Health and Environment Committee of the Queensland Parliament

Inquiry into the provision of primary, allied and private health care, aged care and National Disability Insurance Scheme (NDIS) care services and its impact on the Queensland public health system

Joint submission from health charities and non-government organisations

23 DECEMBER 2021

Executive summary

Thank you for the opportunity to provide this joint submission to the inquiry into the provision of primary, allied and private health care, aged care and National Disability Insurance Scheme (NDIS) care services and its impact on the Queensland public health system (the *inquiry*). We welcome this inquiry as an important opportunity to reflect on the pressures impacting Queensland's public health system and identify opportunities for greater coordination to improve the health and wellbeing of Queenslanders over the long term.

This submission has been prepared by:

- Arthritis Queensland
- Breast Cancer Network Australia
- Cancer Council Queensland
- Canteen
- Cystic Fibrosis Queensland
- Diabetes Queensland
- Heart Foundation
- Hepatitis Queensland
- Lung Foundation Australia
- Public Health Association of Australia
- Stroke Foundation
- Queensland Walks

(More information about us can be found on pages 15-17.)

Our organisations present this joint submission as we work in collaboration to improve the health of Queenslanders impacted by, or at risk of, a range of preventable chronic diseases, as well as their carers and loved ones. Chronic diseases are the leading cause of illness, disability and death in Australia, with cardiovascular disease, respiratory disease and cancer accounting for four of the top five causes of death in 2019.[1] It is important not to lose sight of this as we grapple with the significant challenges and unknowns emerging from the Covid-19 pandemic.

With this in mind, we present this submission to voice our strong shared support for the following priorities:

1. Increase investment in preventive health measures (pages 2-4).
2. Take action to address health inequities in the community (pages 5-10).
3. Commit to a coordinated, person-centred approach to the delivery of healthcare (pages 11-13).

We have included a summary of our recommendations across these priorities at page 14 (and acronyms on page 18 and references on pages 19-20).

1. Increase investment in preventive health measures

Chronic diseases are the leading cause of illness, disability and death, with respiratory disease, cancer, and cardiovascular disease responsible for some of the greatest death and disease burden in Australia. The Australian Institute of Health and Welfare (**AIHW**) recently published a report that found more than 38% of the disease burden was preventable due to modifiable risk factors. This is significant, and more needs to be done to address these risk factors. Preventing disease enables Queenslanders to live healthy, happy and productive lives, keeps people well, and reduces pressure and excess expenditure on the health system.

In Queensland, the rate of health service provision to meet community demand has been growing exponentially over the last decade. Even before the Covid-19 pandemic, there was a $1.137 billion increase in Queensland Health's operating budget.[2] Without a commitment to increasing investment in long-term preventive health measures, this demand will continue to put Queensland's public health system under extreme pressure. Investment in preventive health measures is proven to be cost-effective, with significant benefits stemming from helping people live healthier lives and preventing disease at a population level.[3] Benefits include reduced pressure on the public health system, reduced burden on individuals and communities, better use of health system resources, healthier workforces, increased health literacy, and improved economic performance and productivity.[4,5]

While the Queensland Government's investment in preventive health fluctuates, it is currently well below the level needed to ensure optimal health, wellbeing and economic benefit for Queenslanders. Data from 2016-17 shows that Queensland spent significantly less than nearly all other Australian jurisdictions on preventive health.[6] There are, however, examples where Queensland has led the way in prioritising action on preventive health. Notably, successful efforts in tobacco control over the last two decades have resulted in a 50% reduction in the rate of daily smokers in Queensland to just 11%, which is lower than the national average.[7]

Example: Tobacco control[8]

Smoking prevalence in Australia has fallen significantly over the past 20 years due to successful preventive health measures.[9] Since 1995, the proportion of Australian adults who are daily smokers has decreased from 23.8% to 13.8% in 2017-18.[10] Young people (aged 18-24) are more likely to have never smoked than a decade ago (75% compared with 34%).[11]

This success has been achieved through multiple interventions, delivered in coordination across both state and federal governments, including taxation, indoor and outdoor smoking bans, and product regulation, as well as support from health services and public education campaigns. The implementation of these strategies, combined with high quality evaluations and data from continuous monitoring, is widely viewed as a world-leading case study for achieving sustained public health outcomes. It also demonstrates the importance of multiple governments and sectors working together to achieve incremental change.

Through the implementation of preventive health measures, fewer Australians have died prematurely due to smoking, and there has been a reduction in overall healthcare and productivity costs.[12]

Although significant progress has been made, tobacco remains the leading cause of cancer in Australia, contributing 22% of cancer burden, as well as contributing 41% of respiratory diseases and 12% of cardiovascular disease.[13] Tobacco use also remains a leading burden of disease for First Nations Peoples. Ongoing effort is essential to continue the downward trend for current and future generations.

Tobacco control is just one example of how successful preventive measure can be, with evidence showing that for every dollar invested in preventive health programs, there is a return on investment of $14.[14] There is a strong and growing body of evidence about what works in preventive health, and preventive health strategies to reduce the impact of chronic disease and associated risk factors must be a priority to reduce pressure on the public health system.

Earlier this month, the Commonwealth government launched the National Preventive Health Strategy. In the spirit of collaboration and working across all levels of government, we encourage the Queensland government to take an active role in implementing this strategy in Queensland.

Risk factors such as poor diet, physical inactivity, tobacco smoking, unprotected sun exposure, excessive alcohol consumption, overweight or obesity, and high blood pressure are all largely preventable. These risk factors can be reduced or eliminated through behavioural changes, managed with medical treatments, or addressed through a combination of solutions including improved guidelines and legislation to increase funding for health programs and media campaigns. However, because the benefits of these programs may not be seen until many years after implementation, they can be negatively impacted by the short-term nature of our political processes and electoral cycles. For this reason, it is important to undertake long-term planning and embed a strong commitment to preventive health into our governance arrangements to ensure funding continuity, transparent decision making and public accountability.

Example: *My health for life*

My health for life is a free healthy lifestyle program helping Queenslanders to live and age well.

The program supports people to get their health back on track, particularly those who are at high risk of developing cardiovascular disease or type 2 diabetes. With the help of a professional health coach, participants learn about the benefits of a healthy lifestyle while working towards achieving their own health goals.

Funded by the Queensland Government, through Health and Wellbeing Queensland (**HWQ**), and managed by the Healthier Queensland Alliance, the program provides structured sessions over a six-month period, covering topics such as healthy eating, physical activity, weight management, quality sleep and stress management. Alliance partners Ethnic Communities Council of Queensland (**ECCQ**) and Queensland Aboriginal and Islander Health Council (**QAIHC**) deliver culturally tailored group programs for Aboriginal and Torres Strait Islanders, Pacific Islanders, Mandarin and Cantonese speaking communities, Vietnamese communities and Arabic speaking communities.

Independent evaluation of the program has shown:

- 96% of participants rated the support, materials and program information as excellent
- 70% of participants have reduced their waistline
- 99% of participants agree the program is positive and easy to understand
- 60% of participants are eating better

My health for life works in partnership with general practice and is a practical extension to the advice and care provided by GPs and nurses to their patients.

The Queensland Government has a responsibility to protect the health of Queenslanders,[15] and there needs to be a significant shift towards investing and supporting a focus on preventing disease. The benefits of this are far reaching; including improved quality of life, increased productivity, reduced mortality and Disability-adjusted life years (**DALYs**), and reduced burden and cost to the health system. Covid-19 has highlighted how agile our health system is, but we need to ensure that

as Queensland's population continues to grow that we are aiming to keep the population healthy and prevent disease which can reduce the mounting pressure on health professionals. This will be essential to achieve Queensland's *My health, Queensland's future: Advancing health 2026* vision for Queenslanders to be among the healthiest people in the world by 2026.[16]

Example: Queensland Walking Strategy

The *Australian Physical Activity and Sedentary Behaviour Guidelines* recommend adults do at least 150 minutes of moderate intensity physical activity (such as brisk walking) each week and children do at least 60 minutes of moderate to vigorous physical activity (such as running) every day.

Encouragingly, 15% more Queensland adults meet these physical activity guidelines today compared to a decade ago. In 2004, Queenslanders spent an average of around 120 minutes per week walking but this increased to 220 minutes per week in 2018.[17] Unfortunately, around 1.4 million adult Queenslanders are still not getting enough physical activity.[18]

The Queensland Government's vision for walking is set out in the ***Queensland Walking Strategy 2019-2029:***[19] for walking to be an easy choice for everyone, every day. The Strategy notes that getting more people walking will help to achieve the objectives of Our Future State: Advancing Queensland's Priorities to keep Queenslanders healthy, keep communities safe, and give all our children a great start.

We welcome the recent establishment of Health and Wellbeing Queensland, and its focus on improving the health and wellbeing of Queenslanders, including reducing health inequities. However, there is still much more that the Queensland Government can do to prevent chronic disease and keep Queenslanders living healthy and productive lives.

Specifically, we recommend all levels of government commit to:

1. Directing at least 5% of the annual health budget towards preventive health measures.
2. Long term and consistent funding for preventive health initiatives, with a minimum 10–15-year time horizon and review points every five years.
3. Identifying and recognising the preventative health workforce as an integral part of the health system workforce with associated workforce planning strategies developed to support this.
4. Taking an active role in implementation of the *National Preventive Health Strategy*.

2. Take action to address health equities in the community

Covid-19 has changed the way we access health care in Queensland, with providers embracing technology to help people connect with vital health services at this time. However, despite ongoing innovations we continue to face challenges in ensuring equitable access to quality care and health outcomes for every Queenslander, particularly for First Nations Peoples, those who live in regional and remote areas, people from culturally and linguistically diverse (**CALD**) backgrounds, LGBTIQ+ (lesbian, gay, bisexual, transgender, intersex, queer people and other sexuality and gender diverse) communities, adolescents and young adults (**AYAs**), people with a disability and those who experience socio-economic disadvantage. The prevalence of chronic disease is higher for people who identify with one or more of these groups. For this reason, efforts to ease pressure on the health system must include targeted strategies to address health inequity.

First Nations Peoples

Queensland has a pivotal role to play in closing the national gap in health outcomes for Aboriginal and Torres Strait Islander people, as 28% of First Nations Peoples live in Queensland, second only to NSW.[20] Unfortunately the target to close the life expectancy gap between Aboriginal and Torres Strait Islander people and non-Indigenous Australians is not on track.[21] In Queensland, the three leading drivers of the life expectancy gap are cardiovascular disease, cancer and diabetes, with cancer the leading cause of death.[22]

We support the development of localised Health Equity Strategies by the Hospital and Health Services (**HHSs**) as a welcome process to improve the cultural appropriateness and accessibility of mainstream services to ensure quality and timely healthcare for all. However, we must also work to further strengthen the Aboriginal and Torres Strait Islander Community Controlled Health Organisation (**ACCHO**) sector in Queensland, including increased funding and policy actions in consultation with First Nations communities. A strong ACCHOs sector, supported by the Queensland Aboriginal and Islander Health Council (**QAIHC**), is critical to tackling this challenge. ACCHOs not only play a critical role in addressing the immediate healthcare needs of Aboriginal and Torres Strait Islander People, but also work to create change in the structural determinants of health, both of which are essential to closing the gap.[23]

Example: Heart disease in First Nations Peoples[24]

Cardiovascular disease is the largest contributor to preventable morbidity and mortality in Aboriginal and Torres Strait Islander peoples.[25] Although age-standardised cardiovascular disease mortality has fallen by 40% over the past few decades, cardiovascular disease still accounts for a quarter of Aboriginal and Torres Strait Islander deaths overall and 21% of all premature years of life lost.[26] Cardiovascular disease events and cardiovascular disease-related mortality in the Aboriginal and Torres Strait Islander population occur, on average, about 10–20 years earlier than in non-Aboriginal and Torres Strait Islander Australians.[27]

People from culturally and linguistically diverse backgrounds

More than one in five Queenslanders were born overseas and more than one in ten speak a language other than English at home.[28] Our cultural diversity continues to increase over time with over 300 cultures, 270 languages and over 100 religious beliefs existing in Australia today.[29] Each culture is unique and intertwined with customs, traditions, religious and spiritual beliefs. For most people from CALD backgrounds, culture provides a framework that influences their decisions about health, sickness, disease prevention, treatment of disease and disease management. Our hospitals and health services must be responsive the unique needs of each person.

Example: People from CALD backgrounds and cancer

The Federation of Ethnic Communities Councils of Australia (**FECCA**) has found that culture and cultural beliefs impact on acquisition of knowledge about cancer, as well as subsequent participation in screening and decision making about cancer treatment and management.[30] Research reveals that generally pessimistic attitude towards cancer among most populations from CALD backgrounds exist.[31] Many people from CALD backgrounds do not fully understand the word 'cancer', or cancer prevention, early detection, treatment or management. In some languages the word 'cancer' and associated terminology do not exist making education about different aspects of cancer is challenging.[32] Many believe that cancer is a 'death sentence' and as such little can be done about preventing it or treating it. As a result, people from CALD backgrounds may view cancer as an illness that disrupts their life, contributes to social isolation, lessens their self-esteem and recognition in their community. Health services – including preventive health and screening programs, as well as treatment and support – should consider these negative attitudes and beliefs about cancer and cancer treatment.

People experiencing socio-economic disadvantage

Socio-economic disadvantage is associated with a higher prevalence of, and a higher mortality from, most diseases, particularly the major chronic diseases.[33] This is the case regardless of whether socio-economic disadvantage is defined by area of residence, occupation, income or education level. For example, Cancer Council Queensland research has shown a woman's survival after a diagnosis of breast cancer depends on the socio-economic characteristics of the area where she lives, independently of her individual-level characteristics.[34]

Socio-economic disadvantage presents a significant challenge for Queensland health system, as seven of Australia's top 10 most disadvantaged Local Government Areas are in Queensland.[35] The financial burden of chronic disease can be significant, but is particularly prohibitive for people on low incomes. High out-of-pocket costs can cause financial stress or bill shock which can lead to people to delay or avoid health services and much-needed treatment.[36] Those from low socio-economic backgrounds are less likely to have private health insurance, which has implications in terms of equity, access to health services, consumer choice and increased burden on public health system.

Example: Socio-economic inequalities in cardiovascular disease, diabetes and chronic kidney disease

While many Australians enjoy good health, the benefits are not shared equally by all. People who are socio-economically disadvantaged have, on average, greater levels of cardiovascular disease, diabetes and chronic kidney disease.

AIHW[37] data reveals that, in 2016:

- males aged 25 and over, living in the lowest socio-economic areas of Australia, had a heart attack rate 1.55 times as high as males in the highest socio-economic areas. For females, the disparity was even greater, at 1.76 times as high
- type 2 diabetes prevalence for females in the lowest socio-economic areas was 2.07 times as high as for females in the highest socio-economic areas. The prevalence for males was 1.70 times as high
- the rate of treated end-stage kidney disease for males in the lowest socio-economic areas was 1.52 times as high as for males in the highest socio-economic areas. The rate for females was 1.75 times as high
- the cardiovascular disease death rate for males in the lowest socio-economic areas was 1.52 times as high as for males in the highest socio-economic areas. For females, the disparity was slightly less, at 1.33 times as high
- if all Australians had the same cardiovascular disease death rate as people in the highest socio-economic areas in 2016, the total cardiovascular disease death rate would have declined by 25%, and there would have been 8,600 fewer deaths.

Adolescents and young adults

Adolescents and young adults (**AYAs**) have distinct needs to both child and adult populations. The unique life stage of AYAs who are diagnosed with a chronic illness often leads to disruption to vital and formative activities—such as education and early employment experiences—that contribute to lifelong social, health and wellbeing outcomes. Illness for AYAs and their families has profound impact including specific stressors related to diagnosis, treatment, and condition management.[38] AYAs have been identified as the 'missing middle' of the Australian health care system, linked to limited engagement in the health sector which leads to worsening outcomes.[39] To this end, we support and endorse the recommendations made by the Consumer Health Forum: Youth Health Forum in their report "Life Transitions and Youth Pathways to Health Services" which broadly calls for greater inclusivity for young people, including but not limited to: affordable access, an uplift in the availability and quality of digital health care and support for healthcare system navigation.

The specific experience of cancer is notable when considering the need for equity in the health care system, specifically for AYAs: this is both for the ways in which their social and wellbeing outcomes are met, but also for the ways in which the current trajectory for AYAs diagnosed with cancer differs from adult or paediatric patients. The past 30 years has seen an increase in the survival rates of paediatric and older cancer patients, however, AYAs have not experienced the same improvement.[40] This can be attributed to low levels of investment and enrolment in clinical trials.[41] Barriers for enrolment are systemic including a lack of understanding of processes that support protocol approval; absence of paediatric-adult oncology relationships that reduce awareness of open trials and age exclusions for adolescents; who are routinely excluded from relevant adult cancer trials and likewise, paediatric trials.[42] Therefore, it is imperative that systemic barriers to equitable care for AYAs, and access to novel treatments is considered with particular attention by this inquiry.

People with disability

Nearly one in five Queenslanders (18.3%) live with disability and rates are 1.8 times higher for Aboriginal and Torres Strait Islander peoples.[43] 42% of adults with disability rate their health as poor

or fair, compared with 7% of people without disability.[44] One in five people with a disability who need help with healthcare activities have their need only partly met or not at all.[45] According to the AIHW *People with disability in Australia 2020 report*, people with disability are more likely to have poorer general and mental health than people without disability, and are more likely to experience difficulties accessing and using health services. Barriers include longer than desired waiting times, the cost of services, the accessibility of buildings, discrimination by health professionals and lack of communication between health professionals. Lack of coordination across the health system is a significant problem for many people with disability, as one in five (21%) report problems caused by a lack of communication between the different health professionals they rely on for support to treat and manage their condition.[46]

LGBTIQ+ Queenslanders

Although many LGBTIQ+ people live healthy lives, a disproportionate number experience poorer mental health outcomes when compared to their peers. [47] Compared to the general population, LGBTIQ+ people are two and a half times more likely to have been diagnosed or treated for a mental health condition in the past 12 months.[48] LGBTIQ+ communities are also at higher risk of developing certain chronic health conditions such as breast cancer, cervical cancer, non-Hodgkin's lymphoma and anal cancer.[49] Fear of discrimination can result in people who identify as LGBTIQ+ failing to disclose their sexual identity to health care providers, which is associated with poorer health outcomes. There is often a lack of privacy and a safe place for LGBTIQ+ people to have conversations with healthcare providers in a supportive environment. [50]

People in regional and remote areas

Queensland's public health system also faces challenges associated with equity and access to healthcare for regional and remote Queenslanders. The size of our state and the highly dispersed nature of our population creates unique challenges for the Queensland public health system, and makes it difficult to draw comparisons with what works in other Australian jurisdictions. The barriers to living a healthy life faced by people living in remote Queensland, when compared to those in metropolitan areas, are considerable. They experience poor access to quality and timely healthcare with issues including waiting longer to see a GP, having to travel longer distances to receive treatment, lack of continuity of care, shortages of clinicians, clinics closing and lack of facilities for critical services. Risk factors such as high rates of obesity, lack of exercise and high blood pressure are also worse for people in regional Queensland in comparison to metropolitan areas, partly due to the reduced access to affordable healthy food, infrastructure and programs to support physical activity and targeted prevention. These issues can heighten risk or result in delays in treatment which can have serious and life-threatening implications.

As a result, people living in regional and remote areas have poorer survival rates for diseases such as cancer, and the further from a major city a person with cancer lives, the more likely they are to die within five years of diagnosis. More recent shifts to telehealth models can both address or compound these problems, depending on the quality of access to well-functioning telehealth and digital innovation to support access to high quality health services in regional and remote areas. It is important for the Queensland Government to represent the needs of its significant regional and remote population in advocating for improvements in the quality, affordability and accessibility of digital innovation in health care.

Example: Covid-19 Temporary MBS Telehealth Services

Commencing 13 March 2020 and extending **until 31 December 2021**, temporary MBS telehealth items have been made available to help reduce the risk of community transmission of Covid-19 and provide protection for patients and health care providers.

The temporary MBS telehealth items are available to GPs, medical practitioners, specialists, consultant physicians, nurse practitioners, participating midwives, allied health providers and dental practitioners in the practice of oral and maxillofacial surgery. A service may only be provided by telehealth where it is safe and clinically appropriate to do so.[51]

The increased use of telehealth has been welcomed by both patients and health professionals.

- A recent Consumer Health Forum patient survey found more than 80% of those offered telehealth took up the offer and viewed the service as of excellent or good quality.[52]
- In a survey of cancer health professionals conducted by Cancer Council Australia and the Clinical Oncology Society of Australia the responses were overwhelmingly unanimous in their support for telehealth.[53]
- A recent (unpublished) Lung Foundation Australia survey found that 80% of respondents reported a very positive or positive experience with telehealth and other digital technologies.[54]

Pleasingly, on 13 December 2021, the Federal Government announced continuing funding for Telehealth to become a permanent feature of primary health care:[55]

> *Telehealth has been transformational to Australia's universal health care and has played a critical role in ensuring the continuity of care for hundreds of thousands of Australian patients during the COVID-19 pandemic, protecting the health of patients and health professionals. It offers greater flexibility to health care as part of universal Medicare.*
>
> *Since early March 2020, more than 86.3 million COVID-19 MBS telehealth services have been delivered to 16.1 million patients, with $4.4 billion in Medicare benefits paid. More than 89,000 providers have used telehealth services.*

Despite recent innovations in telehealth, there is much more that needs to be done to improve health equity across the community, and ease pressure on Queensland's public health system. We must take a holistic view of health outcomes for all Queenslanders, and that requires coordination and collaboration across all levels of government and sectors to actively address the socio-structural barriers preventing people from living healthy lives. We support the work of Health and Wellbeing Queensland to better address the socio-structural determinants of health in Queensland. It is most often policies around employment, income support and housing that sit outside the health sector which prevent health equity from being achieved.[56] We must therefore work together across the system and take a holistic view of health outcomes for all Queenslanders, to actively address the socio-structural determinants of health such as income, education, unemployment, food insecurity, housing, early childhood development and discrimination.[57]

Recommendations to improve health equity

There is still much more that can be done to improve health equity across the community. Specifically, we recommend all levels of government commit to:

5. Taking a holistic view of health outcomes that includes consideration for socio-structural determinants of health outcomes.
6. Strengthening the community-controlled sector in Queensland by delivering increased funding and policy actions in consultation with First Nations communities.
7. Improving the cultural appropriateness and cultural accessibility of mainstream services for Aboriginal and Torres Strait Islander people.
8. Adopting population-based service planning to ensure equity of access to health care, regardless of where people live in Queensland, including assessing where there is unmet demand.
9. Developing targeted strategies that seek to increase equitable access to holistic, coordinated, and integrated health care options to ensure health equity.
10. Addressing systemic barriers which hinder vulnerable groups from being able to access novel treatments, particularly as they relate to clinical trials.
11. Increasing funding for targeted programs in partnership with community-based organisations, local government and non-clinical services which can be implemented locally in regional communities to further reduce the burden on local healthcare systems.
12. Including people who experience disadvantage, discrimination and social and economic exclusion in health system decision making to build health literacy and ensure everyone can appropriately access and engage with general health services when and where they need them.

3. Commit to a coordinated, person-centred approach to the delivery of healthcare

Much has been said about the importance of taking a person-centred approach to health care, however successful implementation of this approach requires significant efforts to ensure effective coordination across the system – including all levels of government, government departments and with NGOs, community services, industry groups and local communities. The importance of this cannot be overstated for people with chronic disease. We support enhanced efforts to deliver joined up services and reduce duplication across the system. While local management of Hospital and Health Services (**HHSs**) and Primary Health Networks (**PHNs**) support locally led service delivery, there remain significant opportunities to better connect this with state-wide strategic oversight to ensure a holistic view of the systems change required to improve the equity of health outcomes for all Queenslanders.

Multidisciplinary care

People living with lifelong health conditions require ongoing support and access to many different types of health professionals. The people that we represent often live with multiple conditions making their treatment complex. Effective treatment of these conditions requires access to multidisciplinary care.

A multidisciplinary approach involves patients being supported to build a team of health professionals who work collectively to support the patient's needs. This can include GPs, allied health professionals, pharmacist, nurses and medical specialist. Ensuring that people living with the chronic conditions have access to multidisciplinary care results in better health outcomes for patients and reduced costs to the health system. Examples of significant impacts that this approach can produce include reduced incidence of limb amputation in patients with diabetes and removing the need for joint replacement surgery in osteoarthritis patients. The benefits to individual patients and the health system are immense.

However, current structural, funding and workforce issues do not support the delivery of multidisciplinary care in Queensland. Our health system is siloed and difficult to navigate for patients, particularly those with lower health literacy.

While we welcome the recent introduction of new MBS item numbers to support GP's and allied health professionals undertake case conference meetings, the current cap of 5 allied health sessions per year is insufficient to provide effective care to people living with chronic health issues.

Workforce challenges

In addition, the current allied health work force is poorly distributed and too small to meet patient needs. This is particularly true in regional and remote areas where recruitment and retention for all types of health care professionals is a significant challenge. Lack of access to care close to home results in increased costs to patients and can also be a complete barrier to care in some instances. We call on the Queensland Government to enhance its focus on workforce mapping, planning, training, support and development to address this challenge.

A key barrier contributing to health disparities between metropolitan and regional/remote communities is the uneven distribution of the health workforce, as a result of recruitment and retention challenges. Health workforce shortages are more pronounced in regional and remote areas (particularly our workforce supporting First Nations Peoples), and difficulties in maintaining an

adequate and appropriately qualified health workforce in regional and remote communities has a flow-on effect, limiting the ability of health services to provide appropriate, accessible, comprehensive and high-quality care. This in turn contributes to the poorer health status of Australians living in regional and remote areas.

Example: National Strategic Action Plan for Lung Conditions

More than 1 in 3 Australians experience a lung disease. People with lung diseases can be stigmatised, experience delays in diagnosis, and challenges in accessing appropriate and timely care, which in turn can impact the way they live, work and play. To effectively manage lung disease, several different health professionals are involved in the care and often a range of health professionals work together in Multidisciplinary Teams (**MDTs**) to deliver comprehensive patient care. To diagnose lung conditions correctly and provide the best care possible, health professionals need ongoing education on lung conditions. This is particularly important for primary care professionals, including those in regional and remote areas where the greatest variation in care exists and poorer health outcomes are evident.

'Access is really important in regional and remote areas, where there are often limited or no services or support for patients and families. People often have to leave their community and support network to access services or care, this is of concern particularly for Aboriginal and Torres Islanders who have to leave family, country and support.' – Dr Kerry Hall, Research Fellow, Menzies Health Institute

Innovative models of care

We appreciate that the health system is working in a period of increased demand and that this is likely to worsen in the next 12 months. In this climate the importance of embracing innovation and sharing knowledge is vital. Innovative Models of Care such as GPs with a special interest and outreach hub and spoke models are needed if we want to maximise the limited resources that we have available. This can only occur with collaboration and communication. We strongly support the importance of Statewide Clinical Networks which facilitate information sharing and build connections across the silos of our health system. The work of these networks is vital in reducing duplication and achieving systems-level thinking. We welcome the recent creation of the Queensland Aboriginal and Torres Strait Islanders Clinical Network and call for other gaps in the provision of these clinical networks to be addressed.

Example: Networked Cardiac Care Model

Queensland's networked cardiac care model provides specialised cardiac clinical teams to reach regional and remote areas, using a hub and spoke model to extend the reach of regionally located clinicians.

The Networked Cardiac Services model of care provides a central hub of statewide specialist care for cardiac services—improving system-wide service efficiency and sustainability, access to high-quality healthcare for regional and remote communities and offering increased efficiencies through the bulk purchasing of cardiac devices.[58]

Effective partnerships

Queensland's Auditor-General has recognised that HHSs have partnerships with other providers within their region, but notes that this can be enhanced. The Auditor-General has also flagged a

need for his office to explore how well Queensland Health works with these providers on healthcare pathways and managing integrated care of chronic disease.[59]

As health charities and NGOs, each of our organisations can contribute to easing pressure on the health system by working in partnership across the health system. Health NGOs deliver valuable health services to Queenslanders every day, including specific and highly bespoke support tailored to the needs of the specific cohorts we exist to serve. In providing these services, we fill an important gap as these specialised supports are less likely to be found within the wider health sector or generalised health services. Our organisations have reach, expertise and deep community connections which have great value to offer as part of a mix of services, and, if leveraged appropriately, can help to ease pressure on the health system.

Finally, we note the Commonwealth government this week launched the National Preventive Health Strategy. In the spirit of collaboration and working across all levels of government, we encourage the Queensland government to take an active role in implementing this strategy in Queensland.

Recommended actions

We have identified the following opportunities to improve coordination across the system and achieve genuine person-centred healthcare in Queensland:

13. Addressing gaps in Clinical Networks to ensure all chronic diseases are supported by best practice and evidence-based healthcare solutions.
14. Strengthening focus on workforce development, particularly for the workforce supporting First Nations Peoples.
15. Embedding and measuring performance against clinical pathways and guidelines that include various sectors/segments of the health system.
16. Strengthen partnerships and funding support with health charities and non-government organisations who hold strong connections to community and hold high level expertise.

Conclusion

In summary, we recommend that all levels of government take the following actions to ease pressure on Queensland's public health system:

1. Directing at least 5% of the annual health budget towards preventive health measures.
2. Long term and consistent funding for preventive health initiatives, with a minimum 10–15-year time horizon and review points every five years.
3. Identifying and recognising the preventative health workforce as an integral part of the health system workforce with associated workforce planning strategies developed to support this.
4. Taking an active role in implementation of the *National Preventive Health Strategy*.
5. Taking a holistic view of health outcomes that includes consideration for socio-structural determinants of health outcomes.
6. Strengthening the community-controlled sector in Queensland by delivering increased funding and policy actions in consultation with First Nations communities.
7. Improving the cultural appropriateness and cultural accessibility of mainstream services for Aboriginal and Torres Strait Islander people.
8. Adopting population-based service planning to ensure equity of access to health care, regardless of where people live in Queensland, including assessing where there is unmet demand.
9. Developing targeted strategies that seek to increase equitable access to holistic, coordinated, and integrated health care options to ensure health equity.
10. Addressing systemic barriers which hinder vulnerable groups from being able to access novel treatments, particularly as they relate to clinical trials.
11. Increasing funding for targeted programs in partnership with community-based organisations, local government and non-clinical services which can be implemented locally in regional communities to further reduce the burden on local healthcare systems.
12. Including people who experience disadvantage, discrimination and social and economic exclusion in health system decision making to build health literacy and ensure everyone can appropriately access and engage with general health services when and where they need them.
13. Addressing gaps in Clinical Networks to ensure all chronic diseases are supported by best practice and evidence-based healthcare solutions.
14. Strengthening focus on workforce development, particularly for the workforce supporting First Nations Peoples.
15. Embedding and measuring performance against clinical pathways and guidelines that include various sectors/segments of the health system.
16. Strengthen partnerships and funding support with health charities and non-government organisations who hold strong connections to community and hold high level expertise.

About us

Arthritis Queensland is a not-for-profit organisation that represents the 730,000 Queenslanders affected by arthritis. Established in 1975, Arthritis Queensland provides free-to-access support, information and exercise programs to allow people to better manage their condition. We advocate for systems level changes to improve health outcomes through prevention, awareness and increased access to health care for people with arthritis. We fund leading research into new treatments and cures for arthritis. Our vision is freedom from the burden of arthritis. www.arthritis.org.au

Breast Cancer Network Australia (**BCNA**) is a not-for-profit organisation that supports Australians affected by breast cancer. BCNA aims to ensure that Australians affected by breast cancer receive support, information, treatment and care appropriate to their needs. BCNA is the peak national organisation for Australians affected by breast cancer and consists of a network of more than 150,000 individual members. bcna.org.au.

On average, one Queenslander will be diagnosed with cancer every 20 minutes. **Cancer Council Queensland** is dedicated to improving quality of life for people living with cancer, through research, patient care, prevention and early detection.

We were established in 1961 as the Queensland Cancer Fund, in response to an increasing need for cancer-related services across the state. This year, we are celebrating 60 years of supporting Queenslanders, affected by cancer. www.cancerqld.org.au

Canteen is the only organisation in Australia dedicated to providing tailored support for young people aged 12-25 who are impacted by cancer. Through Canteen, they learn to explore and deal with their feelings about cancer, connect with other young people in the same boat and, if they've been diagnosed themselves, Canteen provides specialist, youth-specific treatment teams. www.canteen.org.au

Cystic Fibrosis Queensland is the peak community not for profit charity working with and for the increasing number of people living with cystic fibrosis who attend a Queensland Health clinic for treatment. Founded in 1960, Cystic Fibrosis Queensland provides support, services, and hope to those fighting cystic fibrosis. We advocate for the entire cystic fibrosis community, raise fund for research and for our membership programs, and seek to raise much needed awareness of this debilitating condition. We all look forward to the day when we will live Lives unaffected by cystic fibrosis. www.cfqld.org.au

Diabetes Queensland supports more than 240,000 Queenslanders living with all types of diabetes. We do this in several ways: by providing the latest information on diabetes and diabetes care, our Helpline, advocating on behalf of Queenslanders with diabetes, and delivering practical education programs across the state. We are involved in vital research and are active in raising community awareness about this condition. www.diabetesqld.org.au

For over 60 years, the **Heart Foundation** has been the trusted peak body working to improve heart disease prevention, detection and support for all Australians.

Since 1959 we have funded research projects worth over $670 million (in today's dollars).

To help us realise our vision of **an Australia free of heart disease**, we continue to harness the energy and intellect of Australia's best minds, and combine this with the teamwork and passion of our supporters and the generosity of millions of Australians.

Coronary heart disease is Australia's number 1 killer, and still claims the lives of 45 people every single day. But thanks to generous donations from individuals and organisations, we are able to continue our work in risk reduction, support & care and research for the benefit of not only the 150,000 Australians that are here today because of life-saving heart research, but we're equally for the more than 4 million that are currently living with a compromised heart, their carers and family members. www.heartfoundation.org.au

Hepatitis Queensland is a community based, non-government organisation and registered charity. For 26 years we have represented the interests of people affected by, or at risk of viral hepatitis and liver disease in Queensland. We want all Queenslanders to enjoy the benefits of a healthy liver and ensure everyone has access to appropriate medical treatment, up to date and accurate health information and opportunities to learn and understand how to manage their own wellbeing. We achieve this through conducting health promotion campaigns, providing information for the general public and health professionals, delivering clinical services and advocating for systems change. www.hepqld.asn.au

Lung Foundation Australia is the only national charity and leading peak-body dedicated to supporting anyone with a lung disease including lung cancer. For over 31 years we have been the trusted national point-of-call for patients, their families, carers, health professionals and the general community on lung health.

Our mission is to improve lung health and reduce the impact of lung disease for all Australians. We will continue working to ensure lung health is a priority for all, from promoting lung health and early diagnosis, advocating for policy change and research investment, raising awareness about the symptoms and prevalence of lung disease and championing equitable access to treatment and care. www.lungfoundation.com.au

The Public Health Association of Australia (**PHAA**) is recognised as the principal non-government organisation for public health in Australia working to promote the health and well-being of all Australians. It is the pre-eminent voice for the public's health in Australia.

The PHAA works to ensure that the public's health is improved through sustained and determined efforts of our Board, National Office, State and Territory Branches, Special Interest Groups and members. www.phaa.net.au

The **Stroke Foundation** is a national charity that partners with the community to prevent, treat and beat stroke. We stand alongside stroke survivors and their families, healthcare professionals and researchers. We build community awareness and foster new thinking and innovative treatments. We support survivors on their journey to live the best possible life after stroke. We are the voice of stroke in Australia. www.strokefoundation.org.au

Queensland Walks is a community-based membership organisation advocating on behalf of all Queenslanders who walk, roll and stroll. We are the peak body representing walking for all Queenslanders with an aim to see more Queenslanders walking more often. Our vision is for healthy and active Queenslanders living in walkable neighbourhoods where walking is valued, and part of our everyday lifestyle. www.queenslandwalks.org.au

List of acronyms

ACCHO	Aboriginal and Torres Strait Islander Community Controlled Health Organisation
AYA	Adolescent and young adult
ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
BCNA	Breast Cancer Network Australia
DALYs	Disability-adjusted life years
CALD	Culturally and linguistically diverse
ECCQ	Ethnic Communities Council of Queensland
FECCA	Federation of Ethnic Communities Councils of Australia
HWQ	Health and Wellbeing Queensland
HHSs	Hospital and Health Services
LGBTIQ+	Lesbian, gay, bisexual, transgender, intersex, queer people and other sexuality and gender diverse
MDTs	Multidisciplinary Teams
NDIS	National Disability Insurance Scheme
PHNs	Primary Health Networks
PHAA	Public Health Association of Australia
QAIHC	Queensland Aboriginal and Islander Health Council

References

[1] Australian Institute of Health and Welfare (**AIHW**), *Australia's health 2016* (Australia's health series no. 15 Cat. No. AUS 199, 2016).

[2] The State of Queensland (Queensland Treasury). *2019-2020 Queensland Budget* (2019).

[3] Theo Vos et al, *Assessing cost-effectiveness in prevention (ACE-prevention): Final Report* (2010). Available at https://public-health.uq.edu.au/files/571/ACE-Prevention_final_report.pdf

[4] Su Gruszin Diana Hetzel and John Glover, *Advocacy and action in public health: lessons from Australia over the 20th century* (Australian National Preventive Health Agency, December 2012). Available at https://phidu.torrens.edu.au/pdf/2010-2014/public-health-successes-2013/advocacy_action_public_health_full.pdf

[5] AIHW (n 1).

[6] AIHW, *Health expenditure Australia 2016-17* (Health and welfare expenditure series no. 64. Cat. No. HWE 74, 2018).

[7] Queensland Health, *The health of Queenslanders 2018: Report of the Chief Health Officer Queensland* (Queensland Government, 2018) 20.

[8] Adapted from Department of Health, *National Preventive Health Strategy 2021–2030* (December 2021), 2. Available at www.health.gov.au/resources/publications/national-preventive-health-strategy-2021-2030.

[9] Public Health Association of Australia (**PHAA**). *Top 10 public health successes over the last 20 years* (PHAA Monograph Series No. 2, 2018).

[10] Australian Bureau of Statistics (**ABS**), *National Health Survey: First results. Reference period 2017-18 financial year* (2018). Available at www.abs.gov.au/statistics/health/health-conditions-and-risks/national-health-surveyfirst-results/latest-release.

[11] ABS, *Smoking, 2017-18 financial year* (2018). Available at www.abs.gov.au/statistics/health/health-conditions-and-risks/smoking/2017-18.

[12] PHAA (n 9).

[13] AIHW, *Burden of tobacco use in Australia: Australian Burden of Disease Study 2015* (Australian Burden of Disease series no. 21. Cat. no. BOD 20, 2019).

[14] Rebecca Masters et al, 'Return on investment of public health interventions: a systematic review' (2017) 71 J*ournal of Epidemiology and Community Health* 827.

[15] Queensland Health, *My health, Queensland's future: Advancing health 2026* (May 2016). Available at https://www.health.qld.gov.au/__data/assets/pdf_file/0025/441655/vision-strat-healthy-qld.pdf.

[16] Ibid.

[17] Queensland Health. (n 7).

[18] Ibid.

[19] Available at www.queenslandwalks.org.au/walk-hub/.

[20] AIHW, *Australia's health 2018* (Australia's health series no. 16. AUS 221, 2018). Available at www.aihw.gov.au/getmedia/7c42913d-295f-4bc9-9c24-4e44eff4a04a/aihw-aus-221.pdf.

[21] Commonwealth of Australia, *Closing the Gap Report 2020* (2020). Available at ctgreport.niaa.gov.au/sites/default/files/pdf/closing-the-gap-report-2020.pdf.

[22] Queensland Health, 'Closing the Gap' (Web Page, 17 October 2019) www.health.qld.gov.au/public-health/groups/atsihealth/closing-the-gap.

[23] Odette Pearson et al, 'Aboriginal community controlled health organisations address health equity through action on the social determinants of health of Aboriginal and Torres Strait Islander peoples in Australia'. (2020) 20 *BMC Public Health* 1859. Available at https://doi.org/10.1186/s12889-020-09943-4.

[24] Jason W Agostino et al 'Cardiovascular disease risk assessment for Aboriginal and Torres Strait Islander adults aged under 35 years: a consensus statement'(2020) 212(9) *Medical Journal of Australia* 422. Available at www.mja.com.au/journal/2020/212/9/cardiovascular-disease-risk-assessment-aboriginal-and-torres-strait-islander.

[25] AIHW, *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples* (Cat. No. IHW 147, 2015). Available at www.aihw.gov.au/reports/indigenous-australians/indigenous-health-welfare-2015/contents/table-of-contents .

[26] Ibid.

[27] AIHW, *Cardiovascular disease, diabetes and chronic kidney disease — Australian facts: Aboriginal and Torres Strait Islander people* (Cat. No. CDK 5]. Canberra: AIHW, 2015. Available at www.aihw.gov.au/reports/heart-stroke-vascular-disease/cardiovascular-diabetes-chronic-kidney-indigenous/report-editions.

[28] Department of Local Government, Racing and Multicultural Affairs (Qld), Queensland Multicultural Policy: Our Story, our future (December 2018). Available at www.cyjma.qld.gov.au/resources/dcsyw/multicultural-affairs/policy-governance/multicultural-policy.pdf

[29] ABS, *Census of Population and Housing. Australia Revealed* (2017).

[30] Federation of Ethnic Communities' Councils of Australia. *Cancer and Culturally and Linguistically Diverse Communities* (October 2010).

[31] Geri-Ann Galanti, *Caring for patients from different cultures* (University of Pennsylvania Press, 4th ed, 2008).

[32] Federation of Ethnic Communities' Councils of Australia. *Cancer and Culturally and Linguistically Diverse Communities.* (2010) Australian Government, Cancer Australia, FECCA. October 2010.

[33] John D Glover, Diana MS Hetzel and Sarah K Tennant, 'The socioeconomic gradient and chronic illness and associated risk factors in Australia' (2004) 1(8) *Australia and New Zealand Health Policy*. Available at https://anzhealthpolicy.biomedcentral.com/articles/10.1186/1743-8462-1-8.

[34] Paramita Dasgupta et al, Multilevel determinants of breast cancer survival: association with geographic remoteness and area-level socioeconomic disadvantage'' (2012) 132(2) *Breast Cancer research and Treatment* 701. Available at https://pubmed.ncbi.nlm.nih.gov/22160639/.

[35] ABS, *Census of population and housing: Reflecting Australia – stories from the Census, 2016* (2018).

[36] Annie Bygrave et al, 'Australian Experiences of Out-of-Pocket Costs and Financial Burden Following a Cancer Diagnosis: A Systematic Review' (2021) 18(5) *International Journal of Environmental Research and Public Health* 2422. Available at www.mdpi.com/1660-4601/18/5/2422

[37] AIHW, 'Indicators of socio-economic inequalities in cardiovascular disease, diabetes and chronic kidney disease' (2019).

[38] Bruce E Compas et al, 'Coping with chronic illness in childhood and adolescence' (2012) 8 *Annual Review of Clinical Psychology 455.* Available at https://pubmed.ncbi.nlm.nih.gov/22224836/.

[39] Consumers Health Forum of Australia, *Life Transitions and Youth Pathways to Health Services* (2021). Available at https://chf.org.au/sites/default/files/life_transitions_youth_pathways_to_health_services_completereport_final.pdf.

[40] Peter H Shaw et al, 'Improved clinical trial enrolment in adolescent and young adult (AYA) oncology patients after the establishment of an AYA oncology program uniting paediatric and medical oncology divisions*'* (2011) 118 (14) *Cancer* 3614. Available at https://pubmed.ncbi.nlm.nih.gov/22213134/.

[41] Pandora Patterson et al, 'The Australian Youth Cancer Service: Development and Monitoring the Activity of Nationally Coordinated Adolescent and Young Adult Cancer Care' (2021) 13(11) *Cancers* 2675. Available at www.mdpi.com/2072-6694/13/11/2675/htm#B18-cancers-13-02675

[42] Justine A. Ellis et al, 'Systems-Level Change to Alleviate Barriers to Cancer Clinical Trial Access for Adolescents and Young Adults in Australia' (2020) *Journal of Adolescent and Young Adult Oncology* (2021) *Journal of Adolescent and Young Adult Oncology* (ahead of print). Available at http://doi.org/10.1089/jayao.2021.0026.

[43] ABS, *Survey of Disability, Ageing and carers* (2015).

[44] AIHW, *People with disability in Australia 2020* (2020).

[45] Ibid.

[46] Ibid.

[47] LGBTIQ+ Health Australia, *Snapshot of Mental Health and Suicide Prevention Statistics for LGBTIQ+ People'* (April 2021). Available at www.lgbtiqhealth.org.au/statistics. See also Bridget K Gorman et al, 'A new piece of the puzzle: Sexual orientation, gender, and physical health status' (2015) 52(4) *Demography* 1357.

[48] AIHW (n 20)

[49] Cancer Council NSW, Cancer: It's out of the closet (2016). Available at www.cancercouncil.com.au/news/cancer-its-out-of-the-closet/.

[50] Ibid.

[51] Department of Health (Cth), *COVID-19 Temporary MBS Telehealth Services* (Web Page, 17 November 2021). Available at www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-TempBB

[52] Consumers Health Forum of Australia, What Australia's Health Panel said about Telehealth - March/April 2020 (Web Page, 2020). Available at www.chf.org.au/ahptelehealth.

[53] Cancer Council Australia and Clinical Oncology Society of Australia, *Telehealth for people with cancer* (2020). Available at www.cosa.org.au/media/332664/telehealthpostpandemic_200601.pdf

[54] Lung Foundation Australia (unpublished). *Survey results October 2021*.

[55] Hon Greg Hunt MP, 'Permanent telehealth to strengthen universal Medicare' (Media release, 13 December 2021). Available at www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/permanent-telehealth-to-strengthen-universal-medicare.

[56] World Health Organisation, 'Social determinants of health' (Web Page, 2021). Available at www.who.int/health-topics/social-determinants-of-health#tab=tab_3

[57] Ibid.

[58] Queensland Health, *2019-2020 Annual Report* (2020). Available at www.health.qld.gov.au/__data/assets/pdf_file/0013/1016302/2019-20_DOH_annual_report.pdf.

[59] Queensland Audit Office, Planning for sustainable health services (Report 16: 2020-21, 25 March 2021). Available at www.qao.qld.gov.au/reports-resources/reports-parliament/planning-sustainable-health-services.