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 rural and remote Primary Health Networks

Submission to 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

Queensland Parliament Health and Environment Committee

December 2021

Northern Queensland Primary Health Network acknowledges the traditional Custodians of the lands and seas on which we live and work, and pay our respects to Elders past and present.

phn NORTHERN QUEENSLAND

An Australian Government Initiative

Introduction

Primary Health Networks (PHNs) are independent organisations funded by the Australian Government to analyse the health needs of their communities and coordinate primary health care for their region. There are seven PHNs in Queensland.

This submission is made to the Health and Environment Committee on behalf of PHNs servicing the rural and remote communities of Queensland:

- Northern Queensland PHN (NQPHN)
- Western Queensland PHN
- Darling Downs and West Moreton PHN
- Central Queensland, Wide Bay and Sunshine Coast PHN.

As primary health care is funded by the Australian Government, many of the issues raised in this submission fall under its responsibility. PHNs are involved in ongoing discussions regarding system reform and improvement with the Australian Government.

For instance, it is relevant to the committee that the Australian Government has announced a review of the Distribution Priority Area (DPA) indicator and is in the final stages of developing the Primary Health Care 10 Year Plan, which outlines significant reform of the primary care sector, including specifically for regional, rural, and remote primary healthcare delivery. It has also recently completed a review of the 19.2 Exemption – Improving Access to Primary Care in Rural and Remote Areas (s19(2) Exemptions) Initiative.

Whole-of-system reform, however, can only occur with the support and commitment of all levels of government. The interface between primary healthcare and the hospital/tertiary health system is more important than ever as the COVID-19 pandemic tests the capacity and capability of the health system.

Designing a person-centred health system relies on a solid understanding and recognition of the social determinants of health and their impact on how and when patients access primary healthcare services. Many of these social determinants of health are State Government responsibilities including housing, public transport, education, early childhood development, employment, and community and disability services.

In rural, regional, and remote communities, where geographic isolation and lack of resources can considerably impact access to services, the consideration of these social determinants of health in planning health services are especially important.

While the National Health Reform Agreement 2020-2025 (NHRA)[1] details the need for Local Hospital Networks (HHS' in Queensland) and state-funded health and community services to work collaboratively with PHNs to integrate services, there are no clear guidelines defining this integration. While most PHNs have excellent working relationships with their corresponding HHS', there is little to no recognition of the PHNs' work in primary healthcare at a State Government level. This adds to a siloed approach to planning for and delivering health services for Queenslanders.

[1] Australian Department of Health, 2020, National Health Reform Agreement 2020-2025.

This submission responds to the Terms of Reference by way of outlining the current state of primary healthcare services in rural and remote PHN regions, and issues impacting service delivery. The recommendations outlined below focus on how the Queensland Government can work more effectively with PHNs to improve the health of Queenslanders.

Recommendations

Recommendation 1

That the Queensland Government considers how it can support a joint workforce and recruitment model between Queensland Health and PHNs to support a place-based approach to service delivery.

Recommendation 2

That the Queensland Government formally commits to joint planning, including the development of a single local area needs assessment that reflects the requirements of both PHNs and HHS'.

Recommendation 3

That the Queensland Government leverages the existing network of PHNs as service delivery partners for work that is best designed and implemented at a regional level, to reduce duplication of effort and resources across the system and to appropriately address local needs.

Current state of services and factors affecting availability and accessibility

Workforce shortages

Addressing health workforce shortages in regional, rural and remote areas of Australia has long been a challenge for all levels of government. Availability of health workforce is the single biggest contributing factor to access to primary care services in Queensland's rural and remote communities.

The COVID pandemic in Australia has resulted in increased awareness of health workforce issues, significantly, the recruitment and retention of primary health professionals[2].

This is especially apparent in regional, rural, and remote communities where the pandemic has adversely impacted access to a mobile health workforce, locums, and new international medical graduates.

[2] Queensland Health, Office of Rural and Remoter Health, General Practitioner Roundtable, 9 November 2020

Long-term systemic failures have still yet to be adequately addressed. These challenges include:

- maldistribution of the primary care workforce across Australia.
- declining favourability of general practice among medical graduates.
- complex processes for new general practitioners and other primary health professionals to work in Australia.
- failure of the Distribution Priority Area (DPA) system to properly respond to local needs.
- adequate preparation and training of medical professionals for a long-term career in rural and remote areas.

In December 2021, the Australian Government announced changes to the DPA classification of regional and larger rural towns with Modified Monash Model (MMM) status of 3-4. These changes mean that, from 1 January 2022, MMM locations from 3-7 will automatically be granted DPA status.

While this has an obvious benefit for those affected locations, issues remain with the DPA framework and its reliance on the MMM system that does not take into account the local health needs of a community and its current access to primary healthcare services.

Workforce recruitment efforts must also consider the varied compensation offered by employers to entice general practitioners (GPs) to work in rural, regional and remote areas, particularly the impact of the high remuneration of GPs by Queensland Health. Without a collaborative and shared state-PHN workforce approach, primary care will remain unable to compete in the recruitment of GPs because of a lack of alignment across the system.

As an indication of the current demand for primary healthcare practitioners in rural, regional and remote Queensland, there are 97 vacancies for GPs in the NQPHN region and 27 vacancies for allied health practitioners.

In the WQPHN region, 38 GP, 22 nurse and 30 allied health positions are currently vacant. Community pharmacy vacancies are also impacting on the ability for extended services, with vacancies for pharmacists also existing in the HHSs.

Approximately 50 per cent of the 28 community pharmacies across the WQPHN region are operated by single pharmacists, with inherent significant risks of closure due to illness or emergencies.

An ageing primary healthcare workforce will also impact on the provision of services in rural and remote communities, as older GPs retire and are not replaced. In Queensland, the average age of general practitioners is 50.4 years old.

Impact of the COVID-19 pandemic

The complexities of the COVID-19 vaccine rollout have placed additional stressors on a sector already experiencing workforce shortages and increased demand due to chronic and co-morbidity complexity and an aging population.

The demand for health professionals because of the COVID-19 pandemic has impacted on workforce availability for the primary care sector. An already-limited pool of health

professionals has been impacted by the large numbers being contracted to the state and federal governments for the vaccine rollout.

As borders re-open and general practice pivots to delivering services in a COVID-dominant environment, practices will be forced to implement changes to procedures, infrastructure, and clinical governance without additional funding from government.

The additional demands of testing and treating COVID positive patients while delivering cornerstone primary healthcare services will increase pressure and fatigue across the primary healthcare system. It is expected this will result in workforce movement away from traditional primary healthcare employment.

The rollout of booster vaccinations and vaccinations for 5 – 11 year old children in 2022 will further impact on primary healthcare accessibility.

Increasing demand for services and impact on patient capacity

The most recent NQPHN Health Needs Assessment revealed the number of GP services delivered across the NQPHN catchment is increasing over time. However, the number of patients receiving a GP service is increasing much more slowly. This may reflect the impact of chronic diseases on the population and a requirement for more frequent GP attendance for some population subgroups in the community.

An increasing number of primary care practices in rural, regional and remote communities have closed their books to new patients. In a recent survey of Mackay practices, 32 per cent of practices surveyed said they were not accepting new patients.

In Roma, one practice has recently closed and another is for sale. There are six GP vacancies across the whole Roma community, with processes for engaging overseas trained doctors onerous.

The ‘gatekeeper’ role of GPs means there is a flow-on impact of patients not being able to access a general practitioner. Patients often require a referral from a GP to access allied health, mental health or specialist services, or to access a prescription for medication. Failure to do so may result in preventable presentations to hospital emergency departments.

Aged care access

Access to GPs and other primary care providers by Residential Aged Care Facility (RACF) residents has been adversely impacted by the impact of the COVID-19 pandemic and persistent workforce shortages.

RACFs in regional, rural and remote communities are often serviced by a sole GP, placing them at considerable risk if that GP’s circumstances change and they are no longer able to provide those services. This has occurred recently in Townsville, where a sole GP servicing 650 RACF patients ended those arrangements, and is not an isolated occurrence in rural and remote-based RACFs. RACFs are also having to refuse admission to clients due to the inability to find a GP to take on their care.

Impact on Queensland public health system

Since the beginning of the COVID-19 pandemic, we have seen a change in how people access primary healthcare. Telehealth is being used more frequently, however is less suitable for chronic conditions management, resulting in higher presentations to the emergency department (ED).

Workforce shortages in regional and rural areas also contribute to avoidable ED presentations, where patients have been unable to access primary care services in the community. In a number of rural and remote places, the General Practice is operated by the public health system (HHS), meaning that workforce deficits affect both sectors in parallel and the reduction in access is more pronounced.

In 2020-21, Mackay HHS emergency departments have seen 11 per cent more patients compared to 2019-20. Almost half of all presentations for Mackay HHS were considered Category 4 or 5 patients (patients that presented to ED with GP-like presentations). Similar findings (48 per cent) were observed in a research project conducted on presentations to the Mount Isa Base Hospital emergency department[3]. There was a nine per cent increase in Category 4 and 5 patients in the Mackay HHS region in 2020-21 compared to 2019-20.[4]

Capacity issues in primary healthcare also hold up the patient flow from Queensland Health in the management of complex and chronic patients. Where there is no access to GPs in the community, patients are unable to be discharged and are held longer than necessary by Queensland Health.

The COVID-19 pandemic has also been attributed to the rise in demand for mental health services and support. Primary care bears the brunt of this increased demand, but complex and severe cases that are not treated in the community due to a lack of mental health practitioners or coordinated care pathways often result in ED presentations.

Rural and remote context

Working in regional, rural and remote locations

Primary care providers servicing regional, rural and remote communities are subject to additional pressures and professional challenges than their counterparts in metropolitan areas. These can include:

- professional isolation and the financial sustainability of practicing in rural and remote areas.
- lack of supporting health services in the primary care ‘team’, for example allied health providers and primary health nurses.
- housing pressures, including volatile rental markets or high house prices.
- social issues including family relocation and schooling.
- overload and burnout due to limited opportunities for relief.

[3] Drivers of general practice-type presentations to the emergency department in a remote outback community, Western Queensland PHN research project
[4] Data provided by Mackay HHS to NQPHN, 7 December 2021

- poorer health status of rural and remote communities compared to metropolitan. areas, resulting in more complex care[5].
- confusion and duplication regarding the frequency, access, and types of outreach health services that Fly In, Fly Out (FIFO) or Drive In, Drive Out (DIDO).
- the coordination and navigation of state, private and federally funded outreach type services further compound the complexity of rural and remote health services delivery.

Rural and remote workforce requirements

Because of the challenges outlined above, workforce planning for regional, rural and remote areas of Queensland requires a whole-of-government, place-based approach to promote a strong rural health workforce that supports the needs of local communities.

This includes, but is not limited to, a shared workforce model whereby both the State Government and PHN commit to joint planning and shared resources that leverage those resources that are locally available.

In Clermont, the Mackay HHS is working with primary care to implement a shared workforce model that increases the attractiveness of GP positions that have a lighter, shared workload across primary and acute care.

A more sustainable model of general practice in rural and remote communities, shared workforce models allow GPs to live and work in the community while operating out of one practice to reduce overheads and administration.

With more doctors available in the community, patient access is increased and doctors can work across general practice and acute hospital care.

Clermont, Moranbah and Dysart are all implementing similar innovative models of care as part of James Cook University's Isaac Health Partnership Action Project. The project is looking at the elements of a rural healthcare system and how arrangements for planning coordination and partnership across agencies, and between agencies and communities, can be improved.

Joint planning

Since their establishment in 2015, PHNs have been required to undertake local needs assessments for their region to guide decision making and priority setting.

Known as Health Needs Assessments (HNA), the data gathered during this process is used to identify service provision gaps and population groups at risk of poor health outcomes. The HNA is provided to the Department of Health, and there are strict guidelines around data collection and reporting requirements.

Under recent changes, Queensland Health now requires HHSs to conduct their own Local Area Needs Assessment (LANA) to identify areas of unmet need in the region. This may

[5] Rural and remote health, Australian Institute of Health and Welfare https://www.aihw.gov.au/reports/australias-health/rural-and-remote-health

duplicate work already undertaken by PHNs and contributes to siloed data sources used for planning services at a regional level.

HHSs should be required to work collaboratively with corresponding PHNs (noting that some may already work in this way) to develop joint needs assessments that respond to the requirements of both state and federal health departments, while providing access to shared data and resources – including service utilisation data which is currently not provided to PHNs.

Funding flexibility and PHN capacity

The rigid design of the current Medicare Benefits Schedule (MBS) model is impacting on the sustainability of rural and remote general practices and primary care providers. It neither reflects the unique requirements of rural and remote practitioners, nor provides adequate renumeration for practices located in regions with much higher costs than metropolitan practices.

A blended funding model for rural, regional and remote service providers that recognises the additional costs and challenges of delivering primary health services in these areas is required.

The primary healthcare funding system has too little flexibility to respond to local needs, especially in regional, rural and remote communities. Each of the PHNs represented in this submission have recognised the need for adaptive, place-based models of care that meet and respond to local needs and are advocating for more flexible funding streams for rural and remote PHNs to design and implement these innovative models.

PHNs also have untapped capacity to commission or co-design services at a regional level, leveraging their extensive community and system partnerships. COVID-19 has demonstrated the agility and responsiveness of PHNs to work with health system and government partners to plan and coordinate local service delivery.

Though PHNs are primarily funded by the Commonwealth Government, many PHNs are exploring ways to improve the interface between primary care and related state government services. This could include for example disability and community services, education and employment initiatives.

Regional, rural and remote PHNs urge the Queensland Government to consider how it can partner with PHNs to support and coordinate service delivery to improve health outcomes for Queenslanders living in these regions.