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IWC™ where communities matter

16th December 2021

Committee Secretary
Health and Environment Committee
Parliament House
George Street
Brisbane Qld 4000

RE: Queensland Public Health System Inquiry

The Indigenous Wellbeing Centre (IWC) is an Aboriginal Community Controlled Organisation with 18 years' experience in supporting disadvantage, vulnerable and Indigenous members of our communities. IWC delivers over 28 different programs and services across primary health, allied health and community service sectors. IWC has extensive experience in navigating the complex health systems under review through this inquiry with firsthand operational and strategic experience. The feedback recorded below summarises the different challenges experienced and IWC invite the Committee to consult further with our organisation for more detailed and specific feedback throughout the Inquiry.

Primary Health Care

Inadequate resources to meet mental health needs in community

Mental Health Unit – acute and community service

- Patients are often discharged back to their GP with mental health conditions including psychosis with no formal diagnosis and started on anti-psychotic medication, with no case management or follow up planned.
- Where 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 forced onto GPs 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 one 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 a few reasons I won't disclose here

- Thus, GPs can be left managing very complex mental health patients with very little or no public or private psychiatry input
- Exert below from 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.

Excerpt from email to Dr Fionna Hadden, GPLO, 02.09.2021:

'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.'

Psychology – PHN managed stepped care program

- Very long wait times in between appointments
- Very little gained had from appointments every 1-2 mths with a psychologist – often leading to patients not feeling they have built any rapport with the psychologist, finding it unbeneficial and discontinuing with visits
- Telehealth psychology being offered without patient being consulted due to lack of local psychology options; many preferring a face-to-face option

Pain Clinic

- No public or private Pain Specialist service

- Closest public clinic is Nambour
  - 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

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
- Medicare rebate freeze
- Certain items are ridiculously undercompensated to the point of being insulting to the medical profession:
  - IUD insertion rebate of $55.70 – 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, we are having to outlay significant resources in recruiting and training overseas doctors to fill the void for our patients. Practices and doctors left to train these doctors are not adequately recognised or compensated for this.
- There is very little incentive to attract Australian trained doctors to regional towns. Previously there was financial incentives, but this is now very limited and it does not recognise or incentivise doctors to move 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.

- 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.

- More training of medical students in regional QLD hospitals and GP clinics will assist with this problem.
- 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 Australia and Overseas trained doctors.

Availability of medical training places at Queensland universities compared to other jurisdictions

- As I mentioned earlier, increasing the medical training places in more regional QLD universities, as well as improving the training opportunities for specialist and GP pathways in more regional and remote towns, will improve the number of doctors working in regional and remote communities and improve retention.

Aged Care

Commonwealth Home Support Program is moving to payment in arrears model with the expectation that the additional costs of providing the services be placed on the client through fee contributions.

- The expectation that the financial burden be placed on clients / consumers. Given the Socio-economic profile of the regions IWC serves (Bundaberg and North Burnett), there are many clients who simply do not have the financial means to pay fees for access to Home Care services. IWC has a clientele where at least 99% would be classed as undergoing financial 'hardship' therefore unable to pay / contribute fees for services. This will result in cessation of home care services and further isolation for existing clients.

- This will force many Home Care clients into either Residential Care earlier and / or cease their services placing an increased burden on the Health and Community Care setting (as access to Home Care services no longer is affordable).

- In rural / remote areas where there are fewer services / less competition / lack of infrastructure the services that are remaining can potentially charge higher client contribution fees, placing these already financially disadvantaged communities with little / no options.

- From an Organisational standpoint the new Model will place increased burden on administration and business costs.

- COVID has also resulted in increased living costs / rentals impacting on homelessness, number of clients couch surfing, living with extended family / community.

Allied Health Services

With the increase in participants accessing the NDIS, there is an ever-growing demand for allied health professionals and services. This is impacting the availability for non-NDIS funded clients to access regular allied health services. Additionally, with an existing NDIS price guide, new graduates are able to bill the same fee as highly experienced and competent professionals. The price guide is failing in generating a quality service fee/outcomes service fee schedule.

Disability Services

In general, the quantity of disability service providers is growing at a rapid rate. Organisations are growing at increased rates and failing to adequately train staff to deliver high quality and safe services. The NDIS Quality and Safeguards Commission is failing to proactively manage disability services, act and protect participants. The approach with providers is very mild and education based, failing to promote early risk management, quality and safety measures to ensure participants have access to appropriate services.

Additionally, many support workers have transitioned to provide independent private services, for which there are inadequate insurances and systems in place to protect participants from neglect, exploitation and unsafe service delivery.

Many disability providers are failing to protect the participant and establish appropriate support models, rather over supporting participants unnecessarily, continuing to reduce individual capacity, and failing to provide ongoing continuity of care (or identify suitable options).

Review Existing Health Funding Strategies

There are numerous funded health programs and initiatives across our regions, where strategies are failing to support the needs of the communities at the coal face. These failures are due to:

- Duplication of service types.
- Lack of collaboration and failure to leverage off existing successful systems / services.
- Absence of accountability within an outcomes framework.
- Through an over diversification of funding distribution, health funding initiatives / programs fail to capitalise on economies of scale.
- Ineffective procurement processes lacking transparency and core understanding of local and regional needs
- Heavy focus on coordination activities effecting available workforces (clogging up the supply chain) and funding to deliver treatment, clinical care for clients / patients.

Summary

IWC appreciate the opportunity to provide feedback to the committee and recognise the effort and importance of such an inquiry to ensure government systems are effective and promote environments to facilitate the delivery of high-quality, outcome-focused health services.

On behalf of IWC, Wayne Mulvany, CEO.