

---

# Safe applicable healthcare for rural and remote areas of Queensland

May 2013

Report to Minister for Health  
Honourable Lawrence Springborg MLA

by Associate Professor Alan **Bruce** Chater  
Chair, Statewide Rural and Remote Clinical Network (SRRCN)

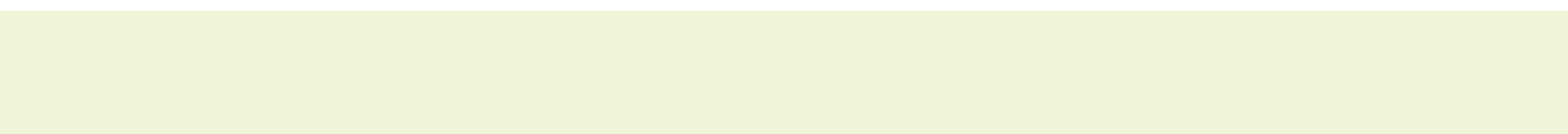
---

---

**Safe applicable healthcare for rural and remote areas of Queensland**

© Statewide Rural and Remote Clinical Network [2013]

For more information contact: [rural\\_network@health.qld.gov.au](mailto:rural_network@health.qld.gov.au)



## Purpose

The purpose of this report and accompanying documents is to:

- provide an overview of the current level of services provided by rural and remote facilities across Queensland
- propose a number of initiatives to improve health services in rural and remote areas
- outline an inclusive and open process for consultation with communities.

This report outlines recommendations to assist with the adoption of safe and applicable models of care, the cost-effective use of rural and remote health services and workforce improvements.

## Principles

This report is based on the following principles:

- Rural and remote Queenslanders should have access to healthcare that is accessible, appropriate, effective and affordable both to them individually as consumers and to the broader community of Queensland collectively as taxpayers.
- High-quality, responsive, safe local services will encourage consistent clinical practice and models of innovative service delivered by a flexible and skilled workforce.
- Modern technology such as Telehealth, bedside pathology, radiology and ultrasound will be available to support contemporary service delivery.

## Process

The Statewide Rural and Remote Clinical Network (SRRCN) in partnership with the Department of Health, and in consultation with Hospital and Health Services (HHSs), the Australian Medical Association Queensland (AMAQ) and Rural Doctors Association of Queensland (RDAQ), have prepared three documents that aim to support this report with a transparent and evidence-based approach to delivering effective rural and remote health facilities and services:

- *Queensland rural and remote health service framework*
- *Rural and remote health service planning process incorporating community engagement*
- *Rural and remote facilities data and map.*

The *Queensland rural and remote health service framework* seeks to provide an easily understood classification of rural and remote hospitals and facilities that will assist patients, HHSs and government to have a common understanding of the services their local facility can, does and should supply.

The *Rural and remote health service planning process* provides a template for HHSs and communities to discuss their communities, their needs and their health service. Data will be reviewed, tested and confirmed through an active community engagement strategy.

The *Rural and remote facilities data and map* provides communities and HHSs with a basis for a common understanding of:

- their existing facility and its effectiveness
- their comparative performance against other facilities in Queensland and at a national level
- community profile and needs
- options for health service enhancement and improved effectiveness
- how the service can be enhanced by linkages and partnerships with a range of service providers.

This report has also considered a number of other documents. The *Blueprint for better healthcare in Queensland (1)* identified improving access to a new generation of safe and sustainable health services for residents of small rural or remote communities as a priority for the Queensland Government. The Public Service Commission Service Delivery Principles (2) highlight alignment to strategic directions, being citizen-centric, simple and accessible, integrated, measured and sustainable, strong partnerships and adaptable regional rural and remote services as priorities.

## Context

Queensland is a decentralised state with more than 150 rural and remote facilities variously labelled hospitals, multi-purpose health services (MPHSs), primary healthcare centres (PHCs) and outpatients clinics spread across 1,730,648 square kilometres.

The modern era is characterised by an environment of increasingly sophisticated technology, increased longevity and increasing patient needs and expectations.

To address this there has been an increasing move towards evidence-based and cost-effective interventions, cost sharing, and avoiding duplication of service through partnerships.

In rural and remote Queensland, the complexity of providing health services is further magnified by unique community characteristics. Facilities vary from remote to proximate, high to low number of Indigenous people, long-established to fly-in/fly-out, large to small, thriving to declining. Each has its own needs. The higher proportion of Indigenous people requires specific attention to their health and cultural needs.

It is essential that services are to have capability to respond to these evolving changes while being able to meet the expectations of government and community.

## Summary of findings

The review of rural and remote services showed a significant variation in mix of services provided in these hospitals. This reflects the varying circumstances and needs of rural and remote communities and the adaptation of locally available resources. The endeavour that this represents is to be commended and encouraged but leaves some consumers uncertain of what they can expect of their local service.

Having said this, there are many lessons to be learnt from the more successful hospitals that have adapted the range of services provided to increase local access to safe, sustainable and appropriate services. The analysis of the data shows that some hospitals are less costly and provide more services than others of similar size. There are lessons and opportunities to learn here.

The hospitals have been classified broadly in terms of the services they offer—specifically obstetric services—activity levels, availability and aged care services (specifically MPHSs). These are influenced by the catchment and proximity to alternate and support services.

Infrastructure needs have previously been identified at Atherton, Ayr, Biloela, Charleville, Charters Towers, Emerald, Kingaroy, Longreach, Mareeba, Sarina Roma, and Thursday Island (3). This report will not add to this discussion except to raise the possibility that there may be more cost-effective options for replacement.

The health workforce is vital to the needs of rural and remote communities and a separate taskforce has looked at this issue to inform this report. Issues raised by them are included in these recommendations and the *Queensland rural and remote health service framework*.

Local planning will need to drive local solutions. The planning must be based on rigorous data assessment of service use, flows to other services, the local catchment population and its demographics, current service arrangements and service delivery models (including workforce, infrastructure and funding), and a transparent cost analysis. The value of local knowledge from communities must not be underestimated in this.

## Recommendations

### Organising services for safety

To provide an effective network of rural and remote health services, a graded system of health service is necessary for Queensland residents to be able to easily understand what they can expect from their local health service and where they can go for higher levels of care. This must be transparent and reliable and ensure that each level of service supports and is supported by the others in providing this mantle of care. Efforts must be made to maximise use of facilities at all levels.

#### Recommendation 1

It is recommended that health facilities be classified and named in line with the classification system outlined in the *Queensland rural and remote health service framework*.

1. District hospitals—provide acute and inpatient services including (but not limited to) 24-hour emergency and operative obstetric cover.
2. Rural hospitals—provide acute and inpatient services that may include birthing services.
3. MPHS—rural hospitals should where appropriate become MPHS services to improve the mix of services, efficiency of facility and staff and increase Commonwealth revenue.

4. Community hospital—smaller facilities that provide acute and inpatient services but cannot, after a community consultation process, meet the criteria for MPHSSs.
5. Community clinic—24-hour care.
6. Community clinic—limited or day hours only.

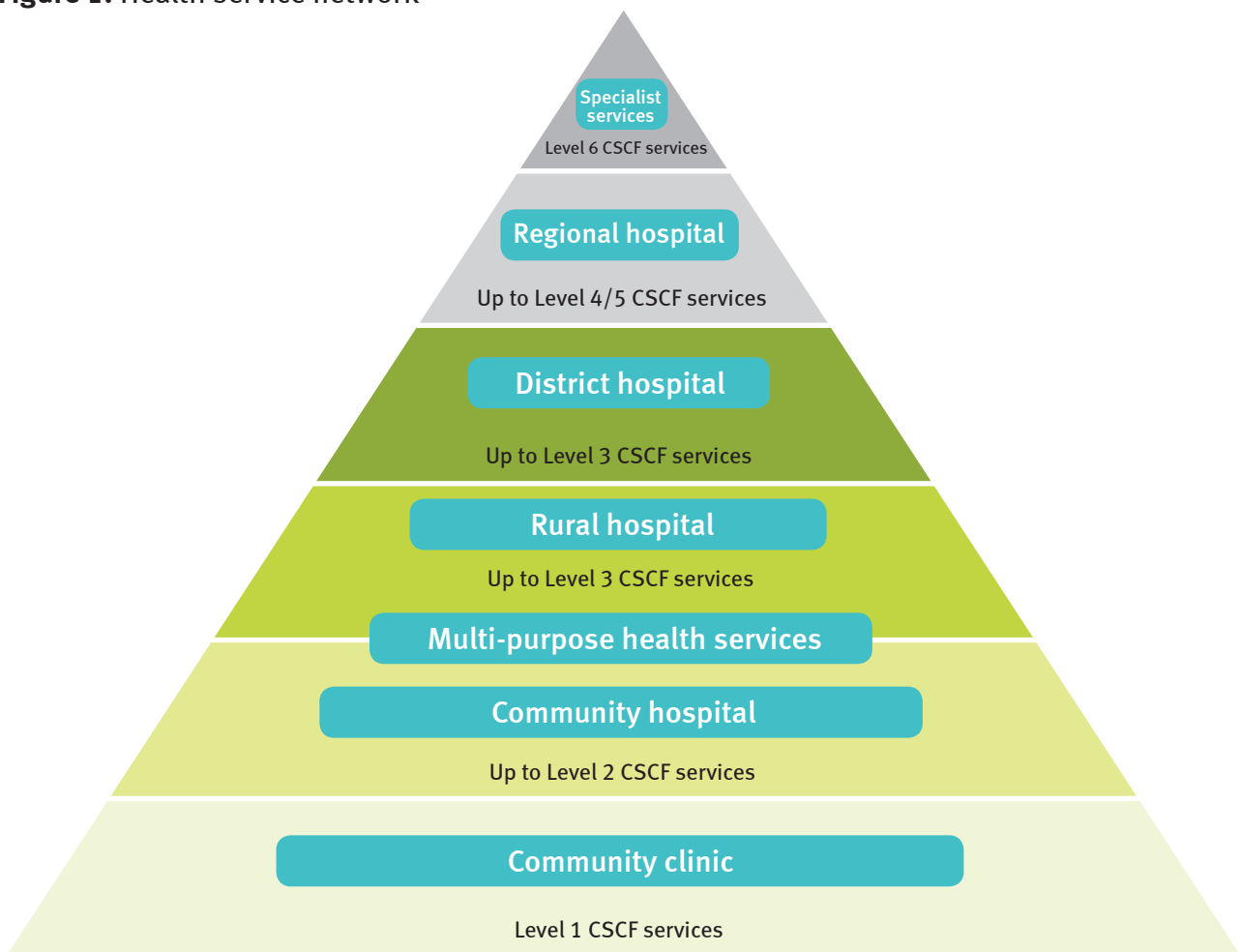
It is further recommended that:

The role of district hospitals in providing a reliable mantle of service and support, especially with respect to birthing services, be recognised formally in legislation

Rural hospitals and MPHSSs may provide birthing services in conjunction with a proximate district hospital. The role of the flying obstetrician and gynaecologist (FOG) should also be taken into account in supporting safety.

The Clinical Service Capability Framework (CSCF v 3.1) is a tool designed to measure individual components of a service and to then provide an overall level of service. This is often predicated on urban workforce models and workforce availability. (Refer to Figure 1)

**Figure 1: Health service network**



## Recommendation 2

It is recommended that as part of a review and release of a further version of CSCF:

1. The following interim classification be applied
  - a. District hospitals Level 3
  - b. Rural, MPHS, community hospital Level 2
  - c. Community clinic Level 1.
2. That a study be undertaken to identify and address
  - a. Existing standards within the CSCF that are restricting the expected levels of care within rural and remote facilities and need amendment.
  - b. Facility infrastructure and services which might be inadequate for the interim service level.

## Achieving efficiency

A key aspect of improving the performance is having a transparent availability of reliable and trustworthy data. Communities and HHSs differ sometimes on the data sets that they rely on and this can cause significant conflict and impasse. The provision of data will allow communities to work with their facilities and HHS to achieve optimum performance. Data should include the non-government sector and consider their role in any solution.

## Recommendation 3

1. That the relative performance of rural and remote facilities should be made freely available to both the public and HHSs via a website that would allow review of data within and between facilities.
2. This should include clinical activity and financial performance data.
3. That further analysis should be undertaken with the top performing hospitals with respect to national efficient cost (NEC) to identify success factors that could be spread more widely
4. That further analysis should be undertaken with the lowest performing hospitals with respect to NEC to identify factors that could be modified.
5. That the aberrations in the NEC with respect to Queensland hospitals be referred to the Independent Health Pricing Authority (IHPA) for review with respect to their modelling.
6. That new models of service introduced should be systematically reviewed.
7. Non-government agencies, general practitioners and Medicare Locals be included in this planning.

## Redevelopment and reinvigoration

The reorientation and redesign of rural and remote services can be seen by communities as a potential threat of downgrading. It is suggested therefore that redevelopment of rural and remote services be considered as a way to capture the options for service enhancement in an effective manner and describe and measure the patient journey. It should reflect a person centred approach to service delivery and relationships with primary care organisations, general practice, disability care and aged care.

## Recommendation 4

It is recommended that wherever possible:

1. Hospitals be collocated with local medical centres and that they jointly effectively share or subcontract services, equipment and human resources.
2. MPHSs be established wherever possible (dictated by the needs of aged care population) except where there is an existing high care provider or where it can be clearly demonstrated that there is no need for an aged care high care service.
3. Such MPHS arrangement could include partnerships with existing low care facilities.
4. At all levels, hospitals work effectively with private aged care organisations to ensure economies of scale through effective partnerships.
5. Local service planning is undertaken in targeted communities to develop an implementation plan to change services to better meet community need. This should be undertaken with extensive stakeholder consultation and partnership.
6. Local innovation should be encouraged.
7. Visiting services be arranged to use theatre and provide local teaching and upskilling.
8. Redevelopment of hospitals should look at alternative technologies that meet standards but provide more cost-effective serviceable solutions.
9. Partnerships be created with private providers to explore ways to effectively enhance and improve rural and remote facilities including the installation of computed tomography (CT) scanners and other modern technology in district hospital centres.

## Providing the services closer to home

There are numerous studies both internationally and locally which demonstrate the feasibility and safety of service closer to home. (4-7)

Despite this, there have been reductions in birthing services (8). The introduction of regional cancer centres have ironically been accompanied by a loss of oncology services in the areas around these services (9). Such therapy can be effectively managed in selected cases in rural and remote areas saving patients considerable travel during times of significant stress (10). For the increasing number of patients with renal failure, modern renal dialysis allows patients to be treated closer to home. The value of Telehealth services has been recognised for many years in the Australian outback (11). Although universally available in Queensland public facilities, it remains mainly used for non-clinical uses. Barriers remain but newer technologies hold promise for simpler and more desktop Telehealth technologies. Other technologies in the point-of-care testing (POCT) area also show great promise in providing better care closer to home.

### Recommendation 5

- Telehealth
  - specialist and allied health outpatient services are to be made available to rural and remote communities via Telehealth, linking metropolitan, regional centres and other rural centres with rural and remote health facilities and general practitioners
  - emergency management advice and support to be made available to rural and remote communities through Telehealth linkages between health facilities and regional or metropolitan emergency departments
  - inpatient management suitable to a remote supervision model including but not limited to cancer care, renal medicine and obstetric services
  - all uses of Telehealth must assist and complement local services
  - a statewide strategy, based on common infrastructure and open source secure systems, scalable scheduling solutions and a robust provider database that remains accessible to primary care providers and patients.

### Recommendation 6

- Birthing
  - facilities within a reasonable distance (12, 13) of a district hospital or regional hospital be encouraged to consider providing Level 2 birthing services providing that governance, workforce and quality measures that address the safety and needs of the local community are in place
  - FOG services provide routine theatre and support with emergency backup caesarean section cover.

### Recommendation 7

- Chemotherapy
  - chemotherapy using agreed protocols should be performed locally supported by regional cancer centres
  - Regional Cancer Centre be required to support such models as part of their charter.

### Recommendation 8

- Renal dialysis
  - renal dialysis be made available in rural and remote areas and be supported by rural and remote hospitals and facilities.

### Recommendation 9

- New technology
  - new technology relevant to rural and remote areas be referred to the SRRCN for assessment.

## Workforce

The area of workforce has been problematic with undersupply and maldistribution undermining efforts to address service delivery. The increasing supply in some areas of the workforce, together with specific workforce programs, is improving the recruitment and retention outlook.

The industrial relations framework needs to support the overall direction of rural and remote health services delivery.

1. Employment should be supported by a flexible, portable, remuneration framework.
2. Employment arrangements need to adapt to a range of service delivery needs i.e. public, private and a mixture of both.
3. Whole-of-family support needs to be built into engagement strategies to encourage health practitioners to rural and remote communities.
4. Improving online data and information capability should be a key priority in developing awareness of rural and remote opportunities.
5. The training and employment of local health professionals should be encouraged. including longitudinal exposure of students to encourage long-term vocational placement.

## Areas for specific action

### Recommendation 10

- Allied health professional services

Allied health services are more attracted to district hospitals but are often not available in Level 2 services. This is for a number of reasons, including workload and career opportunities (14).

  - district hospitals have at least a resident pharmacist, physiotherapist, occupational therapist, speech therapist and mental health professional (possibly shared with the private sector)
  - generalist allied health professional models of practice be initiated to safely expand the scope of practice and effectiveness of rural and remote allied health workers
  - public private partnerships, including joint employment with Medicare Locals, are encouraged
  - local resident services should be given priority opportunity to provide services to public hospitals
  - where resident services are not available, allied health professional services be provided by Telehealth with allied health assistant complemented by onsite visits.

### Recommendation 11

- Medical
  - rural generalist pathway (RGP) continue to be supported and developed
  - employment in rural medical officer/ director positions which allow flexible work arrangements to all rural practitioners that service the public system
  - State Recognised Practice Committee remain a key forum for discussion about these matters.

### Recommendation 12

- Nursing and Midwifery
  - encourage rural and remote training and competencies for nurses
  - encourage nurse practitioners across public and private sectors
  - explore further options for establishment of a rural and remote generalist nursing program
  - encourage the training and retention of midwives and nurse midwives.

### Recommendation 13

- Other providers
  - explore further options for other mid-level providers such as physicians assistants.



## Glossary

Australian Medical Association Queensland (**AMAQ**)  
Clinical Service Capability Framework (**CSCF v 3.1**)  
Flying obstetrics and gynaecology (**FOG**) Service  
Hospital and Health Services (**HHSs**)  
Independent Health Pricing Authority (**IHPA**)  
Multi-purpose Health Services (**MPHSs**)  
National efficient cost (**NEC**)  
Point-of-care testing (**POCT**)  
Primary healthcare centres (**PHCs**)  
Rural Doctors Association of Queensland (**RDAQ**)  
Rural generalist pathway (**RGP**)  
Statewide Rural and Remote Clinical Network (**SRRCN**)

## References

1. Queensland Health, 2013, *Blueprint for better healthcare in Queensland*, Brisbane.
2. Queensland Government, 2013, *Service Delivery Principles In: Commission PS*, Brisbane.
3. Queensland Government, 2010, *Statewide Implications for Rural Service Provision – Infrastructure Renewal Planning Project for Rural and Remote Area Parts A and B In*, Brisbane.
4. Tracy M, 2005, *The safety of small maternity units in Australia – a population-based study. Symposium on birthing services in small rural hospitals.*
5. Iglesias S, Grzybowski S, Klein MC, Gagne GP & Lalonde A 1998, *Rural obstetrics. Joint position paper on rural maternity care. Joint Working Group of the Society of Rural Physicians of Canada, The Maternity Care Committee of the College of Family Physicians of Canada, and the Society of Obstetricians and Gynaecologists of Canada. Can Fam Physician*, vol. 44, pp. 831–843.
6. Nesbitt TS, Connell FA, Hart LG & Rosenblatt RA 1990, *Access to obstetric care in rural areas: effect on birth outcomes. Am J Public Health*, vol. 80, no 7, pp. 814–818.
7. Humphreys JS 2009, 'Key considerations in delivering appropriate and accessible health care for rural and remote populations: discussant overview'. *Aust J Rural Health*. vol. 17, no. 1, pp. 34–38.
8. Health Workforce Queensland, 2006, *Overview of the Queensland Rural Maternity Workforce – Presentation to Maternity Rural Clusters*, Workshop, Brisbane, 7 October.
9. Chater AB, 2013, *Anecdotal discussions with rural doctors previously providing oncology services.*
10. Sabesan S, Larkins S, Evans R, Varma S, Andrews A & Beuttner P 2012, 'Telemedicine for rural cancer care in North Queensland: bringing cancer care home'. *Aust J Rural Health*, vol. 20, no. 5, pp. 259–264.
11. Yan V & Sloman G 1973, 'Clinical value of the telephone-transmitted electrocardiogram'. *Med J Aust*, vol. 2, no. 1, pp. 33–35.
12. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2012, *Categorisation of urgency for caesarean section.*
13. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2010, *Maternity Services in Remote and Rural Communities in Australia.*
14. Chisholm M, Russell D & Humphreys J 2011, 'Measuring rural allied health workforce turnover and retention: what are the patterns, determinants and costs?'. *Aust J Rural Health*, vol. 19, no. 2, pp. 81–88.

