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

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QUEENSLAND PRIMARY HEALTH NETWORKS

Submission to the Queensland Parliament 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.

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On behalf of the Chief Executive Officers of:

Brisbane North PHN

Brisbane South PHN

Central Queensland, Wide Bay, Sunshine Coast PHN

Darling Downs West Moreton PHN

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Northern Queensland PHN

Western Queensland PHN

Introduction

This submission is made on behalf of the Queensland Primary Health Networks (QPHNs).

In 2015, the Commonwealth PHN Program established 31 PHNs nationally to strengthen primary care and improve patient centric service integration.

PHNs are primarily funded by the Commonwealth Department of Health with the aim of increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and to improve coordination of care to ensure patients receive the right care in the right place at the right time, through:

- increased understanding of local health needs,
- the development of effective partnerships fostering integration (particularly with Hospital and Health Services (HHSs) and
- innovative ways of commissioning services.

PHNs are also funded for specific services or projects by various Queensland Government Departments (eg Child Safety) or individual HHSs.

The focus of the QPHNs is on primary care through the support of General Practitioners (GPs) and working with a range of government and community organisations, service providers and the community to develop and better integrate health and community care services and improve access to services with an emphasis on those most vulnerable people at risk of poor health outcomes.

PHNs are the experts on the primary health needs of their region and the central drivers for planning, reform, integration and equitable access across its health and social care system. As regional commissioners, they reduce fragmentation and address unmet needs working with HHSs and other partners through innovative and consistent service delivery.

PHNs support the health care workforce to build capacity and capability and are positioned to support coordinated primary health care responses to emergency and natural disasters.

The PHN role in coordinating primary healthcare to improve whole-of-life health and wellbeing over the last few years, have proved to be an important resource to the community and the health system in disaster situations including drought, flood, fire and now, the Coronavirus pandemic.

Primary Health Care in Queensland

Provision of high quality primary health care is challenging across Queensland. However, in 2020-21, Queensland's primary health care providers had greater population coverage, and delivered more services per capita, than the average for other States and Territories.

The number of primary health care services increased dramatically since the previous year – above population growth – to help meet the needs of the community and response to the COVID-19 pandemic.

Supporting facts (taken from AIHW report October 2021[i]):

- In 2020-21, Queensland General Practices provided Medicare-subsidised care to approximately 86% of the resident population, with allied health professionals providing care to approximately 39%;
- This population coverage of Queensland's primary care services was higher than the average for other States and Territories;

- Compared to the previous year, Medicare-subsidised services provided by General Practice increased 4%, and for Allied Health professionals the increase was 14%. This was well above population growth of 1.6%;
- The number of primary care services per capita in Queensland exceeds the national average rate for both General Practice and allied health professionals.

Key Issues impacting primary health care delivery

Primary health care services across Queensland (from metropolitan to outer metropolitan regional, rural and remote) are as diverse in their structures as the communities they service. They range from small privately owned clinics to larger corporate entities. Most general practice have access to at least one nurse onsite and some allied health services. In general, GPs are increasingly reporting they are working longer hours and seeing more complex patients including a higher number of patients per day.

The Deloitte Access Economics General Practitioner Workforce Report 2019[ii] found that Australia is heading for a significant undersupply of GPs in both urban and rural areas by 2030. The report highlights that:

- there will be a 37.5% increase in the demand for GP services between 2019 and 2030 (139.8 million increasing to 192.1 million).
- by 2030, there is projected to be a shortfall of 9,298 full-time GPs (24.7%) of the GP workforce, with the deficiency of GPs to be most extreme in urban areas with a shortfall of 7,535 full-time GPs (31.7%) by 2030.

The number of new general practitioners entering the market will not keep pace with increasing demand for health care. One of the determinants of the shortfall results from limitations on the number of overseas trained medical graduates. An ageing health workforce across the regions further diminished as senior GPs retire with no alternative care pathway for their patients, and the residential aged care facilities (RACFs) have no new GPs coming through to share the patient load.

New GPs have different expectations of where they wish to work, typically close proximity of the city with work-life balance are highly valued. There is little to no appetite to assume the added pressures associated with the aged care sector or managing care after-hours. It is not financial viability for GPs to provide services outside of core hours, in home or in RACFs. Without addressing these issues, EDs and hospitals will continue to see increased demand.

Patient waiting times for both GP and allied health appointments are lengthy, sometimes several weeks to months and in some cases not available at all. Access to particular allied health services is problematic with conveniently located, low cost or bulk billed diabetes education, dietetics, pulmonary rehabilitation, occupational therapy, mental health nursing and psychology services particularly difficult, however need for these services is high. Service consultation availability, affordability, location and transport are the most regularly reported barriers for people.

The quality of patient care and outcomes is reliant on the time and expertise of the GP and their available resources within the general practice rather than a skilled multidisciplinary team (MDT) and community supports. Community based health programs and services are often delivered through short term funding arrangements so are sporadic and neglect to make any long term or sustainable impacts on the patients or their communities.

Innovative models of care that build the capacity of the practice team through incorporating nurses and allied health specialties to broaden the expertise available, would enable person-centered, team-based care within a region or community[iii].

Other destabilising workforce trends affecting access and continuity of care are a greater number of GPs working part-time, the unwillingness of GPs to work weekends and after-hours, use of locums to fill staffing gaps and retention issues. Since 2016, there has been a 20% reduction in GP Registrar numbers[iv].

Students are opting to take up other specialisations with training opportunities, collegial support, remuneration rates and work-life balance identified as possible barriers. In the regions facing workforce shortages, implementing models that embrace MDTs and care coordination may alleviate some of the pressure experienced by working independently. Such models enable health professionals across different disciplines to work at the height of their scope to support better health outcomes for patients and initiate improved professional connections across the sector. However, the existing funding arrangements can pose barriers to these models of care.

Market Variations

Below is some of the regional challenges in provision of primary health care.

Outer metropolitan

Metropolitan areas are not homogenous, and there are substantial differences in access to primary health services between outer metropolitan growth areas and established inner and middle suburbs. Outer areas of Australia's major cities are growing quickly, with new suburbs and developments making up the top three fastest growing areas of almost all capital cities in Australia in 2019-20[v]. While these areas are part of large metropolitan cities (eg part of greater Brisbane), the context for primary health care provision is very different.

In general, communities living in outer metropolitan areas are more diverse, with variable but substantial CALD, refugee and Aboriginal and Torres Strait Islander populations, have poorer health outcomes, lower socio-economic status, and less access to health services. Private billing models, common in primary health care, form barriers to people seeking care. Outer metropolitan areas have fewer general practitioners, so patients have to wait longer for appointments, becoming sicker as they wait.

General practitioners have little choice but to work longer hours, to see as many patients as possible, even though they are treating patients with complex needs that require more effort and resources to manage. Access to other specialists and allied health professionals is also reduced, with lower numbers and little bulk billing available. Therefore, general practitioners are required to manage more complex patients with little support.

The viability of practices is reduced, as the population is reliant on bulk-billing, with a reduced capacity to pay for care. The reluctance of general practitioners to work in outer metropolitan areas means that there is little back up or support to spread the load and reduce burn out. The gaps may be filled by locums, but they are expensive and provide only a short-term fix, not altering the underlying structural problems. With such high community need, structural limitations on remuneration, and requirements for long work hours, recruiting general practitioners to these areas is particularly difficult.

Outer metropolitan training positions are seen as undesirable, and medical students are choosing to train in other specialties if they can't get inner metropolitan places. In addition, recruitment is further blocked by the blunt categorisation of outer metropolitan areas as 'major cities' (MM1) in the Modified Monash Model and resulting exclusion as a Distribution Priority Area for the recruitment of international medical graduates (IMG).

Regional and Rural

Regional and rural areas often have higher socio-economic disadvantage, poorer rates of literacy, physical activity and nutrition, older and ageing populations and greater health needs. In many areas populations are forecast to both decline and become older, requiring increased per capita health services, while struggling to maintain the population required for viable health service delivery. The high needs of regional and rural areas are often compounded by significant barriers to delivering primary health care, including:

- significant health workforce shortages, relative to both state averages and patient need;
- inability to attract and retain health care practitioners to health care settings that can't offer the career and lifestyle opportunities found in inner metropolitan areas;
- lack of viability of practices, especially with reduced throughput and fee for service funding;
- patient costs, out of pocket costs are more likely in regional and rural areas, despite patients' inability to pay;
- requirements to travel large distances to access or deliver health care, and
- lack of scale, meaning that health services may not have the skills or knowledge to address community needs, including cultural factors[vi].

In addition, compared to urban health provider levels, the existing workforce is often precarious, comprised of many sole practitioners, who may be professionally isolated, and on the edge of service viability. Smaller services often lack the infrastructure, economies-of-scale and capacity that medium or large sized services have to diversify their funding sources or provide dedicated services for vulnerable populations[vii.] Some large regional centres have an adequate number of primary health care practitioners based locally however they are also servicing the health care needs of many smaller surrounding communities. This generates access issues as travel to the larger regional centres for health care constitutes significant time, cost and transport barriers for residents of those smaller communities.

Remote

Remote areas are geographically distant from towns and cities, and contain a small, dispersed population. Typically, remote communities have populations that are generally younger than other areas of Australia, with less people over 65 years. They are more likely to live in multigenerational families. There is a higher proportion of Aboriginal people, especially in very remote areas (although most Aboriginal and Torres Strait Islander people live in metropolitan areas).

People living in remote areas have significantly worse health outcomes, with rates of preventable hospitalisations and mortality being significantly higher when compared to major metropolitan cities[viii.] Providing primary health care services in remote areas is difficult. People living in remote areas are less likely to have a general practitioner nearby[ix]. Many primary health care services in remote areas are provided by remote area nurses or Aboriginal Health Practitioners, meaning that less funding is available through the MBS.

Services can be funded through short term grants, although often with confusing and non-transparent application processes. In areas with low volume or throughput, a fee for service model is hard to sustain. In addition, running a clinic in remote areas can have higher costs, due to factors such as extensive travel, weather impacts, and costs in accessing IT or communication services, further impacting the ability to operate a financially viable service[x].

Services are often provided by visiting practitioners, or expensive locum providers, rather than resident health practitioners. Attracting health practitioners to remote areas can be very challenging, with practitioners concerned about both professional factors such as a lack of support, professional isolation,

financial viability of their practice and career progression, as well as non-professional factors such as connection with family and friends, work or education for family members, and accommodation availability. Often health professionals without primary health care or remote area health care experience are recruited, significant orientation into the remote funding and operating model is required, consuming additional resources.

Issues facing Primary Health Care in Queensland

A more detailed overview of a number of key issues impacting the provision of primary health care across Queensland are outlined below:

Funding Models

Provision of high quality primary health care is challenging across Australia. The small-scale businesses and private practices that make up primary health care in Australia are no longer sustainable outside of inner metropolitan areas and aren't enabled to operate in ways that meet contemporary community needs. Uncompetitive remuneration, high workloads and a lack of support in primary health care for outer metropolitan, regional, rural and remote areas are leading to substantial workforce shortages. The small adjustments and add on incentives to the primary health care funding model over the last 30 years haven't changed the underlying fee-for-service structure. Fee-for-service funding doesn't support effective team-based care or chronic disease management, isn't viable in many parts of Australia, and can't provide the flexibility and local contextual adaptation required to meet the specific challenges experienced in each area, due to a combination of workforce, geography, community need and population density.

Predominantly service delivery, especially in primary care, is funded on a fee for service basis. People present to providers with symptoms and the practitioner looks for a medical cause for the symptoms and recommends a course of treatment. There is little capacity to understand the underlying social determinants of health and possible social prescriptions for care.

Further a complex arrangement of funding and associated regulations, including federal, state and local governments, private health insurance, and patients themselves, the fee-for-service model relies on throughput volume for viability. The small-scale nature of most primary health care provision is unable to generate the scale of activity and capacity required for sustainability in a market driven environment. Access to primary health care is improved when financial viability is not totally reliant on fee for service models, especially when there is specific funding to provide services to vulnerable or higher need groups[xi].

Access to General Practitioners and other primary care services is constrained by gap fees, and the MBS billing model – with the freeze on the Medicare rebate making it unsustainable to provide, high quality, and universal MBS bulk-billing in private general practices, especially for rural and remote practices. Funding models that incorporate elements like blended payments, performance based incentives, community complexity and the ability to pool funding, and increased targeted investment will allow primary health care provision to escape from the constraints of the fee for service paradigm and enable the development of truly patient centered approaches to delivering primary health care.

Medicare rebate freeze

The Medicare rebate freeze has been very unpopular with GPs from its introduction. The running costs of the general practices such as leases, utilities, staffing costs, medical consumables have continued to increase. As such, the Medicare rebate freeze has reduced the profitability of the business, limiting opportunities to expand or recruit further. The freeze has particularly impacted the bulk-billing practices.

Workforce

Primary health care is experiencing a workforce crisis. For doctors, a career in general practice is increasingly seen as less desirable, with the number of new registrars declining by almost 20% from

2016 to 2019, due to factors such as a lack of career progression opportunities, low financial remuneration, undervaluing of the profession and a lack of flexibility to enable part time work, and provide afterhours support.

Registrars are increasingly reluctant to venture beyond inner metropolitan areas or to relocate to regional and rural areas. Locums are often used to fill staffing gaps, but this is expensive and doesn't solve the underlying workforce shortages. Recent, still evolving changes to general practice training arrangements may result in a further reduction in registrar enrolment and interest in general practice as a career, while the new arrangements are confirmed and communicated.

Recruitment and retention strategies that counteract the GP shortage are paramount. Medical, allied health professionals and nurses can be attracted to working conditions and entitlements in the state system, but if it leaves primary, community, aged and disability care without a workforce, the state system is also impacted.

A commitment to investment that provides security and certainty and moves away from profession-based workforce strategies developed in silos, particularly in rural areas is necessary[xii].

Support for health professionals

Primary health professionals in outer metropolitan, regional and rural areas often have limited support from colleagues for supervision or peer support, feel professionally isolated, and have concerns about non-work issues such as isolation from family and friends or impacts on partners and children, which can impact recruitment and retention. Training for allied health and medical professionals generally diverts them away from rural areas, which can make it difficult for qualified professionals to move back to rural areas.

Distribution Priority Area (DPA) and the Modified Monash Model (MMM) geographical classification system

The DPA classification which identifies locations in Australia with a shortage of medical practitioners has caused contention with many general practice owners and managers in recent years. A number of regions have lost their DPA classification under the revised MMM, particularly in outer metropolitan areas. This has significantly impacted the ability of practices in these regions to maintain their GP workforce. Most General Practices would be willing to expand their services, however they don't meet the criteria for Distribution Priority Area (DPA) classification which presents a barrier to recruitment and maintaining a stable workforce. As a result, most practices have closed their books to new patients.

GP training reforms

Recent evidence has shown that the number of GPs starting their Registrar training has decreased by 20% since 2016[xiii]. The planned reforms, including a transition to college led training aim to do better to equip new doctors with more comprehensive skills to work in a range of settings.

Changing patterns of morbidity

Australia's primary health care system evolved through the 20th century to manage infectious disease, accidents, and episodic care. It consists of a series of primarily small or medium sized, usually single discipline, private practices, alongside community health services. While Australians are living longer and have more years in good health, over the last 20 years the proportion of Australians with chronic illnesses has risen considerably[xiv]. Patients with chronic illnesses require continuing multi-disciplinary team care, with integration across team, service and sector boundaries, which is difficult to provide in our current health system.

Structural stagnation

Despite nearly 30 years of Australian pilots dating back to the Coordinated Care trials, there have been only limited attempts at system wide change to better integrate the organisation of primary health care services to improve patient outcomes. Workforce role redesign and care coordination models have been established to try to address these challenges, although without structural and financial change,

significant, sustainable impacts are impossible. Primary health care provision remains broadly unchanged and isn't structured to respond to current patient needs for care coordination and ongoing chronic disease management.

Linking reform agreed by all Health Ministers under the NHRA Long-term Health Reforms Roadmap and partnering with primary care particularly in areas relating to joint planning and funding at the local level, will support a model shift from volume to paying for value and outcomes[xv].

Marked local context variation

Provision of primary health care is variable across Australia, with significantly different contexts from metropolitan to remote, a variety of patient demographics and available infrastructure and support. In outer metropolitan, regional rural and remote areas, the challenges to positive patient outcomes include:

- Poor health and higher patient need in some areas;
- Maldistribution of health professionals (relative to need) means that some communities don't have access to the care or service that they require at the time that they require it;
- Difficulty in accessing the full team of health professionals required for care, due to cost, workforce shortages or distance;
- Lack of integration between state and federal funded health services in local areas;
- The lack of viability of small-scale practices serving small populations especially when spread over large geographic areas;
- An ageing workforce, as younger health professionals don't seem to be attracted to take on the challenges (including financial and workload) of providing primary health care outside of inner metropolitan areas;
- Changing cultural work practices. Outside of inner metropolitan areas, general practice has relied on a heavy full-time load as well as after-hours burden. The increasing proportion of general practitioners wanting part-time or family friendly hours of work or taking parental leave has impacted the capacity to deliver previous levels of health care;
- Systematic barriers to junior health professionals coming through training outside of inner metropolitan areas;
- Remote access to services (ie telehealth) is not sustainably funded[xvi].

These fundamental issues, and the crisis in registrar numbers are evidence that primary health care in Australia requires wholesale, structural change. Regions that are already underserved, especially outside of inner metropolitan areas, feel a greater impact from these structural issues and the lack of a coordinated, integrated system.

Impact of COVID Response

Over the last 18 months, COVID-19, and the associated restrictions, have exacerbated many of the existing challenges to primary health care provision. Practice viability has reduced, with diminished throughput due to patients avoiding less urgent, ongoing healthcare needs combined with periods of exceedingly intense demand for bulk-bill only vaccination consults, leading to high stress and burnout. The workforce crisis has deepened, with registrars reporting that their training was disrupted due to restrictions on their ability to travel to placements, a lack of patients seeking usual general practice services and a delay in exams, due to lockdown restrictions[xvii]. Nurses working in primary health care have reported a decrease in work hours, and related work insecurity, as well as not feeling well supported by their employers[xviii]. Some of these health professionals will have left the sector, leading to further workforce shortages.

The consequence for these communities is persistent, and escalating regional, rural, and remote primary care workforce shortages. COVID-19 has impacted the health workforce by significantly reducing access to a mobile health workforce, as a result of closed international and state boarders,

compounded by the cannibalisation of the health workforce to address COVAX roll out and COVID responses.

The expansion of digital health use, including telehealth, has had a varying impact on provision of services, increasing access for some community members and reducing access for others, as well as exposing the lack of digital literacy and access for clinicians, practice staff and patients. The digital health response to COVID-19 was reactive, a sustainable virtual health care system that reduces barriers to healthcare for all Australians in the long term has merit[xix].

In some parts of Australia, provision of primary health care was also impacted by clinician fatigue, burnout and the change in practice also impacted on the attractiveness of primary health care as a career choice[xx].

While primary health care practices have been a vital part of the COVID-19 pandemic response, this has relied on goodwill to mobilise and provide relevant care, rather than capacity of the system. Over time, as the needs have continued to be high, there is evidence of fatigue and reduction of goodwill. The COVID-19 pandemic response has highlighted the impact of the lack of flexibility in funding to enable local health providers to work together to deal with local needs.

Impact on Queensland Health Services

Without strong, effective and high-quality primary health care, secondary and tertiary hospital will be overwhelmed by patients with serious acute and chronic conditions, causing significant financial and social costs to individuals and the health system.

In 2017-18 alone there were 750,000 potentially preventable hospitalisations across Australia [xxi].

A stronger primary health system plays a critical role in reducing demand on the hospital system[xxii].

Poor access to general practitioners and primary care services result in:

1. Delays in people accessing care and referrals – GP act as the gatekeeper of the referral process
2. Ultimately resulting in more community members presenting to QH services, that are more unwell and with exacerbation of chronic and complex conditions.
3. Limited access to general practitioners' results in poor discharge rates from Specialist Outpatient Departments back to primary care – resulting in poor new (pt.) to review (pt.) rates
4. Reduced access to a General Practitioner in regional, rural, and remote communities has witnessed a reduction in service provision to RACF – further compounding the provision of primary care services to older, and/or at-risk Queenslanders.

Recommendations

The QPHN makes the following recommendations to the Committee:

1. That new models of primary health care funding are investigated to incorporate blended payments, performance based and pooled funding, allowing for innovation and locally responsive models of care.
2. That investment in primary health care to develop place based solutions is increased to:

   a) meet local primary health care workforce needs, including supporting health professionals through peer support, training and continuing educational pathways, sustainable, competitive remuneration and sustainable workloads

   b) modernise primary health care, by developing locally responsive, patient centered models of care, co-designed with the community.
3. Agreement to share data between local, state and federal agencies to inform the delivery of services in areas of identified need is required.
4. That the Queensland Government considers how their planning and resource allocation can be better shared with the primary health sector including but not limited to housing, public transport, education and early childhood development, employment, and community and disability services.
5. That future workforce policy such as the Distribution Priority Areas are determined on a need basis, to reduce the impact on general practitioner recruitment in outer metropolitan areas, with a longer term move to regional flexibility and place based solutions.
6. Re-designing incentive payments and Medicare billing to better support the delivery of health care, recruitment and retention in the outer regions should also be considered.
7. Upskilling the current health workforce to specialise or to diversify their skillsets through roles such as Nurse Practitioner or Medical Practice Assistant can bolster local capacity and broaden the existing teams service scope.
8. A review of GP remuneration for after-hours, in home or in RACFs patient services is needed. The work involved is time consuming, challenging and financially unviable.
9. The Qld Government consider working collaboratively with the QPHN to leverage off:
   - the existing network and capability of PHNs as commissioning organisations that can codesign and support targeted interventions that meet local needs throughout Queensland;
   - build responses that are informed by national and statewide data as well as drawing from QPHN local need assessments;
   - leverage QPHNs ingrained knowledge and understanding of their communities and vulnerable groups within them;
   - tap into QPHNs ability to plan, respond and scenario test program responses in clinical and community settings.

Acronyms used

CALD	Culturally and Linguistically Diverse
DPA	Distribution Priority Areas
HHS	Hospital and Health Service
IMG	Internal Medical Graduate
MDT	Multidisciplinary Teams
MMM	Modified Monash Model
NHRA	National Health Reform Agreement
PHN	Primary Health Network
QH	Queensland Health
QPHN	Queensland Primary Health Network
RACF	Residential Aged Care Facility

Endnotes

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