequities is well established; disadvantaged populations almost always have poorer health[1] and poorer access to health care.[2] Western Queensland Primary Health Network (WQPHN) since operation in 2015 have worked under a clear mandate to address health inequality within a framework of respect and accountability to those living and working in the region. A social determinants model has been adopted together with a patient-centred health systems integration approach, enabling a broader perspective on the health and social care needs of individuals, their families and communities in which they live.

The change to legislation to incorporate an Act to establish **Health and Wellbeing Queensland** to improve the health and wellbeing of the Queensland population is supported by WQPHN. Our PHN will play a key role and function across Western Queensland (56% of Queensland landmass) as a cornerstone organisation, tasked with linking, coordinating, engaging and commissioning the health, social and economic sectors to bring about change so that the patients receive the right care in the right place at the right time. We come from a broader social determinants lens and would like to bring to the attention of the members of Parliament the strengths of WQPHN and the influence this will have on the proposed legislation. Expected impacts include:

1. Making the health and social care system accessible and culturally safe
2. Shift towards care that is personalised and better coordinated
3. Investment in multi-sector approaches and partnership models
4. Greater understanding of priority populations through data surveillance systems, research, analysis and sharing of information
5. Implementation of strategies that focus on illness prevention and wellbeing promotion across the life course, including continuing to target risk factors at key life stages.

[1] Marmot M., Allen J. Bell R., Bloomer E & Goldblatt P (2012) WHO European review of social determinants of health and the health divide. *The Lancet*, 380, 1011–1029.

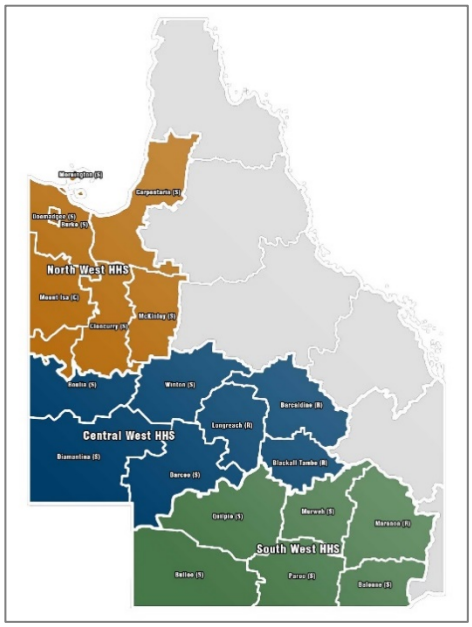
[2] Commission on the Social Determinants of Health (2008) *Final Report—Closing the Gap in A Generation*. World Health Organisation, Geneva.

Sustained progress for improving the health and wellbeing of Western Queensland people, reducing risk factors of chronic disease and reducing health inequity will require action across the both the health system and the social determinants of health. WQPHN is well positioned to drive multi-sector approaches to build capability both by eliciting ideas and fostering innovation, through structural mechanisms (such as Service Level Agreements, performance targets, incentives) and championing change across the WQPHN region. Collaboration and partnership approaches bring strength to drive improvements in illness prevention and health promoting behaviour.

Background

People in Western Queensland communities are renowned for their strength and resilience in adversity. The WQPHN extends across a geographically (55% of Queensland mass) and demographically vast and diverse area accounting for much variation across the region. There are over 50 identified communities within the WQPHN catchment, incorporating regional centres, small towns, agricultural communities, pastoral stations and remote Indigenous communities. Vast distances are required to travel to provide services.

The Western Queensland population has mixed health status with small pockets of high advantage and in stark contrast areas of extreme disadvantage. This is compounded by the remoteness of the region and higher incidence of chronic disease and lower life expectancy when compared with Queensland and Australia.[3] These challenging health outcomes are realised by high hospitalisation rates including Potentially Preventable Hospitalisations (PPHs,) significant health service disadvantage, and limited access to general physician input and support.[31]



As stated, people in Western Queensland communities are renowned for their strength and resilience in adversity, however the recent floods and ongoing drought has compounded the complexity of response required in supporting people in the region.

The total number of people in WQPHN with one chronic disease or more is 27,682 persons (38% of the general practice population), and WQPHN practices also report over 12,000 patients with two or more chronic conditions.[4] When considering Potentially Preventable Hospitalisations (PPHs) in Queensland's public hospitals, WQPHN has the highest rate of all Queensland PHNs with 17.7% of the total admitted patient separations in 2016/17.[5] Diabetes complications form the highest proportion of Chronic PPH in WQPHN with 833 admitted patient episodes or 44% of chronic PPH and

[3] Queensland Health. (2018). The Health of Queenslanders 2018. Brisbane: Seventh Chief Health Officer Report, Brisbane.
[4] WQPHN (2019) PAT CAT Data for Combined Practices for Month of January 2019. Mount Isa
[5] Queensland Health. 2019. http://www.performance.health.qld.gov.au/Hospital/SpecialistOutpatient/99999 (accessed March 2019).

23.8% of all PPHs. In 2016/17 there were also 21.2% of admitted patient episodes of care for COPD, the 2nd highest cause of potentially preventable hospitalisation in the region.

In our PHN the estimated leading causes of death from chronic conditions includes coronary heart disease, cancer and COPD.[6] The increasing chronic disease burden in WQPHN is mostly associated with unhealthy behaviours such as smoking and poor diet, where 30% of the burden in WQPHN could have been prevented by reducing exposure to modifiable risk factors.[7]

WQPHN has the highest proportion of overweight and obese persons (18+), 67% (2 in 3 people) compared to every other PHN in Queensland (73% males, 60% females). Even more concerning is the number of children aged 5 to 17 years in WQPHN who are overweight and obese (39% v 24% QLD), which is nearly double when compared to other Queensland children. [8] Likewise, daily smoking rates are highest of all PHNs in Queensland (20%), with smoking rates for Indigenous double that of non-Indigenous and maternal smoking rates for Indigenous women more than five times higher compared to non-Indigenous women living in the region (51.4% v 9.4%).[9] Not surprisingly, lung cancer is the leading cause of premature mortality in WQPHN.[8] Excessive alcohol consumption is also a major concern with 30% of people (I in 3) reporting a risky lifetime alcohol consumption (more than two standard drinks per day on average), with men particularly at risk with nearly half (43%) reporting excessive alcohol consumption (v 32% QLD males). Poor diet and physical inactivity are also contributing to ill health and impacting on the increasing chronic disease prevalence across WQPHN. Comorbid conditions in Western Queensland has led to increased complexity of care, especially mental health with nearly one in four people (23.1%) at risk of developing a mental health disorder.[10] WQPHN three Hospital and Health Service (HHS) regions had the highest mental health Emergency Department (ED) presentation to population ratios in Queensland (ranging from 1.3% CWHHS, 1.5% SWHHS and 2.3% in NWHHS). In 17/18 approximately 500 suicide specific ED presentations occurred in WQPHN (almost 3% of the total in Queensland and almost half of the MH ED presentations in WQPHN). Of these types almost 60% were Indigenous. These types of ED presentations were very high in the 15-34 age group and high in the 35-54 age group.[11]

The Indigenous population living in WQPHN (17.2%) are the most vulnerable group within the catchment. Chronic diseases are responsible for a major part of the life expectancy gap between Indigenous and non-Indigenous. The burden of disease for Indigenous begins much earlier in life, and is principally due to the excess burden of chronic disease—the burden rate in the age group 35–54 years was about 2.8 times that of non-Indigenous Queenslanders.[12] The mortality gap between rural and remote areas and major cities continues to be high in Australia. This mortality gap is influenced by the higher death rates of Aboriginal and Torres Strait Islander people and by higher death rates among young adults living outside major cities. The median age of death for Indigenous

[6] ABS. (2017). Causes of death 2017 (3303.0). September 2016. Retrieved from Australian Bureau of Statistics: http://www.abs.gov.au/ausstats/abs@.nsf/mf/3303.0
[7] WQPHN (2018) Our People, Our Health, Our Partnerships. 2017-2018 Health Needs Assessment Summary, Western Queensland Primary Health Network, Mount Isa. http://wqphn.com.au/resources/wqphn-publications (accessed March 2019)
[8] Queensland Health. (2016). Preventative Health Survey regional results (adults and children) 2009-10 through 2015-16. Retrieved February 2, 2018, from https://www.health.qld.gov.au/research-reports/populationhealth/preventive-health-surveys/results/regional (accessed March 2019)
[9] Queensland Health. (2018). The Health of Queenslanders 2018. Brisbane: Seventh Chief Health Officer Report, Brisbane.
[10] WQPHN. (2017). Mental Health, Suicide Prevention, Alcohol and Other Drug Services, Regional Plan 2017- 2020. Mount Isa: WQPHN.
[11] Queensland Health (2018) Emergency Department Information System (EDIS). (unpublished data).
[12] Queensland Health. (2016). The burden of disease and injury in Queensland's Aboriginal and Torres Strait Islander people 2014. Brisbane.

people was approximately 18 years lower compared to non-Indigenous in WQPHN. Deaths that could have been avoided or prevented are higher in the region than the Queensland average.[13]

Obesity is a significant public health challenge for WQPHN and is compounded by significant issues associated with food security, particularly access to healthy food in remote and very remote communities. The built environment and limited access to sport and recreation services is a major barrier to accessing healthy lifestyle options (increases with remoteness), together with a lack of access to early intervention and prevention services. Health promotion and prevention capacity has been severely diminished since state government restructures in 2012 where many prevention services were abolished. This has resulted in very limited health promotion and prevention services (early intervention, screening, detection, education) including clinical, healthy lifestyle and community workforce initiatives. Evidence exists that the existing workforce including public, private and NGO providers are working hard to support access to health checks and clinical prevention services, with increases in MBS utilisation uptakes, increases in health checks in remote communities and increased access to mainstream services by Aboriginal and Torres Strait Islander people. [14,15] However, despite these positive gains, significant gaps exist in capacity to truly address inadequate access to prevention and health promotion needs across the lifespan. This compromises the risk and protective factors available to individuals and communities to mitigate their risk of developing disease by adopting healthy behaviours.

Addressing the modifiable risk factors is a key priority for WQPHN and the establishment of the Health and Wellbeing Queensland agency will make a significant contribution to addressing risk factors associated with chronic disease and ultimately reduce the disease burden and health inequalities experienced by people living in WQPHN. For gains to be made, we need to address the root cause of ill health and the factors that influence them. This will require collaborative cross sector response as there are many drivers of ill health that lie outside the direct responsibility of the health sector. Section below outlines the expected impacts the proposed legislation will have building on the capacity of WQPHN as a key organisation who can support the achievement of policy objectives for the Health and Wellbeing Queensland Bill 2019.

Expected Impacts

1. **Making the health and social care system accessible and culturally safe**

- WQPHN have implemented a new regional care model known as the Western Queensland Health Care Home (WQ HCH) that is focused on transitioning to value-based healthcare that improves the efficiency and sustainability of services, improves the provider experience, but also directly contributes to a better patient experience and understanding of their needs.[16] Ultimately, this model translates to a new patient-centred model where consumers participate in their own healthcare, where a team of professionals are accountable for their needs, and where care is well coordinated including expanded access to services. A culture of reflective

[13] Queensland Health. (2018). The Health of Queenslanders 2018. Brisbane: Seventh Chief Health Officer Report, Brisbane.
[14] MBS. (2016). MBS data by PHN and MBS Item for 2012-13 to 2015-16. Australian Government, Canberra
[15] WQPHN (2019) PAT CAT Data for Combined Practices for Month of January 2019. Mount Isa
[16] WQPHN (2017). A Health Care Home for Western Queensland, Health Care Home Plan. November 2017, Ernst & Young, Mount Isa.

practice and quality improvement is central to the implementation of the model and initial outcomes from the formative Early Adopter Program (EAP) evaluation highlights that the program has positively impacted on improved practices and patient experience outcomes. The WQ HCH program will commence rollout in July 2019. The model has been adapted from international models and includes 10 Foundation pillars to supporting high performing primary care. Our model also incorporates 'access to care' and 'preventative care' as key domains for driving change together with 'chronic and complex care' to address WQPHN needs assessment priorities as outlined in the background section above. The model is a vehicle for change, primary care performance and sustainability that will connect individuals, their families and carers with the broader health and social care system and will provide a platform for the proposed Health and Wellbeing Queensland entity to drive the change needed to meet the objectives and functions outlined in the Health and Wellbeing Bill 2019 Explanatory Notes.[17]

- WQPHN are building engagement capacity with the Aboriginal and Islander Community Controlled Health Sector (AICCHS) through the Nukal Murra Alliance and continue to invest in planning to improve health outcomes and culturally appropriate access to health services for the Indigenous population. This includes improving cultural competency at the heart of lifestyle risk factor management for Aboriginal and Torres Strait Islander peoples through WQPHNs commissioning for better health framework.
- WQPHN are building workforce capacity and innovations where teams of Indigenous and non-Indigenous staff are working side by side, supporting the health needs of patients. Roles such as Aboriginal Health Workers (AHWs) have had a significant impact as two-way learning has built an environment of mutual respect, cultural safety and respect for the community. This inter-cultural view has seen increased access to Aboriginal Health Assessments, improvements in treatment compliance, particularly in AICCHS and enabled trusted relationship building.
- Workforce challenges in recruiting and retaining skilled staff has long been a challenge in Western Queensland, however opportunities for creation of new career pathways and roles has emerged as a consequence.
- Introducing career pathways that encourage a "grow your own" approach in remote regions that commence at school and are continuing through the youth sector and employment agencies is seen as a key priority in WQPHN. It is well documented that remote regions have significant challenges is recruitment and retention of workforce, not only in the health sector but more broadly.
- As a priority for the Health and Wellbeing Bill 2019, WQPHN would encourage a workforce strategy that includes new and innovative approaches to attracting and growing a health workforce with roles such as Aboriginal Health Workers/Practitioners, Health Coaches and Preventive Health workers linked to General Practices as well as the broader community at the fore.
- Leveraging from Nursing and allied health students across the University Departments of Rural Health in supporting LRFM for child and adult risk factors in alignment with local education and lifestyle modification organisations, but importantly linked with and informed by local general practice networks.
- Hard to reach and marginalised groups such as those re-entering society from the justice system will benefit from lifestyle risk factor modification given WQPHN focus on supporting

[17] Queensland Government (2019) Health and Wellbeing Bill 2019 Explanatory Notes, Authorised by the Parliamentary Counsel on behalf of the Parliamentary Committee, Brisbane.

psychosocial and wellbeing support, including access to stepped care and linkage through social care networks and coordination through general practice teams.

- Housing for Health (Indigenous housing support to address overcrowding) is a priority with 14% of Aboriginal and Torres Strait Islander people living in overcrowded conditions (v 2% non-Indigenous).[18] With significant rates of infectious disease, cellulitis and RHD in very remote Indigenous communities, there are significant opportunities to collaborate in long term environmental health improvement initiatives that directly respond to the critical role healthy living environments contributed to maintaining healthy lifestyles, particularly functioning safe home environments for Queensland's most vulnerable populations. Remote PHNs are ideally positions to augment Commonwealth support and harmonise primary care and housing and environmental health improvement.

2. Shift towards care that is personalised and better coordinated

- Care pathways traditionally — especially between primary and acute care — are often poorly coordinated. Clinicians and patients operate under a *veil of ignorance* posed by inadequate information flows and haphazard data collection. Whilst, regulatory and jurisdictional obstacles frustrate both HHSs and general practitioners, WQPHN are building capacity through better coordination of the system, including the acceptance of people themselves as partners in their own health management. Examples of enabling levers that are shifting care that is more personalised and better coordinated include:
    - development of decision support systems (visualisation dashboards)
    - development of disease registers
    - effective data collection and management systems
    - collaborative data collection tools
    - increased access to telehealth through links between specialists and general practice (eConsultation model)
    - care pathways documented and communicated effectively
    - Health information technology used to build connectedness
    - Links to public health and social capital
    - Governance and partnerships have created a coalition of interests aimed at an integrated health system (e.g. Clinical Chapters and Councils, Community Advisory Council)

- Activating the patient through harnessing / incentivising non MBS lifestyle risk factor management support in general practice populations through WQPHN partnerships and support for programs such as My Health for Life
- Use of technology that enables and activates self-guided patient interventions (e.g. Weathering Well App, New Access health coaching)

3. Investment in multi-sector approaches and partnership models

[18] ABS, Census of Population and Housing, 2016, unpublished data

WQPHN have invested significantly in partnership development and multi-sector approaches. Evidence includes:

- WQPHN has formal protocols with the three WQ HHSs that provides for greater collaboration and joint planning of primary health care services, including the Maranoa Accord and Western Queensland Health Services Integration Committee (WQHSIC)
- WQPHN also maintains close working ties with QAIHC and the WQ ACCHOs and is actively developing a formal co-commissioning agreement to inform joint planning, data sharing and joint commissioning
- The WQPHN regional Clinical Chapters (SW, CW, NW) and network-wide Clinical and Consumer Advisory Councils enable effective clinical leadership and community engagement in planning and policy making
- Co-commissioning opportunities and leveraging from the PHN Commissioning for Better Health Program (and providers)
- WQ HCH model of care has created an environment to support greater partnership across all the key providers in the region (e.g. HHSs, AICCHSs, CheckUp, private General Practice, RFDS, allied health professionals, NGO social care providers)
- The development of a Lower Gulf Strategy in partnership with Gidgee Healing and NWHHS
- Child and Family Health Framework implementing 'Healthy Outback Kids' in Charleville, Cunnamulla and Mornington Island.
- Introducing the Western Queensland Health Care Home model of care through Charleville RFDS.
- Introducing a care coordination model for mental health in General Practice across WQPHN region.
- QH Integrated Care Innovation Funds (ICIF) projects plans
- Diabetes and mental health general practice based collaboratives

4. Greater understanding of priority populations through data surveillance systems, research, analysis and sharing of information

WQPHN have invested significant infrastructure in understanding priority populations. This includes QlikSense platform, a Health Intelligence Portal (HI) and clinical dashboard for Practices. These platforms are being used to develop / leveraging shared health intelligence to inform, design and measure interventions tailored for priority population segments. WQPHN is also uniquely positioned with 95% data sharing arrangements with HHS, ACCHO and General Practice networks, as well as the customised Qliksense data (HI) portal which acquires more than 15 validated data sources and configured to HHS, Locality and LGA mesh reporting levels, (including SA1, 2 and 3). The HI portal is available to partner organisation and enables users to monitor and measure population based performance and metrics in real-time. Users can visualise and analyse data on a set of Key Performance Indicators (KPIs) across four domains including: population and social determinants; health status; population focus groups (e.g. Indigenous health) and health system performance. The data platforms are providing visibility in understanding priority populations, enabling the identification of hot spots, and priority health issues.

5. implementation of strategies that focus on illness prevention and wellbeing promotion across the life course, including continuing to target risk factors at key life stages.

Experiences with My Health 4 Life (MH4L)
WQPHN has developed a partnership with Diabetes Qld to assist with the roll-out of the MH4L program in the challenging remoteness of the regions we serve. My health for life is a free, lifestyle modification program designed for people at high risk of developing a chronic disease. Eligible participants are moved through a behaviour change model to assist them in identifying a personal lifestyle change goal and are then provided the support and tools they need to help enact change. The evidence-based program is delivered in six sessions over six months.

The programs model has had some challenges to being delivered on the ground within the WQPHN region. These have included the transient workforce where 15 facilitators for the program have been trained in the past 12 months and only 3 remain in the region. Different models including tele/videoconferences as well as face to face delivery with regional coordinators are now being implemented. These challenges highlight the need for several different modes of delivery for programs such as these are needed and although face to face delivery is preferred by communities, a mixed delivery mode is often more realistic.

WQPHN is well placed to advise and provide learnings and experience to the Health and Wellbeing Bill 2019 when planning, designing and implementing early intervention and prevention programs and services to remote regions.

Motivational interviewing competency at the heart of effective lifestyle risk factor modification (LRFM)
Empowering and activating patients and carers to be involved in goal setting, self-management and delivered health messages at the health literacy level required is central to comprehensive chronic disease management, early intervention and prevention program delivery. The motivation interviewing and CBT models are used in many contemporary programs now being delivered nationally.

WQPHN Mental Health programs (e.g. New Access, Weathering Well, Social and Emotion Wellbeing) use these well know models to engage patients in improving their own health and wellbeing. Working with the Health and Wellbeing Bill 2019 to continue and build on these evidenced-based models will be key to build on the outcomes as they emerge from these programs.

School based health promotion
WQPHN are increasingly developing constructive engagement with primary and secondary schools throughout the catchment, including the harder to reach 'school of the air' families. Primarily the Commissioning approach enables significant agility and flexibility in primary care activities and bundled payment arrangements that accommodate a range of face to face, virtual and group activities. Upskilling of school curriculum (i.e Orygen, Beyond Blue) targeting well-being and child and adolescent resilience are key avenues to expand support for remote and very remote schools who are often providing the main focus of engagement and a key avenue for early LRFM education and healthier behaviours. More needs to be done through leveraging from the school routine, infrastructure and curriculum to better integrate and primary care approaches and linkage for life long health living practices including mental health, physical activity, STI and nutrition.

Mental health
The WQPHN *Mental Health, Suicide Prevention and Alcohol and Drug Regional Plan 2016-2020* places an emphasis on the significant risk of chronic disease for people experiencing mental illness. Also highlighted in the 5th National Mental Health Plan, the high prevalence of chronic disease risk in people with mental illness is a key focus of the WQPHN Plan as is the recognition physical activity

and healthy lifestyles contribute to better mental health and wellbeing outcomes. In WQ it is estimated up to 40% of the population are at risk of or are experiencing mild, moderate of severe mental illness [20] . As a peak provider of community low intensity and general psychological services, the WQPHN is very well positioned to work with the HWQ to ensure this significant burden of illness and the strong association with maintaining well-being is afforded innovation, flexibility and integrated commissioning approaches in practice.

Food security

Low income households, single-parent households and Aboriginal and Torres Strait Islanders are those most at risk from food insecurity, with up to 30 per cent of Aboriginal and Torres Strait Islander households in remote Australia being food insecure.[19] WQPHN support the development of food strategy for the region including policies to support access to a healthy diet and supply chain issues that impact on access to healthy food. WQPHN is well positioned to support the development of innovative approaches to addressing food insecurity and translation of successful models into different community settings.

Child and family health antecedents to lifelong well being

Building on success and evidence base across several National Strategic Frameworks, WQPHN has introduced a Child and Family Health Framework that forms a basis to implement the Healthy Outback Kids program with is being piloted in 3 communities in the WQPHN region.

The Western Queensland Child and Family Health Framework is an evidence-informed, contemporary guide for the development and adoption of universal child and family health services in Western Queensland. The Framework centres around critical development milestones with a focus on the first 3,000 days and supports the securing of culturally safe health services for Aboriginal and Torres Strait Islander children.

WQPHN's aim is to provide a Framework to guide the commissioning of patient-centred, joined up care in direct response to the Health Needs Assessment, and to craft new pathways of support around the issues unique to Western Queensland communities.

The planning architecture of the framework is inclusive of local provider networks and recognises that through a shared spirit of collaboration and willingness, the region can adapt to achieve the whole of population outcomes. Similarly, new approaches that incorporate cultural identity and focus on continuity across the life-span, can underpin wellbeing outcomes for children and their families.

As a priority strategy for the region, WQPHN would encourage the Health and Wellbeing Bill, 2019 to escalate child and family health in remote communities as key priority in shifting the life trajectory for children in the region. This requires urgent attention including introduction of a more proactive and systematic model of care that empowers families and improves access to timely child and family health support services.

[19] National Rural Health Alliance (2016) Food security and health in rural and remote Australia. National Rural Health Alliance for the Rural Industries Research and Development Corporation

[20] WQPHN *Mental Health, Suicide Prevention and Alcohol and Drug Regional Plan 2016-2020*