Health Workforce Queensland

16 December 2021

Committee Secretary
Health and Environment Committee
Parliament House
George Street
BRISBANE QLD 4000

Email: hec@parliament.qld.gov.au

Dear Sir/Madam,

Inquiry into the Provision of Primary, Allied and Private Health Care, Aged Care and NDIS Care Services and its impact on the Queensland Public Health System

Please find attached Health Workforce Queensland's submission to the parliamentary committee which addresses our understanding of the current state of play in relation to the provision of primary, allied and private health care in Queensland. It includes key themes regarding aged care and NDIS care services. This insight has been gained through our engagement with stakeholders in rural and remote communities.

Our submission also outlines the opportunities we see for primary care, allied and private health in Queensland.

Health Workforce Queensland is a not for profit, non-government Rural Workforce Agency (RWA) focused on making sure remote, rural, Aboriginal and Torres Strait Island communities have access to highly skilled health professionals when and where they need them, now and into the future. With a focus on primary health care workforce in Queensland, Health Workforce Queensland aims to create sustainable health workforce solutions that meet the needs of remote, rural, regional and Aboriginal and Torres Strait Islander communities challenged by a supply shortage of health professionals. Further information on our organisation can be found at www.healthworkforce.com.au.

Any questions relating to our submission can be directed to me by phone [redacted] or email [redacted]

Yours sincerely,

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Chief Executive Officer

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Parliamentary Inquiry by the Health and Environment Committee – 2021/2022
Health Workforce Queensland Submission
16 December 2021

Terms of Reference (Committee Website)	*Health Workforce Queensland Response*
1. Consider the current state of those services in Queensland **Inquire into provision of primary and allied health care**	Primary Care – Current State • The primary care sector remains vulnerable in remote and rural Queensland with growing incidences of market failure in general practice and legislative barriers restricting entry to workforce programs designed to support regions with critical workforce shortages. • Since Health Workforce Queensland's Health Workforce Needs Assessment (HWNA) survey commenced in 2018, there has been a gradual increase in the primary care service and workforce gap rating means across all services and workforce groups. The results suggest that there are considerable concerns amongst primary care staff and practice managers in remote and rural Queensland about primary care services and the availability of primary health care workforce. • At the national level, there is no singular voice for general practice and no clear, cohesive vision for the future. • The split governance and accountability for health services between federal and state compounds this and an endorsed (state and federal) overarching vision is needed for primary care that is proactive, preventative, coordinated and integrated. Primary Care - Opportunities • General practice is the most efficient part of the healthcare system, and a well-resourced general practice sector is essential to addressing both the sustainability of healthcare services and improving the health outcomes of people living in remote and rural Queensland. This will require a genuine focus on a patient centred approach for communities with multiple enhanced targeted funding models and different business models to ensure sustainability of service to communities. • Without policy and funding model reforms, it is unlikely that meaningful redistribution of the GP workforce will occur in the foreseeable future. • There is also a need to attract and support early career nurses and graduates into practice nursing. • More opportunities are needed for undergraduate students to gain exposure to rural and remote primary care through place-based, integrated learning and extended clinical placements in remote and rural areas. • There is also a perceived low status of practice nursing among graduates and this, together with higher pay opportunities with Queensland Health, can create disincentives to attracting and retaining primary care nursing staff

Parliamentary Inquiry by the Health and Environment Committee – 2021/2022
Health Workforce Queensland Submission
16 December 2021

	Allied Health - Current State • Despite numerous initiatives over recent decades, persisting rural allied health workforce challenges remain a key factor limiting access to allied health services in rural and remote communities. • Factors include lack of professional development opportunities, concerns for deskilling, perceived lack of local training opportunities and concern that time in a rural role will limit career progression • Workforce data for regulated allied health professions is limited but the situation is even more critical for the self-regulated and nonregulated allied health professions. This reduces the capacity to examine, analyse, plan and address community and workforce needs. • Although the need for allied health practitioners may vary from region to region, the biggest perceived workforce gaps across all remote and rural Queensland were for psychology, speech pathology, and occupational therapy (HWNA 2021)[1] • Allied health practitioners are essential in providing multidisciplinary care within communities and can work across various settings including health, disability, education, aged care, and social service sectors. • Practitioners in remote areas often work across large geographical areas, visiting multiple communities. This includes being able to provide affordable, culturally safe and responsive services, address chronic disease management, as well as undertake health promotion and prevention. • Allied health practitioners may also deal with lower workforce to patient ratios and less infrastructure and resources than those in metropolitan areas. • The scope and role of allied health practitioners in primary health is not always well defined or governed, and often not understood or utilised effectively within health services or the community. • Lack of clarity of allied health roles, clinical silos, lack of clarity around HHS appointed positions, and the underutilisation of co-commissioning and funding pools of private allied health practitioners has resulted in inadequate integration of allied health staff into local teams. • Stakeholders note there is no funding available for health education, increasing health literacy, health promotion etc. this could be utilised to bolster up already employed allied health employees e.g., dietitians and exercise physiologists to provide health education/ promotion sessions within rural/ remote schools etc. or conduct food security/healthy choice audits in local shops/roadhouses in smaller rural communities etc.

[1] 2021 Health Workforce Needs Assessment - Summary of the Primary Care Workforce Needs in Remote and Rural Queensland
https://www.healthworkforce.com.au/rails/active_storage/blobs/eyJfcmFpbHMiOnsibWVzc2FnZSI6IkJBaHBBei8zQXc9PSIsImV4cCI6bnVsbCwicHVyIjoiYmxvYl9pZCJ9fQ==--16cd670536061dcf3404fd9e1a8a8ebc529326fe/2021%20HealthWorks_NeedsAssessment.pdf?utm_source=website&utm_medium=email&utm_campaign=2021_hwna&utm_id=2021_hwna

Parliamentary Inquiry by the Health and Environment Committee – 2021/2022
Health Workforce Queensland Submission
16 December 2021

Health Workforce Queensland

	Allied Health - Opportunities • Factors influencing recruitment and retention are extensively described in the rural allied health literature. Modifiable factors influencing workforce stability include supervision and professional support, rural training experience including education and qualifications in rural and remote practice, supportive work environments, capacity to work to full scope of practice and the role and recognition of allied health in the wider healthcare team. • Better ways to improve access to allied health care and integrate this workforce sector is needed with primary care networks, hospital and health services, aged care services, disability services, schools and other community services working together (HWNA 2021)[1]. • The utilisation of allied health assistants, as well as outreach services and telehealth will continue to be necessary in many remote areas. • Workforce policies must also accommodate the growth of public, not for profit and private service capacity. • With a clear understanding of the role and impact allied health practitioners can make on an individual's health and in the long-term alleviation of the burden of chronic disease, some system changes are required to support professional sustainability. • To leverage existing workforce data to understand local priorities for allied health workforce and to look at opportunities to collate nationally consistent data sets for allied health • To identify existing workforce initiatives and gaps within the allied health career life-cycle, from promoting health careers, training, ongoing professional development through to succession planning • To work collaboratively to develop joined-up 'pathways' which attract, train and support allied health professionals • The single most significant factor predicting long term rural practice was early career rural practice. Improved capacity for allied health students to undertake rural based training and an expansion of rural placement opportunities particularly in the primary care setting is needed. • Expanding the allied health rural generalist pathway could provide another means to deliver wrap-around support to new graduates and early career professionals • To address gaps in workforce pathways through collaborative initiatives using pooled funding where appropriate. • Co-commissioning and fund pooling appear best suited to support the private/public business mix that will make the allied health workforce sustainable and accessible. • Increasing engagement and collaboration, such as engaging with National Disability Insurance Scheme (NDIS) and aged care systems to develop shared training and employment models

Parliamentary Inquiry by the Health and Environment Committee – 2021/2022
Health Workforce Queensland Submission
16 December 2021

Inquire into provision of aged and NDIS care	Aged care and NDIS are not formally a part of Health Workforce Queensland scope however some key themes that have emerged from our rural and remote stakeholder engagement include: Aged Care • Standalone residential aged care facilities (RACF) in more rural and remote settings are generally unviable from a private business perspective • Where there are RACFs in regional and rural settings, there is often a shortage of GPs willing or able to attend these facilities • Multipurpose Health Services are a very efficient and effective arrangement to allow aged care patients to stay within their communities and expansion of this model in specific settings could be beneficial to communities • There are not enough aged care packages to meet community need and response times to requests for aged care packages are not timely • The My Aged Care website is not intuitive and requires a high level of health literacy to navigate NDIS • In the 2021 HWNA, there was a marked increase in the number of comments specifically referring to the low availability of occupational therapists and speech pathologists, particularly for children. • If there is workforce, there is limited choice for patients to access support services however, in many rural and remote communities it is not possible to access these services locally. • The allied health workforce in rural and remote is generally limited and disability services are competing for the same workforce pool as the mainstream health workforce. • There is a need for upskilling of ACCHOs, general practices and other mainstream health services around NDIS and how to support people with disability and potentially consider being NDIS providers. • The compliance activities for NDIS providers have been reported to being extremely onerous, particularly for small providers
Inquire into provision of the private health care system	Private health care – Current State • There are multi-factorial barriers to addressing the health and wellbeing of remote, rural and regional Queensland where thin markets, recurrent catastrophic climate events and policy impacts all contribute to a fragile and increasingly failing health service and workforce environment. • In terms of the medical workforce and private general practice, this fragility is revealed through: ○ Increasing General Practitioner (GP) workforce maldistribution and shortages

Parliamentary Inquiry by the Health and Environment Committee – 2021/2022
Health Workforce Queensland Submission
16 December 2021

Health Workforce Queensland

- Increasing general practice closures
- Greatly reduced access to GP registrars
- Greatly reduced access to International Medical Graduates (IMGs)
- Continued high turnover and high reliance on visiting and outreach medical services
- Low (or sometimes) no access to bulk billing services outside of the public hospital system
- Increase in wait times for appointments in many towns putting pressure on local emergency departments. Higher burden and extra hours worked each week by more remote doctors.

- The reasons for these issues are complex however some include:
  - Current 'fee for service' funding models that don't focus on the needs of the community or support the unique business and workforce challenges in remote and rural areas
  - The differing funding sources between primary and secondary care create siloed service delivery.
  - The lack of focus on the specific needs of each community
  - The lack of well-designed funding and business models which provide the necessary service delivery and workforce arrangements to meet the needs of communities
  - Policy changes including the move from Districts of Workforce Shortage to Distribution Priority Areas (DPA) in 2019 and changes to 3GA program (RLRP to MDRAP) have made access to the IMG workforce more complex and more restrictive
  - Poor appeal of general practice as a career choice amongst medical graduates
  - Declining GP Registrar numbers due to reduced applications for AGPT posts and the unintended consequences of the 'rural pathway' policy
  - Uncertainty regarding the future of GP Training with the transition of responsibility to the colleges
  - Significant disparity of a GP registrar's income and entitlements to that of a hospital-based registrar
  - The declining motivations of the future medical workforce to run their own businesses and participate in often onerous on call arrangements
  - Australian trained graduates unwilling to go rural
  - Disparity in pay rates for general practice compared with state salaried doctors
  - The QRGP (Queensland Rural Generalist Program) has been successful within Queensland Health as a workforce solution, but this has not always translated to more positions being filled in private general practice. It has also created another "layer" of hierarchy in terms of salary and attractiveness within rural medical practice to the potential detriment of the traditional rural GP model.
  - The widespread utilisation of exemptions under section 19(2) of the Health Insurance Act 1973 enabling Medicare rebates to be claimed for state remunerated primary health care services (non-admitted and non-referred

Parliamentary Inquiry by the Health and Environment Committee – 2021/2022
Health Workforce Queensland Submission
16 December 2021

Health Workforce Queensland

	patients) in rural and remote communities also can create competition with local general practice, many who are not able to bulk bill patients to remain financially viable. ○ 19.2 exemption sites 'competing' with private general practice services and hospital-based services are attractive as they are bulk billed. ○ Lack of clinical leadership and mentorship required to support attraction and retention, especially in isolated environments ○ Lack of supervisors to sustain training practices for students and registrars as well as meeting the substantial supervision requirements required for non-VRed IMGs (VRed = Vocationally Registered Doctor). ○ The short-term funding cycles and program uncertainty for organisations that support general practice and primary health care does not ensure a foundation for a long-term comprehensive vision for General Practice • The more remote you travel, the less private health services are available and communities are unable to effectively utilise private health insurance within their local setting Private health care - Opportunities • More policy enablers and financial incentives are required to increase the appeal and viability of private rural general practice and primary care. • Review of MBS item numbers for allied health and nurse practitioners would also support further viability of private practice in rural and remote. • Greater flexibility in service and workforce models for remote and rural is also required to attract and support capable and culturally responsive health professionals. • Priorities could include shared funding models, changes to staffing levels and skill mix, delivery modality, and maximisation of multidisciplinary teams. • There is also recognition of the importance of workforce support and training for a sustainable and quality rural and remote health system. • Local solutions are essential to support sustainable service delivery as well as providing meaningful, fulfilling work to the health workforce. • Models need to support collaborative, place-based planning and commissioning with community involvement, funding needs to be blended and pay disparities between public and private settings should be addressed.

Parliamentary Inquiry by the Health and Environment Committee – 2021/2022
Health Workforce Queensland Submission
16 December 2021

	• The RACCHO model[2] may be a way forward and with that, new opportunities for workforce models that are hamstrung by fee for service models. This in turn will reduce the reliance of general practitioners generating the only income for health services in the private/NGO setting.
Inquiry into any impacts the availability and accessibility of these services have on the Queensland public health system	• There have been fundamental policy failures / challenges that are leading to a self-perpetuating cycle of primary care, disability and aged care failures. • When these services fail Queensland Health must become the provider of last resort for these communities. The community, given the option of paying fee-for-service or MBS gap for private AH services or GP services, unsurprisingly will choose "free" Queensland Health services, compounding the failure of primary care provider market and making it extremely difficult for new entrants in a local service market • The current funding models do not work in thin markets such as rural and remote. The Commonwealth need to revisit how these services are funded and delivered.
2. Consider bulk billing policies, including the Commonwealth Government's Medicare rebate freeze	• Medicare rebate freezes have severely impacted the financial viability of the private practice. • General practices are still playing catch up from the Medicare rebate freeze. They are paying more for their practices, staff, medical products, utilities and just about anything else that goes into running a medical service but the rebates still are not adequate, particularly for rural and remote where economies of scale cannot be supported. • GP practices in rural and remote are unable to rely solely on bulk-billing and patients are having to pay higher out-of-pocket costs which can be challenging for lower socio-economic communities. This in turn places higher pressure on state-funded emergency departments with rises in Category 4&5 and GP Type presentations • Arguably, incremental increases in funding to GP services will not improve the quality of the Australian health care system. Fundamental funding reforms for general practice and the way primary health care services are delivered is vital if we are to see significant reform.

3. Consider the Commonwealth Government's definition of the Commonwealth Distribution Priority Areas	• The Commonwealth's definition - Distribution Priority Area (DPA) identifies areas where people don't have enough access to doctors, based on the needs of the community.
	• The Australian Department of Health use DPA as a mechanism to encourage doctors subject to Section 19ab of the Health Insurance Act to work in under-serviced communities across Australia. These cohorts include:
	  ○ Temporary Resident International Medical Graduates (both VRd and Non-VRd)
	  ○ Permanent Resident International Medical Graduates (both VRd and Non-VRd)
	  ○ Australian Graduates (Non-VRd) looking to access rural medical workforce support programs

[2] https://www.ruralhealth.org.au/sites/default/files/Infographic-proposal-for-better-health-care-a4v2.pdf

Parliamentary Inquiry by the Health and Environment Committee – 2021/2022
Health Workforce Queensland Submission
16 December 2021

	○ Australian Graduates with a return of Service Obligation under the various Bonded Medical Programs (both VRd and Non-VRd) ○ Foreign Graduates of an Australian Medical School (FGAMS) • There are many towns in regional areas who are not classified as a DPA even though they have an under-supply of General Practitioners • Non-DPA classification precludes practices in these towns accessing rural medical workforce support programs. It also prevents employment of doctors who have permanent residency because it is a requirement of their visa to practice in a DPA area. This is also the case for 19AB replacement exemptions. • International medical graduates who are subject to section 19AB will need to ensure that their practice location is in a DPA in order to be eligible for a Medicare Provider Number • The DPA calculations need to be publicly available and transparent with clear details about the influence of each component on the statistical aspect of the DPA decision, this is to better inform local communities, community leaders and DPA process applicants. • The new DPA exceptional circumstances process is welcomed and the RWAs are in a good position to support communities to progress these applications, using their on the ground knowledge and workforce data. • The DPA review currently undertaken by the Nous Group is supported as it is vital that the determination of workforce need for a community is equitable and transparent. • The new blanket MM 3 – 7 DPA rating recently announced is welcomed by many towns, but the more towns that have DPA status reduces the potency of this lever to attract workforce to those most in need in MM 5-7. • Different levers or mechanisms are required to address workforce challenges in outer metro/MM1 that do not compete or overtake the greater need for rural and remote medical workforce
4. <u>Consider the availability of medical training places at Queensland universities, compared to other jurisdictions</u>	Queensland ranks third, behind NSW and Victoria in the number of medical students enrolled each year. Of the five universities that offer medical education in Queensland, only one (James Cook University) currently offers end to end education opportunity outside of an MM1 location. This is set to change from 2022 onwards when the University of Queensland commences the establishment of two end to end regional medical training pathways in Toowoomba and Rockhampton. Medical student placements within the primary care setting are key to establishing career pathways which increase and sustain a future general practitioner workforce. There are currently limited opportunities for medical students to experience extended placements in the rural general practice setting. One such program within the University of Queensland is the Extended Placement Program. This involves Year 3 medical students undertaking their General Practice and Rural & Remote Medicine placements back-to-back in the same rural location, this model enables students to spend an extended time in a rural area, enhance their knowledge

of rural medicine and continue to develop their clinical skills. Though this program is limited to the South West region of Queensland it is possible to scale up across other regions.

Below is the number of medical students **enrolled in year 1 in 2021** – noting that these will come via different entry pathways (CSP, full fee paying)

	DOMESTIC		INTERNATIONAL	
QLD	853	24.14%	164	26.45%
NSW	1,075	30.43%	180	29.03%
ACT	94	2.66%	1	0.16%
VIC	718	20.32%	172	27.74%
TAS	109	3.09%	22	3.55%
SA	265	7.50%	63	10.16%
WA	419	11.86%	18	2.90%
	3,533	**100.00%**	**620**	**100.00%**

Below are the numbers in their **final year in 2021** (after attrition, deferrals etc. that occur during the course of the program)

	DOMESTIC		INTERNATIONAL	
QLD	747	23.35%	126	23.35%
NSW	880	27.51%	225	27.51%
ACT	96	3.00%	15	3.00%

Parliamentary Inquiry by the Health and Environment Committee – 2021/2022
Health Workforce Queensland Submission
16 December 2021

	VIC	762	23.82%	139	23.82%
	TAS	100	3.13%	20	3.13%
	SA	254	7.94%	62	7.94%
	WA	360	11.25%	21	11.25%
		3,199	**100.00%**	**608**	**100.00%**

The numbers enrolled are available on the Medical Deans website at this link https://medicaldeans.org.au/data/.