Australian Governments and Health Inequities Project: SUMMARY FOR QUEENSLAND


Contents:

PART A – Detailed summary (8 sections)
PART B – Documents used for this analysis

Note: The background and methods related to this project and a comparison of all Australian jurisdictions, along with a short summary for Queensland, are contained in the following journal article: Newman L, F Baum & E Harris (2006), ‘Federal, State and Territory government responses to health inequities and the social determinants of health in Australia’, Health Promotion Journal of Australia, 17(3):217-225 [http://www.healthpromotion.org.au].

PART A – Detailed summary

The Director of the Policy & Development Unit, Population Health Branch of Queensland Health recommended six documents which had been guiding the Queensland health department’s strategic directions between the year 2000 and mid-2006. However, it was pointed out that Queensland Health was redrafting its directions following a Health Systems Review.

1. THE DOCUMENTS

Six documents were recommended by Queensland Health. The Smart State: Health 2020 Directions Statement (2002) resulted from a project commissioned by the Queensland Government to provide an overview of future directions in health and health care nationally and internationally, and to outline influences likely to impact on the health and health care of Queenslanders to the year 2020. It provides a vision and strategic directions for promoting health and wellbeing, and managing the Queensland health system. Action Plan: Building a Better Health Service for Queensland (2005) was written after the Queensland Health System Review to outline the changes needed for the system to “cope with the health challenges of the future”. It outlines the plans for using the “biggest single injection of health funding in the State’s history” and the beginning of a “transformation” and renewal of health services, systems and structures for users and health workers alike. The Review identified a need to balance acute hospital care with a stronger focus on prevention and early management. Keeping Our Promise - Health Action Plan Progress Report (2006) lists the promises set out in the Action Plan and details against them the action taken. This mainly revolves around amounts of funding allocated or numbers of
new staff or services. The Queensland Strategy for Chronic Disease 2005-2015 (2005) is seen as a “critical component” of the public health system “renewal” and was written to help move the focus from acute hospital care to prevention and reduction of illness, earlier identification of disease and better chronic management. The Strategic Policy for Aboriginal and Torres Strait Islander Children & Young People’s Health 2005-2010 (2005) was written specifically because of the young population profile of Queensland’s indigenous population (half aged under 18) to ensure a healthy Indigenous Australian population for the future. The Annual Report provides a regular overview of achievements, initiatives and funding.

Other documents which were not recommended by the Department but which were referred to by the researchers include the Charter of Social & Fiscal Responsibility from the Treasury Department, and Queensland Health’s Strategic Plan 2004-2010, the more recent 2006-2011 version, and State of the Health of the Queensland Population. The Charter of Social & Fiscal Responsibility outlines the broad objectives and priorities of the Queensland Government and establishes a framework for assessing the Government’s performance in achieving progress towards its objectives. The Strategic Plans (2004-2010 and 2006-2010) outline the Department’s broad strategy and identify its mission and strategic directions, what they mean and why they are important. The State of the Health of the Queensland Population (2001) provides a population profile of Queenslanders’ health and overview of the most significant health issues. The Multicultural Policy Statement was written by Queensland Health in response to the Queensland Government’s direction to agencies to implement its Multicultural Queensland Policy in their strategic, operational and planning processes and program/service delivery to take account of a diverse population. Related to this is the Report on Activity under the Multicultural Action Plan which details actions taken by Queensland Health in this regard.

2. PROCESS, DEVELOPERS, STAKEHOLDERS

Health 2020 was developed by the Queensland Health by working with key stakeholders and through a discussion paper which asked how the health system, businesses, the community and individuals could work together to improve the health of Queenslanders. The Action Plan 2005 appears to be solely an internal document. It says it was written after the Queensland Health System Review to outline the changes needed for the system to cope with the health challenges of the future. The associated Progress Report “Keeping our Promise” was written by the Department to show how plans had been put into action. The Strategic Plan 2006-2010 was also an internal document developed by the Department of Health to outline its own mission and directions, and the Multicultural Policy Statement appears to be Queensland Health’s interpretation of its responsibilities in relation to implementing the Government’s Multicultural Policy in the area of health. The Strategy for Chronic Disease was developed by a large steering committee comprising key groups, a wide range of key informants including universities, consumer groups, and consultancy support from the Primary Health Care department at two universities. Similarly, the Strategic Policy for Aboriginal and Torres Strait Islander Children was developed by an expert reference group, a working group from the Queensland Aboriginal and Torres Strait Islander Health Partnership, and a broad range of key stakeholders including the Queensland Aboriginal and Islander Health Council, the Torres Strait Regional Authority, and an external consulting firm who assisted with researching, writing and developing the draft document. State of the Health of the Queensland Population appears to be produced by the Health Information Centre within Queensland Health, while the Department of Treasury’s Charter of Social & Fiscal Responsibility was written under a legal obligation under the Financial Administration and Audit Act 1977 which stipulated that such a Charter should set out a range of statements and arrangements relating to the Government’s activities, including “The Government’s objectives for the community and the outcomes the Government wants to achieve in pursuing the objectives”, and associated arrangements for reporting to the community on these.

3. VALUES, DEFINITIONS & LANGUAGE

The Queensland Government and Health Department documents outline broad objectives which include “a fair, socially cohesive and culturally vibrant society”. Some note the need to address the social determinants of health and to reduce “disparities in health” or “health inequalities” and to “address
equity issues”. Health 2020 states that “the Queensland Government is committed to tackling the wider social and economic factors for all Queenslanders”, and says that as a document it links into the Charter of Social and Fiscal Responsibility which shows that the Government’s priorities are underpinned by “values for a vibrant, cohesive state in which all citizens have the opportunity to achieve their personal goals” [although the Charter does not talk explicitly of equity or health equity]. 2020 also states that achieving good health brings not only social but also economic benefits. It talks implicitly of the social determinants of health in one Strategic Direction which takes “a wider perspective on health” which includes “ensuring every Queenslander is given the opportunity to succeed at school, to pursue post secondary training and career development and as far as can reasonably be expected, to remain in employment”. It also talks of the need to improve health for all but also for those “most at risk of ill health”, and says that funding for health will come from “raising awareness and recognition that the economic and social growth of Queensland is directly linked to investment in healthy populations and care of the socially disadvantaged”. It explicitly states that “improving health… for all Queenslanders must include strategies to address the challenges faced by socially disadvantaged people and communities”.

The Strategic Plan 2004-2010 aimed to “systematically identify people at greatest risk of illness, injury or complications from existing health conditions and take steps to reduce their risk and improve their quality of life”, but otherwise says little else about health inequities or the social determinants of health. The 2006-2011 Plan does not include equity as a fundamental value but does include “equitable health outcomes” in its strategic directions, and “equity” as a key performance indicator (but gives no details as to how performance on equity will be measured). The Annual Report says that “Queensland Health is committed to increasing equity and access to high quality acute hospital services for clients on a State-wide basis and enhancing tertiary level services in cities and rural areas”.

Compared with Health 2020 and these Strategic Directions documents, the 2005 Action Plan focuses mainly on increased funding to services and staffing, and changes to health subsidies rather than talking about health outcomes, or improved health status and access. It contains no values statements or equity comments. It does aim to increase more flexible models of primary health care which may indirectly benefit disadvantaged groups, but this is not an implicitly stated intention. Similarly, the associated Action Plan Progress Report focuses on detailing amounts of funding allocated to services (eg emergency departments, elective surgery) and workforce improvement (eg staff wages and conditions), plus numbers of new health staff and funding for the Chronic Disease Strategy. State of Health has sections which highlight health inequalities, such as “How healthy are Queenslanders? Is it the same for everyone?” and “Are the factors determining health improving for the better? Is it the same for everyone”. It also provides data that shows links between health and disadvantage, for example stating that people living in socioeconomically disadvantaged areas have higher suicide rates and a higher prevalence of smoking, obesity and overweight, while lower physical activity levels are recorded in remote areas and for women and the aged. Health 2020 echoes this with a section to address suicide which includes the comment that suicide is affected by “social factors, such as poverty, poor educational achievement, discrimination and bullying”. However, Health Department strategies to prevent suicide do not target socioeconomically disadvantaged groups or areas.

The Strategy for Chronic Disease talks of reducing risk factors and improving health for all Queenslanders “but particularly those people who live in rural and remote areas, Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds, and people who are experiencing socio-economic disadvantage, who often have more risk factors and higher rates of chronic disease”. This document explicitly talks of the need to “address equity issues” for these groups and to “reduce health inequalities”. Similarly, the ATSI Children and Young People’s Health Strategy talks specifically of “persisting health and social inequalities” faced by ATSI people and aims to address these.

Who is responsible for health equity?

The Health Department ascribes itself a leadership role in supporting “wider socioeconomic health improvements opportunities”. Some department documents talk of health inequalities, “equity issues for
people in low socioeconomic circumstances”, and the need for targeted programs to improve health for disadvantaged groups (particularly for the Aboriginal population, and for rural and remote areas).

4. HEALTH OUTCOMES AND HEALTH ACCESS

The **Charter of Social and Fiscal Responsibility** includes a commitment by the Queensland Government to work at the broad level towards Community Engagement and Better Quality of Life to “ensure equality of opportunity and equitable access to high standards of education, health, housing and family services”, and to achieve this through greater participation in choices made by Government… and strengthening engagement with “Queensland’s communities”. In the aim to work towards Safe and Supportive Communities, the Government intends to address both the social and economic causes of crime.

**Health 2020** aims to “lead the development of health policy for improving the health outcomes of the Queensland population”, and also to take a leadership role in planning and prioritising for health improvement through participating in and coordinating planning, budgeting and monitoring activities with all government agencies to support “wider socioeconomic health improvements opportunities”. Both this and the Chronic Disease Strategy have plans to start developing responses to equity issues. Examples of initiatives which target the social determinants of health and disadvantaged groups include the Community Renewal Program. By comparison, Queensland Health’s **Action Plan 2005** focuses on a massive funding injection to expand services and staff numbers to cope with Queensland’s rapidly rising population numbers, ageing, and insufficient health infrastructure. In seeking to renew the health system it aims to find new ways to promote healthy lifestyles and prevent illness to keep people “healthy and out of hospital”, and to promote care in the community.

The **2004-2010 Strategic Plan** had priorities including “improve the standard and accessibility of hospital and health services”, “support an increased quality of life through disease prevention and active participation”, “develop and implement strategies to support Queensland families”, “improve the lives of people with a disability, their families and carers”, “work with Aboriginal and Torres Strait Islander communities to improve economic and social wellbeing” and “improve Queenslanders’ access to affordable housing”. The **2006-2011 Plan** aims to “create supportive environments” and support behaviours that protect and promote health, reduce health risk factors and improve health outcomes for people with long-term conditions. There is one major strategic direction of “responding directly and fairly to need” to achieve equitable health outcomes, and to enable timely access to the “right” health service at the “right” time in the “right” setting. However, it does not mention any need to target disadvantaged groups, except for singling out the Aboriginal population and noting the need to upskill health practitioners in rural and remote locations to provide a broader range of services.

The **Chronic Disease Strategy** aims to “help prevent chronic disease” by reducing risk factors (eg smoking, poor diet, lack of physical activity), and to help people with a chronic disease identify and manage their disease earlier and access “the full spectrum of services” faster. The aim is to avoid “unnecessary complications and hospital admissions”. The Strategy aims to improve health for all, but particularly those from disadvantaged groups who it says often have more risk factors and higher rates of chronic disease (named as ATSI people, those from a CALD background, and those experiencing socio-economic disadvantage). The Strategy says that its principles include addressing the needs of disadvantaged groups in order to reduce health inequalities and that therefore disease prevention and health promotion approaches need to be targeted at these groups. The **ATSI Strategy** similarly aims to improve the health status of Aboriginal and Torres Strait Islander children and young people by acting on the social and environmental factors affecting health and increasing access to skilled and appropriate health care. It has four key goals under the Queensland Government’s whole-of-government policy framework Partnerships Queensland: Future directions framework for Aboriginal and Torres Strait Islander policy in Queensland 2005-2010, which are to develop a) strong families, strong cultures; b) safe places; c) healthy living; and d) skilled and prosperous people and communities. The Strategy takes a population-based approach and wants health and other human service providers take more responsible for both the healthy and unhealthy in their population, and for service providers to be responsible for
maximizing the reach, accessibility and acceptability of their services to those who find it hard to attend owing to transport, financial, cultural or other barriers.

5. STRATEGIES FOR ACTION: HEALTH

There is some discrepancy between indicators reported in State of Health which highlight certain health inequities, and health policies and strategies which do not clearly address these. As an example, State of Health notes that suicide rates are higher in socioeconomically disadvantaged areas and are affected by social factors such as poverty, yet Health Department strategies to prevent suicide do not target socioeconomically disadvantaged groups or areas. Health 2020 targets for action those areas most likely to have “the most significant impacts on health and health care over the coming two decades”. In its six priorities this does not include priority for “disadvantaged groups” or reducing health equity in a comprehensive way. Nevertheless, Health 2020 says it focuses on “issues where Queenslanders’ health is below that of other Australians” and especially on “targeting health improvement and increased life expectancy for Indigenous Queenslanders”. It has one objective of improving health for all by “implementing targeted health strategies to address those areas of illness and injury which offer significant health improvement opportunities”, and this particularly includes chronic disease. It says “there are persistent health inequalities for Indigenous Queenslanders and those suffering socioeconomic disadvantages” and that “the role of the health system is to provide health education and support, with “special emphasis on providing targeted programs for the more disadvantaged sections of the community”. The strategies name these groups as ATSI, children and the aged. The 3-5 year strategies include developing an inter-sectoral and coordinated response to the health needs and wellbeing of disadvantaged Queenslanders including Indigenous communities, and supporting healthy ageing initiatives.

The two Strategic Plans have no specific plans or actions outlined which focus on reducing health inequities. However, there are intentions to develop funding models based on population and health data, and health targets for strategic health improvement. In contrast to these, the Chronic Disease Strategy is specific in aiming to “address equity issues in relation to people in low socioeconomic circumstances, Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds and people from rural and remote areas”. It sets out a large number of specific strategies that aim to improve health by preventing disease and promoting health for all by including both population-wide and at-risk group approaches. For example, there are strategies to “implement anti-smoking mass media campaigns targeted at specific population groups” and to “implement campaigns for specific population groups to sustain key messages about risky and high-risk drinking”. However, “targeted” does not necessarily mean “disadvantaged”, since elsewhere targeted groups are identified as children, young people, adults, and older adults, and not those on low income or those who are health-disadvantaged. Other strategies aim to improve access to, and the availability of, healthy foods particularly in rural and remote areas by implementing initiatives under Eat Well Queensland, to support education sectors to address smoking issues for students and wider school communities such as the Health Promoting Schools anti-smoking resource (but it is not clear whether this is targeted to disadvantaged areas/areas of high smoking prevalence), and to improve access to diagnostic and treatment services for all Queenslanders, particularly those living in regional, rural and remote areas. The ATSI Children & Young People’s Health Strategy aims to address critical issues. It says it will build on the learning from initiatives that have been shown to make a difference at the local level, and emphasises Queensland Health’s role in health promotion, prevention and early intervention.

The only equity-related comments in the 2005 Action Plan are related to the aim to introduce more flexible models of primary health care, and of means-testing or seeking co-payments for services to ensure funding is targeted to those in need.

TARGETING CHILDREN AND REFUGEES

CHILDREN

The Strategic Plans and Action Plan do not mention general child health or children from disadvantaged backgrounds. However, the Annual Report does mention recurrent funding being provided to the
Expanded Child Health Centre Initiative in ten Health Service Districts to provide parenting support and services for “families with high needs”. It also mentions increased attention to child protection. The specific Aboriginal Children’s & Young People’s Health Strategy was written because half the Queensland ATSI population is aged under 18 and there is a wish to ensure “a healthy indigenous population for the future. This strategy identifies the “high level of inequality and weight of disadvantage in the health status of Aboriginal and Torres Strait Islander people, and the intergenerational effects of poor health and wellbeing”. It identifies the need to address the incidence and prevalence of poor long-term health and social outcomes, such as poverty, chronic disease and decreased educational participation. Specific strategies for health under this plan target babies and children, for example, in seeking to “establish access for all [ATSI] expectant mothers and parents to evidence-based culturally competent pregnancy information and care by: implementing and evaluating integrated community programs to support sexual health, healthy pregnancy, foetal and infant development (for example, maternal nutrition, including adequate folate and iron intake), smoking and alcohol reduction or cessation, substance misuse, breastfeeding promotion, Sudden Infant Death Syndrome (SIDS) education including safe sleeping environments, and full immunization.

REFUGEES
In relation to refugees, Health 2020 notes that health policies and services should generally meet the specific needs of Queensland’s ethnic communities, and refugee health is specifically mentioned in the Report on Activity under the Multicultural Action Plan. This reports on “local activity directed at specific disadvantaged groups” and gives details of a refugee health clinic in Logan, and the Nourishing New Communities project to help settlement agencies familiarise refugees with healthy eating and kitchen safety.

6. STRATEGIES FOR ACTION: OTHERS INVOLVED

As with other jurisdictions, most Queensland documents acknowledge that health is not the sole responsibility of the health department, and that to improve health for all the health department needs to work in partnership with other sectors and “the community”. Some Queensland Health documents also recognise the need to work with other agencies or sectors, or to take a whole-of-government approach to address the broader social determinants of health. For example, Health 2020 states that governments “play an important role, helping to ensure the essentials for health, including safe and healthy food, safe environments (eg. water, air quality), transport, housing, community facilities and employment are accessible to all.” 2020 also talks of the need to give “careful consideration to how we fund and prioritise the development of health services and the responses to health issues through agencies responsible for education, families and the environment through budget allocation, the setting of strategic priorities and the reporting on outcomes”. It also says that businesses and communities contribute to a healthy society through fostering healthy environments, opportunities and cooperation, while individuals have responsibility for adopting healthy behaviours “if many preventable and chronic illnesses are to be avoided”. The Strategic Plan 2006-2011 has a specific strategy of “Working with Communities to Improve Health”, and another to “Work Together” with “the community”, clinicians, government and non-government partners to improve the health of all. This collaboration was evidenced in the development of Health 2020, the Chronic Disease Strategy and the ATSI Children’s Strategy, but not in the development of Queensland Health’s other documents (see section 2). The 2005 Action Plan in particular points out that the Queensland Government needs to be supported by the Federal Government in providing hospital funding, and allocating numbers of university training places and numbers of GPs who can register in the State. It also talks of working together more with community and clinicians to find smarter ways to deliver health services, new ways to promote healthy lifestyles.

7. IMPLEMENTATION

The Annual Report gives examples of initiatives which target the social determinants of health and disadvantaged groups in the section on Policies and Initiatives for Better Health. For example, it cites the Child Health Partnership Project with Rio Tinto which was established to introduce preventative measures to reduce antenatal exposure to smoking and alcohol in Aboriginal communities. The
Queensland Health Annual Report also mentions the Community Renewal Program but does not identify it as specifically targeting disadvantaged areas. It is a Government initiative coordinated by the Department of Housing in conjunction with local residents, State and local government, and non-government agencies, currently operating in 15 communities throughout Queensland “to address issues including health and welfare, employment and training, crime prevention and access to essential services”. In 2004-05 Queensland Health contributed to the 12-month planning process, and it is contributing with other agencies to a Memorandum of Understanding to identify priorities for action across the Community Renewal Zones. Queensland Health is also exploring opportunities to align responses with its current strategic directions. The Annual Report says that $75 million has been allocated to the second five-year phase of the program to 2009. Another section of the Annual Report identifies that a review was implemented of the multicultural health policies and that this led to Queensland Health allocating $638,000 in 2005-06, $1.027 million commencing in 2006-07 and $2.005 million from 2008-09 to enhance implementation and develop a sustainable model of interpreter services, coordinate resource development and provide cross-cultural awareness training for staff statewide (which may benefit refugee groups). However, otherwise the Annual Report 2004-05 is predominantly focused on funding and the retrospective reporting of numbers of services or staff, rather than how these have been targeted to disadvantaged areas or groups. The health outcomes that it reports are limited by being only by sex or Aboriginality and not by socioeconomic status or area. It says that “priorities include reducing key risk factors for disease and reducing disparities in health status between population sub-groups”, but most initiatives reported appear to be whole of state approaches (eg vaccination, school nurse program) rather than targeted to population sub-groups with poorer health.

In terms of health funding, Health 2020 aims to start “allocating resources based on complementary, population-based economic, social and health-related policies and demonstrated health improvement outcomes… A funding model that takes account of population health and age profile and geographic location”. The ATSI Children’s Strategy also talks of needs-based resourcing (a point that was included because it is one of the National Framework’s nine principles). It talks of the need for funding levels to address children and young people’s health inequalities to be determined using measures of need (for example, socio-economic disadvantage, health status, and premature and avoidable mortality and morbidity) in the context of evidence based practices and a sound knowledge of local service systems. It also talks of the need to use population data, community profiles, health service data and health status data at the Queensland Health Service District (District) and community levels to inform planning, priority setting and decision-making at the local and regional levels.

8. EVALUATION

Although some documents aim to reduce health inequities, Queensland Health has no benchmark targets that clearly aim to reduce health inequities for disadvantaged groups beyond the Aboriginal population. Monitoring and evaluation programs are just being established, and these could include clearer articulation of aims and achievements in addressing or improving health equity, for both Aboriginal and non-Aboriginal disadvantaged groups and areas. The most obvious location of specific outcomes that are linked to indicators are in the ATSI Children’s Strategy, although this does not generally set targets for improved outcomes. For example, it aims for an increase in the percentage of clients (parents/families/ caregivers of 0-12 year old children) accessing parent support programs who identify as being of Aboriginal and/or Torres Strait Islander origin but does not talk of the current percentage or set a targeted increase. On the other hand, there is one aim with a measurable outcome of “increasing the number of Indigenous Health Workers trained in the Triple P parenting program to 65 by July 2006”. This Strategy also has several tables which set out objectives and outcomes which are linked to key indicators eg Immediate outcome: increase use of antenatal services (proportion of mothers attending more than 1 antenatal visit); Main Outcome: reduced perinatal and infant death rates; Indicator: perinatal death rate and SIDS rate. Other measurable indicators of health include “Number of people in overcrowded households”; “Number of communities (population more than 50) with no connection to townwater supply”. However, there are no targets set for improvement.
Other documents state intentions to improve arrangements for monitoring and reporting. For example, **Health 2020** says that “The Queensland Government will release a series of strategies providing detail for the implementation of specific elements of the directions statement. The implementation plan will include key milestones and actions to monitor progress of implementation”. It also states that “Queensland Health will develop a long-term model for performance monitoring based around the [National Health Performance] framework, reflecting a set of health targets for strategic health improvement of the Queensland population, performance indicators for measuring the effectiveness of the health system and links to improving the wider social and economic environment through the *Priorities in Progress Report* under the *Charter of Social and Fiscal Responsibility*. The Strategic Directions document is to have triennial reviews. The Chronic Disease Strategy document sets out a comprehensive and detailed evaluation framework that will include the ability to track change across time in key outcome areas and allow comparison within the state between place-based initiative communities and other communities, plus comparison with data from communities outside Queensland. The Strategy’s evaluation is to use existing data sources and to collect additional data through seven new survey/study/interview processes to fill data gaps. However, it is not clear whether such data will allow measurement of the health inequities for disadvantaged groups that the Strategy talks about (beyond the ATSI population).

The 2005 **Action Plan** says the Queensland Government “will establish a $7.7 m Health Commission to monitor Queensland’s health performance and keep the public informed”, although this mainly seems to target waiting list and health service issues. It also states that the Chief Health Officer will report on burden of disease issues, but does not mention reporting on the reduction of health inequities. The ATSI Children’s Strategy in particular aims to improve the data which is collected to indicate health outcomes. It aims to improve the availability, consistency and cost-effectiveness of user-friendly information and reliable data collection systems to monitor a wide range of health indicators and outcomes for children”

**PART B - Key documents used for this analysis**

Recommended by Ms Robyn Clark, Director, Policy & Development Unit, Population Health Branch, Queensland Health.

Queensland Health

(2002) **Smart State: Health 2020 Directions Statement**  


(2005) **Strategic Policy for Aboriginal and Torres Strait Islander Children and Young People’s Health 2005-2010**


**Also referred to by the researchers:**
Queensland Health


Queensland Health Strategic Plan 2004-2010

(2006) 2006-2011 Strategic Plan

Report on Activity under the Multicultural Action Plan 2005-06


Queensland Health's Mission, Vision, Values and Strategic Intents

Queensland Government

Charter of Social and Fiscal Responsibility (2001)