Health and Environment Committee

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

Submission from Queensland Health

Contents

Overview

- Queensland's public health system is being stretched due to a broad range of factors and interdependencies, many of which sit outside Queensland Health's control or remit. This includes demographic changes, gaps in primary health care, the interface with aged care and National Disability Insurance Scheme (NDIS) services, and the need for an adequate and skilled health workforce.

- As a population, Queensland is growing, ageing, experiencing increased complex chronic conditions and morbidities, and requiring increased access to mental health and wellbeing support. Queenslanders have higher expectations for their care and are relying less on private health insurance in favour of accessing the public health system for care and support.

- While Queensland's residents and health system are resilient, the added complexity of COVID-19 has resulted in rising costs, forced changes to workforce and models of care, and most significantly, is taking its toll on the mental health and wellbeing of our population.

- Queensland's public hospitals and emergency departments are experiencing increasing demand, including for conditions that could have been prevented or better managed in the community or other sectors.

- Limited access to general practitioners (GPs) and bulk-billing practices is adding to the demand pressures on the public health system. There are significant gaps in Medicare Benefits Schedule (MBS) funded primary health care services related to:
    - episodic treatment for acute conditions rather than provision of holistic person-centred care for chronic conditions
    - limited support for allied health and nurse specialist services, inhibiting the use of multidisciplinary teams to treat patients with chronic conditions
    - indexation of Medicare rebates not keeping pace with costs of providing primary care, leading to increasing out of pocket costs for patients
    - barriers in accessing culturally appropriate care for First Nations peoples, and
    - insufficient incentives for GPs to service people in residential aged care facilities or for after-hours services.

- Delays in accessing aged care and NDIS services are contributing to avoidable hospital admissions and resulting in unnecessarily prolonged hospitalisations, which increases the risk of adverse patient outcomes and adds to the cost pressures in the public health system. This includes:
    - increased presentations to emergency departments from RACFs due to limited access to primary care services and GPs
    - delays in accessing Home Care Packages, leading to deterioration of health while waiting and potentially preventable hospitalisations
    - barriers to discharging long-stay patients who are medically ready for discharge but do not have access to appropriate NDIS supports or accommodation.

- The COVID-19 pandemic has disrupted workforce supply chains and exposed gaps in medical workforce distribution across specialities and geographic locations. Further, the staffing and skills shortages across nursing and midwifery, allied health, First Nations workforce and mental health workforce are adversely affecting delivery of primary health, aged care and NDIS supports in the community. This is increasing patient flow into public hospitals, impacting resources available for patients requiring acute care and imposing additional strain on hospital staff.

- Shortfalls in access to appropriate service provision and workforce across primary, allied and private health care, aged care and NDIS care services inevitably result in Queensland Health being the provider of last resort. This is particularly true in rural and remote locations, as well as some regional areas, where Commonwealth funded primary care services are limited or not available.

- An effective, sustainable and integrated health care system, underpinned by strong primary care, is key to managing the complex array of issues impacting on Queensland's public health system. Integrated healthcare is fundamental to improving the patient experience by achieving connected, accessible, and continuous care that feels seamless for patients. It is critical that patients receive the right care at the right place at the right time. To achieve this, the Commonwealth funded health services and State health system need to work together seamlessly.

Background

The Health and Environment Committee (the Committee) has requested information from Queensland Health to assist with its 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. The inquiry was referred to the Committee on 17 November 2021 and a final report is due by 31 March 2022.

The terms of reference provide that the Committee inquire into and report on –

1. the provision of:
    a. primary and allied health care
    b. aged and NDIS care
    c. the private health care system

    and any impacts the availability and accessibility of these services have on the Queensland public health system

2. in conducting the inquiry, the Committee should consider:
    a. the current state of those services (outlined in 1) in Queensland
    b. bulk billing policies, including the Commonwealth Government's Medicare rebate freeze
    c. the Commonwealth Government's definition of the Commonwealth Distribution Priority Areas
    d. the availability of medical training places at Queensland universities, compared to other jurisdictions.

The Committee invited representatives from Queensland Health, the Queensland Ambulance Service, the Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships, and the Department of Education to provide an oral briefing on these matters on 29 November 2021.

This submission supports Queensland Health's oral briefing. It discusses in more detail the key issues relating to the provision of primary, allied and private health care, aged care and NDIS care services, which impact on both health outcomes and the Queensland public health system.

Commonwealth and State responsibilities

The *National Health Reform Agreement 2020-2025* (NHRA) recognises the responsibility for health is shared between the Commonwealth and the states, and that all governments have a responsibility to ensure that systems work together effectively and efficiently to produce the best outcomes for people, including interfaces between health, aged care and disability services, regardless of their geographic location[1].

The States are responsible for providing health and emergency services through the public hospital system based on Medicare principles:

- eligible persons must be given the choice to receive public hospital services free of charge as public patients
- access to public hospital services is to be on the basis of clinical need and within a clinically appropriate period
- arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of their geographic location.

States are also responsible for system management of public hospitals and taking a lead role in managing public health activities. Funding for public hospital services is a joint responsibility of the Commonwealth and the States.

The Commonwealth is responsible, among other things, for:

- system management and support, policy and funding for GP and primary health care services including lead responsibility for Aboriginal and Torres Strait Islander Community Controlled Health Services (noting contributions of the States)
- maintaining Primary Health Networks (PHNs) to promote coordinated GP and primary health care service delivery, and service integration over time
- working with each State and with PHNs on system-wide policy and State-wide planning for GP and primary health care
- supporting and regulating private health insurance to enable an effective private health sector and patient choice
- planning, funding, policy, management and delivery of the national aged care system; and
- continuing to focus on reforms in primary care that are designed to improve patient outcomes and reduce avoidable hospital admissions.

The Commonwealth is also responsible for regulating the provision of services under the NDIS. In the NHRA the Commonwealth affirms its commitment to:

- funding the MBS to ensure equitable and timely access to affordable primary health care and specialist medical services
- funding the Pharmaceutical Benefits Scheme (PBS) to ensure timely and affordable access to safe, cost-effective and high-quality medicines
- affordable aged care services so that people needing this care can access it when required, regardless of geographic location.

[1] On 29 May 2020, the Prime Minister announced the new *2020-25 National Health Reform Agreement*. The final report can be found using the following URL:
Microsoft Word - FINAL NHRA 2020-25 Addendum (consolidated version) - May 2020.DOCX (federalfinancialrelations.gov.au)

As noted above, while the Commonwealth and States have distinct roles and responsibilities under the NHRA, all governments have a responsibility to ensure that systems work together effectively and efficiently to produce the best outcomes. The public hospital system is generally the system of last resort for emergencies and acute health issues. Service gaps in other parts of the health system inevitably impact on the public hospital system.

Health system demand

Queensland has experienced very strong ongoing demand for public hospital services such as emergency departments, mental health, specialist outpatients and elective surgery. In 2020-21 compared to the previous year:

- there was a 15.4 per cent increase in public emergency department presentations
- ambulance arrivals to emergency departments increased by 5.4 per cent
- there was an 11.2 per cent increase in patients requiring resuscitation or critical care, and Queensland recorded a 6.9 per cent increase in emergency surgeries.

Data for the period July to October 2021 indicates these pressures are continuing into 2021-22. Emergency department presentations increased by a further 6.6 per cent and there was a 9 per cent increase in the number of patients requiring resuscitation/critical care.

Health system pressures have been exacerbated by the direct effects of COVID-19, including the backlog resulting from the pandemic and the need to maintain hospital readiness. While Queensland has an excellent public health system, these pressures have inevitably led to some decline in performance metrics relating to patient off-stretcher times and the percentage of emergency department and elective surgery patients seen within clinically recommended times. As vaccination rates continue to increase and borders are opened up, these pressures will accelerate.

While many of these issues are beyond the control of governments, pressure on the public hospital system is exacerbated by issues relating to areas of Commonwealth policy and funding responsibility.

In 2020-21, there was a total of 39,358 ambulance transfers (Code 1 and 2) from residential aged care facilities to Queensland Health hospital Emergency Departments. This was an 8.2 per cent increase from the 36,372 ambulance transfers in the previous year. Latest data suggests this trend is continuing, with a total of 13,007 ambulance transfers recorded in the period from July to October 2021.

Delays in accessing Commonwealth-funded home care packages are contributing to the increased demand for public hospital services. As at 31 October 2021, people on a Level 1 Package can expect to wait three to six months and for people allocated Levels 2, 3 and 4 Packages, the wait time is six to nine months. Without access to adequate support, the health of people while waiting on the National Prioritisation Queue tends to decline faster, resulting in the need for residential aged care services or an increase in hospital admissions.

Furthermore, inadequate access to aged care services and NDIS supports is contributing to unnecessarily prolonged hospitalisations. As at 24 November 2021, the highest reported barrier to discharge for long-stay older patients was waiting for a residential aged care facility bed (63.6 per cent). The highest reported barriers to discharge for long-stay young patients were NDIS-related administrative delays in access and planning (31.5 per cent) and availability of supported independent living (13.2 per cent).

The impact of the COVID-19 pandemic response measures has resulted in significant increased and unmet demand reported by adult and child youth public mental health, alcohol and other drug services. Referrals for mental health community treatment services has increased, especially for adolescents whose presentations with eating disorders almost doubled in 2020-21. Service capacity limits of current models are putting additional pressure on the public hospital system, leading to longer waiting times, shorter periods of service and an intensity of service insufficient to meet consumer needs.

Primary health care

Primary health care is the cornerstone of the Australian health system. Primary care is typically the first point of contact an individual with a health concern has with the health system. Primary health care professionals include GPs, nurses, nurse practitioners, allied health professionals, midwives, pharmacists, dentists, and Aboriginal and Torres Strait Islander health professionals. They provide primary health care across a range of settings – general practices, community health centres, allied health practices, and increasingly are also delivering telehealth and video consultations. Primary health care includes health promotion, prevention, early intervention, treatment of acute conditions, and management of chronic conditions.

The primary health care system is based primarily on Medicare. "Medicare is Australia's universal health insurance scheme. It guarantees all Australians (and some overseas visitors) access to a wide range of health and hospital services at low or no cost"[2].

Medicare is a private practice model underwritten by the MBS and PBS. However, as a market-driven model it is subject to significant service gaps. It focuses on episodic care, which may be suitable for acute conditions but is less suited to chronic conditions. It is focused primarily on medical practitioners and provides only limited access to services from allied health professionals. It is also subject to significant market failure and does not incentivise services for many groups who are disadvantaged from a health perspective, such as First Nations peoples, people in rural and remote communities and even in many regional centres, and people in aged care. As such, many Queenslanders do not have access to timely and affordable primary health care through the MBS system.

To some extent, the Commonwealth seeks to address these gaps through PHNs and through other programs such as support for Aboriginal and Torres Strait Islander Community-Controlled Health Organisations. However, these programs are not sufficient to overcome the market failures arising from the MBS system.

For instance, PHNs are independent organisations that are funded by the Commonwealth to coordinate primary health care in their region. PHNs assess the needs of their community and commission health services so that people in their region can get coordinated health care where and when they need it. All Hospital and Health Services (HHSs) in Queensland work closely with PHNs to integrate services. However, PHNs have very limited budgets with which to commission services, and their ability to influence GP services is indirect rather than direct.

Accessible and culturally appropriate primary health care services for First Nations peoples are critical to achieving government's commitment to close the gap in life expectancy between

[2] Medicare, Australian Government Department of Health, website can be found using the following URL: Medicare | Australian Government Department of Health

Indigenous and non-Indigenous Australians by 2031. However, First Nations peoples have relatively low rates of MBS usage.

For example, preventable chronic disease continues to be a major contributor to the Aboriginal and Torres Strait Islander health gap[3]. While health assessments are available at no cost to patients, in 2016, only 35.7 per cent of First Nations peoples in Queensland received a (MBS item 715) health check to screen for chronic disease risk factors and maintain health. This reflects a range of barriers including lack of knowledge by GPs and First Nations peoples themselves, the fact that mainstream GP practices may not collect Indigenous status information for all patients and the fact that there is no requirement for GPs to bulk bill for the health check. MBS item 715 should also focus not just on the annual health check but be expanded to encourage appropriate follow up processes, referrals, treatment and care planning to target prevention and delaying disease progression.

Focus on episodic care

While the MBS schedule includes a number of chronic disease management items, it is still designed primarily on episodic treatment for acute conditions, rather than providing the holistic, ongoing person-centred care required to meet current and future health needs.

A greater focus on promotion, prevention and early intervention is critical to preventing or slowing the deterioration of underlying health conditions or trajectories[4]. There is a need for the MBS to transition to a contemporary system which caters to the needs of today's consumers, in order to ensure:

- High quality, safe and accessible primary health care to an ageing population who are living longer – both independently at home and in residential aged care facilities
- Integrated, coordinated, and ongoing care for chronic conditions and multiple morbidities, including through multi-disciplinary care
- Increased mental health and wellbeing support
- Consumers feel empowered and have the support/tools to take control of their own health management.

[3] The report, *An MBS for the 21st century – recommendations, learnings and ideas for the future*, Australian Government Department of Health, can be found using the following URL: Medicare Benefits Schedule Review Taskforce final report | Australian Government Department of Health

[4] The report, *An MBS for the 21st century – recommendations, learnings and ideas for the future*, Australian Government Department of Health, can be found using the following URL:
An MBS for the 21st Century Recommendations, Learnings and Ideas for the Future (health.gov.au)

Access to mental health services for people with eating disorders

For patients with eating disorders, access to private psychologists and the affordability of these services is likely contributing to increased presentations to public emergency departments and admissions. This is because GPs are not being able to refer individuals into treatment when the condition is first diagnosed and lack of access to stepped care when individuals are discharged from hospital.

Queensland Eating Disorders Service (QuEDS) have approximately 50 private practitioners who are known to be trained in evidence-based therapy for eating disorders. Of these practitioners, 25 currently have their books closed to new clients, with the others having on average a three month wait. Despite the introduction of MBS items for eating disorder the gap remains significant for the individual. On average the gap for psychology is $100-130. The evidence base suggests treatment for eating disorders typically requires around 40 sessions which is unaffordable for many.

As a result, free and low-cost services are experiencing an increasing wait times for essential individual therapy:

- Public service (QuEDS) – 4 – 6 months
- Eating Disorders Queensland (NGO) 6 months
- Headspace – as of June 2021, three practices with clinicians trained in eating disorders were closed to new clients.

Significant barriers still exist for consumers with eating disorders accessing NDIS, despite lobbying by many organisations[5].

Allied health services

Related to the focus on episodic care, the MBS schedule provides only limited support for ongoing allied health services that are key to managing chronic conditions.

Continuous, long-term multidisciplinary care is required to effectively manage chronic disease. Currently, patients with a chronic disease can access benefits for allied health services only if they have a GP Management Plan and Team Care Arrangements[6] written by a GP.

This model is problematic for both consumers, and allied health practitioners in private practice, particularly in rural and remote communities. It is reliant on an available, stable GP workforce that also understands allied health access and availability in the consumer's location. It also employs a reactive approach to health management, as opposed to a preventative approach.

[5] Significant barriers still exist for consumers with eating disorders accessing NDIS. Butterfly Foundation - *National Disability Insurance Scheme (NDIS) Costs: Productivity Commission Study Report* - Commissioned study, Australian Government Productivity Commission. The Report can be found using the following URL: Productivity-Commission-National-Disability-Insurance-Scheme-NDIS-Costs-full-report.pdf (cfecfw.asn.au)

[6] *The Chronic Disease GP Management Plans and Team Care Arrangements*, Australian Government Services Australia, can be found using the following URL: Chronic disease GP Management Plans and Team Care Arrangements - Services Australia

The November 2021 MBS update failed to address the inadequacy of funding for allied health services for chronic disease to provide effective treatment and multi-disciplinary care. To be eligible for a Chronic Disease GP Management Plan and Team Care Arrangements, a patient must have had a chronic disease for at least six months. Under this plan, patients can then receive a total of five allied health visits over a calendar year (ten for Aboriginal and Torres Strait Islander peoples). As a patient is likely to require input from more than one allied health profession for their chronic disease, this means that they are only able to access one to three visits for each profession they need to see, which is inadequate to address the multiple co-morbidities associated with the chronic disease.

Patients may also be out of pocket up to several hundred dollars for the gap between the Medicare benefit and the amount charged by allied health practitioners, because the Medicare benefit does not reflect the cost to the allied health practitioner to provide services. In addition, the MBS rebate is approximately $55 for a minimum 20-minute appointment, meaning that an individual is likely to be out of pocket by $250 to $300 for their five allied health visits. As a result, even with the MBS subsidy, primary care allied health services are unaffordable for many patients. These patients are often then referred to a Queensland Health specialist outpatient clinic in order to access services.

All of these factors impact on the viability of private allied health services, compounding a lack of choice and access in the private sector for consumers and adding additional burden on the public sector.

While the introduction of new MBS item numbers that allow MBS reimbursement for allied health practitioners to participate in case conferences is a positive step, Commonwealth funding for primary allied health care remains inadequate to meet community needs. Many consumers who are receiving care from allied health professionals do not meet the strict criteria for reimbursement of the new items (General Medical Services – Allied Health Case Conference) which are limited to patients who are already under an approved management plan and only if the case conference is *initiated and includes the GP* or medical specialist.

Scenario 1: chronic pain management

A 52 year old cleaner, Kevin, seeks an appointment with his GP to discuss a flare up of a longstanding low back pain. His GP assesses his condition and notes that he is unable to sit for more than 30 minutes and has pain limited range of movement. Kevin is not able to work and is not currently doing any exercise. The GP also believes that Kevin's weight may be contributing to the exacerbation of his condition. The GP determines that he may benefit from some allied health services, including physiotherapy and dietetics.

Kevin's GP can complete a GP Management Plan to enable Kevin to have five partially MBS subsidised allied health appointments. However, it is likely that Kevin will be significantly out of pocket because he will be required to pay a gap fee (for example, private physiotherapy session fees may be between $75 - $150 depending on the practice, with the Medicare benefit per session set at $55.10.). He is also likely to require more than five visits in total to enable both allied health practitioners to assess Kevin and implement a treatment plan to address his condition in the short and long term.

Alternatively, his GP could complete a referral for a specialist outpatient clinic at the local public hospital where Kevin may have to wait, but he will not be out of pocket and will be able to receive care from a multidisciplinary team.

Kevin opts for his GP to refer him to the local public specialist outpatient clinic. However, in the meantime, he needs to attend the local public emergency department for pain relief on two occasions due to unmanageable pain after hours.

Scenario 2: chronic disease management

After treatment for breast cancer, Benita, 58, has been diagnosed with malignancy-related lymphoedema, a chronic condition that causes swelling of one or more limbs and can lead to serious health issues such as cellulitis. It cannot be cured but can be managed through a program of self-management strategies, professional support and, when required, periods of active treatment by an allied health professional trained in lymphoedema care such as a physiotherapist or occupational therapist.

Benita has a GP Management Plan prepared by her GP, who suggests she sees a private allied professional with expertise in lymphoedema. Benita can access up to five Medicare subsidised sessions per year under the Chronic Disease Management Allied Health Service MBS (item numbers 10950-10970[7]). A study of Australian women with breast cancer related lymphoedema found that the average number of attendances to a lymphoedema therapist per year was 5.8, increasing with lymphoedema severity.

Benita's lymphoedema therapist's usual service fee is $110 so Benita will be $275 out of pocket for her five visits. If she requires more than 5 visits, she will be required to pay the full service fee for each additional visit.

Benita's GP also recommends she see a dietician for weight control, because it is strongly linked to lymphoedema diagnosis and progression. Professional guidelines for dietetic management of weight loss recommend six fortnightly visits over a 12-week period with continued monitoring for 12 months thereafter. As Benita has already used her five allied health visits on her physiotherapist, she will have to pay the full dietician fee ($100) for each appointment which she cannot afford.

[7] *Education guide - Chronic disease individual allied health services Medicare items 10950-10970*, Australian Government Services Australia, can be found using the following URL:
Education guide - Chronic disease individual allied health services Medicare items 10950-10970 - Services Australia

Out of pocket expenses

Commonwealth Government indexation of Medicare Benefits Schedule (MBS) fees for service have not kept pace with real increases in practice costs since Medicare began, contributing to increasing levels of out of pocket costs[8].

The Commonwealth Government froze indexation on all Medicare services from July 2013 to July 2017. While some services such as GP bulk-billing incentive payments were lifted in July 2017 and standard GP and other specialist consultations in July 2018, other Medicare services had their freezes gradually removed until July 2020. This freeze has reduced incentives for GPs to bulk bill and provide services that are higher cost.

At $39.10 for a standard GP consultation Medicare rebate, increasing out of pocket costs for many patients are having to bridge the divide between the Commonwealth Government's rebate and the real cost of providing medical services, impacting on the viability of general practice.
Around 88 per cent of GP non-referred attendances in Queensland were bulk billed in 2020-21. For those services that were not bulk billed, the average patient contribution per service was $42.08 creating significant impediments and disincentives to visit the GP.

The Australian Institute of Health and Welfare (AIHW) found that in 2016-17, 34 per cent of patients nationwide with GP visits incurred out of pocket expenses, including 37.8 per cent in Northern Queensland PHN and 36.2 per cent in Western Queensland PHN. Nationwide, 4.1 per cent of people who needed to see a GP delayed or did not see a GP due to cost. Delaying treatment exacerbates the underlying health condition and may result in avoidable emergency department presentations and hospital admissions[9].

After-hours services

The MBS does not provide sufficient incentive for GPs to provide after-hours services. This means that many patients requiring primary health care after hours have no option but to visit the emergency department.

In the years prior to 2018, this gap was increasingly filled by medical deputising services. These services are designed to provide general practice services for and on behalf of a patient's regular practice. The Approved Medical Deputising Services (AMDS) program enables non-vocationally recognised GPs to access MBS benefits for providing after-hours services on behalf of other doctors[10]. This helps them get general practice experience, while ensuring people can access health care after hours.

[8] The Australian Medical Association is the peak professional body for doctors in Australia. The AMA's *Guide for Patients on How the Health Care System Funds Medical Care* can be found using the following URL:
Guide for Patients on How the Health Care System Funds Medical Care | Australian Medical Association (ama.com.au)

[9] *Patients' out-of-pocket spending on Medicare services, 2016-17*, Australian Government Australian Institute of Health and Welfare, can be found using the following URL: aihw-mhc-hpf-35-patients-out-of-pocket-spending-Aug-2018.pdf.aspx

[10] The *Approved Medical Deputising Services program*, Australian Government Department of Health, can be found using the following URL: Approved Medical Deputising Services (AMDS) program | Australian Government Department of Health

The MBS items for the provision of urgent after-hours primary care services were reviewed in 2017. Following this review, the Commonwealth Government introduced new arrangements for these services on 1 March 2018. The change mostly affected non-vocationally recognised GPs working in metropolitan areas.

The changes included a reduction in fees payable to non-vocationally recognised GPs from $129.80 to $100, and then to $90 from 1 January 2019 (since increased to $93.65 from 1 July 2021), for urgent services provided between 6pm and 11pm in metropolitan areas.

Since these changes the total number of after-hours services has declined significantly, falling from 505,122 services in 2017 to 369,255 services in 2018. The services have continued to fall in recent years. It appears these changes have contributed to further pressure on emergency departments.

Access to primary care

Many regions throughout Queensland do not have sufficient access to GPs. In 2020, there was one GP for every 767 people in metropolitan areas such as Brisbane, Gold Coast, Ipswich but only one GP for every 1,160 people in small rural towns like Ingham and Condamine. Remote communities like Cape Tribulation and Cloncurry had only one GP for every 1,429 people.

Poorer access to primary care services is demonstrated by the differential in the per capita MBS spend across regions in Queensland. In 2018-19, Western Queensland PHN had the lowest MBS spend per capita at $977, one third lower than the Gold Coast where the MBS spend per capita was $1,467.

Lack of access to appropriate primary health care services results, whether intentionally or not, in cost-shifting from the Commonwealth to the States. This has had two major impacts on Queensland Health.

First, while primary health care is a policy and funding responsibility of the Commonwealth Government, the significant gaps in services have meant that the Queensland Government has had to step in as a direct provider of primary health care, especially in rural and remote areas.
Second, lack of accessible and affordable primary health care puts additional pressures on the Queensland's public hospital system, through patients presenting to emergency departments in instances where it would be more appropriate and cost-effective for them to see a GP, and through a worsening or deterioration in their underlying health conditions leading to potentially preventable hospitalisations.

State provision of primary health care

The Hospital and Health Services (HHSs) have responded to these challenges by maintaining primary health care support to rural areas through a variety of interim solutions including locum doctor engagement, outsourced medical models to private providers, telehealth support and medical officer rotations from other Queensland Health facilities.

For instance, in 2020 and 2021 Queensland Health has been actively working to address primary health care medical workforce issues in a wide variety of locations, including Springsure, Julia Creek, Longreach, Hughenden, Quilpie, Blackall and Tambo, Mornington Island, Clermont, Chinchilla and

Woorabinda, to name a few. This frequently requires direct financial support from the relevant HHS. For instance, the First Avenue Medical Practice in Chinchilla closed in May 2021, losing the only bulk billing facility in the region and creating additional pressure on the Chinchilla Hospital. The Darling Downs HHS has been working with Darling Downs West Moreton PHN and other key stakeholders to consider options for primary healthcare in Chinchilla. The HHS's immediate response has been to provide extra support to the general practices in both Miles and Taroom and additional locum cover at Chinchilla.

In many cases, HHSs directly provide primary healthcare services as the provider of last resort. In 2020-21, it is estimated that Queensland Health spent about $161.2 million on primary healthcare services, including $61.7 million in Torres and Cape HHS. While it is not possible to separately identify MBS revenue relating to primary healthcare, only a small proportion of this expenditure would have been recovered from the Commonwealth.

The scope to obtain Commonwealth funding is limited by the operation of section 19(2) of the *Health Insurance Act 1973* (Commonwealth), which prohibits the payment of MBS benefits where other government funding is provided for that service.

In some locations such as Biggenden, Richmond and Theodore, Queensland Health has established GP clinics in rural locations where there is no private GP or where the previous GP has retired or left. In such instances, a non-specialist senior medical officer (SMO) employed by Queensland Health would work part-time at the GP clinic in addition to working at the public hospital. Generally, the SMO would work under a granted private practice arrangement, and the patients are considered to be patients of the SMO, not of Queensland Health. The SMO would be able to bulk-bill the patients to the MBS. Depending on the employment arrangements, the MBS revenue may be retained by the SMO or may be assigned to Queensland Health in exchange for attraction and retention allowances. The MBS benefits are generally insufficient to cover costs given the high cost of service delivery in rural locations and because services are bulk-billed. Hence Queensland Health is required to fund the additional costs.

In some small locations, Queensland Health is able to claim MBS benefits for primary healthcare services provided to public patients under the Council of Australian Governments (COAG) section 19(2) exemptions initiative. This is an exemption from Section 19(2) of the Health Insurance Act 1973 and is designed to improve primary health care in small rural communities with an identified general practitioner district workforce shortage. This initiative provides for exemptions to allow eligible sites to claim against the MBS for primary healthcare services provided in emergency departments and outpatient clinic settings. The exemption is only available in locations classified as MM5 (small rural towns), MM6 (remote communities) and MM7 (very remote communities) in the Modified Monash Model[11].

The exemption enables MBS rebates to be claimed for state-remunerated primary health care services—that is public non-admitted, non-referred primary care services. The revenue generated from these initiatives is to be used to enhance primary care services at the sites where the revenue is generated. For a site to gain a COAG Section 19(2) exemption a local negotiation and implementation plan must be completed and forwarded to the Commonwealth Government for

[11] The Modified Monash Model defines whether a location is a city, rural, remote or very remote. The model can be found using the following URL: Modified Monash Model | Australian Government Department of Health

review[12]. It is a prerequisite that no local private practitioner will be materially affected by the granting of the exemption. There are currently 51 active sites in Queensland, including localities such as Childers, Hughenden and Longreach, with MBS revenue of $6.0 million in 2020-21.

In addition, the Rural and Remote Medical Benefits Scheme (RRMBS) enables listed sites to bulk-bill for primary healthcare services in eligible communities which have a significant Aboriginal and Torres Strait Islander population and whose members have little or no access to services through the private sector. MBS revenue from the RRMBS was $11.1 million in 2020-21. Again, the revenue generated from these initiatives is to be used to enhance primary care services at the site.

While the RRMBS is a very welcome initiative, it should be noted that in many remote Aboriginal and Torres Strait Islander communities Queensland Health operates primary healthcare clinics led by a nurse practitioner and/or Aboriginal and Torres Strait Islander health practitioner, with a medical officer visiting on a periodic basis. Nurse practitioners and allied health workers have only limited access to the MBS, especially in the absence of a supervising medical practitioner.

In summary, Queensland Health plays a very active role in providing primary health care services as a 'provider of last resort' in areas that are under-serviced or not serviced by private GPs. While there is access to MBS revenue for some of these services, the vast bulk of this expenditure is funded by Queensland Health.

Lower urgency presentations to emergency departments

The AIHW defines lower urgency emergency department presentations as those where people are assessed as needing semi-urgent care (triage category 4) or non-urgent care (triage category 5) and does not include people who arrived by ambulance or police, were subsequently admitted to hospital or died. A high proportion of these patients could be treated in a primary care setting.

In 2018-19, the AIHW found that there were 406,057 lower urgency care presentations in Queensland, representing 26.4 per cent of emergency department presentations in that year. A high proportion of these presentations occur after hours (that is, on Sundays, public holidays, before and after business hours on weekdays and weekends) reflecting a lack of GP services after hours.

Lower urgency care is also more prevalent in rural areas. For example, 48.7 per cent of presentations in the area covered by Western Queensland PHN were classified as lower urgency care in 2018-19[13].

With the average cost of an emergency department presentation being $729, it is clear that more appropriate funding of GP consultations by the Commonwealth would reduce demand and cost on the public health system, leading to a more sustainable and cost-effective health system.

There is a strong case for the Commonwealth to fund the full cost of GP-type presentations to emergency departments. Not only would this lead to more equitable funding arrangements, it would

[12] The *Council of Australian Governments (COAG) Improving Access to Primary Care in Rural and Remote Areas – COAG s19(2) Exemptions Initiative*, Australian Government Department of Health, the initiative can be found using the following URL: Department of Health | Council of Australian Governments (COAG) Improving Access to Primary Care in Rural and Remote Areas – COAG s19(2) Exemptions Initiative

[13] *Use of emergency departments for lower urgency care: 2015–16 to 2018–19*, Australian Government Australian Institute of Health and Welfare. The web report can be found using the following URL: Use-of-emergency-departments-for-lower-urgency-care-2015-16-to-2018-19.pdf.aspx (aihw.gov.au)

drive reforms to primary health care policy and funding models that provide the right care, at the right time in the right setting.

Queensland Health has a range of policies in place to reduce the number of lower urgency presentations and reduce pressure on emergency departments.

In response to very high demand for emergency and unplanned care, the Queensland Government has developed the Care4Qld Strategy to improve emergency access and patient flow through Queensland's public hospitals (launched 11 May 2021). The package targets investment in aspects of the critical care pathway including targeted investment in additional hospital beds, improving models of care and management strategies, and providing alternatives to emergency and hospital admissions where clinically appropriate and aligned to patient outcomes.

The strategy invests in new models of care such as the Transfer Initiative Nurse models in emergency departments which enables ambulances to get back on the road and achieve faster response times. Similarly, it expands access to the successful Mental health co-responder model, which provides non-hospital care options for people experiencing mental health issues.

In addition, Care4Qld makes significant investments to improve access for patients to receive care in community and home-based settings[14]. This includes permanently expanding Hospital in the Home initiatives (HitH) which were temporarily established as part of the COVID-19 response, and permanently increasing the funding for Residential Aged Care Support Services (RASS) for vulnerable elderly populations in communities across Queensland and funding to pilot targeted expansions of post-acute care services (such as physiotherapists, occupational therapists to support faster and safer discharge from hospital).

Potentially preventable hospitalisations

Service gaps in primary health care also lead to potentially preventable hospitalisations (PPH). PPH are a proxy measure of primary care effectiveness[15].

PPHs are specific hospital admissions that potentially could have been prevented by the provision of appropriate preventative health interventions and early disease management in primary care and community-based care settings (including by GPs, medical specialists, dentists, nurses and allied health professionals). The AIHW notes that PPH rates are indicators of the effectiveness of non-hospital care. The rate of PPH may reflect access to primary health care, as well as sociodemographic factors and health behaviours. There are 22 conditions for which hospitalisation is considered potentially preventable, across three broad categories: chronic, acute and vaccine-preventable conditions.

In Queensland there were a total of 174,839 PPH in 2019-20, representing 6.6 per cent of all separations. Of these, 152,948 episodes were in public hospitals, at a total cost of $1.164 billion. PPHs vary significantly in line with access to primary health care services and are highest for Aboriginal and Torres Strait Islander people and people in rural and remote areas.

[14] On 11 May 2021, the Queensland Government announced a $100 million funding boost to tackle unprecedented demand in Queensland's public hospitals. The Queensland Health's *Care4Qld* strategy can be found using the following URL: Care4Qld strategy | Queensland Health

[15] *Disparities in potentially preventable hospitalisations across Australia, 2012-13 to 2017-18*, Australian Government Australian Institute of Health and Welfare. The publication can be found using the following URL: Disparities in potentially preventable hospitalisations across Australia, 2012-13 to 2017-18, Summary - Australian Institute of Health and Welfare (aihw.gov.au)

As with GP-type presentations to emergency departments, there is a strong case for the Commonwealth to fund the full cost of PPH, in order to incentivise reforms to primary health care policy and funding models aimed at reducing PPH.

Queensland Health provides a wide variety of programs aimed at reducing PPH, including prevention and early intervention programs, primary and community health and specialist outpatient services.

In addition, in 2020 the Queensland Government announced the Satellite Hospital Program, a $265 million commitment to deliver seven new facilities to support public healthcare delivery in rapidly growing communities across South East Queensland[16].

Each facility will provide healthcare services that are more appropriately delivered in the community, closer to home and in a more convenient setting. They will:

- deliver a range of services informed by the needs of the local community
- incorporate outpatient community-based health services with virtual healthcare opportunities to service the local community, and
- potentially include simple day therapy services such as chemotherapy, complex wound management, renal dialysis, and care for minor injuries or illnesses.

Consultation and planning for each facility, including the services to be provided, is currently underway. It is expected that one benefit of the program will be to reduce potentially preventable hospitalisations.

Private health insurance and public hospital market share

Across Queensland the level of private health insurance coverage is near the lowest levels seen in the past 20 years. There are now more Queenslanders without some form of hospital insurance than at any other period, with 3.1 million Queenslanders uninsured.

Moreover, less than 40 per cent of all insured persons now have a policy which covers all hospital admissions and more than 85 per cent have a policy requiring co-payments – increasing reliance on the public system.

These changes in private health insurance are contributing to increased demand for Queensland Health services. This is true for most Queensland regions and medical specialties, including elective admissions and obstetrics. In the last seven years the public hospital market share has increased from 58.5 per cent in 2013-14 to 63.4 per cent in 2020-21, an increase of 4.9 percentage points:

- In South East Queensland the market share shift to the public sector has been 5 percentage points from 56 per cent in 2013-14 to 61 per cent in 2020-21.
- The market share for elective admissions has increased from 38.5 per cent to 45.9 per cent; an increase of 7.4 percentage points in the last seven years.

[16] In 2020 the Queensland Government announced the *Satellite Hospitals* program. The program can be found using the following URL: Satellite Hospitals | Queensland Health

A strong example of the shift to Queensland Health hospitals is demonstrated in the public market shares for obstetrics:

- The share of work in the public sector has increased from 72 per cent to 78 per cent, and conversely, the private sector has fallen from 28 per cent to 22 per cent of the market.
- Private sector volumes over this period have fallen from a peak of 17,156 births in 2013-14 to 13,005 to 2020-21.

These changes have also affected the viability of some private hospitals. For instance, in 2019 Mercy Health and Aged Care announced it would close the Mater Private Hospital in Gladstone. The hospital was purchased by Queensland Health in April 2020.

There remains considerable uncertainty around the likely level of the future public market share with a combination of several factors contributing to the outlook, including private health insurance levels, public sector funding, and the availability of private hospital providers.

The decline in private health insurance coverage leads to reduced costs for the Commonwealth Government through lower private health insurance rebates and increased revenue through the Medicare levy surcharge. The consequent increase in the public market share leads to increased pressure on the public hospital system and increased expenditure by the State Government.

Under the National Health Reform Agreement, the Commonwealth Government funds 45 per cent of 'efficient growth' in public hospital services. Hence in theory, the Commonwealth should fund a portion of this increase in public hospital services. However, it is important to note that national growth in Commonwealth funding for public hospital services is capped at 6.5 per cent per year, including both price growth and volume growth. With health price inflation increasing as a result of COVID-19, the funding cap means that in future years the Commonwealth is likely to fund little if any of the growth in public hospital services arising from the increase in the public market share.

As such, it is critical that the Commonwealth waive the funding cap to ensure that it pays for a share of the increase in public hospital services. Moreover, given that the Commonwealth would still only fund 45 per cent of the increase in public market share without the cap, there may also be a case for the Commonwealth to transfer a portion of the savings from lower private health insurance rebates and increased revenue from the Medicare levy surcharge to the States for reinvestment in the public hospital system.

Aged care

In Queensland, people are living longer than ever before, often with an increased burden of disease and complex healthcare needs. The associated increase in demand for health services presents a significant challenge for Queensland's hospitals and health system, and to Queensland Health as an approved provider of public aged care services under the *Aged Care Act 1997 (Cwlth).*

The Commonwealth Government is responsible for the regulation and funding of aged care services for people aged 65 years and over (50 years and over for Aboriginal and Torres Strait Islander people).

In 2019-20, a total of 291,880 people in Queensland received aged care services, including home care or residential aged care. There are approximately 42,000 operational places in over 500 residential aged care facilities (RACFs) – public and private – in Queensland.

Queensland Health is an approved provider for delivering aged care and operates 16 Residential Aged Care Facilities across Queensland, mostly in larger centres. It also operates a further 35 Multi-Purpose Health Services located in rural and remote areas. Queensland Health provides a total of 1,413 places, representing 3.3 per cent of the Queensland market. These facilities range from relatively recent purpose-built facilities, to older facilities that have been converted from old hospitals.

The Royal Commission into Aged Care Quality and Safety was highly critical of the aged care system throughout its Inquiry, which concluded in March 2021 with the release of the final report: *Care, Dignity and Respect*[17]. This final report called for a significant ongoing funding increase and transformational reform to improve Australia's aged care system, estimating that in 2018-19 the sector was underfunded by approximately $10 billion.

The Commonwealth Government has responded with a $17.5 billion over five years ($3.5 billion per year) funding commitment. However, Queensland Health has concerns about the ability of the funding committed by the Commonwealth Government to build a sustainable aged care sector or deliver the improvements that were envisaged by the Royal Commission and expected by stakeholders.

An unsustainable, underfunded and fragile aged care sector reduces the health and wellbeing of older people and increases the risk of them moving into the acute hospital system.

Queensland Health is being directly impacted by many of the issues highlighted in the Royal Commission final report, including:

- Lack of primary care services in RACFs
- Significant workforce pressures and challenges, including recruitment, retention and skills shortages
- Avoidable admissions due to delays in accessing Commonwealth-funded home care packages
- Long-stay older patients experiencing hospital discharge delays, and
- Stepping in to act as the provider of last resort where there are business continuity failures.

Access to MBS services in RACFs

Several HHS as well as other stakeholders have raised concerns about the lack of GPs who are willing to visit RACFs.

GPs visiting a residential aged care facility are eligible for a call-out fee of $57.25 for the first patient seen on a RACF visit. Once a call-out item is billed, GPs may then bill an attendance item for each patient they see. These are $17.90 for the most straightforward matters, $39.10 for standard appointments lasting less than 20 minutes, $75.75 for appointments lasting more than 20 minutes and $111.50 for appointments lasting more than 40 minutes.

The Royal Australian College of General Practitioners has argued that these fees do not provide sufficient incentive for GPs to visit residential aged care facilities. This reflects factors such as the time to get to the facility and to get patients into a private situation to do a consultation, the fact that many patients have chronic conditions and co-morbidities and the additional time required to take a medical history and examine frail and elderly patients compared to seeing patients in the GP's

[17] The Royal Commission into Aged Care Quality and Safety released the final report: *Care, Dignity and Respect*. The report can be found using the following URL: Aged Care Royal Commission Final Report: Care, Dignity and Respect Volume 1

consultation rooms. These issues are evident in the difficulty that patients in many facilities have in accessing GP services.

For instance, advice has been received that some RACFs in Brisbane, Sunshine Coast, Townsville and Cairns, as well as other locations, rely on telehealth to provide GP services to aged residents. This is unlikely to deliver the standard of care required for older people.

Townsville example – Mr Brown's story

Mr Brown's case is an example of how RACF residents, their families, their carers, the care facilities and the local hospital resources are ultimately (and potentially avoidably) compromised by the rapid cascade of problems associated with a lack of good, consistent and timely primary care for RACF residents in our community.

- Mr Brown, an 88 year old man was admitted to local RACF in Townsville HHS following functional decline.
- Following Mr Brown's transfer to the RACF, his family was advised that his regular GP is unable to provide ongoing care for Mr Brown in the RACF. This leaves him without a primary carer / GP.
- Mr Brown's family was given an extensive list of local GPs and Medical Centres. However, after multiple calls over several days, the family has been unable to identify a GP willing or able to take on the care of Mr Brown (now that he is living in an RACF).
- Meanwhile Mr Brown requires his usual prescriptions and a medication administration record. Mr Brown is anticoagulated for a mechanical heart valve. Without a continued prescription for his anticoagulants his valve is at risk of thrombosing.
- The options for the care staff are:
    - to keep administering non-prescribed medication at their professional risk
    - to contact the Frailty Intervention Team (the Townsville HHS local ED substitutive outreach service for RACFs) requesting primary care support which is outside their scope
    - to send the resident to the ED for the prescription of their regular medication (which may result in an overnight admission to Short Stay and inadvertent iatrogenic injury).
- All three of these scenarios are taking place on a regular basis due to a shortage of local GPs with capacity to support RACF residents.
- This scenario may be extrapolated to any RACF resident and any time critical or outstanding medication.
- Remote telehealth primary care services are available in some RACFs, urgent appointments are only available late in the evening between 8pm and 9pm and are provided by locum GPs via a Victorian based phone service.
- On site nurses employed to facilitate telehealth consultations or family members are rarely available at this time. This phone line is answered inconsistently, messages are not always responded to and calls are triaged by a non-medical administrator.
- Routine appointments require booking at least a week prior. No medications will be charted pending an initial face to face consultation by a solo part-time GP who is already overseeing the primary care of over 600 residents (approximately half of the entire local RACF resident community).

Ongoing challenges

- During the first few weeks following his move to a local RACF, Mr Brown is likely to have been in the ED overnight (at least once), will have met several members of the Frailty Intervention Team (stepping outside strict scope with the goal of mitigating against further returns to the

ED), and along with his family will have had the additional anxiety of attempting to find anyone willing to continue his care and write his prescriptions now that he is no longer considered a 'community dweller'.
- He will have briefly met a GP who will report back to an interstate agency and from there on his consultations are likely to consist of a late night tablet-based exchange with an otherwise unknown medical officer.

This lack of GP services results in increased emergency department presentations from residential aged care facilities. A number of studies have identified that emergency department presentations can be reduced through advance care planning, use of management guidelines for acute illness and improved primary care. Moreover, the lack of access to GP services reduces the scope to manage patients in the facility, leading to avoidable hospital admissions. In many cases, HHSs have been required to establish RACF in-reach teams to partially fill the service gaps arising from the lack of GP services.

Case study – Cairns and Hinterland HHS

In the Cairns and Hinterland HHS, several hundred RACF residents are under the care of a telehealth GP. This is not optimal for many residents. In one case, the RACF in-reach team was asked by a RACF nurse to see a resident for management of urinary tract infection with some behavioural changes. On review the resident explained that during a GP telehealth consult he had a doctor asking him lots of questions that he thought should already be on his file and he couldn't hear him properly. He said that the doctor was getting increasingly agitated with him for not answering the questions but that he genuinely could not hear and was getting frustrated himself. He said the session ended with the doctor telling him he would not see him in future, that he would be pulling his medications charts and he would need to source alternative primary care. This resident is currently without a GP.

In some other RACFs, residents must be pre-scheduled to see the GP on their once-weekly round. Residents cannot access a GP outside of this and must attend the emergency department or be seen by the Cairns and Hinterland HHS RACF in-reach service for medical care. In one case, the RACF in-reach team received a call on a Monday afternoon for a resident with 24-hour symptoms of chest infection. The RACF nurse had initiated inhalers and patient was stable but feeling unwell. The treating GP was contacted by the RACF nurse but was unable to attend until Thursday. The symptoms did not require an emergency department presentation but if left untreated would have potentially developed in severity. The RACF In-reach service presented to facility and prescribed oral antibiotics.

Staffing levels and skills

There are currently significant workforce pressures in the residential aged care sector, across nursing, personal care workers and ancillary and operational staff. The Royal Commission into Aged Care Quality and Safety noted in its final report that skill shortages and difficulties filling positions are common, particularly in regional, rural and remote areas.

The 2016 Aged Care Workforce Census and Survey showed that 63.2 per cent of RACFs reported having a skill shortage in at least one direct care occupation[18]. This varied between 55.9 per cent in major cities to 87.8 per cent in very remote areas.

This has been exacerbated by the impact of COVID-19 on the aged care workforce. Typically around 30 per cent of the RACF workforce comes from the overseas migrant population. During the pandemic fewer skilled and semi-skilled workers have been able to move to Australia due to arrival caps.

The 2020 Aged Care Workforce Census and Survey identified that that there were almost 10,000 aged care vacancies across Australia, mostly comprising personal care workers[19]. It also showed high turnover in the sector, with 30 per cent of workers leaving RACFs in the previous 12 months. This may mean that providers have to reduce bed numbers, potentially creating pressure on the hospital system and increasing the risk that providers may not have enough staff to manage COVID-19 outbreaks. A lower skilled or overstretched workforce is also more likely to result in emergency department presentations as staff are unable to undertake some procedures in the facility.

Despite the additional funding provided by the Commonwealth Government's response to the Royal Commission into Aged Care Quality and Safety, the Commonwealth did not mandate any increases to the salaries paid to aged care staff. It did however increase the need for additional training. While a better trained aged care workforce is essential given the findings of the Royal Commission, the Commonwealth has created the perverse situation where a career in aged care may be less attractive now than it was before the Royal Commission. This situation arises since prospective employees must undergo additional training, without being given any additional compensation for doing so.

Avoidable hospital admissions (aged care)

A further source of additional stress on the Queensland Health system arises from delays accessing Commonwealth-funded home care packages. Given the increasing trend for older people to choose to age in their own home, there has been continuing growth in the demand for home care packages, which are currently funded at four levels depending on need, with Category 4 packages being funded at the highest rate. While the Commonwealth has increased the number of packages available, demand continues to outstrip supply.

The number of Level 3 and Level 4 packages provided by the Commonwealth Government underestimates the level of need in the community. In addition, the supply of these higher-level packages is not keeping up with the approval rate or reflecting growing demand for community aged care. This issue was recognised during the Royal Commission into Aged Care Quality and Safety.

As at 30 September 2021, 21,566 Queenslanders were waiting for their approved level of Home Care Package. Of this figure, 8,842 Queenslanders were waiting for a Home Care Package and had not been offered an interim lower level Home Care Package.

[18] *The Aged Care Workforce, 2016* was released in March 2017 by the Australian Government Australian Institute of Health and Welfare. The report can be found using the following URL:
THE AGED CARE WORKFORCE, 2016 (gen-agedcaredata.gov.au)

[19] The *2020 Aged Care Workforce Census,* presents the findings of the 2020 Aged Care Workforce Census conducted by the Australian Government Department of Health. The publication can be found using the following URL:
2020 Aged Care Workforce Census | Australian Government Department of Health

Without access to adequate support, the health of people while waiting for a home care package tends to decline faster resulting in the need for residential aged care services or an increase in hospital admissions.

As a result, Queensland Health incurs the cost of admissions from older people who would be able to remain in their own home if they received their home care package more quickly.

Case study – limited access to home supports

Mr M, 84 years old, has had 9 hospital admissions in 2021. Mr M and his wife live in a rented home with limited financial ability to support home care services as a result to date they have not engaged with any service providers. Mr M has a chronic illness that requires home oxygen with his wife acting as his carer. The only accessible services to this couple at the present time will be through the Commonwealth Home Support Program as these services are more readily available than the Home Care Package funding, however these services require co-payment. This poses an increased financial strain to the couple and therefore they have been reluctant to engage with service providers to date. The ramifications of this situation are frequent admissions to hospital due to carer stress and fatigue and put Mr M at risk of iatrogenic harm.

Case study – limited access to home supports

Mrs P, 81 years old female, living alone in own home with limited support from family due to isolation and mental health issues. There are current Home Care Package arrangements in place, but the care needs of the patients are exceeding what can be provided these provisions.

Frequent presentations to hospital recently resulted in a Hospital in the Home (HitH) admission to facilitate a supported discharge however, the timeliness of services to be implemented resulted in a failed discharge and subsequent re-presentation to an acute hospital ward which has been prolonged, and attributed to the lack of funding available to facilitate home modifications & increased service provision. If this patient was able to be supported through community services to remain at home this may reduce the requirement of prolonged hospital admission which has subsequently resulted in a general decline in function as she is no longer participating in activities of daily living independently.

When trying to facilitate safe discharge planning from hospital the barriers often faced by clinicians are around the difficulty of navigating a convoluted process, in particular for patients that have limited family support.

The system that is currently in place has two components with home care packages and commonwealth home support program approvals which is often confusing not only for the clinicians attempting to support patients but for the patients themselves and the family. Time frames are impacted by the fact that patients cannot be considered for reassessment until they are back in their own home which puts them in a vulnerable position and considerable risk of representation as it is not an instantaneous fix and there is often a considerable length of time passed until increase service provision is able to be facilitated.

Long stay patients

Once in the hospital system, older persons needing aged care services face a significant risk of becoming long-stay patients whilst awaiting adequate aged care supports whether in the home or in residential aged care facilities.

On 24 November 2021, about 175 older patients remained in public health settings waiting for Commonwealth-funded aged care supports despite being medically ready for discharge. The cost to the Queensland health system is significant; at over $2,000 per person per day, the current cohort of older patients waiting for aged care is costing over $350,000 per day.

Discharge delays divert resources away from patients who need acute care. In addition, unnecessarily prolonged hospitalisations are associated with adverse patient outcomes including deconditioning, institutionalisation, hospital acquired infection and the psychological distress that comes from being forced to live in a hospital bed unnecessarily.

Case study – Long stay older patients at Toowoomba Hospital

Patient 1 was not managing at home and was seeking admission to an RACF. However, there were difficulties in finding an RACF placement due to a lack of vacancies, and because private RACFs were reluctant to accept him as he was deemed 'low care' and would not attract sufficient funding (i.e. they would rather accept high care patients). After 20 days in Toowoomba Hospital and 94 days in a virtual ward he was eventually discharged to an RACF in October 2021.

Patient 2 was exhibiting behaviours of concern and mild dementia. The patient has been in Toowoomba Hospital for around four months and has made 59 unsuccessful applications to RACFs. Most of these were declined because of an inability to manage the patient's behaviours as described.

Many of the barriers to discharge for older persons are the responsibility of the Commonwealth Government, however Queensland Health is taking direct action while advocating to the Commonwealth for systemic change.

Within the context of disability long-stay patients, Queensland established the Long-Stay Rapid Response (LSRR) initiative to help facilitate long-stay patient discharge for both disability and aged care patients.

Nurse Practitioner-led models of care such as RADAR and the Geriatric Emergency Department Intervention (GEDI) are also providing outreach services to residential aged care services to reduce unnecessary hospital admissions for residents.

Continuity of care

Where there are business continuity failures, local hospitals are often required to provide interim care for residents.

An extreme example was seen in the Earle Haven incident when 69 vulnerable residents of the aged care facilities at the privately-run Earle Haven Retirement Village, were evacuated from their home without warning. This situation arose when an emergency call alerted the Queensland Ambulance

Service that staff at Earle Haven may have left the facility leaving patients without care. Subsequent reports were received of equipment, food, electronic patient records, and linen being removed from the site. This incident was triggered by a contract dispute between the approved provider and the sub-contractor appointed to deliver services and is an example of costs that can be imposed on Queensland Health in a sector that has been inadequately regulated by the Commonwealth.

Queensland Health is also at risk of becoming a de-facto provider of last resort when services decide to exit the market. Market failure can arise where the market either does not exist, as in rural and remote locations, or for older people with very high needs that the private market may choose not to accept.

This is especially the case in rural and remote Queensland given its large distances and dispersed, small population centres away from the coastal fringe. For example, a private facility closed at short notice in Cunnamulla, required Queensland Health to convert the local hospital to a Multi-Purpose Health Service to continue to provide appropriate aged care services to those displaced from the closure.

Given that the aged care sector as a whole is struggling financially, particularly away from large metropolitan centres, the risk of Queensland Health being required to step in and respond to similar situations in the future is high.

NDIS care services

Under the NDIS market roles and responsibilities, in the event of ongoing inability of the market to provide supports or services, the NDIA is responsible for implementing strategies to ensure critical supports are maintained for participants, and to coordinate the response with states and territories where mainstream responsibility exists. States and territories are responsible for supporting the implementation of market interventions and providing mainstream services (consistent with the Applied Principles and Tables of Support (APTOS)).

Prior to the NDIS, state and territory disability services provided accommodation and services for people with disability who required temporary supports to avoid hospitalisation, homelessness or incarceration to varying extents. Individuals received intensive case management to plan and coordinate supports.

Since the advent of the NDIS, state funding for these services has been cashed out to the NDIS. In the event of NDIS market, administrative or provider failure, the public health system has become the default provider of last resort. In many cases this is because of ‘thin markets’, which occur when there is a lack of suitable providers prepared to provide care to participants at the price set by the NDIA. Thin markets of adequate disability supports are more likely when the needs of participants are complex or in rural and remote regions.

Access to NDIS services

Several factors impact the market’s ability to meet the needs of participants living in rural and remote areas. Providers find it more difficult to get established or offer a full suite of services as the demand for services is not dependable, there is a limited pool of skilled labour, the cost of providing services is higher (especially the costs of travel and travel time) and the risks that must be borne by providers to meet required standards are incompatible with the price paid for services.

Providers have reported the current NDIS pricing schedule does not adequately flex to account for the increased costs associated with disability care in rural and remote areas – including the increased costs associated with the COVID-19 response and the sometimes significant price fluctuations associated with increased demand for labour from other sectors. As a result, people with disability in rural and remote areas sometimes have limited choice of providers, or no providers at all.

The supply of specialist disability accommodation (SDA) in rural and remote areas is plagued by challenges. Accommodation supports with the levels of care needed by NDIS participants with complex care needs may not be viable due to limited numbers of participants in the area, making service provision financially unsustainable. While the publication of SDA demand data has been improving, there is still insufficient visibility of unmet demand and no guarantee that participants will take up vacancies if a residence is built. Even where demand is visible and dependable, it is often difficult to attract construction workers who are often employed in well-remunerated roles within other sectors (including the mining sector). When this workforce needs to be sourced from cities or regional areas, the cost of labour increases. The combined effect is that SDA is in limited supply in remote and rural areas, often not in locations preferred by participants, and sometimes providers can carry SDA vacancies for long periods because participants cannot secure approval for SDA or sufficient plan funding.

Since 1 December 2020, Residential Aged Care Facilities (RACFs) caring for participants under 65 years have been required to adhere to dual regulatory regimes (aged care and disability). This has resulted in a reduction in the number of RACF providers willing to accept NDIS participants over 65 years. In rural and remote areas, this often means that these participants must live in hospital.

Under the Commonwealth Government's *Younger People in Residential Aged Care (YPIRAC) Strategy* significant work has been underway to meet the goals of no people under the age of 65 entering residential aged care by 2022; and no people under the age of 65 living in residential aged care by 2025. However, in situations where there are no alternative providers, these goals can result in NDIS participants living in hospital where a RACF is the only viable option for them to stay in their community[20].

Avoidable hospital admissions (NDIS)

Many presentations to emergency departments and acute psychiatric admissions are due to providers relinquishing support as they are unable to manage a participant's escalating behaviours of concern. Participants are regularly relinquished to emergency departments by NDIS providers and families when they can no longer cope, where NDIS-funded supports have failed or when the participant has depleted their plan funding.

NDIS providers cite the combined factors of high risk, demand, NDIS pricing and a lack of workforce capability as reasons they are reluctant to offer accommodation and services for these NDIS participants. This has significant impacts on the wellbeing of these participants, and on the health system. The cost of participants who remain in hospital due to thin markets is borne directly by the health system.

[20] *Younger People in Residential Aged Care Strategy 2020-25*, Australian Government Department of Social Services. The strategy can be found using the following URL: Younger People in Residential Aged Care (dss.gov.au)

Case study: Tommy's story – 7-month social admission

- Tommy, aged 18, was admitted to hospital following a breakdown in his accommodation and support arrangements. He did not require medical treatment. The state health system became the "provider of last resort" due to NDIS market failure.
- Tommy has a diagnosis of Autism Spectrum Disorder (level 3), moderate to severe Intellectual
  Disability, Unspecified Mood Disorder, and OCD. He displays difficult behaviours including destroying
  objects (e.g. blankets, mattresses, walls), punching, kicking, biting, and head banging.
- Due to the risks that he posed to himself, other patients and staff during this admission, he required
  24/7 security and 1:1 nursing support. Lack of NDIS policy flexibility, an underperforming NDIS provider market and poorly structured Specialist Disability Accommodation (SDA) pricing all contributed to the discharge delays experienced.
- Tommy was successfully discharged in July 2021, after seven months of unnecessary bed days and
  with his hospital stay costing over $2 million to the health system.
- In order to facilitate discharge, Queensland Health needed to fund home modifications to the interim housing solution in lieu of an appropriate and timely response from the NDIA. The NDIA has also indicated that it is unlikely to fund home modifications to the long-term SDA and the additional care requirements to sustain him in his current accommodation, as they are beyond the highest categories of support in the NDIS according to the NDIA.
- This is incongruous with the principles of the scheme which are designed to provide all reasonable and necessary supports. These expenses will likely fall to the state. Despite Tommy being in the community, the health system continues to pay for his disability-related care.
- Since his discharge to an appropriate disability support provider he has thrived in the community. His mother has applauded the supports provided to her son.

Long-stay patients

There are significant implications for people with disability and the public health system due to delays in discharging long-stay patients awaiting disability supports. These are patients who are medically ready for discharge but cannot transition to the community because they do not have access to the appropriate disability supports or accommodation.

As at 24 November 2021, there were a reported 235 long-stay patients occupying Queensland Health beds awaiting disability supports at a cost of approximately $472,000 per day. The cost estimate is based on a $2,011 bed day cost. In reality, the costs are even higher given the complex needs of some patients. The top two barriers to discharge for long-stay patients are NDIS administrative delays in access and planning (31.5 per cent) and awaiting NDIS-funded Supported Independent Living (13.2 per cent).

This is an unsatisfactory situation for Queenslanders with disability, their families and carers, and it places these people at risk of poorer health and social outcomes. As with long-stay older patients, unnecessarily prolonged hospitalisations are associated with adverse patient outcomes including

deconditioning, institutionalisation, hospital acquired infection and psychological distress. Further, discharge delays divert resources away from patients who need acute care.

The NDIA does not have a financial incentive to prevent participants remaining in hospital longer than is medically required. This is because a person is receiving their care and supports from the health system when they should be getting these supports through the NDIS, but have not yet gained access to the Scheme or have not been able to secure an appropriate support provider or level of plan funding. Also, if a participant is admitted to hospital, any accommodation payments under their NDIS plans are paused.

Case study: Jim's story

- 66-year old Jim has been in Townsville University Hospital since March 2021, over 220 days.
- Jim was supported on an NDIS plan for over 7 years but came to hospital after a fall. He has physical and intellectual disabilities, and an underlying mental health condition.
- The fall was due to a gradual decline in his condition, and now his NDIS plan is not suitable, because his support needs have increased for overall physical, cognitive or psychological functioning.
- Jim does not need hospital care and is medically well enough to be discharged. He remains in hospital, due to a failure of the NDIS system to execute the approval processes and implement new NDIS support arrangements for his discharge.
- His change in circumstance was initially submitted in May 2021, with detailed information from Hospital clinicians about the additional supports he requires to remain safe in his home. NDIS has deemed medical reports from hospital doctors and experienced allied health professionals to be insufficient to support his care ratio increase.
- Since that time, there has been an endless frustration of requests for assessments, information, and approval processes, as NDIS attempts to validate his care needs. Part of the approval process is to undertake an extensive functional needs assessment. Unfortunately doing functional needs assessments in a foreign environment of a hospital does not provide an accurate picture of needs when at home. And so, the NDIS finds the assessments from the hospital not sufficient to "prove" Jim needs the level of care indicated.
- This situation is unfortunately more frequent than it needs to be. At any point in Townsville, there would be eight people in this position, and over the course of a year, this would equate to approximately 2,920 hospital bed days in Townsville alone. Watching well people decline in hospital is both distressing and frustrating for healthcare providers, consumers and families.
- Consumers would benefit from the NDIS having a greater sense of urgency, pragmatic approval processes, and formal escalation structures to solve complex care requirements, so that Queenslanders are not left stranded in a hospital environment unnecessarily.

In an attempt to accelerate long-stay patient discharge, state public health resources are often used to provide additional support that should sit with the NDIS. This includes innovative programs such as the Long-Stay Rapid Response initiative (which provides funding for NDIS-type arrangements to support patient discharge), as well as our allied health professionals providing disability support functions (such as transitional support arrangements, developing positive behaviour support plans, supporting NDIS access requests) to facilitate timely discharge from hospital.

Queensland Health has committed significant workforce effort and investment to support long stay patients who no longer require medical care in a hospital to be discharged into an out-of-hospital setting more appropriate to their needs and wellbeing.

The following summarises some key initiatives, noting that in addition, frontline HHS staff including doctors, nurses and allied health staff work daily to support discharge of long stay patients through interactions with the NDIA, aged care providers and other stakeholders.

Long-Stay Rapid Response

As part of the $100 million Care4Qld Strategy to address unprecedented demand in Queensland's public hospitals, $4 million was invested into the Long-Stay Rapid Response (LSRR) to support appropriate hospital discharge for patients awaiting access to disability and aged care supports.

LSRR is an internal escalation pathway for HHSs and operates by funding solutions that should be the responsibility of the Australian Government. Possible solutions include interim accommodation, home modifications or increased nursing supports. LSRR has also established six new clinical staff dedicated to facilitating hospital discharge for long-stay patients and those at risk of becoming long-stay.

As at 22 November 2021, 154 patients involved in the program have been able to leave hospital and a further 61 patients are in the process of being supported to discharge.

As an example, one of the patients involved in LSRR was admitted to hospital in March 2021 following a stroke which left him with the inability to swallow and speak. He was treated in Cairns and Atherton hospitals with a total length of stay of 217 days. Eighty of these days were clinically unnecessary. The reason for his extended stay was the failure of the NDIS to provide a suitable supported, independent living option.

This patient experienced low moods and high levels of frustration awaiting to go home. Through LSRR, the patient transitioned to interim accommodation on 9 October 2021 following a rapid approval of required disability supports. The patient expressed his happiness to be out of hospital and excitement to get on with his life.

Queensland Civil and Administrative Tribunal (QCAT) program

In March 2020, Queensland Health collaborated with QCAT to fund a trial expansion of a program which accelerates the QCAT process for long-stay patients awaiting QCAT decisions to ensure they are discharged to appropriate accommodation in a timely manner. The program is based in Metro North and the expansion trial has successfully reduced average waiting times for QCAT hearings by approximately 61 days, from 98 days to 37 days as at November 2021.

As a COVID-19 response, the Department of Health provided funding for the Metro North model to be expanded to all HHSs in Queensland. Metro North coordinated the COVID-funded expansion concurrently with its own program.

The COVID-19 funding concluded on 30 June 2021 and the initiative is now funded under the Care4Qld Strategy.

Summer Foundation Hospital Discharge and Housing Project

In November 2019, Queensland Health partnered with the then Department of Housing and Public Works to fund the Summer Foundation to deliver its Hospital Discharge and Housing project aimed at reducing extended stays in hospital for patients with disability across Metro South, Gold Coast and West Moreton HHSs.

The project improved staff capability, supported discharge for complex long-stay patients, assisted to prevent unnecessary admissions and improved clinical governance structures. The project also contributed to the reduction of long stay younger patients seen in 2020.

Advocacy to improve the health and disability interface

The shortcomings in the NDIS market are well documented. On 29 October 2021, the Queensland Productivity Commission's Inquiry into the NDIS market in Queensland final report was released, stating the Scheme's regulatory and policy framework is operating in a way that impedes the effective and efficient functioning of the NDIS market. The Queensland Government accepted most of the recommendations outlined in the final report, noting that NDIS market development and regulatory responsibility falls primarily to the Commonwealth.

This situation is not unique to Queensland. On 4 November 2021, Health Ministers met with Senator the Hon Linda Reynolds CSC, Minister for the NDIS, to discuss issues at the health and disability interface. Ministers participated in a robust discussion about the issues and there was broad commitment to work together on implementing solutions to improve the interface.

Queensland Health has led the Health Ministers and the Health and Disability Senior Officers Working Group, responsible for working up practical solutions for immediate impact for Ministers' consideration. The table below highlights some of the key challenges and issues facing the system and some practical solutions that could be explored further to achieve immediate impact.

Challenges and issues	**Practical solutions for immediate impact**	**Examples**
Long-stay hospital patients as a result of discharge delays	Ensure Commonwealth and NDIS processes are streamlined and flexible to enable inpatients to more easily access disability supports	• Reinstating the policy directions adopted by the NDIS in response to COVID-19, such as allowing access to Medium Term Accommodation for participants who are awaiting an NDIS funded home and living solution without a final discharge destination confirmed. • Upskill NDIS support coordinators to better understand and navigate the health system, including establishing local partnerships • Joint CW and State development of a new, national targeted Hospital Discharge Delay Action Plan that outlines interface points between hospital and community, including responsibilities and timeframes.

Challenges and issues	Practical solutions for immediate impact	Examples
	Increase the level of local engagement by the NDIA to improve participants' access to supports – and provide an individualised immediate response where required	• Establish a network of dedicated NDIS planners with health expertise that are engaged in the health system and able to work proactively to resolve discharge barriers. • As part of this, local staff must have sufficient levels of planning delegations to affect safe and timely discharge.
Significant cost of long-stay patients on public hospital system	Commonwealth cost coverage of NDIS participants medically fit for discharge but who remain in hospital for extended periods	To encourage positive outcomes for NDIS participants and health systems, the NDIS should reimburse hospitals for excess length of stay caused by NDIS delays or market failures. This will require the development of nationally consistent definitions for long-stay (e.g. may include a minimum time frame).
Avoidable hospital admissions of NDIS participants	Improve access to timely supports for NDIS participants to enable them to remain in the community and avoid hospitalisation	• Strengthen the Participant Service Guarantee to implement regular checks to monitor participants' needs and any changes in needs over time. • Better identify when participants are not receiving appropriate supports.
	Review and expand the crisis referral line functions of the Exceptionally Complex support Needs programs	• Increase funding for the crisis referral line to facilitate an expanded scope to enable referral of patients facing crisis within the community at risk of hospitalisation – before they present to an emergency department. • Include access for providers who are intending to cease providing services that result in a hospital admission to support them to continue to deliver services while issues are resolved.
Many presentations to emergency departments and acute psych admissions are due to providers relinquishing support due to escalating behaviours of concern.	Presentations and admissions could be avoided if providers were supported to manage escalating behaviours in situ. This requires specific and high-level behaviour intervention expertise.	• NDIA commissioned tertiary consultancy to support providers with NDIS participants who are showing behaviours of concern. • Consultancy could also provide wide-ranging policy and practice development and training for disability workers and professionals.

Workforce

A key objective of the Commonwealth Government is ensuring Australia has the health workforce necessary to improve the health and wellbeing of all Australians. This includes improving the quality, distribution and planning of the Australian health workforce to better meet the needs of the community and deliver a sustainable, well distributed health workforce[21] (Commonwealth Department of Health 2021-22 Portfolio Budget Statement, p.74).

There are currently significant challenges in maintaining a sufficient workforce to meet increasing demands for public health services. The COVID-19 pandemic has intensified the workforce pressures, with disruption to supply chains exposing issues with health workforce distribution across specialities and geographic locations.

Insufficient workforce capacity to deliver primary health and allied health, aged care and NDIS supports in the community has a direct effect on patient flow into public hospitals, impacting the resources available for treatment of patients requiring acute care and imposing additional strain on hospital staff.

Medical practitioners

The Commonwealth is responsible for different levers to influence the medical health workforce in a number of ways. For example, workforce supply and distribution can be influenced through:

- funding programs and incentive payments to improve the supply of medical professionals throughout Australia
- increasing or decreasing the number of overseas trained doctors through the immigration portfolio
- restrictions on Medicare provider numbers (e.g. requirements for overseas trained doctors and foreign graduates of accredited medical schools to serve in rural regional and remote locations for a period under the Health Insurance Act 1973, and
- funding for Commonwealth Supported Places for university students to study medicine.

Queensland's medical workforce is facing critical challenges due to geographic maldistribution and the shortfalls in key medical specialties. The Queensland experience and data demonstrates a significant need to grow the junior medical workforce, evidenced by workforce gaps and frequent supplementation of workforce with overseas doctors and locums, particularly in regional Queensland. This is an issue that has been further exacerbated during 2020 and 2021 by restricted access to these cohorts as a result of international and state border closures during the COVID-19 pandemic.

Australian Medical Schools have been significantly impacted by COVID-19 due to the loss of international student numbers from their onshore courses. This is likely to have an impact on graduate numbers available for Queensland internships in the next two to three years.

[21] The *Health Portfolio Budget Statements 2021–22 Budget Related Paper No. 1.7, p. 74* was published on 11 May 2021. The publication can be found using the following URL: budget-2021-22-portfolio-budget-statements-budget-2021-22-health-portfolio-budget-statements.pdf

It is recommended that the Commonwealth review its investment in the medical workforce and increase the Commonwealth Supported Places allocation to Queensland Medical Schools to enable a reliable domestic pipeline of medical practitioners.

In addition, the University of Queensland, James Cook University and Griffith University have been negatively and financially impacted by a Commonwealth Government decision to re-allocate 35 Commonwealth Supported Places (CSPs) over five years from Queensland Medical Schools to support the Murray-Darling Medical Schools Network, under the banner of 'supporting development and redistribution into regional areas'.

Distribution Priority Area classification

The Commonwealth has a critical role to play in addressing shortages of GPs in regional, rural and remote areas. The Commonwealth's DPA system identifies locations where people do not have enough access to GPs based on the needs of the community. International medical graduates (IMGs) who are GPs, are required to work in a location classified as a DPA to access a Medicare provider number under Section 19AB of the Commonwealth's Health Insurance Act 1973.

Regional areas rely heavily on supplementing their workforces with IMGs; traditionally it is difficult to attract and retain domestically trained staff to regional areas. Insufficient staffing in general practices has a direct flow on impact on the surrounding HHS emergency departments due to increased patient presentations.

From 1 July 2019, the Commonwealth health workforce Distribution Priority Area (DPA) classification system replaced the Districts of Workforce Shortage (DWS) Assessment Areas for GPs and Bonded Doctors. The DPA also applies a number of blanket rules:

- Inner metropolitan areas are automatically deemed non-DPA
- Modified Monash Model* categories (MM) 5 – 7 (small regional towns and remote and very remote locations) are automatically deemed DPA

As the DPA redistribution policy has taken effect, GP catchment areas have gained and lost DPA status. The system allocates a three-year classification period. Areas such as Mackay for example, have recently lost their DPA status thereby rendering them unable to employ IMGs in their general practices. As a result, many general practices in the area have stopped taking new patients due to doctor shortages which makes it extremely difficult for new people to the area to access primary care.

The Modified Monash Model is used by the Commonwealth to define whether a location is a city, rural, remote or very remote location based on a scale of 1 to 7 where 1 is a major city and 7 is a very remote location.

Of the MM 3 — 7 locations, there are four non-Distribution Priority Areas in the entire State, namely, Beaudesert, Dalby, Gatton, and Maryborough. In addition, there are several MM2 areas that are non-Distribution Priority Areas which include Cairns, Townsville, Hervey Bay, towns within the Sunshine Coast Hinterland, and towns between Gold Coast and Logan.

The DPA data does not take into account medical locum or fly-in-fly-out workforces which may go into communities. The pandemic has demonstrated that a reliance on temporary/transient workforce (and a disruption to this supply) can impact access to primary care and other medical services. The DPA would be more effective if it considered this supply side factor, rather than just the provision of services in community.

Nursing and midwifery

Demand for health services continues to rise and a highly skilled and experienced nursing and midwifery workforce is required to provide the quality, holistic care required to meet community need.

Nursing shortages are particularly acute in private RACFs. The private sector aged care nursing workforce is covered by the *Commonwealth Aged Care Award - 2010* which does not provide the same level of salary and employment conditions as the *Nurses and Midwives (Queensland Health) Award – State 2015*. This has resulted in nursing staff seeking employment within the Queensland Health RACFs and acute care services, especially as additional nurses have been required for the COVID-19 response.

Consequently, private RACFs are experiencing difficulties providing services due to nursing shortages, requiring Queensland Health to provide nursing support from the HHS internal workforce and accept residents for care due to partial RACF closures.

Commonwealth support would be beneficial to enable the nursing and midwifery professions to increase access to primary healthcare services as well as in aged care and disability settings, where appropriate. Examples where improvements could be made include:

- a review of the MBS to assist nurses and midwives to work to their full scope of practice and provide valuable services to the community, including where medical-led models of care are unsustainable, and
- increase the scope of practice for nurse practitioners in primary health care, aged care and mental health.

Allied health

The health, disability and aged care sectors project continued strong demand for the allied health workforce. Geographic maldistribution of the allied health workforce is a long-standing issue, particularly in rural and remote areas.

In 2019, Jobs Queensland estimated the anticipated jobs growth through to 2024 to be between 20 per cent and 25 per cent for allied health professions such as podiatry, physiotherapy, medical imaging professionals and psychology. The COVID-19 pandemic has further increased demand for the allied health workforce within Queensland, with public health services reporting failure to secure locums and permanent staff and an increase in extended vacancies.

Access to most allied health professions decreases with rurality. For example, national practitioner registration data in 2019 showed that communities classified as Very Remote in the Modified Monash Model have fewer than half the full-time equivalent pharmacists per capita compared to Metropolitan locations, and for podiatry and occupational therapy it is closer to a third.

Since 2018, the Health Workforce Needs Assessment, that is conducted annually by Health Workforce Queensland, has identified allied health professions as significant workforce gaps in regional, rural and remote areas, particularly psychology, social work, occupational therapy and speech pathology. Mental health, alcohol and other drug services, community-based rehabilitation, social support and disability services were identified in the 2021 report as significant service gaps.

Commonwealth Government leadership is required to address key challenges in the allied health workforce pipeline, including:

- policy, regulatory and resourcing strategies to facilitate the rapid intake and deployment of overseas-trained allied health professionals, particularly to regional areas as border restrictions allow, and
- revision of the number and distribution of university training places as well as the focus of course curriculum to ensure alignment to community, aged care and disability service demands for key allied health professions (such as physiotherapy, podiatry, speech pathology, social work, and occupational therapy).

First Nations health workforce

First Nations peoples are underrepresented across all health workforces and professional streams.

Renewed approaches are needed to:

- increase the supply of First Nations peoples entering the health sector
- support the career mobility and development of existing First Nations peoples working in the health system, and
- to remove barriers for the creation of regional integrated workforces between Queensland Health and the primary health care sector.

More needs to be done by all governments to increase the First Nations health workforce.

Queensland Health is progressing the development of a First Nations Health Workforce Strategy for Action for Queensland jointly with the Queensland Aboriginal and Islander Health Council (QAIHC). This is the first time a joint workforce strategy is being developed for Aboriginal and Torres Strait Islander people across the health system. The strategy will be released in mid-2022 and focuses on removing the barriers and obstacles that have prevented the achievement of our state and national workforce targets.

Further, amendments to the *Hospital and Health Boards Act Regulation 2012* require HHSs to increase First Nations peoples workforce representation to be at least commensurate with local population size across every stream/category and every level. This will require HHSs to agree targets accordingly and undertake regional health workforce planning with the A&TSICCHS and other healthcare providers.

Mental health workforce

The draft National Mental Health Workforce Strategy, recent Productivity Commission report into mental health, and the proposed National Alcohol and Other Drugs Workforce Development Strategy identify significant national shortfalls across the mental health, alcohol and other drugs (MHAOD) workforce.

The Commonwealth, States and Territories and training providers have complementary roles to play in addressing causes of the shortfalls in the mental health workforce. These include ageing of the existing workforce particularly nursing, insufficient pre-entry and post-graduate exposure to MHAOD training, and stigma associated with MHAOD consumers and careers.

Action is required to address shortfalls in the mental health workstreams of psychiatry, psychology, mental health nursing, Aboriginal and Torres Strait Islander health workers and lived experience (peer) workforce. The specialist alcohol and other drugs workforce is also insufficient to meet existing demand for services and requires enhancements.