Inquiry into the provision of primary, allied and private health care, aged care and NDIS care and its impact on the Queensland public health system

Queensland Parliament Health and Environment Committee

Australian Government Submission

February 2022

Preface

Health and other care systems are a shared responsibility

Australians should have equitable access to high-quality, safe health services, aged care and disability supports, regardless of where they live. Throughout the COVID-19 pandemic, we have proven we can work collaboratively as governments to ensure the best outcomes for patients and consumers across care settings.

The Australian and Queensland Governments share responsibility for funding and administering different parts of health and other care systems, with no one level of government fully responsible for any of these systems.

The Australian Government is dedicated to fulfilling its funding responsibilities for primary health care, private specialist care, aged care and supports for people with permanent and significant disability that in combination will deliver almost $90 billion in 2021-22 for these services nationally. This is in addition to the Australian Government's record contribution to state and territory public hospital services of over $25 billion in 2021-22, growing to almost $30 billion in 2024-25, and the $1.25 billion Community Health and Hospitals Program.

The Queensland Government is responsible for managing its public hospital and health care system, including service planning and performance, for which the Australian Government's funding contribution has grown significantly from $2.6 billion in 2012-13 to $5.2 billion in 2020-21 through the National Health Funding Pool, or by 99 per cent. Over the same period, the Queensland Government's contribution has grown by 53 per cent.

Our record investment is further bolstered by the Australian Government's commitment to a 'minimum funding guarantee' during the COVID-19 pandemic, where if a state or territory's public hospital funding entitlements fail to meet a minimum level, the Australian Government uplifts its funding to equal that amount.

During the unprecedented COVID-19 pandemic, the Australian Government has recognised the pre-eminent role Queensland public hospitals and public health professionals have in keeping people safe and well cared for, by investing $930.5 million so far under the National Partnership on COVID-19 Response (as at 7 February 2022). Funding is demand driven and uncapped. The Partnership is in place until 30 June 2022 and has ensured critical responses such as vaccines, personal protective equipment, infection control training, contact tracing teams, private hospital capacity and surge workforces are available when and where they are needed. This has included funding 3.2 million COVID-19 tests and 3 million doses of COVID-19 vaccines delivered by Queensland state health clinics.

In addition to its role as manager of its public hospital and health care system, the Queensland Government continues to be responsible for providing and funding aged care and disability services where people are not eligible for wide-ranging Australian Government funded supports, and ensuring their public hospitals work collaboratively with other local organisations to deliver the best services for their communities.

The National Disability Insurance Scheme (NDIS) is designed to support the independence and social and economic participation of Australians with permanent and significant disability, originally estimated in 2015 to be up to 10 per cent of the 4.3 million Australians who have a disability. The NDIS is a world-first reform to the way disability support is provided, significantly increasing the funding available for disability services, and putting choice and control over how those services are delivered into the hands of people with disability. The NDIS recognises that services and supports for NDIS participants is a responsibility shared with states and territories, and acknowledges that NDIS participants may require contributions from other service systems. The Australian Government is committed to continuing to work together with states and territories to support the alignment of the NDIS with mainstream service systems.

Integrating services for rural, regional and remote communities

The Australian Government takes seriously its essential role in funding primary health care services, and supporting programs to ensure these services integrate locally with other health and care in rural, remote and regional areas.

Innovative collaborations between several Queensland Primary Health Networks (PHN) and Hospital and Health Services (HHS) demonstrates the opportunities to support joint planning, collaborative commissioning and health service integration between Australian and Queensland Government funded health services. PHNs continue to develop collaborative working relationships with HHSs and other key stakeholders to improve integration across the health system by reducing avoidable hospital admissions, reducing duplication of effort and resources, and improving PHNs' ability to purchase or commission medical and health care services.

The Australian Government continues to provide substantial workforce incentives and supports for medical and allied health professionals to practice in rural and remote communities across Queensland. This includes funding for the Australian General Practice Training program, the Remote Vocational Training Scheme, the Rural Health Multidisciplinary Training Program, and the national Rural Generalist Training Scheme.

The Australian Government also continues to fund and support Aboriginal and Torres Strait Islander comprehensive primary health services across Queensland. These services, most of which are community controlled, deliver a broad range of culturally safe clinical and population health activities tailored to the needs of their communities.

All Governments have also agreed to progress long-term system-wide health reforms under the National Health Reform Agreement. The reform work underway is examining how the different components of the health system and other care sectors interact to improve service integration and outcomes for people. Through the reforms, Queensland will have the flexibility to try innovative solutions and ensure health services best suit the needs of their local communities, including to look at new ways of delivering and funding services across hospital, primary care, aged care and disability support sectors.

People's outcomes and quality of life matter most

All Australians should have equitable and free access to public hospital services as public patients when they need them, regardless of geographic location. Under the NHRA, the Queensland Government has agreed to adhere to these Medicare Principles in their responsibility as system managers of public hospitals and health services across the state. This includes for older people and people with disabilities who have the same rights to high-quality and safe care that is respectful of, and responsive to, their preferences, needs and values. The Australian Government takes exception to characterising older people and people with disabilities as 'bed blockers' in public hospitals, which dehumanises individuals and sees the issues only from a systems perspective.

Our collective challenge is to continue improving the ways we work together, and how our programs and services work together, to provide pathways of care across systems that are better connected, and that will improve peoples' experiences, quality of life and outcomes.

Key Australian Government investments and commitments

Through the following programs and services, the Australian Government is committed to continue working in partnership with the Queensland Government to meet the health and care needs of Queenslanders now and in the future.

- **Mental health** investments and initiatives demonstrate the Australian Government's ongoing commitment to mental health services across settings and providers:
    - The Health Portfolio investment in mental health and suicide prevention services and supports in 2021-22 is estimated to be a record high of $6.5 billion, doubling since 2012-13.

- Since March 2020, the Australian Government has made available more than $1 billion in funding to respond to the mental health impacts of the COVID-19 pandemic. This includes significant investments in mental health telehealth services and Medicare-subsidised psychological therapy sessions.
- Through the 2021-22 Budget, the Government is investing $2.3 billion in the National Mental Health and Suicide Prevention Plan to deliver significant reform of the mental health system.

- **Primary and allied health care**
  - In 2020-21, over 35 million MBS-subsidised general practice (GP) services were provided in Queensland at a cost of $1.8 billion. Of these services, 88.1 per cent were bulk-billed, which is in line with the national average.
  - For allied health care, 3.3 million MBS-subsidised services were delivered in 2020-21 with a bulk-billing rate of 60.9 per cent, over 4 percentage points higher than the national average. Separately, practice nurse and optometry services were bulk-billed in line with average national rates, at 99.7 per cent and 94.6 per cent respectively.
  - In the 2020-21, the Pharmaceutical Benefits Scheme (PBS) provided close to $2.8 billion funding for medicines for people in Queensland, out of the overall $13.6 billion in national expenditure. These figures include both Section 85 and Section 100 medicines.[1]
  - Since 2013, the Australian Government has listed over 2,800 new or amended items on the PBS. This represents an average of around 30 listings per month – or one each day – at an overall cost of around $14 billion. Recent listings on the PBS include medicines for the treatment of conditions such as multiple sclerosis, spinal muscular atrophy, heart disease and various types of cancer.
  - The Australian Government is also providing over $1 billion to Queensland Primary Health Networks from 2019-20 and 2022-23 to deliver and commission services under seven priority areas: mental health, Aboriginal and Torres Strait Islander health, population health, digital health, health workforce, aged care, and alcohol and other drugs.
  - The Australian Government is providing approximately $329 million from 2020-21 to 2022-23 for the delivery of culturally appropriate, comprehensive primary health care services for Aboriginal and Torres Strait Islander people under the Indigenous Australians' Health Programme (IAHP), which supports 32 organisations across Queensland, including 27 Aboriginal Community Controlled Health Services.
  - The Australian Government also announced the $180 million Living with COVID-19 Primary Care Package in October 2021 to further strengthen and support the health system as Australia opens up.
- **Aged care**
  - The Australian Government will invest $17.7 billion as part of the 2021-22 Budget in response to the Final Report of the Royal Commission into Aged Care Quality and Safety. This includes $7.8 billion for residential aged care services and sustainability reform.
  - The Australian Government is also committed to addressing the critical need for home-based care for senior Australians. Since the 2018-19 Budget, the Government has invested $11.9 billion in new funding to deliver 163,105 additional Home Care Packages (HCPs). This includes an additional 80,000 HCPs announced in the 2021-22 Budget (40,000 in 2021-22 and a further 40,000 in 2022-23) at a cost of $6.5 billion. In Queensland the number of people receiving a HCP has increased by 50 per cent in the two year period between 30 June 2019 (21,257) and 30 June 2021 (31,895).

[1] These data exclude Doctors Bag (certain pharmaceutical benefits that are provided without charge to prescribers who in turn can supply them free to pa ients for emergency use) and under co-payment prescriptions. These data are based on the state of the dispensing pharmacy and are subject to change due to pharmacy claiming activity.

- **National Disability Insurance Scheme**
  - In 2020-21, the National Disability Insurance Agency (NDIA) committed $6.7 billion in plans for NDIS participants residing in Queensland which is approximately 21 per cent of the national NDIS funding commitment, of which $4.9 billion was spent by participants. This represents an average utilisation of 73 per cent in 2020-21, compared to national utilisation of 73 per cent. The average plan budget per NDIS participant residing in Queensland as at 31 December 2021 was $70,800 with the average amount spent being $59,200.
- **Private health care services**
  - For private specialist care and diagnostic services in Queensland, the Australian Government continued to make significant contributions in 2020-21 under the MBS:
    - 6.5 million medical specialist attendances, for which $529.1 million in benefits were paid. Bulk-billing rates for these services in Queensland are below the national average but have grown from 23.2 per cent in 2012-13 to almost 30 per cent in 2020-21. The Government has recently invested in ongoing telehealth arrangements under Medicare to support additional access to medical specialist services via videolink and telephone.
    - 6.5 million diagnostic imaging services, for which almost $1 billion in benefits were paid. The Queensland bulk-billing rate is well above the national average, at 83.3 per cent.
    - 34.1 million pathology services, for which almost $800 million in benefits were paid. The Queensland bulk-billing rate is in line with the national average, at 89.6 per cent, with out-of-hospital services bulk-billed at 99.7 per cent.
  - The Australian Government also supports people to take out private health insurance through tax rebates, supporting access to private hospital services for 2.1 million Queenslanders (41 per cent of the population) who have hospital treatment cover. In addition, private health insurance general treatment provides subsidised access to private allied health and other preventive care services for 2.5 million Queenslanders (47.9 per cent of the population) who hold this insurance.
- Further information is provided at **Attachment A**. More detail on primary care services and workforce initiatives in regional, rural and remote areas is included at **Attachment B**.

We trust this information will assist the Committee to better understand the substantial contributions the Australian Government is making to support the health and wellbeing of all people in Queensland.

The Hon Greg Hunt MP
Minister for Health and Aged Care

Senator the Hon Linda Reynolds CSC
Minister for the National Disability Insurance Scheme

Attachment A – Detail on Australian Government programs and initiatives

This attachment is structured around the Committee's Terms of Reference where possible, noting most items under Part 2 of the Terms of Reference are addressed under relevant sections of Part 1.

Primary and allied health care

- The Australian Government is responsible for system management and support, policy and funding for general practice (GP) and primary health care services. The Government provides various forms of funding through the Medicare Benefits Schedule and other programs such as the Indigenous Australians' Health Program, by subsidising the cost of services and supporting service delivery organisations, providing incentives for primary care professionals, funding training programs, and investing in mechanisms to improve primary health care system management. Key aspects of primary health care funding within the Australian Government's responsibilities include:
    - *Medicare Benefits Schedule (MBS)*[2] – The Government funds a wide range of primary care services through the MBS, which provides financial assistance to patients in the form of Medicare rebates. The MBS covers a range of primary care services, meaning patients can access many medical, diagnostic and allied health services for free (bulk-billed) or at a subsidised cost.
        - An indexation pause on MBS benefits was introduced in the 2013-14 Budget. In the 2017-18 Budget the Government announced a $1 billion commitment to the phased re-introduction of indexation of MBS benefits. Indexation commenced on 1 July 2017 with increases to GP bulk-billing incentives and on 1 July 2018 for standard GP consultations and specialist attendances. These items have been indexed on 1 July in every year since then. Specialist procedures, allied health services and all other GP services were indexed from 1 July 2019. Diagnostic imaging fees for targeted items have included annual indexation since 1 July 2020.
    - *Primary Health Networks (PHNs)* – The Government funds a network of regionally-based PHNs, which work to reorient and reform the primary health care system by taking a patient-centred approach to medical services in their regions. They have responsibility for undertaking data analysis and working with state and local governments, local communities, clinicians, non-government organisations, National Disability Insurance Scheme providers and other related services, organisations and providers to identify and commission health services to meet the prioritised health care needs of their communities.
    - *Aboriginal and Torres Strait Islander Health* – Through the Indigenous Australians' Health Program (IAHP), the Government funds a range of activities that aim to provide Aboriginal and Torres Strait Islander people with access to effective high-quality, culturally appropriate primary health care services in urban, regional, rural and remote locations across Australia. The IAHP's primary health care activity provides grants for primary care services, including services delivered by Aboriginal Community Controlled Health Services (ACCHSs), as well as mainstream services across the health system. Through a Direction issued by the Minister for Health under section 19(2) of the Health Insurance Act 1973 (HIA), ACCHSs can also access MBS billing while receiving primary health care funding through the IAHP. In 2019-20, ACCHSs provided services which were rebated by $116.3 million in MBS benefits.
    - *Workforce programs* – The Government funds a range of primary care workforce incentive and training programs, including the Workforce Incentive Program, the Remote Vocational Training Scheme (RVTS), Rural Generalist GP Training (RGTS), the Rural Health

[2] All Medicare statistics are available at: https://www1.health.gov.au/internet/main/publishing.nsf/Content/Medicare per cent20Statistics-1

Multidisciplinary Training (RHMT) Program, and the Australian General Practice Training (AGPT) program.

- The Australian Government has made continuing investments to strengthen primary health care, most recently $700 million in the 2021-22 Budget which built on $1.6 billion over three previous Budget updates. These include measures to support general practice, after hours care, allied health, mental health and the rural workforce. The Australian Government provided $2.3 billion in primary health care funding in the 2020-21 Budget for responding to the COVID-19 pandemic, and a further $180 million for living with COVID measures announced in October 2021, outlined below.
- These investments will provide care for people in the community and help relieve the pressure on hospital systems. The Australian Government is finalising its Primary Health Care 10 Year Plan covering three streams of work which includes a stream for integrated care, locally delivered. This stream provides for additional actions to improve the integration of primary health care with hospitals and other parts of the health system, aged care, disability care and social care systems. This aligns with commitments all governments have made under the 2020-2025 National Health Reform Agreement and the Health Ministers' Long-term Health Reforms Roadmap.

Living with COVID Primary Care Package

- All Australian Governments recognise the increasing demand on Australia's health workforce to respond to COVID-19 and to continue to deliver high quality health and aged care. In the initial stages of the pandemic the pressure was felt particularly in the hospital system. Australia is now one of the mostly highly vaccinated countries in the world, and that number is growing daily. With a highly vaccinated population, many COVID-positive people can be appropriately cared for in the community.
- To facilitate this transition, the Australian Government is making further investments of more than $180 million in a major primary care package announced in October 2021 that aims to reduce pressure on the hospital system and more appropriately provide services and supports through the primary health care system. This has included PHNs collaborating with HHS in Queensland to develop robust COVID Community Care Pathways to define the roles and responsibilities of various parts of the health system in managing COVID patients in this new stage of the pandemic.
- As part of this work, the Australian and Queensland Governments are working together with healthdirect to provide a COVID-19 assessment and triage service to connect COVID-positive people with the right level of care.
- The Living with COVID package includes:
    - **National COVID triage, management and escalation infrastructure** – to ready the national call centre, healthdirect, to connect COVID positive people with the right level of care. This will support state and territory Public Health Units to contact, triage and monitor patients.
    - **COVID Community Care Pathways** - updating COVID-positive care pathways in every region of Australia through collaboration between PHNs and their corresponding local hospital networks. These will provide clear plans on where and how COVID positive people will be managed through primary and community services or through hospitals.
    - **Additional MBS item for general practitioners** - providing a rebate of $25 which can be claimed on top of existing general consultation items, to support face-face care for COVID-19 positive patients.
    - **Home visits for patients recovering at home** - commissioning home visits by practice nurses, nurse practitioners and medical deputising services for patients requiring home visits or after hours services while under GP management with a particular focus on regional and rural areas.
    - **National Medical Stockpile** – procuring supplies of pulse oximeters and personal protective equipment (PPE) for general practice, with a focus on strengthening the supply chain for rural and remote practices.

- **General Practice Respiratory Clinics (GPRCs)** - extending the reach and the role of our network of GPRCs so that COVID-positive people without an available usual GP have a general practice that they can safely attend for assessment and management rather than presenting to hospital in non-urgent circumstances.
- **Changes to COVID-19 management guidelines** – the Royal Australian College of General Practice (RACGP) is updating its COVID-19 management guidelines to include treatment of COVID positive patients, including children, with moderate symptoms at home. The first update was released 17 November 2021.
- **Extension of the current dispensing arrangements** – extending the temporary Continued Dispensing (Emergency Measures) to allow community pharmacists to dispense a one month supply of PBS medicines, under certain conditions, when patients cannot access their prescription.

Mental health services commissioned by PHNs

- As part of the Australian Government's major investment in regionally-coordinated primary health care, Queensland PHNs will receive $360.6 million from 2020-21 to 2022-23 to plan and commission regionally appropriate primary mental health and suicide prevention services, including to respond to the COVID-19 pandemic.
- The Government also funds PHNs to commission psychosocial support services for adults with severe mental illness and reduced functional capacity who are not accessing services through the National Disability Insurance Scheme (NDIS). A total of $53.6 million over 2 years, from 2021-22 to 2022-23, has been allocated to Queensland PHNs to commission these support services.
- In order to increase access to needs-appropriate services, initial steps have been taken to improve the interface between Australian Government-funded psychosocial support services and the NDIS, including:
  - providing assistance for people to test or retest their eligibility for the NDIS. This assists consumers with more intensive, ongoing support needs in collecting the evidence to submit a NDIS access request and 'walks with consumers' during the process,
  - Service Navigation to provide information, advice and referral assistance to consumers, their families and carers to better connect to services and improve integration, and
  - funding the delivery of sector capacity-building resources on practical interface topics, including any changes to NDIS that have implications for psychosocial supports.

After hours care

- The Australian Government provided $728.2 million in funding for after hours care in 2020-21. This included $536.6 million in MBS benefits, $89.8 million through the After Hours Practice Incentives Program, $71 million through the Primary Health Network After Hours Program and $30.8 million through healthdirect.

Telehealth services

- The introduction of MBS telehealth items has had a significant effect on the way patients access primary care. In 2020-21, over 171.5 million non-referred GP consultations were provided through the MBS nationally – a 5.1% increase over the previous 12 months. Over 38 million of these services were provided by telehealth. This increased access to care extends to the after hours period. Where clinically appropriate, after hours services previously provided face-to-face can now be provided by telehealth. Telehealth has increased access to primary care in hours, particularly for patients with mobility issues or those who have difficulty accessing services during work hours. A number of these patients would previously have relied on after hours providers to access care. The introduction of telehealth has proved popular with patients, with the 2020-21 Australian Bureau of Statistics

report on Patient Experiences in Australia, showed that more than 83% of respondents reported that they would use telehealth for a consultation again if it was offered.[3]

- In September 2020, the Australian Government provided $550,000 (GST inclusive) to support a trial of after hours services on Bribie Island. The trial is being administered by Brisbane North PHN. Brisbane North is currently working with general practices to design a model of care that is supported by local practices and meets the needs of the local community.

Practice Incentives Program (PIP)

- Long-standing Australian Government-funded incentives are available to support general practice activities that encourage continuing improvement and quality care, enhanced capacity and improved access and health outcomes for patients. The PIP is comprised of eight on-going incentives; Indigenous Health; Quality Improvement; eHealth; After Hours; General Practitioner Aged Care Access; Procedural GP Payment; Teaching; Rural Loading; and two time limited COVID-19 Incentives; COVID-19 Vaccine General Practice Incentive and the COVID-19 In-reach Vaccination Payment
- In 2020-21, approximately $450 million was paid to general practices under the PIP nationally. This includes a doubling of funding for PIP Quality Improvement activities, recognising the importance of ensuring business continuity for general practices and to incentivise practices to continue to perform face-to-face consultations for patients during the COVID-19 response period. Of the total incentives, $96.3 million went to PIP practices in Queensland.

Indigenous Australians' Health Programme (IAHP)

- The Australian Government is providing approximately $329 million from 2020-21 to 2022-23 for the delivery of culturally appropriate, comprehensive primary health care services under the Indigenous Australians' Health Programme (IAHP), which supports 32 organisations across Queensland, including 27 Aboriginal Community Controlled Health Services.
- This funding allows for a broad range of clinical and population health activities tailored to the needs of the community including; health checks, prevention, detection and management of chronic conditions, child and maternal health, health crisis intervention and referrals and health promotion programs in areas such as harm and injury reduction, sexual health, blood borne viruses, holistic health services, women's health, and men's health.
- Online Service Report data (OSR) shows that IAHP primary health care funding provided access to care for approximately 125,421 clients in Queensland in 2019-20, including the delivery of over 880,700 episodes of care.[4]

Workforce training and distribution

- The Australian Government makes substantial investments to support a primary health care system to keep Australians healthy and reduce demand for hospital services. There are a wide range of programs across the Australian Government supporting primary health care and the workforce that delivers primary care services.
- Some key primary care workforce programs with relevant Queensland information and data are included below. More detail on the full range of regional, rural and remote workforce and other primary care arrangements is contained in **Attachment B** (Australian Government Department of Health submission from October 2021 to the Senate Standing Committee on Community Affairs[5]).

[3] https://www abs.gov.au/statistics/health/health-services/patient-experiences-australia-summary-findings/latest-release
[4] AIHW analysis of OSR data collection - Aboriginal and Torres Strait Islander specific primary health care: results from the nKPI and OSR collections.
[5] https://www aph.gov.au/DocumentStore.ashx?id=379fba97-8d67-4831-9f1c-cc3a8c6a4eb7&subId=716543

Australian General Practice Training program (AGPT)

- The Australian Government funds the Australian General Practice Training (AGPT) program to deliver postgraduate vocational training for medical graduates wishing to pursue a career in general practice.
- Successful applicants accept a training position in one of 11 training regions across Australia. Nine Regional Training Organisations (RTOs) are responsible for administering and managing registrar training in the regions. Queensland has two RTOs that cover the state. General Practice Training Queensland (GPTQ) is responsible for South Eastern Queensland which includes Brisbane, Gold Coast and Darling Downs, and West Moreton District. James Cook University (JCU) is the RTO responsible for North Western Queensland.
- Queensland has a total of 1,180 enrolled AGPT registrars training as of June 2021. GPTQ has 662 registrars enrolled with average annual funding of $22 million between 2019 and 2021, and JCU has 518 enrolled registrars with average annual funding of $24 million.

Distribution Priority Areas

- The Distribution Priority Areas (DPA) system is used to distribute general practitioners (GPs) subject to Medicare location restrictions to work in areas where there are GP service shortfalls, and helps to compare relative shortages of GPs between communities, as most communities appear to self-identify that they have a shortage of GPs. The DPA compares the actual level of GP services provided to a population with the level of services that the same community should receive if it had access to a benchmark level of services.
- The DPA considers the level of services that should be received by taking into account the community's composition, including gender, age demographics and socio-economic status. This is because these factors are social determinants of health that drive a community's service needs up and down.
- A community or practice can apply for special consideration if they are not in an area categorised as DPA. This is assessed based on advice from the expert Distribution Working Group.

Remote Vocational Training Scheme and Rural Generalist Training Scheme

- The Remote Vocational Training Scheme (RVTS) is a 3 or 4-year program that delivers structured distance education and supervision to medical practitioners while they continue to provide general medical services in Aboriginal and Torres Strait Islander communities and rural and remote locations throughout Australia, while obtaining their GP fellowship. There are currently 3 practitioners in training or close to commencing in remote communities across Queensland.

National Rural Generalist Training Scheme

- Funding for Rural Generalist Training Scheme was initially announced as part of the 2018-2019 for Stronger Rural Health Strategy to produce Australian trained GPs with extended skills where they are needed.
- The RGTS was formally established in April 2021 with funding of $48.5 million over 4 calendar years. The Australian College of Rural and Remote Medicine is responsible for delivering the RGTS which will fund the gradual delivery of up to 100 Rural Generalist GP training places each year.
- In 2021, 21 registrars commenced on the program of which 6 were training in Queensland.

Rural Health Multidisciplinary Training program (RHMT)

- The Rural Health Multidisciplinary Training program improves the recruitment and retention of health professionals in rural and remote Australia. The RHMT program supports medical, nursing, midwifery, allied health and dental students to undertake rural training through a network of Rural Clinical Schools (RCS), Regional Training Hubs (RTH), University

Departments of Rural Health (UDRH), dental faculties offering extended rural placements and the Northern Territory Medical Program.

- A number of Queensland universities take part in the RHMT program, including:
  - Griffith University, funded $8.8 million in 2019-20 and 2020-21 to operate a RCS and a rural dental placement program. The major training sites for medical placements are Toowoomba, Kingaroy, Stanthorpe, Warwick, Dalby, Gympie, Maleny with dental placements in Kingaroy, Warwick and Stanthorpe.
  - James Cook University, funded $25.3 million in 2019-20 and 2020-21 to operate a UDRH, RCS and three RTHs. The major training sites for medical placements are Mackay, Cairns, Mount Isa, Thursday Island, Atherton and Longreach with RTH activity in Mount Isa, Townsville, Mackay, Cairns and Thursday Island. The Murtupuni Centre for Rural and Remote Health supports allied health and nursing training in Mount Isa, Longreach, Weipa and Cloncurry.
  - The University of Queensland, funded $31.4 million in 2019-20 and 2020-21 to operate a UDRH, RCS and three RTHs as well as the rural dental placement program. The major training sites for medical placements are Toowoomba, Bundaberg, Hervey Bay and Rockhampton with RTH activity in Bundaberg, Toowoomba and Rockhampton. UQ offers allied health training through Southern Queensland Rural Health in Toowoomba, Charleville and dental placements in Dalby and St George.

Aged care

- The Australian Government announced an investment of $17.7 billion as part of the 2021-22 Budget in response to the Final Report of the Royal Commission into Aged Care Quality and Safety. This includes $7.8 billion for residential aged care services and sustainability reform.
- This announcement includes the formal introduction of the new Australian National Aged Care Classification (AN-ACC) funding model, which will replace the Aged Care Funding Instrument from 1 October 2022.

Residential aged care

- As at 30 June 2021, there were 36,273 people in Queensland receiving permanent residential care, with a total of 43,002 operational residential aged care places in Queensland that are funded by the Australian Government.
- In the 2018-19 and 2019-20 Aged Care Approvals Rounds, the Government allocated a combined 5,206 new residential aged care places, 383 short term restorative care places and $54 million in capital grants to support aged care providers in Queensland to establish new service offerings and expand existing aged care services.
- As part of the aged care reform package announced in the 2021-22 Budget, the Government announced the removal of the Aged Care Approvals Round (ACAR) and the allocation of residential aged care places to providers. From July 2024, places will be assigned directly to senior Australians, giving them more choice and control to choose an approved provider that can best meet their care needs. The new system, along with other associated reforms, will strengthen the aged care market through increased competition. Providers will have greater incentives to deliver high quality and innovative models of care and accommodation to meet the needs of senior Australians.
- Consultations have commenced with providers, peak bodies and assessors regarding the assignment of places to senior Australians. The consultations will ensure the key concerns and risks are identified prior to moving towards a more competitive market. A second round of consultation, including consumers, to be undertaken in 2022.

Home care

- The Australian Government is committed to address the critical need for home-based care for senior Australians. Since the 2018-19 Budget, the Government has invested $11.9 billion in new funding to deliver 163,105 additional Home Care Packages (HCPs). This includes the additional 80,000 HCPs (40,000 in 2021-22 and a further 40,000 in 2022-23) the Government

announced at the 2021-22 Budget at a cost of $6.5 billion. Government expenditure on HCPs will more than double in the three years between 2018-19 ($2.5 billion) and 2021-22 ($5.3 billion) and almost triple in the six years to 2024-25 ($7.1 billion). This funding will ensure that around 275,600 HCPs will be available to senior Australians by 30 June 2023. Investment to date has seen a significant increase in people receiving a HCP and significant reductions in the size of the National Priority System (NPS) and wait times for HCPs. The additional 80,000 HCPs that commenced rolling out in July 2021 will see further improvements to people receiving care in an HCP and the size of the NPS.

- The HCP Program is designed so that senior Australians can access affordable and coordinated aged care services at home. Depending on the level of HCP funding received, assistance can be provided for a range of different services. The three main categories of services are:
  - services to keep people well and independent – including personal care, nursing services, allied health;
  - services to keep people safe in their home – including cleaning, home maintenance and modifications, assistive technology; and
  - services to keep people connected to their community – including transport, social support services.
- In Queensland the number of people receiving a HCP has increased by 50 per cent in the two year period between 30 June 2019 (21,257) and 30 June 2021 (31,895).
- The number of senior Queenslanders waiting in the NPS for a HCP at their approved level has decreased by 37 per cent in the two year period between 30 June 2019 (20,921) and 30 June 2021 (13,133). Of the people waiting in the NPS, 99 per cent had either been offered an interim level HCP or been approved for Commonwealth Home Support Programme assistance.

Facilitating discharge of older Australians into aged care

- The Department of Health assists with the discharge of older Australians from hospital as outlined below. These actions complement the National Health Reform Agreement requirement that local hospital networks must engage with aged care services, to enable their views to be considered when making decisions on service delivery at the local level.

Advocacy

- The Older Persons Advocacy Network (OPAN) delivers the National Aged Care Advocacy Program (NACAP) through its network of 9 service delivery organisations across Australia.
- OPAN can support older Australians who are hospitalised by providing information about what aged care services are available, engagement with Aged Care Assessment Teams (ACAT), involvement with discharge care planning and facilitation of access to services. This can involve connecting older people to transition care and accessing transitional care in the home following a hospital admission.

Transition Care

- The Transition Care Programme (TCP) is a flexible aged care programme, jointly funded by the Australian and state/territory governments, which provides short-term therapy focussed care and services to older Australians for up to 12 weeks (with a possibility of a 6 week extension) following discharge from hospital. Transition care seeks to optimise the functioning and independence of older people post-hospitalisation, and where possible, delay a person's entry into residential aged care. The states and territories are the approved providers for the TCP, with Queensland Health being the approved provider in Queensland. Under the joint funding arrangements for the TCP, total funding is comprised of an Australian Government contribution of approximately 75 per cent provided through a flexible care subsidy ($214.39 per occupied place, per recipient, per day in 2021-22), and a state/territory contribution of 25 per cent.

- Currently, Queensland Health has an allocation of 753 transition care places. This includes 20 time-limited TCP places allocated to Queensland Health in 2020-21 to assist with their response to the COVID-19 pandemic. Queensland Health will be able to apply to make these 20 places permanent in early 2022.
- Additionally, on 5 November 2021 the Australian Government announced the creation of additional time-limited TCP places to assist in the timely discharge of more older Australians from hospital, which is intended to relieve capacity pressures on the public hospital system. As part of this an additional 60 time-limited TCP places have been offered to Queensland.

Respite

- Where appropriate, an older person can be assessed for residential respite if they are unsure of their long-term accommodation options (even where there is no carer stress). While the primary aim of residential respite is giving a carer or care recipient a short-term break from their usual care arrangement, residential respite can be used by people following discharge from hospital while they make longer term care arrangements.

Dementia support

- Where placement in aged care homes may be being affected by behavioural and psychological symptoms of dementia (BPSD), health services are encouraged to talk with Dementia Support Australia (DSA) about how they can assist.
- DSA deliver the Dementia Behaviour Management Advisory Services (DBMAS) and Severe Behaviour Response Teams (SBRTs) as well as the eligibility assessment for the Specialist Dementia Care Program (SDCP).
- DSA Dementia Consultants can provide the following support:
    - individual transition support from hospital to aged care homes, including preparing receiving aged care homes with behaviour support planning and developing suitable activities through DBMAS, SBRTs and brokerage support. This can include increased funding initially to up staffing numbers and provide 1:1 care to help settle the person;
    - advise on the referral process for SDCPs, including the status of existing referrals for individuals within hospitals, as well as the availability of places in SDCP units;
    - develop recommendations to provide to staff working in the existing setting to assist with changed behaviours and work with staff in its implementation; and
    - can be part of the discharge planning team to provide input on transition support that can be offered, noting that DSA is unable to assist with finding suitable care homes or play a role in ‘convincing’ a care home to accept the person.

Aged Care Regional Network

- In order to strengthen governance of aged care and improve senior Australians’ local experience of aged care services, the Government is increasing the Department of Health staffing footprint in regional areas as part of the 2021-22 Budget. This will enable the Department to build a better understanding of senior Australians’ needs as well as aged care and other services including local hospital networks and workforce, to help identify areas of need, gaps in services, and the progress of changes to the system.

Other relevant aged care measures

- A number of aged care initiatives were announced in the 2021-22 Budget that will help reduce pressure on public hospitals. Specific details and figures for Queensland are not yet available.

Primary Care incentives

- The Practice Incentives Program (PIP) GP Aged Care Access Incentive (ACAI) aims to increase face-to-face GP services in residential aged care facilities. Improved regular access to primary care can prevent unnecessary complications that require admission to hospital.

The Australian Government has committed $42.8 million (2021-22 to 2022-23) to increase face-to-face servicing by GPs within residential aged care facilities.

Primary Health Network Aged Care measures

- Support through Primary Health Networks will assist residential aged care facilities (RACFs) to avoid unnecessary hospitalisations, through improved infrastructure to support on-site telehealth, and establishment of comprehensive after hours plans. Nationally consistent dementia and aged care referral pathways will support better community-based management of complex care needs, preventing complications that lead to hospitalisation.
- Commissioning of early intervention and monitoring activities to support better health and wellbeing will commence in early 2022 and will aim to reduce early entry into residential care, and also the need for acute care. The Australian Government has committed $178.9 million (2021-22 to 2024-25) to:
  - ensure RACFs have the right capabilities and equipment to enable best practice on-site telehealth care for residents
  - ensure RACFs have comprehensive after-hours care plans and arrangements in place to enable residents to access appropriate services whenever they need them
  - develop nationally consistent dementia and aged care referral pathways using the HealthPathways platform, to support clinical assessment and referral, as well as developing relevant dementia consumer health literacy resources
  - commission early intervention and monitoring activities to support senior Australians with better health and wellbeing and reduce early entry into residential care.

Supporting medication management in residential aged care

- The Australian Government will provide $45.4 million (2021-22 to 2024-25) to deliver enhancements to My Health Record to improve clinical information system interoperability and uptake in the aged care sector, as well as incentives for RACFs to adopt electronic National Residential Medication Charts (eNRMC). This will have the potential to improve quality use of medicines, which prevents complications leading to unnecessary admissions to hospital. Access to electronic records assists the transfer of essential clinical information during older people's transitions between residential aged care facilities, when entering and leaving hospitals.

Greater Choice for at Home Palliative Care

- The Australian Government has committed $37.3 million (2021-22 to 2024-25) to expand palliative care to all 31 Primary Health Networks, up from the 11 Primary Health Networks previously participating in the pilot. This will improve access to safe, quality palliative care and end-of-life services within a person's home across the country, including those living in residential aged care.

Ageing and aged care – quality standards reform review

- Improved quality and safety in aged care is likely to reduce people's need for acute care. As part of the Australian Government's immediate response to the Royal Commission into Aged Care Quality and Safety's Final Report, the Government through the 2021-22 Budget allocated $14.2 million over four years to support the review and enhancement of the Aged Care Quality Standards. The Government announced that it would:
  - urgently review the Quality Standards with a focus on governance, dementia, diversity, and food and nutrition by December 2022
  - appoint a new Assistant Commissioner for Sector Education and Capability in the Aged Care Quality and Safety Commission (Aged Care Commission) ad
  - transfer responsibility for setting the clinical components of the Quality Standards to the Australian Commission on Safety and Quality in Health and Aged Care (Health Commission) from 1 July 2021.

Access to aged care for communities with unmet needs

- In response to the Royal Commission, the Australian Government is investing $630.2 million to make the aged care system more accessible for senior Australians with specific needs. This includes:
  - Aboriginal and Torres Strait Islander people;
  - People who are experiencing homelessness or at risk of homelessness; and
  - People living in regional, rural, and remote Australia.
- New supports include:
  - Infrastructure: $397 million over 5 years for capital investment to enable aged care providers to make needed improvements to their buildings and build new services in areas where senior Australians currently do not have access, or where staff caring for their needs do not have suitable housing.
  - Funding rounds expected to commence in the second half of 2022.
  - Eligibility will extend to all locations but with an expected focus on improved access to services in regional and remote locations.

Disability services and supports

National Disability Insurance Scheme (NDIS)

- The National Disability Insurance Scheme (NDIS) was designed to support people with permanent and significant disability, originally estimated in 2015 to be up to 10 per cent of the 4.3 million Australians who have a disability. The NDIS is a world-first reform to the way disability support is provided, significantly increasing the funding available for disability services, and putting choice and control over how those services are delivered into the hands of people with disability. The *August 2011 Productivity Commission Inquiry Report into Disability Care and Support* identified key drivers for reform that disability services were underfunded, unfair, fragmented and inefficient with little choice and control for people with disability. The Productivity Commission's recommendation of an NDIS that should enable unified, national, long-term high quality care and support, offering certainty to people with disability, was accepted by all governments.
- The aim of the NDIS is to support the independence and social and economic participation of Australians with significant and permanent disability. The NDIS recognises that services and supports for NDIS participants is a responsibility shared with states and territories, and acknowledges that NDIS participants may require contributions from other service systems.
- In 2015 all governments agreed the principles to determine the responsibilities of the NDIS and other service systems, including the Applied Principles and Tables of Support (APTOS). These tables set out the responsibilities of the Commonwealth and state governments to provide a range of supports to people with disabilities, through both the NDIS and mainstream systems. The NDIS is intended to complement the vital role that mainstream service systems play in the lives of all Australians (including those with a disability). The APTOS can be viewed here: www.dss.gov.au/the-applied-principles-and-tables-of-support-to-determine-responsibilities-ndis-and-other-service.
- The NDIS funds disability supports that are found to be reasonable and necessary unless those supports are part of another service system's universal service obligation, or are covered by reasonable adjustment required under law dealing with discrimination on the basis of disability. In its August 2011 *Inquiry Report into Disability Care and Support*, the Productivity Commission highlighted the importance of this principle: 'it will be important for the NDIS not to respond to shortfalls in mainstream services by providing its own substitute services. To do so would weaken incentives for governments to properly fund mainstream services for people with disability, shifting the cost to another part of government. This approach would undermine the sustainability of the NDIS and the capacity of people with

disability to access mainstream services'.[6] The Commonwealth is committed to continuing to work together with states and territories to support the alignment of the NDIS with mainstream service systems.

NDIS expenditure and participant population in Queensland

- This Government's commitment to the NDIS is demonstrated across eight years of government, to fully funding the NDIS as a demand driven scheme. This commitment was most recently demonstrated with more than $17 billion in additional funding in the last two Budgets.
- Prior to the NDIS, combined Commonwealth and state and territory funding on services to support people with disability was around $7.9 billion. In the July 2021 to January 2022 period alone – only seven months - the NDIS made total payments of $15.29 billion to participants.
- State and territory contributions – which are defined in full scheme bilateral agreements struck with each state (excepting WA – this is expected to occur in 2022-23) – are fixed, with annual growth of 4 per cent. Although there is a commitment in the full scheme bilateral agreements for a review of costs in 2023 and again in 2028, it should be noted that the parties are only committed to "considering the outcomes" of these reviews.
    - Despite state and territory contributions increasing at 4 per cent per annum, it should be noted that scheme average participant cost (APC) growth has been at or around 12 per cent per annum over the last three years. Combined with growth in participant numbers overall, this has seen total expenditure on participant supports increase by 33 per cent between 2019-20 to 2020-21, and further projected to grow by 25 per cent this year from last year, and between 16 and 8 per cent each year for the next 4 years. The Commonwealth is responsible for the balance of scheme costs, and therefore bears all of the financial risk of the scheme costing more than expected.
- This year's MYEFO estimates, released in December 2021, provide for total expenses on supports for NDIS participants of $29.2 billion this financial year, reaching $41.4 billion in 2024-25. In 2021-22, the Commonwealth's expected contribution to the NDIS is $18.2 billion and the state contributions in total are expected to be $11.1 billion. Queensland's contribution is estimated at $2.213 billion, representing 34 per cent of estimated NDIS participant support costs of $6.502 billion in Queensland.
- In 2020-21 the Commonwealth contribution to the NDIS was $12.829 billion, with state contributions of $10.519 billion. Queensland's contribution was $2.095 billion, representing 42 per cent of NDIS costs in Queensland.
- The NDIA committed $6.7 billion in plans for NDIS participants residing Queensland which is approximately 21 per cent of the national NDIS funding commitment, of which $4.9 billion was spent by participants. This represents an average utilisation of 73 per cent in 2020-21, comparable to national utilisation also of 73 per cent. The average plan budget per NDIS participant residing in Queensland was $70,800 with the average amount spent $59,200.
- Nationally, as at 31 December 2021, there were 502,413 active participants with approved plans in the NDIS with 56 per cent of these participants receiving support for the first time.
- Of these participants, 102,458 resided in Queensland, representing about 20 per cent of active NDIS participants. Of this number:
    - 16 per cent were children aged under 7 years.
    - 9.6 per cent were Aboriginal and Torres Strait Islander (ATSI). This number is higher than the national proportion of ATSI participants in the NDIS which is 7 per cent.
    - 60 per cent of Queensland NDIS participants self-reported[7] accessing mainstream health and wellbeing supports.

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[6] Inquiry report - Disability Care and Support Productivity Commission (pc.gov.au)
[7] Archived quarterly reports 2020-21 | NDIS – Queensland Performance

- The figures above are taken from the NDIS Quarterly Report to disability ministers to 31 December 2021, which is a summary of the performance and operations of the NDIS for the past 3 months as required by the NDIS Act. The NDIS Quarterly reports to disability ministers include information on the growth of the Scheme; number of participants, growth in plan spend and market metrics, and are published on the NDIS website. Each Quarterly report includes appendices of state specific information, with information on Queensland at Appendix H in each report.

Regulation of NDIS supports by the NDIS Commission

- A core function of the NDIS Quality and Safeguards Commission (NDIS Commission) is to uphold the rights of, and promote the health, safety and wellbeing of, people with disability receiving supports or services, including those received under the National Disability Insurance Scheme (NDIS). The NDIS Commission has been focused on a range of specific health priorities since its inception, with a focus on ensuring that NDIS providers understand their obligations under the NDIS Code of Conduct and NDIS Practice Standards (for registered providers) to support participants in maintaining and protecting their health and wellbeing.
- The NDIS Commission does not regulate health services. The work of providers of Disability Related Health Supports are regulated by their relevant health board through the Australian Health Practitioner Regulation Agency (AHPRA). There are some NDIS items which can be provided by nurses or other clinicians. Where their work requires clinical registration they are also regulated by AHPRA. All other supports are required to meet the NDIS Code of Conduct and NDIS Practice Standards (for registered providers).
- NDIS providers who support participants for activities with higher or more complex clinical risk are required to adhere to NDIS Practice Standard Module 1 - High Intensity Daily Personal Activities (HIDPAs). The skills and capabilities of these HIDPAs are defined by a set of High Intensity Support Skills Descriptors (HISSDs). The NDIS Commission has recently contracted KPMG to provide an independent review of the HISSDs to ensure it is clear, consistent with best practice, manages clinical risk appropriately and aligns with other NDIS Commission resources providing guidance on similar activities, such as the NDIS Workforce Capability Framework. This review is scheduled to be complete in early 2022.
- The NDIS Commission continues to engage with Commonwealth departments and cross-jurisdictional processes to improve health outcomes and coordination. Recent examples where health interface strategies have been developed include:
    - Joining with the Australian Commission on Safety and Quality in Health Care (ACSQHC) and the Aged Care Quality and Safety Commission (ACQSC) to provide a coordinated response to the inappropriate use of psychotropic medications to manage behaviour, across the health, aged care and disability systems.
    - Deep engagement with the Department of Health in their development and implementation of the National Roadmap for Improving the Health of People with Intellectual Disability.
    - Engagement with the NDIA in their development and implementation of the Psychosocial Recovery Framework, including advice on quality and safety issues related to the service agreements they plan to develop with jurisdictional Mental Health Services.
    - Ongoing discussion and dialogue with Commonwealth, state and territory agencies concerned with the health and safety of people with disability, and any practice governance concerns that may need to be addressed.
    - Regular correspondence with the NDIA on regulatory, practice and competency issues for specific conditions or NDIS items.
- The core functions and safeguarding activities of the NDIS Commission are directly aimed at identifying health risks and improving the health and wellbeing of participants through monitoring, engaging and educating NDIS providers and taking compliance action where necessary. The NDIS Commission is also developing its data and analytics capacity to identify patterns where avoidable deaths and precursor health conditions can be prevented.

This work will inform educative and regulatory activities with NDIS providers to contribute to lowering the rates of chronic health conditions, fewer emergency presentations and inpatient admissions for people with disability in states and territories, including Queensland.

NDIS Data and Insights

- The NDIS Data and Insights website (available at https://data.ndis.gov.au) provides detail into specific areas, including participant outcomes, market data and deep dives into particular groups of participants. For example there are reports and insights available on:
    - Health and wellbeing of NDIS participants and their families and carers – the Health and Wellbeing report uses health and wellbeing data from the NDIS Outcomes Framework survey. This includes information about healthy living, mental health, how participants and families/carers rate their health, and access to health services. The survey measures the progress of participants, shows how the Scheme is improving the lives of participants, and areas for improvement.
    - Specialist Disability Accommodation (SDA) demand and information about the SDA-eligible participant cohort is regularly available. The data shows the current SDA supply, where the demand for SDA is greatest, and where there are opportunities for more SDA.
    - Market monitoring and reports compare a number of market indicators across geographical regions and participant characteristics. The NDIS Market Report provides insight into potential hot spots where investment might be required to better support participants. This report also shows where the NDIA is intervening in market hot spots to support participants to receive services.

Health and the NDIS

- State, and territory governments provide health services including most acute and psychiatric hospital services. Within the Australian health system, the private sector also delivers primary, specialist and allied health care. The Commonwealth government plays a key role in funding and provision of universal coverage for medical, pharmaceutical and public hospital services through Medicare, the Pharmaceutical Benefits Schedule and the National Health Reform Agreement.
- The NDIS provides funds to participants with significant and permanent disability to purchase disability supports required due to the impact of a person's impairment/s on their functional capacity and their ability to undertake activities of daily living, helping participants go about their daily life. This can include "maintenance" supports, given or supervised by qualified healthcare staff and long term therapy or support and is linked to the care and support a person requires to live in the community and participate in education and employment.[8]

Actions taken by Disability Ministers - NDIS health interface

- On 28 June 2019, Disability Ministers agreed to the funding of disability related health supports by the NDIS, for NDIS participants. Disability related health supports are supports that relate directly to the functional impact of a person's disability, distinct from supports to treat a health condition. Since 1 October 2019, additional disability-related health supports have been available to purchase using funding within NDIS plans. The typical types of support available have been grouped into eight 'support type' categories and may be delivered in a range of ways related to conditions related to the individual's disability.
- Some people with disability with complex support needs can experience difficulties accessing services across a range of needs including health, housing and disability supports. This can result in an extended stay in hospital when one or more their support needs cannot readily be met in the community. This is not new. The 2011 Productivity Commission report that led to the establishment of the NDIS cited examples of people experiencing protracted hospital stays in Western Australia and South Australia, with those in WA averaging more than 3 and

[8] Disability-related health supports | NDIS

half months in hospital, and those in SA more six months, with one patient hospitalised for three and a half years.

- Since the introduction of the NDIS, hospital discharge for people with disability has shifted from a responsibility shared between state and territory agencies to a responsibility shared between the NDIS and mainstream services including housing and health. While the numbers of NDIS participants nationally in hospital is relatively low as a proportion of overall hospital capacity, occupying around 2 per cent of public hospital capacity at any one time, coordinated efforts to enable prompt discharge for those medically ready to be discharged should be a priority across state and NDIS funded services.
- In the past, around 2000 people with disability aged under 65 years old were discharged from public hospitals each year into residential age care, for lack of more appropriate services. As the NDIS has been rolled out nationally, the number of younger people in residential aged care has progressively decreased from more than 6000 nationally in 2017-18 to 3,676 as at September 2021. The number of people under 65 newly entering residential aged care has declined by more than half compared to pre-NDIS figures.
- As at 10 January 2022, information compiled by the NDIA (based on data provided by hospitals to the NDIA) indicated that there were 373 NDIS participants in Queensland hospitals of which 206 were medically ready for discharge. Of those medically ready for discharge, 54 participants had an approved NDIS plan in place. Reasons for delayed discharge include that NDIA planning activities were still underway; lack of some supports; lack of safe and appropriate housing, delays with hospital assessments and allied health reports and in some cases, participants waiting access to mental health services.
- The NDIA is implementing a range of activities nationally to address the issues that contribute to discharge delays for NDIS participants, including:
  - Continued streamlining of access and planning approval processes for NDIS participants who are currently hospital in-patients or who are at risk of being readmitted to hospital following discharge;
  - Improvements to sharing of operational information between the NDIA and states and territories to identify NDIS participants currently in hospital or those at high risk of hospital admission;
  - The establishment of a designated senior executive position with oversight of NDIA responses to these issues, supported by a centralised NDIA hospital discharge team;
  - Appointment of more than 20 Health Liaison Offices nationally, who are providing assistance to NDIS participants medically ready for discharge.
- Early identification of people with disability entering hospital who may be at risk of an extended stay and early liaison with the NDIA, the person's disability support providers and family and, where relevant, their guardian or nominee, are essential to reducing extended hospitalisations due to issues with disability supports.
- In November 2021, the NDIA CEO wrote to senior officials in states and territories with departmental responsibility for operational arrangements for the discharge of NDIS participants, requesting an improved approach to managing NDIS participants in hospital. In January 2022, heads of state and territory health departments responded to the CEO's correspondence, welcoming the NDIA's approach. The NDIA has proposed bilateral meetings with each state and territory to discuss how improvements to data sharing and reporting may be effectively implemented.

Housing and the NDIS

- The Australian Government recognises that safe, affordable and suitable housing is essential for the economic, social and cultural wellbeing of all Australians, including people with disability. State and territory governments are primarily responsible for the provision of housing for people with disability, through public and community housing. A lack of appropriate housing, including mainstream accommodation, is one factor which may impact on NDIS participants transitioning from hospital into living independently in the community. While in June 2020 there were more than 155,000 households nationally on waiting lists for

public housing[9], there is little systematic information on how many of these include people with disability who are also NDIS participants. Given the high proportion of people with significant disability experiencing socio-economic disadvantage, it is reasonable to suppose that people with significant disability are a significant proportion of those in public housing and on public housing waiting lists.

- The NDIS funds a range of home and living supports for eligible NDIS participants through their NDIS plans, including Specialist Disability Accommodation (SDA), Medium Term Accommodation (MTA), home modifications and Independent Living Options. However, SDA is only funded for a small number of eligible NDIS participants who have extreme functional impairment or very high support needs. Currently approximately 6% of all participants nationally are expected to be assessed as eligible for SDA. As at 31 December 2021, 1,969 participants in Queensland received approximately $36 million in annualised SDA funding. This represents a 29 per cent increase in the number of participants receiving SDA in Queensland from the previous year (1,524 participants). However SDA is only for a small minority of NDIS participants. The NDIS is not responsible for meeting the accommodation needs of most NDIS participants.
- The number of dwellings enrolled as SDA in Queensland also increased by 38 per cent from December 2020 to December 2021, from 732 to 1,009 dwellings (excluding dwellings that form part of continued, "in-kind" service provision by Queensland). Over the same period, the number of new build SDA dwellings in Queensland increased by 82 per cent, from 326 dwellings to 592 dwellings. Demand for NDIS supports can be viewed at the following website for information: Discover demand by Post Code (dss.gov.au).

NDIS Workforce

- During the 2019-20 financial year, there were around 52,300 NDIS workers[10] in Queensland. This comprised around 3,700 allied health professionals, around 14,000 Community-based support workers, around 33,000 home-based support workers and around 1,600 in other occupations. Queensland currently has the third largest number of National Disability Insurance Scheme (NDIS) workers nationally and accounts for approximately 18 per cent of the NDIS workforce. Commonwealth Department of Social Services modelling forecasts continued growth of the NDIS workforce in Queensland will be needed due to continued growth in the number of NDIS participants. The Australian Government are undertaking a range of activities to ensure there is a responsive and capable workforce to support the disability sector. These activities include strengthening entry pathways and promoting the benefits of working in the care and support sector to attract more workers; training and supporting the workforce; and encouraging the effective operation of the market including reducing red tape.
- The *NDIS National Workforce Plan: 2021-2025* (the Workforce Plan), launched on 10 June 2021 by the Minister for the NDIS, Senator the Hon Linda Reynolds CSC, provides the framework for these activities. Disability support, aged care and veterans' care programs are highly connected, with over a third of providers operating across all three areas. Many of the priorities in the Workforce Plan are targeted at the NDIS workforce, including allied health, while greater alignment with the care and support sector will strengthen the overall care and support market and workforce.

Australia's Disability Strategy 2021-2031

- Australia's Disability Strategy 2021-2031 was launched by the Australian Government on 3 December 2021. It sets out the national policy framework all governments have agreed for people with disability to attain the highest possible health and wellbeing outcomes throughout their lives, under which governments will focus on identified policy priorities. The three health focused priorities are:

[9] Housing assistance Overview - Australian Institute of Health and Welfare (aihw.gov.au)
[10] The NDIS Commission defines an NDIS worker "as a worker is anyone who is employed or otherwise engaged to provide NDIS supports and services to people with disability. Workers can be paid or unpaid, and can be people who are self-employed, employees, contractors, consultants, and volunteers." Workers | NDIS Quality and Safeguards Commission (ndiscommission.gov.au)

1. All health service providers have the capabilities to meet the needs of people with disability
2. Prevention and early intervention health services are timely, comprehensive, appropriate and effective to support better overall health and wellbeing
3. Mental health supports and services are appropriate, effective and accessible for people with disability

- Australia's Disability Strategy sets the framework for how Commonwealth and state and territory mainstream service systems (including health systems) will support all Australians with disability.
- The Outcomes Framework of the Strategy will measure, track and report on outcomes for people with disability. Health system measurements include the provision of high-quality hospital, allied health, primary care and mental health services to people with disability. Outcomes measures will include increases in health, long-term wellbeing and mental health for people with disability.
- Australia's Disability Strategy 2021-2031 includes a safety element and is accompanied by a Safety Targeted Action Plan to strengthen safeguards for people with disability. The Targeted Action Plan is aimed at improving supports and protections across services systems, including health, housing, education, employment services, domestic family and sexual violence services, child protection, justice, transport systems and the NDIS. The Targeted Action Plan was recently endorsed by Disability Minister's out of session and released on 3 December 2021.

Private health care system

- The Australian Government does not employ doctors or other health practitioners to deliver services on its behalf. Instead, funding is provided in the form of rebates to patients under the Medicare Benefits Schedule (MBS), and tax rebates for private health insurance. In both these systems, this provides choice to patients on where they seek care, and through which providers. Private hospitals are regulated by state and territory governments, including where they are located.
- The Australian Government remains committed to improving access to health and hospital services so that all Australians receive appropriate health care when and where they need it in all states and territories.
- In 2020-21, over 456 million Medicare funded services were provided by providers to private patients nationally at a cost of $27.5 billion. Of these, 81 per cent of all Medicare services were bulk-billed. A comparison between total services provided under Medicare in Australia and Queensland is below.

2020-21	Services	Benefits	Bulk billing Rate
Australia	465,870,553	$27,478,014,416	81.0 per cent
Queensland	95,429,954	$5,699,929,145	80.8 per cent

Diagnostic imaging services

- In 2020-21, over 29 million diagnostic imaging services were funded nationally through Medicare at a cost of $4.5 billion. Of these, 80.9 per cent of all diagnostic imaging services were bulk-billed. A comparison between diagnostic imaging services provided under Medicare in Australia and Queensland is provided below.

2020-21	Services	Benefits	Bulk billing rate
Australia	29,830,356	$4,450,113,915	80.9 per cent
Queensland	6,503,251	$980,140,486	83.3 per cent

- In the 2021-22 Budget, the Government announced that it would index Medicare rebates for magnetic resonance imaging (MRI) services from 1 July 2022, resulting in more than 97 per cent of diagnostic imaging services being indexed from 1 July 2022.

Pathology services

- In 2020-21, over 167 million pathology services were funded nationally through Medicare at a cost of $3.9 billion. Of these, 90 per cent of all pathology services were bulk-billed. For patients who were not admitted to hospital, the Medicare bulk-billing rate for pathology was 99.6 per cent. A comparison between pathology services provided under Medicare in Australia and Queensland is provided below.

2020-21	Services	Benefits	Bulk billing rate	Out of hospital bulk-billing rate
Australia	167,394,751	$3,920,208,565	90.0 per cent	99.6 per cent
Queensland	34,095,142	$796,039,798	89.6 per cent	99.7 per cent

Private health insurance membership

- As at 30 September 2021[11]:
  - 2.1 million people in Queensland were covered by hospital treatment policies, representing 41.0 per cent of the Queensland population. This compares with 44.7 per cent of the total Australian population covered by hospital treatment policies.
  - 2.5 million people in Queensland were covered by general treatment policies, representing 47.9 per cent of the Queensland population. This compares with 54.5 per cent of the total Australian population covered by general treatment policies.
- There has been a sustained increase in hospital treatment membership in both Queensland and Australia over the last five quarters to 30 September 2021. Hospital treatment membership increased by 60,415 persons in Queensland and by 308,954 persons nationally.

Medical workforce

- In 2020 there were 695 medical graduates from Queensland universities – around 23% of the total 3,066 domestic graduates from Australian medical schools.
- The National Medical Workforce Strategy that is nearing finalisation will guide long-term collaborative medical workforce planning across Australia, and will identify achievable, practical actions to build a sustainable, highly trained medical workforce. The Strategy will be a key driver of reform and consists of five complementary priority areas that will drive the actions needed to achieve the Strategy's vision. They are:
  4. Collaboration on planning and design
  5. Rebalance supply and distribution
  6. Reform the training pathway
  7. Building the generalist capability of the medical workforce
  8. A medical workforce that is supported to thrive and train and work flexibly
- In addition to these priority areas, there are three other cross cutting issues to consider - supporting the Aboriginal and Torres Strait Islander workforce and improving cultural safety, changing models of care and doctor wellbeing. Issues such as geographic distribution, collaborative workforce planning and flexibility in training and education for Australia's medical workforce will be key considerations for the Strategy and the Medical Workforce Reform Advisory Committee, in both the short and long term.
- State and territory Health Ministers are currently considering the draft Strategy for approval.

[11] Source: APRA Quarterly private health insurance statistics, September 2021

Specialist Training Program

- The Australian Government's Specialist Training Program (STP) seeks to extend vocational training for specialist medical registrars into settings outside traditional metropolitan teaching hospitals, including regional, rural and remote and private facilities.
- In 2020, the Australian Government provided approximately $31.4 million in funding to specialist medical training in Queensland under the STP, as follows:
  - 215.6 full time equivalent (FTE) places under the core STP across a broad range of specialties including Dermatology, Anaesthesia, Anatomical Pathology, Emergency Medicine, General Paediatrics, Infectious Diseases, Microbiology, Ophthalmology, Obstetrics and Gynaecology, Psychiatry and Radiology (approximately $28 million); and
  - 23 FTE places under the Integrated Rural Training Pipeline across a broad range of specialties including Anaesthesia, Emergency Medicine, General Paediatrics, Psychiatry, Sports and Exercise Medicine and Radiology (approximately $3.4 million).