From: [redacted]
To: Health and Environment Committee; Mental Health Select Committee
Cc: [redacted]
Subject: Additional material for Parliamentary Hearing - Bundaberg 2nd and 7th March 2022
Date: Monday, 14 March 2022 5:43:31 PM
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PHN letter .pdf
Parliamentary Enquiry - Dr Alicia Kohn.docx

Good evening

I attended the Health and Environment public hearing on 2nd March in Bundaberg. However, [redacted], I was unable to attend the Mental Health Committee hearing on 7th March. My initial contribution covers both areas and I have updated this to cover both more broadly. I have also attached a letter that was mentioned in the HEC hearing. I would appreciate both committee's being given these documents.

Kind regards

Dr Alicia Kohn

Dr Alicia Kohn
Doctor (Medical Director) | Bundaberg

[redacted]
Bundaberg | North Burnett

www.iwc.org.au

phn
CENTRAL QUEENSLAND,
WIDE BAY, SUNSHINE COAST

An Australian Government Initiative

18 February 2022

Dear GP,

MENTAL HEALTH TRANSITION TO NEW REFERRAL MODEL

Like other PHNs and service providers across the country, Central Queensland, Wide Bay, Sunshine Coast PHN is experiencing unprecedented demand for its mental health services. The impact of the COVID-19 pandemic, combined with an increase in people moving to our region from other Queensland regions and interstate has led to a growing and unsustainable demand, particularly on the Fee for Service streams 1 and 3 of our Stepped Care Intake and Referral (IAR) Program.

As you will be aware, following communication with you on the subject in August 2021, efforts were put in place to manage demand and referrals into the service by tightening the eligibility criteria. These measures have been monitored over time, however they have unfortunately not sufficiently contained demand to a sustainable level.

Funding for this particular service is capped, unlike other MBS-funded programs. To date our PHN has been unable to secure additional funding or obtain approval from the Department of Health to redirect underspend from other programs to allow us to meet the current demand for this Stream 3 service across our region.

It has therefore been agreed that our PHN will cease taking referrals to the fee for service Stream 3 Psychological Therapies service, as of close of business 4 March.

We will not however, stop taking referrals altogether. We will replace the fee for service model with a more sustainable model that better reflects person-centred, evidence-based best practice. This model will be implemented in March 2022. Further information about this new model will follow in the coming weeks.

The current program will transition from a service that deals primarily with fee for service referrals for a limited population group, to a program that accepts *all* mental health related referrals.

PHN Intake and Referral staff will continue to assess referrals and link people to appropriate services across the stepped care spectrum, including to AOD and psychosocial programs. People with more complex needs will be supported by Service Navigators.

Under the current model, referrals must be made by second parties. The new model will move away from restrictive referral criteria and allow clients to refer themselves.

Whilst a different referral process will soon be in place, community members will still be able to access services and may be referred to alternate services to meet their mental health needs.

This new model will ensure our PHN, in partnership with our commissioned service providers, can sustainably continue to deliver mental health services and provide support to those most in need of assistance in our region.

For any enquiries regarding the transition to the new model, please contact [redacted]

Yours sincerely,

Liz Giles
Senior Manager, Mental Health, Alcohol and Other Drugs

Parliamentary enquiry into provision of primary, allied and private health care, aged care and NDIS

My name is Dr Alicia Kohn, the Medical Director of the Indigenous Wellbeing Centre. I have worked as a GP at the IWC for 7 years and have been heavily involved in the training of Australian medical graduates and overseas trained doctors. I studied medicine at the University of Queensland in Brisbane and completed my GP training in Brisbane also. As part of this training I moved around to several Tertiary and smaller rural hospitals in Southern Queensland and also spent one year at the Toowoomba Rural Medical School and hospital. Needless to say, I have seen my fair share of policy change in the hospital and primary health care sector. I have also experienced the great divide in health care services provided to those living rurally and regionally compared to those in larger cities.

I attended the public hearing on 2 March but [redacted] I was unable to attend the Mental Health Committee hearing. My initial contribution covers both areas and I have updated this to cover both more broadly.

- **Current state of primary health care:**
    - **Inadequate resources to meet mental health needs in community:**
        - **<u>Mental Health Unit – acute and community service</u>**
            - Patients are often discharged back to their GP with mental health conditions including psychosis with no formal diagnosis and being started on anti-psychotic medication, with no case management or follow up planned.
            - When there is no mental health diagnosis meeting the PBS criteria for these prescriptions, these prescriptions are non-PBS and can be costly to the patient.
            - A lot of responsibility and pressure is put onto the GP when these often very unwell patients are discharged back to the GP with no mental health or psychiatry follow up

- Many patients with significant chronic mental health conditions and who are at risk to themselves and others are not being case managed by the mental health unit
- Discharge letters often recommend referral to the local private psychiatrist in town taking new patients or to telehealth psychiatry services.
    - Many patients have had referrals rejected by these telehealth psychiatrists with a recommendation that they should be case managed by their local MHU due to the complexity of the case
    - Many telehealth psychiatry services do not offer ongoing regular consultations and are therefore inadequate for the complex and chronically unwell mental health patients
    - The one private psychiatrist in town is not considered an ideal referral option for some patients
    - Thus, GPs can be left managing very complex mental health patients with very little or no public or private psychiatry input
    - *See attached email that was sent to GPLO, Dr Fionna Hadden. She did visit to discuss this and has sent a comprehensive update of her progress if you would like this to assist your report.*

- <u>Psychology – PHN managed stepped care program</u>
    - Very long wait times in between appointments
        - Very little gain to be had from appointments every 1-2 mths with a psychologist – often leading to patients not feeling they have built any rapport with the psychologist and not finding it useful and not continuing with visits
    - Telehealth psychology being offered without patient being consulted due to lack of local psychology options; many preferring a face to face option

        - In the last week, we received a letter stating the funding has dried up or stream 3 - psychological services - no further referrals being accepted. Those currently seeing a psychologist told that they will now have to pay $150 to continue to see them. Something most cannot afford
        - (Since the hearing, there has again been a turnaround from PHN – they are now accepting referrals to Stream 1 and 3, however with tighter eligibility criteria. We are yet to see what this means for our patients and who in fact is eligible for this only bulk billed option psychology option)

- **Very limited public specialist services provided locally:**
    - In recent years I have seen these once publicly offered services become private services only
    - Forcing patients to be referred to Brisbane public hospitals
        - Significant cost to patient - not adequately compensated by the PTSS
        - Patients often refuse to go due to distance and separation from family
        - Long wait times
        - Burden of managing these patients is put back on the GP
            - Time consuming having to look into management of these conditions outside of patient contact time - this time not reimbursed by Medicare
            - Adds Medicolegal risk to GP
            - Consequent work related stress and burn out
    - We once had a Rheumatologist, Pain Specialist, visiting Urologist - none of these are now available in the local public hospital
    - We have resorted to telehealth options for specialist advice which is suboptimal in the first place as face to face consultation with ability to examine a patient is always preferred
        - Recent Medicare cuts to these telehealth item numbers have meant these services have already or will soon be unlikely to continue to bulk bill these consultations

        - If not bulk billed, these services will be unaffordable to many patients
        - Due to the medicare requirement for patients to pay upfront the entire cost of the consult, in place of just the gap amount, many patients have and will find this option unaffordable
    - The medicare system also only facilitates twice yearly telehealth consultations due to funding frameworks
        - Inadequate for more acute or severe conditions
        - Referrals frequently declined for this reason, with a letter from the specialist recommending the patient be better managed by the local health service

- **Pain specialist - chronic pain**
    - No public or private Pain Specialist service
        - BBH once had a pain specialist at the hospital running a clinic
        - Closest public clinic is Nambour – Persistent Pain Management Service (PPMS)
            - Too far to drive for many patients
            - Being a chronic condition requiring a multidisciplinary team approach, a local option would be much more acceptable to patients
    - With inadequate Pain Specialist support the GP is left to manage complex chronic pain conditions in a climate where opioid medication prescription is becoming more and more discouraged and pain specialist input is being pushed by drug regulatory authorities
    - PPMS at Nambour Hospital Patient can go a whole year seeing the pain specialist on one occasion - being told to be referred back the following year to see the pain specialist again - needless to say, there is no assistance or advice given to the GP for pain medication prescription or any clinical intervention - it is a multidisciplinary allied health service focusing on chronic pain management

- **Cardiology**
    - Unable to refer patients to a cardiology outpatient clinic, we have to refer to RBWH
    - If we are working someone up for ischaemic heart disease, performed necessary tests and get a positive stress test, we are to refer them to RBWH for angiogram and stenting
        - Patients can and have had a myocardial infarction whilst awaiting this appointment
    - If patients are seen in the BBH Emergency Department for cardiac presentations they will be managed and seen in the cardiology outpatient clinic with our local private cardiologists, with outpatient investigations and angiograms and stenting in the private hospital if necessary

- **Urology** - refer to BBH only to be outsourced to Mater South Brisbane
    - We used to have private urologists working in the BBH
    - This service works well
        - Phone call to patient
        - Letter to GP advising of outcome, request certain tests needed
        - Often leading to appt for further investigation or surgery as the first consultation at the Mater Brisbane hospital

- **Private Specialists in short supply, long wait lists, results that have been ordered by specialists to be followed up by GP**
    - Neurology - significant wait times in excess of 6 mths; Nerve conduction studies > 6/12 and expensive – bulk-billed and very accessible in Brisbane
        - Patient told will not follow up on results, to see GP
    - Rheumatology - significant wait times in excess of 4-6 mths
        - Patients told they do not review results and to see GP

- Gynaecology - 6 months for first appointment, 9 months or longer for surgery
- 1 x private psychiatrist accepting new patients
- No private maternity birthing suite at private hospitals
    - Unable to attract sufficient numbers of Obstetricians to the town to cover the oncall roster that would be required to run a birthing suite
- Discharge summaries from private hospital admissions have very little information relating to diagnosis or treatment provided – GP is left trying to guess what happened in hospital

- **Very long wait times for allied health ie. speech pathology, occupational therapy**
    - Speech pathology – many closed books, 12 month wait times, now having to resort to telehealth options eg. for a severe speech delay in a 7 yr old due to cleft palate

- **Patient Travel Subsidy Scheme (PTSS)**
    - Having to see GP for a form to be completed prior to going to appointment, then have specialist fill a separate form, that then needs to be taken to the PTSS office.
    - Parking is always an issue around BBH, let alone mobility issues
    - 3/12 to get reimbursed and often not fully
    - Patients significantly out of pocket to access services in Brisbane that are not available locally

- **Bulk billing policies**
    - The ability to be able to charge the patient only the co-contribution fee instead of having the patient cover the full fee and claim the Medicare portion would allow practices to more readily charge a gap, improving accessibility of health care services to the lower income populations whilst allow for practices to be adequately compensated for their services

        - Patients can often afford the gap fee, but do not have the full amount of the consult - even if it were to be reimbursed immediately.
    - If patients have to contribute financially to a service, they often appreciate the service more and are more likely to take on the advice and instruction given. They are less likely to return weeks later with the same complaint after not heeding the advice or direction given.
    - Obviously, there must be measures in place to ensure the payment of a fee for the service does not stop access to healthcare
        - caps on the total contribution payable per year for those with chronic conditions
        - Lower cap thresholds for those with lower income

- **Medicare rebate freeze**
    - Certain items are ridiculously undercompensated to the point of being insulting to the medical profession:
        - IUD insertion rebate of $55.70, recently increased to $83.40 on 21 Feb 2022– item 35503 -
            - This is the recommended first line long term contraception option in Australia. It has one of the lowest failure rates of all contraceptives. It requires specialised training, skill, equipment and nursing support and carries potential medicolegal risk to the practitioner. Australia has one of the lowest uptakes of this form of contraception in the world. The low medicare rebate offered for the procedure has likely contributed to GPs being less willing to train in IUD insertion and less likely to offer them as a service at their clinic. A more appropriate medicare rebate that more adequately reflects the value and cost of this procedure would certainly improve the uptake of this form of contraception and would have a profound impact on unwanted pregnancies and the social, emotional, health and financial impacts of this problem in the community.

- **Commonwealth Government's definition of Commonwealth Distribution Priority Areas**

    - We have a significant doctor shortage in our region. As a result, I have spent a good part of my time in Bundaberg training and supervising other doctors, mostly Overseas Trained Doctors, through necessity to assist with filling the void of doctors in the community.

    - Practices outlay significant resources in recruiting, supervising and training overseas trained doctor without being adequately recognised or compensated financially for their contribution.

    - There is no requirement to supervise or formally train these OTD on the programs that they are on ie. PEP program. However, under an obligation to our community and our patients, and only because we have the resources as a partially government funded service, we have seen a need to implement a mandatory supervision and training process to ensure the training doctor is practicing safely and meets expected standards in the provision of medical care.

    - Other practices do not have the resources to do this. These same doctors have come to us working in practices alone and unsupervised and would otherwise be doing this in practices all over Australia.

    - The patients in our community, alike many regional and rural communities whose GP workforce is made up of OTD are significantly disadvantaged as a result, having GPs who have not been trained to the standard of Australian trained GPs

    - The interview process for entry into most Australian Medical Training programs emphasise the necessity of good communication skills. The Australian training program focuses heavily on a biopsychosocial model and history taking and communication skills. OTD do not seem to have similar training and this is an area I find myself spending a lot of time on with the OTDs. Communication barriers – not understanding what the doctor is saying, not feeling the doctor understands them or taking their concerns seriously are the most common complaints I hear from patients.

    - There is very little incentive to attract Australian trained doctors. Previously there was financial incentives but this is now very limited and it does not recognise or incentivise doctors to come to less remote places where there continues to be doctor shortages.

- GP income often lower in regional towns due to these towns being lower socio-economic, with more bulk billing and patients less willing to pay for services with an out of pocket or no medicare rebate.

- GPs in regional and rural towns like ours, are often under more pressure and have more responsibility with patient care due to a lack of public hospital specialist departments and an unwillingness for patients to travel to the bigger cities for medical care. Similarly, there is a lack of private specialists with patients less willing or able to pay for private specialist care. This heavy burden and consequent stress on the GP has led many GPs to leave the town once they have finished their training. We are then left to take on more training OTD to fill the void, who also then leave.

- By the time medical students have finished their studies and hospital time in the larger cities, they are often partnered and close to settling down and less likely at this stage to then move away to a regional town to become a GP despite any financial or other incentives on offer.

    - More training of medical students in regional universities, hospitals and GP clinics will assist with this problem –

        - Central Queensland University has taken its first cohort into its undergraduate Medicine Degree this year. However:

            - It is critical we ensure high standard of training to ensure good quality graduates

            - There will be a huge reliance on private practices and doctors compared to larger cities where the public hospitals would take more of a role. This needs to be recognised and financially compensated to ensure these private practices and doctors contribute quality training

        - JCU GP Training Program – good quality graduates coming out of this program

            - However, not many that come out of the program and who work in this area as part of their training end up staying in the area. They have been given very little choice but to come to this area and then have no intention on staying. They are given a choice of only 2 practices that may be in any area outside of the South-

East Queensland. There is very little discussion with the Registrar or consideration given to their preference for final working location.

- To retain these registrars after their GP training, we need to be training them as medical students in this region. The JCU training program could assist retention of GPs after their GP training if they gave more consideration to the Registrars preferences and allow those registrars who want to work in particular regional towns the option to do this.

- Private GP clinics need to be more adequately compensated to encourage ongoing and increased engagement in training of GP registrars and to ensure good quality of training of Australian and Overseas trained doctors.

<u>Suggestions to help ease the pressure on the lack of GPs and Specialists in the region:</u>

- **GPs with Special Interest (GPSIs)**
  - Funded training of GPs in this region to become GPSIs who have close association and support of the public hospital system and specialists would be beneficial in supporting the other GPs managing their patients and remove some burden on the public hospitals.
- **More effort put on social networking and connection between GPs and public and private hospital doctors.**
  - PHN could do more to encourage this social connection
  - Assist with collaboration and creating a team approach to health matters in a currently very disjointed local health care system
  - Assist doctors to feel more connected and part of the community and may be more likely to stay
  - The connections made with colleagues from similar medical backgrounds and the ability to safely offload to someone who has an understanding of the work related pressures of working in medicine and particularly in an under-resourced regional town, may alleviate some of the work related stress that some doctors feel and help them feel more supported and more likely to stay.

Increasing the training of medical students and GPs in regional towns will improve the number of doctors working in regional and remote communities and improve retention. Recognising and compensating the GP practices and GPs adequately for their contribution in training Australian and Overseas Trained GPs will also help. But at the end of the day, even if we train more OTD to adequate standards and we train our own GPs in this region, these GPs will also leave under the immense pressure put on them by the lack of local public hospital and private specialists.

Attachments:

Letter to Dr Fionna Hadden, GPLO, 02.09.2021:

Hi Fionna

I would like to organize a time to discuss some increasing concerns we are having with the lack of Psychiatry support we have for our patients in the community and how we can go about rectifying this. I am curious if this is a consistent area of feedback for you and if the PHN are doing anything to remedy the problem.

With a lack of bulk billing private psychiatrist options in Bundaberg we have been utilizing telehealth options more and more, however these psychiatrists have rejected many referrals for the more complex mental health patients, at times indicating in return letters that it is more appropriate that these patients are case managed by the local MHU. The telehealth psychiatry services do not seem to provide reliable follow up and review of the our mental health patients either. One has openly declared he can only provide 2 bulk billed telehealth consultations per year.

When these patients are then referred to the Bundaberg MHU, they are seen and discharged quickly back to the GP, with no ongoing follow up. In other parts of this state, these patients would be case managed by their local MHU. It is an appalling situation.

Also, there are many instances where patients have been seen by the MHU and prescribed anti-psychotic medications without providing a formal diagnosis and then discharged back to their GP. There are several problems with this. Firstly, with the GP expected to continue to prescribe the anti-psychotic medication without a formal diagnosis that meets the PBS criteria, the script is non-PBS. Faced with this situation of having to pay a higher price for the medication, many patients will discontinue the medication. Secondly, the prescription of anti-psychotic medication without a formal

mental health diagnosis can be seen as a form of chemical restraint which could lead to medico-legal and disciplinary repercussions for the GP. Thirdly, these patients who are at the cusp of severe and life changing mental health diagnoses should be managed by psychiatrists to ensure the correct diagnoses are made and the right support and treatment is provided. A diagnosis from a psychiatrist is also vital for the patient for insurance reasons, NDIS and centrelink paperwork. Most GPs have sound experience with mental health, but the current process of the MHU discharging so quickly back to the GP does not take into account the GPs ability to manage the patients.

Kind regards

Alicia