



**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**

**Report No. 18, 57th Parliament  
Health and Environment Committee  
April 2022**

## Health and Environment Committee

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### Acknowledgements

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All web address references are current at the time of publishing.

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<sup>1</sup> During the inquiry, Mr Jarrod Bleijie MP, Member for Kawana, Mr Trevor Watts MP, Member for Toowoomba North, Mr Stephen Bennett MP, Member for Burnett and Mr Lachlan Millar MP, Member for Gregory, acted as substitute members on the committee for Dr Mark Robinson MP, Member for Oodgeroo. On 17 March 2022, Dr Robinson MP was replaced on the committee by Mr Sam O'Connor MP, Member for Bonney.

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## Abbreviations

AAC	Allied Aged Care
ACAT	Aged Care Assessment Team
ACN	Australian College of Nursing
ACRRM	Australian College of Rural and Remote Medicine
ACT	Australian Capital Territory
AGPT	Australian General Practice Training program
AHPA	Allied Health Professions Australia
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
AMAQ	Australian Medical Association Queensland
AMDS	Approved Medical Deputising Services
AN-ACC	Australian National Aged Care Classification
APA	Australian Physiotherapy Association
APS	Australian Psychological Society
APTOS	Applied Principles and Tables of Support
CCHS	Aboriginal and Torres Strait Islander Community Controlled Health Services
CGS	Commonwealth Grants Scheme
CHA	Catholic Health Australia
COAG	Council of Australian Governments
Committee	Health and Environment Committee
COTA Queensland	Council on the Ageing Queensland
CPD	Continuing professional development
CSP	Commonwealth Supported Places
CSU	Charles Sturt University
DBMAS	Dementia Behaviour Management Advisory Services
DD-SW MP	Darling Downs – South West Medical Pathway
DESE	Department of Education Skills and Employment
DPA	Distribution Priority Area

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DSA	Dementia Support Australia
DSDSATSIP	Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships
DVA	Department of Veterans' Affairs
DWS	Districts of Workforce Shortage
ESSA	Exercise and Sport Science Australia
FACRRM	Fellowship of the Australian College of Rural and Remote Medicine
FARGP	Fellowship of the Royal Australian College of General Practitioners and Fellowship of Advanced Rural General Practice
FRACGP	Fellowship of the Royal Australian College of General Practitioners
FTE	Full-time equivalent
Full Scheme Agreement	Bilateral Agreement between the Commonwealth of Australia and Queensland on the National Disability Insurance Scheme
GP	General practitioner
GPMP	General Practitioner Management Plans
GPTQ	General Practice Training Queensland
GST	Goods and services tax
HCDSDFVP Committee	Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee
HHS	Hospital and Health Service
HNA	Health Needs Assessment
HSU	Health Services Union
HWA	Health Workforce Australia
HWQ	Health Workforce Queensland
IAHP	Indigenous Australians' Health Program
IMG	International medical graduate
Inquiry	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
IUIH	Institute for Urban Indigenous Health
IWC	Indigenous Wellbeing Centre
JCU	James Cook University
Joint Submission	Joint submission from health charities and non-government organisations

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LANA	Local Area Needs Assessment
LHC	Lifetime health cover
LSRR	Long-Stay Rapid Response
MBS	Medicare Benefits Schedule
MDMSN	Murray Darling Medical Schools Network
MHAOD	Mental health, alcohol and other drugs
MLS	Medicare levy surcharge
MMM	Modified Monash Model
MTA	Medium Term Accommodation
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NHRA	National Health Reform Agreement 2020-2025
NPS	National Priority Scheme
NSW	New South Wales
OPAN	Older Persons Advocacy Network
OTA	Occupational Therapy Australia
PBS	Pharmaceutical Benefits Scheme
PHN	Primary Health Network
PIP	Practice Incentives Program
POQA	<i>Parliament of Queensland Act 2001</i>
PPH	Potentially preventable hospitalisation
PSA	Pharmaceutical Society of Australia
QCAT	Queensland Civil and Administrative Tribunal
QLS	Queensland Law Society
QNADA	Queensland Network of Alcohol and Other Drugs Agency
QNMU	Queensland Nurses and Midwives' Union
QPC	Queensland Productivity Commission
QPHN	Queensland Primary Health Networks
QRGP	Queensland Rural Generalist Program
QRRPHN	Queensland Rural and Remote Primary Health Networks

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RACF	Residential aged care facility
RACGP	Royal Australian College of General Practitioners
RaSS	Residential Aged Care Support Services
RDAQ	Rural Doctors Association of Queensland
Royal Commission	Royal Commission into Aged Care Quality and Safety
RRMBS	Rural and Remote Medical Benefits Scheme
RTHs	Regional Training Hubs
RTO	Regional Training Organisations
RWA	Rural Workforce Agency
SARRAH	Services for Australian Rural and Remote Allied Health
SBRT	Severe Behaviour Response Team
SDA	Specialist Disability Accommodation
SDCP	Specialist Dementia Care Program
SMO	Senior medical officer
TCA	Team Care Arrangements
TCP	Transition Care Program
the 10-year plan	The Australian Government's Primary Health Care 10 Year Plan
UWU	United Workers Union
UQ	University of Queensland
UQ Faculty of Medicine	University of Queensland, Faculty of Medicine
WB-CQ RMP	Wide Bay and Central Queensland Regional Medical Pathway
WIP	Workforce Incentive Program

All Acts are Queensland Acts, unless otherwise specified.

## Chair's foreword

As Chair of the Health and Environment Committee, it gives me pleasure to deliver this important report to the Queensland Parliament.

The committee's inquiry was broad ranging, delving into the current provision of primary, allied and private health care and aged and NDIS care services and its impacts on Queensland's public health system.

From the outset, I want to acknowledge the many submitters, healthcare professionals and members of the public who contributed to the inquiry, either by writing a submission or attending one of the public hearings held across Queensland.

I want to apologise to the good people of Hervey Bay and Emerald, where the committee had to cancel scheduled public hearings at short notice. The recent challenges of the South East Queensland flood disaster certainly affected the committee's ability to hear from everyone who wished to be heard.

There cannot be any doubt about the impacts of the COVID-19 pandemic on our health system. I must acknowledge the extraordinary efforts made by our health workers across the State who have continued to deliver professional and dedicated health care to Queenslanders over the last 2 years.

As outlined in this report, the lack of access to primary and allied health care and to medical care in aged care and home care, thousands still waiting for assessment on Home Care and NDIS packages, and an ageing and growing population have each contributed to placing more pressure on Queensland's public health system.

In regional cities, remote towns or busy metropolitan areas, we often heard the term 'provider of last resort' to describe people accessing care in their public hospitals, due to a lack of primary and allied health care.

In my own hometown of Townsville, on each day our local public hospital Emergency Department can and will see over 250 people per day, with many walking in due to their inability to access a GP or afford the gap payment in accessing private health care in a private hospital Emergency Department, (which is only open until 11.00pm).

The reality is that this is simply unsustainable.

More must be done, and as a matter of urgency, to address the many recommendations made in this report and by the former Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee (HCDSDFVP Committee) in its Report No.33, 56<sup>th</sup> Parliament – Aged care, end-of-life and palliative care (Report No.33, 56<sup>th</sup> Parliament).

The Australian Government is responsible for aged care and primary health care, and quite frankly both need fundamental improvements in accessibility, availability and funding. Over 39,000 transports by the Queensland Ambulance Service, out of Queensland's 459 residential aged care facilities to public hospitals, in the last 12 months should flag concern about the fundamental lack of care available in privately run aged care facilities.

Which brings me to my next point. Two years ago (March 2020) the HCDSDFVP Committee tabled its Report No.33, 56<sup>th</sup> Parliament, in which it made a number of recommendations to the Australian Government to address issues in aged and palliative care.

To have had no response from the Australian Government on any of these recommendations troubles me greatly, and it should send a signal to the people of Queensland that the Australian Government appears to have absolved itself of responsibility when it comes to aged care. I note that the HCDSDFVP Committee shared many of its findings with the Royal Commission into Aged Care and Safety.

As the former Chair of the HCDSDFVPC, I am extremely disappointed that the Australian Government did not see fit to respond to this important work of a bi-partisan committee of the Queensland Parliament. I ask again that the Australian Government takes this work seriously. To this end, this report recommends that the Australian Government provides its response as a matter of urgency.

I want to acknowledge and thank the hard working members of the committee who provided substantial contributions to this report and acknowledge the bi-partisan approach to the final recommendations. I applaud the consensual approach adopted by all members, but particularly non-government members of the committee.

I hope this report provides the reader with an insight into the current pressures placed on Queensland's public health system and the opportunities that exist to address these issues which are felt not just in Queensland, but nationwide.

Finally, I would like to thank and acknowledge the Health and Environment Committee secretariat for their hard work, professionalism and dedication in helping prepare this report to the Parliament.

I commend this report to the House.



Aaron Harper MP

Chair

## Recommendations

### **Recommendation 1 – Removal of funding cap and adoption of 50/50 contribution funding model for public hospital system** **12**

The committee recommends that the Australian Government agrees to:

- remove the current 6.5 per cent per annum growth cap on Australian Government funding for public hospitals
- adopt a 50/50 contribution model between the Australian and State and Territory Governments for the funding of the public hospital system.

### **Recommendation 2 – Australian Government to pay fair share of cost of lower acuity emergency department presentations** **24**

The committee recommends that the Australian Government funds the costs incurred by the Queensland public health system of lower acuity presentations to emergency departments, which could have been more appropriately dealt with in a primary care setting.

### **Recommendation 3 – Australian Government to pay fair share of cost of potentially preventable hospitalisations** **30**

The committee recommends that the Australian Government funds the cost of potentially preventable hospitalisations in Queensland's public hospitals in order to incentivise reforms to primary health care policy and funding models aimed at reducing potentially preventable hospitalisations.

### **Recommendation 4 – Australian Government to reimburse costs of excessive long-stay patients due to delays in accessing aged care services** **34**

The committee recommends that the Australian Government establishes arrangements for Queensland's Hospital and Health Services to be reimbursed for the cost of excessive length of patient stays in public hospitals caused by a lack of access to aged care services.

### **Recommendation 5 – Collaboration to improve hospital discharge arrangements (older patients)** **34**

The committee recommends that the Australian and Queensland Governments collaborate to improve discharge arrangements and post-hospitalisation care planning (including the timely completion and availability of discharge documents) between public hospitals, allied and primary health service providers, residential aged care facilities and providers of other aged care services, such as home care packages, to reduce the number of older persons becoming long-stay patients in public hospitals.

### **Recommendation 6 – National Disability Insurance Agency to reimburse costs of excessive long-stay patients due to delays in accessing services** **37**

The committee recommends that the Australian Government commits to the National Disability Insurance Agency reimbursing Queensland's Hospital and Health Services for excessive length of patient stays in hospital caused by delays in accessing National Disability Insurance Scheme care services.

**Recommendation 7 – Queensland Health to collaborate with Hospital and Health Services to review hospital discharge practices** 39

The committee recommends that Queensland Health, in collaboration with the Hospital and Health Services, reviews the current hospital discharge practices, especially in relation to patients who have been transferred long distances to attend hospital and to improve processes to produce discharge summaries.

**Recommendation 8 – Assessment and increased transparency of the availability and accessibility of primary and allied health care** 59

The committee recommends that the Australian Government:

- establishes rigorous and transparent methods to assess the availability, accessibility and affordability of primary and allied health care across Queensland
- publishes the results of the assessments on a regular basis, broken down by each Primary Health Network region in Queensland.

**Recommendation 9 – Medicare Benefits Scheme funding for services that are essential in regional, rural and remote areas and identified outer metropolitan areas of need** 73

The committee recommends that the Queensland Government requests that the Medicare Benefits Schedule Review Advisory Committee reinstates immediately Medical Benefits Scheme items for services that are essential in regional, rural and remote areas and identified outer metropolitan areas of need, including reading an electrocardiogram (ECG), and reviews whether any other items should be added to assist the provision of quality primary and allied health care in these settings.

**Recommendation 10 – Increased number of Medicare Benefits Scheme-funded allied health visits** 77

The committee recommends that the Australian Government reviews the current limit of five Medicare-funded allied health visits per annum, under the General Practitioner Management Plans or Team Care Arrangements, to ensure that patients have appropriate access to allied health care to manage ongoing chronic conditions.

**Recommendation 11 – Improving accessing to allied health services** 77

The committee recommends that the Australian Government reviews the current requirement for general practitioners to complete General Practitioner Management Plans or Team Care Arrangements, with a view to enabling appropriately qualified allied health professionals to undertake this task to increase efficiencies and promote patient access to allied health care.

**Recommendation 12 – Review and comprehensive reform of the Medicare Benefits Scheme** 81

The committee recommends that the Australian Government, as part of the *Primary Health Care 10 Year Plan* process, reviews the current Medicare Benefits Scheme system and commits to reforming the method of funding primary and allied health care. The review should consider the following issues:

- the reversal of the impact of the Medicare rebate freeze and ensuring that Australian Government funding of primary and allied health increases year-on-year at least in line with the Consumer Price Index
- the introduction of blended payments and performance based and pooled funding to promote innovative models of care and a greater focus on early intervention and preventive care

- how to ensure a focus on person-centred, high quality, holistic and integrated care, including facilitating longer general practitioner consultations and the use of multidisciplinary teams
- the funding of counselling services under the MBS
- the removal of rebate differentiation between MBS items based on provider status
- how to ensure that patients have appropriate access to allied health care to manage ongoing chronic conditions
- incentives for general practitioners to provide after-hours services and conduct home visits by ensuring that they are appropriately recompensed for the service
- incentives for general practitioners to provide primary care in aged care settings, including after-hours services
- incentives to optimise the delivery of primary and allied health services in rural and remote areas and outer metropolitan areas of need
- incentives to promote the teaching and training of health professionals in primary and allied health care settings
- the funding of nurses, nurse practitioners and midwives to work to their full scope of practice (eg nurse continence specialists), and provide valuable services to the community in a primary care setting.

**Recommendation 13 – Additional Commonwealth Supported Places for medical programs 116**

The committee recommends that the Australian Government allocates additional Commonwealth Supported Places to the James Cook University, University of Queensland and Griffith University medical programs to enable them to continue, and expand, their programs, pathways and courses aimed at ensuring a sustainable regional, rural and remote medical workforce.

**Recommendation 14 – Australian and Queensland Governments to investigate feasibility of establishing schools of medicine in major regional centres 117**

The committee recommends that the Australian and Queensland Governments collaborate to investigate the expansion of facilities and operations at Cairns, Rockhampton and Toowoomba with a view to establishing university and TAFE supported Schools of Medicine for primary and allied health services.

**Recommendation 15 – Review of the Australian General Practice Training program 121**

The committee recommends that the Australian Government undertakes a comprehensive review of the Australian General Practice Training program, in the context of the *Primary Health Care 10 Year Plan* and the *National Medical Workforce Strategy 2021-2031*, to ensure that the delivery of general practice training achieves the objective of creating a sustainable general practice workforce in rural and remote areas.

**Recommendation 16 – Continued collaboration with James Cook University in delivery of Australian General Practice Training program 121**

The committee recommends that the Australian Government commits to continuing the existing collaboration with James Cook University, which has ensured that general practice training takes place in smaller regional, rural and remote Queensland towns, once responsibility for the delivery of training is transferred to the relevant colleges.

**Recommendation 17 – Review and replacement of the Distribution Priority Areas classification system** **127**

The committee recommends that the Australian Government reviews the mechanism for addressing shortages of medical practitioners in specific communities and replaces the Distribution Priority Areas classification system with a fit-for-purpose scheme that recognises supply side factors and local community health needs.

**Recommendation 18 – Accountability and transparency of the Distribution Priority Areas classification system** **127**

The committee recommends that the Australian Government publishes, as soon as practicable, details of the factors considered, and how decisions are made, under the Distribution Priority Areas classification system, including decisions on applications for the new exceptional circumstances review, to improve transparency and accountability and better inform local communities and applicants.

**Recommendation 19 – Initiatives to promote recruitment, training and retention of a regional, rural, remote health workforce** **131**

The committee recommends that the Australian Government considers the recommendations and initiatives contained in this report about recruiting, training and retaining a health workforce to service regional, rural, remote areas and identified outer metropolitan areas of need, as part of its *Primary Health Care 10 Year Plan* and the recommended National Health Workforce Strategy (recommendation 22), to ensure that a comprehensive, long-term strategy is in place to create a sustainable health workforce in these areas.

**Recommendation 20 – Australian and Queensland Government to review visa requirements and offers and packages available to encourage health professionals to work in regional, rural and remote areas** **131**

The committee recommends that the Australian and Queensland Governments review the current visa requirements, and offers and packages available, to encourage more primary and allied health specialists, doctors and aged care workers to regional, rural and remote areas of Queensland and increase their length of tenure in these areas.

**Recommendation 21 – Capital investment in accommodation for students** **131**

The committee recommends that the Australian and Queensland Governments, in partnership, consult with individual Hospital and Health Services, to provide capital investment for affordable and accessible accommodation for medical, allied health and nursing students to use during their studies and placements in rural and remote areas, as part of a broader accommodation strategy.

**Recommendation 22 – Establishment of National Health Workforce Strategy** **133**

The committee recommends that the Australian and Queensland Governments commit to collaborating to produce a National Health Workforce Strategy to review the suite of Commonwealth and State Health Workforce programs as they apply to primary and allied health providers, including general practice, and the rural and remote health workforce.

The strategy should address the entire training continuum from undergraduate through to ongoing professional development once health practitioners are fully qualified and the incentives and supports needed to produce a sustainable health workforce, particularly in rural and remote areas.

**Recommendation 23 – Review of effectiveness of the Primary Health Networks model 137**

The committee recommends that the Australian Government commissions an independent review of the effectiveness of the Primary Health Networks in discharging their key functions and responsibilities, including how the recent allocation of \$1 billion to Primary Health Networks in Queensland will be spent and the expected outcomes.

**Recommendation 24 – Transparency and accountability for funding and services delivered by Primary Health Networks 141**

The committee recommends that the Australian Government:

- establishes measures to assess the efficacy of services commissioned, or delivered, by Primary Health Networks
- publishes information about the amount of funding provided by service and the outcomes achieved.

**Recommendation 25 – Short-term funding of Primary Health Networks 141**

The committee recommends that the Australian Government reviews the current short-term funding model for Primary Health Networks to ensure programs can be delivered over a sustained period of time to maximise their capacity to make a real, long-term difference to the lives of individuals.

**Recommendation 26 – Queensland Government to provide a progress update on implementation of recommendations 154**

The committee recommends that the Queensland Government provides a progress update on the implementation of recommendations contained in the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Report No. 33, 56th Parliament – Aged care, End-of-life and Palliative Care report.

**Recommendation 27 – Australian Government respond to previous recommendations 159**

The committee recommends that the Australian Government responds to the following recommendations contained in the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Report No. 33, 56th Parliament – Aged care, End-of-life and Palliative Care:

***Recommendation 3 - Review of item numbers for visits by general practitioners to residential care***

*The committee recommends that the Australian Government review the schedule of item numbers that general practitioners, specialists and other allied health professionals can access to claim the costs of care they provide for patients, and their travel to and from residential aged care facilities or patients' homes and the formula used for calculating payment amounts. In reviewing the formula, the government should ensure the formula provides reasonable compensation for doctors and other health professionals for their time whilst removing incentives for practitioners to bulk visit facilities.*

**Recommendation 28 – Australian Government to respond to previous recommendations 162**

The committee recommends that the Australian Government responds to the following recommendations contained in the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Report No. 33, 56th Parliament – Aged care, End-of-life and Palliative Care:

***Recommendation 1 Trial of nurse practitioners***

*The committee recommends that the Australian Government allocate funding through the Primary Health Networks in Queensland to trial the use of nurse practitioners in residential aged care facilities. The trial could include expanding their scope of practice to prescribe certain medications and order certain pathology testing for residents in consultation with general practitioners.*

***Recommendation 2 Consistency of access to health services while in residential aged care***

*The committee recommends that the Australian Government in consultation with individual providers ensure that residents in residential aged care facilities enjoy the same level of access to health service providers as other elderly in their local community living outside of those facilities.*

***Recommendation 4 Care for frail elderly residents in aged care facilities***

*The committee recommends that Queensland Health examine opportunities to expand programs such as the Comprehensive Aged Residents Emergency and Partners in Assessment Care and Treatment program that focus on streamlining the care pathway for the frail elderly residents of aged care facilities.*

***Recommendation 5 Utilisation of nurse navigators in aged care to improve access to primary care***

*The committee recommends that the Queensland Government explore opportunities to better utilise nurse navigators in aged care to improve access to primary care for older people and supplement the care provided by general practitioners.*

**Recommendation 29 – Australian Government to respond to previous recommendations 168**

The committee recommends that the Australian Government responds to the following recommendations contained in the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Report No. 33, 56th Parliament – Aged care, End-of-life and Palliative Care:

***Recommendation 20 Disclosure of staff to resident ratios at residential aged care facilities***

*The committee recommends that the Australian Government require providers to display in a public common area at each residential aged care facility the staff to resident ratios at that facility across each shift, for the information of residents, prospective residents and their representatives.*

***Recommendation 21 Publication of staff to resident ratios on the My Aged Care website***

*The committee recommends that the Australian Government require that information about residential aged care facilities that is published in the Schedule to the My Aged Care website includes staff to resident ratios at each of those facilities.*

**Recommendation 41 Better pay and conditions for aged care workers**

*The committee recommends that the Australian Government raise the minimum pay and conditions of employment for personal carers, nurses, administrators and other workers in the aged care industry to levels equivalent to their peers in the health sectors.*

**Recommendation 30 – Australian Government to respond to previous recommendations 175**

The committee recommends that the Australian Government responds to the following recommendations contained in the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Report No. 33, 56th Parliament – Aged care, End-of-life and Palliative Care:

**Recommendation 10 Increased funding for the Home Care Packages Program**

*The committee recommends that the Australian Government significantly increase the level of funding it provides to the Home Care Packages Program to ensure packages are sufficient to meet the costs of the required hours of care required for each level package, to clear the current backlog of packages that haven't been provided.*

**Recommendation 11 Removal of caps on Home Care Packages**

*The committee recommends that the Australian Government remove its cap on the number of packages available, at all levels, and provides as many packages as are needed.*

**Recommendation 12 Clearing of backlog in Home Care Packages that have not provided**

*The committee recommends that the Australian Government clear the current backlog of packages that haven't been provided.*

**Recommendation 13 Maximum waiting times for Home Care Packages**

*The committee recommends that the Australian Government ensure wait times for packages are reduced to a maximum of three months for delivery of all packages across all levels from the date of approval.*

**Recommendation 14 Access to interim care while waiting for Home Care Packages**

*The committee recommends that the Australian Government commit to provide interim care arrangements, close to the approved package level, for applicants for home care packages while waiting for their package to be provided.*

**Recommendation 31 – Australian Government reviews aged care and NDIS care service provider practices to ensure funds are spent on direct care, rather than case management and administration fees 176**

The committee recommends that the Australian Government reviews the practices of aged care and NDIS care service providers to ensure that Home Care Package and NDIS care funds are spent on direct care and not case management and administration fees.

As part of the review, the committee recommends that the Australian Government considers:

- the introduction of caps for case management and administration fees charged by service providers

- the adequacy of existing consumer protections for people receiving home care packages and NDIS care services.

**Recommendation 32 – Collaboration to improve interface between the National Disability Insurance Scheme and public health system 193**

The committee recommends that the Australian and Queensland Governments collaborate to improve discharge practices, including the appointment of additional NDIS Nurse Navigators, and other initiatives to improve the interface and communication between the National Disability Insurance Scheme and public health system.

**Recommendation 33 – Increased investment in specialist disability accommodation 196**

The committee recommends that the Australian Government increases investment in building specialist disability accommodation, particularly in rural and remote areas, to ensure that National Disability Insurance Scheme participants with complex needs have an appropriate place to live, where their needs can be met.

**Recommendation 34 – NDIS National Workforce Plan 198**

The committee recommends that the Australian Government considers the issues raised by submitters about key shortages in the NDIS workforce and the impact this has on hospital discharges, as part of the *NDIS National Workforce Plan: 2021-2025*.

**Recommendation 35 – Continued funding of Assessment and Referral Team program 200**

The committee recommends that the Australian Government commits continued funding to the Assessment and Referral Team program to assist health consumers to access National Disability Insurance Scheme care services.

**Recommendation 36 – Australian and Queensland Governments to increase investment in preventive health 209**

The committee recommends that the Australian and Queensland Governments increase investment in preventive health, education and support services, so that it accounts for five per cent of total health expenditure across Australian, state and territory governments by 2030, in accordance with the *National Preventive Health Strategy 2021-30*.

**Recommendation 37 – Queensland Government investment in early intervention programs 209**

The committee recommends that the Queensland Government explores options to further invest in early intervention programs in primary care to prevent chronic conditions, such as heart disease and diabetes, and mental health conditions, to reduce the burden of these diseases and conditions and reduce the impact on the public health system.

**Recommendation 38 – Increased investment in primary health clinics and health hubs 214**

The committee recommends that the Australian and Queensland Governments explore partnership arrangements to increase capital investment in primary health clinics and health hubs to deal with low acuity presentations that are currently falling on emergency departments.

**Recommendation 39 – Australian Government and Queensland Health to collaborate to explore opportunities to expand Residential Aged Care Support Services, or similar type services** **217**

The committee recommends that the Australian Government and Queensland Health collaborate to explore partnership opportunities with aged care providers to expand Residential Age Care Support Services, or other similar services, to all Hospital and Health Service regions and service areas across Queensland.

**Recommendation 40 – Scope of practice and nurse-led models of care** **225**

The committee recommends that the Australian and Queensland Governments collaborate to explore opportunities to:

- increase the scope of practice of nurses and nurse practitioners in primary health care settings
- consider trialling nurse-led and nurse practitioner-led models of care and walk-in-clinics for low acuity episodes of care, similar to the model adopted in the Australian Capital Territory.

## 1 Introduction

### 1.1 Role of the committee

The Health and Environment Committee (committee) is a portfolio committee of the Legislative Assembly which commenced on 26 November 2020 under the *Parliament of Queensland Act 2001* (POQA) and the Standing Rules and Orders of the Legislative Assembly.<sup>2</sup>

The committee's primary areas of responsibility include:

- Health and Ambulance Services
- Environment, Great Barrier Reef, Science and Youth Affairs.

The POQA provides that, in addition to its function of examining legislation, performing its public accounts and public works role and considering Appropriation Bills, the committee is responsible for dealing with any issue referred to it by the Legislative Assembly or under another Act.

The committee must also deal with an issue referred to it by the Legislative Assembly, or under another Act, regardless of whether or not the issue is within its portfolio area.<sup>3</sup>

### 1.2 Inquiry and referral process

On 17 November 2021, the Legislative Assembly agreed to a motion for the committee to undertake an inquiry with the following terms of reference (the Inquiry):

That the Health and Environment Committee inquire into and report to the Legislative Assembly by 31 March 2022 on

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

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

2. in conducting this inquiry, the Health and Environment Committee should consider:
  - a. the current state of those services (outlined in 1) in Queensland;
  - b. bulk billing policies, including the Commonwealth Government's Medicare rebate freeze;
  - c. the Commonwealth Government's definition of the Commonwealth Distribution Priority Areas; and
  - d. the availability of medical training places at Queensland universities, compared to other jurisdictions.<sup>4</sup>

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<sup>2</sup> *Parliament of Queensland Act 2001* (POQA), s 88 and Standing Order 194.

<sup>3</sup> POQA, s 92.

<sup>4</sup> Queensland Parliament, Record of Proceedings, 17 November 2021, p 3566.

On 17 March 2022, the Legislative Assembly resolved to extend the reporting date for the Inquiry to Friday 8 April 2022.<sup>5</sup>

### **1.3 Inquiry process**

On 19 November 2021, the committee invited stakeholders and subscribers to make written submissions to the committee. 79 submissions were received - a list of submitters is at Appendix A.

The committee received a public briefing about the Inquiry on 29 November 2021 at which it heard from officials from Queensland Health, the Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships (DSDSATSIP) and the Department of Education. A list of departmental officers who attended the briefing is at Appendix B.

In addition, the committee received written briefings from Queensland Health and DSDATSIP in relation to issues arising from the terms of reference.

The committee held public hearings in Brisbane and across Queensland to hear from submitters, stakeholder groups and members of the public. A list of witnesses is at Appendix C.

Public hearings were held in:

- Brisbane – 8 December 2021, 11 February 2022 and 21 February 2022
- Bribie Island – 9 December 2021
- Cairns – 7 February 2022
- Mossman – 8 February 2022
- Townsville – 9 February 2022
- Logan – 10 February 2022
- Gold Coast – 10 February 2022
- Bundaberg – 2 March 2022
- Rockhampton – 3 March 2022
- Longreach – 4 March 2022.

Public hearings were scheduled in Hervey Bay and Emerald. Unfortunately, these hearings had to be cancelled due to extreme weather conditions and subsequent flooding in South East Queensland. Individuals who were due to attend those hearings were provided the opportunity to express their views, in writing, to the committee.

The submissions, correspondence from departments, transcripts of the public briefing and hearings, tabled papers and responses to questions taken on notice at public briefings and hearings are available on the committee's webpage.

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<sup>5</sup> Queensland Parliament, Record of Proceedings, 17 March 2022, p 528.

## 1.4 Other inquiries into related matters

The committee acknowledges a number of inquiries relating to accessing health care, mental health, aged care and the National Disability Insurance Scheme (NDIS) in other jurisdictions are under way, or have recently been completed, reflecting the importance of these matters.

### 1.4.1 Australian Senate

On 4 August 2021, the Australian Senate referred an inquiry into the provision of general practitioner (GP) and related primary health services to outer metropolitan, rural, and regional Australians to the Senate Standing Committee on Community Affairs.<sup>6</sup>

The Senate Committee was due to table its report by the last sitting day of March 2022. On 8 February 2022, the Senate extended the reporting date to 30 June 2022.<sup>7</sup>

### 1.4.2 Victorian Legislative Assembly

On 4 August 2021, the Victorian Legislative Assembly referred an inquiry into support for elderly migrants and refugees to the Legal and Social Issues Standing Committee.<sup>8</sup>

The inquiry includes an examination of challenges faced by older Victorians, such as dementia and access to aged care and home care services. The inquiry is also exploring ways to improve the overall physical and mental health and wellbeing of older Victorians from culturally diverse backgrounds.<sup>9</sup>

The Victorian Committee was due to report by 17 February 2022, but this was subsequently extended to 30 June 2022.<sup>10</sup>

### 1.4.3 Western Australia Legislative Council

On 23 June 2021, the Standing Committee on Public Administration of Western Australia's Legislative Council announced it had commenced an inquiry into the delivery of ambulance services in Western Australia. Part of the terms of reference require the committee to consider:

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<sup>6</sup> Parliament of Australia, Senate Standing Committee on Community Affairs, *Provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians*, [https://www.aph.gov.au/Parliamentary\\_Business/Committees/Senate/Community\\_Affairs/PrimaryHealthServices](https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/PrimaryHealthServices).

<sup>7</sup> Parliament of Australia, Senate Standing Committee on Community Affairs, *Provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians*, [https://www.aph.gov.au/Parliamentary\\_Business/Committees/Senate/Community\\_Affairs/PrimaryHealthServices](https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/PrimaryHealthServices).

<sup>8</sup> Parliament of Victoria, *Inquiry into support for older Victorians from migrant and refugee backgrounds*, <https://www.parliament.vic.gov.au/lsc-ls/article/4778>.

<sup>9</sup> Parliament of Victoria, *Inquiry into support for older Victorians from migrant and refugee backgrounds*, <https://www.parliament.vic.gov.au/lsc-ls/inquiry/1022>.

<sup>10</sup> Parliament of Victoria, *Inquiry into support for older Victorians from migrant and refugee backgrounds*, <https://www.parliament.vic.gov.au/lsc-ls/article/4778>.

- how 000 ambulance calls are received, assessed, prioritised and despatched in the metro area and in the regions
- the efficiency and adequacy of the service delivery model of ambulance services in metro and regional areas of Western Australia.<sup>11</sup>

#### 1.4.4 Tasmanian Legislative Council

On 27 October 2020, Government Administration Committee 'B' of the Tasmanian Parliament's Legislative Council (Tasmanian Committee B) resolved to form a committee to inquire into, and report on, the Tasmanian Government's responsibilities under its co-arrangement with the NDIS.<sup>12</sup>

On 30 January 2021, Government Administration Committee 'A' of the Tasmanian Parliament's Legislative Council (Tasmanian Committee A) announced it had established an inquiry into the health outcomes and access to health and hospital services for Tasmanians living in rural and remote Tasmania.<sup>13</sup>

The inquiry terms of reference require the committee to have particular regard to a range of aspects of the health system, including the availability and timeliness of a number of health services such as ambulance services, primary care, allied health and general practice services, specialist medical services and hospital services.<sup>14</sup>

#### 1.4.5 Queensland Parliamentary Mental Health Select Committee

The committee also notes the important work being undertaken by the Queensland Parliament's Mental Health Select Committee, which was established on 2 December 2021. The Mental Health Select Committee's inquiry focuses on the opportunities to improve mental health outcomes for Queenslanders and is scheduled to report by 31 May 2022.

The committee's report addresses a number of issues raised with the committee in relation to access and availability of mental health services, where they relate to the terms of reference of this Inquiry. The committee awaits the Mental Health Select Committee's comprehensive report and findings about the wider mental health system.

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<sup>11</sup> Parliament of Western Australia, Legislative Council, 'Public Administration Committee: New inquiry into the delivery of ambulance services in Western Australia', media release, 23 June 2021, [https://www.parliament.wa.gov.au/Parliament/commit.nsf/\(Inquiry+Names+by+Com+ID+Lookup\)/E928A0238B9758DA482586FD0017E23A/\\$file/Media+release+final.pdf](https://www.parliament.wa.gov.au/Parliament/commit.nsf/(Inquiry+Names+by+Com+ID+Lookup)/E928A0238B9758DA482586FD0017E23A/$file/Media+release+final.pdf).

<sup>12</sup> Parliament of Tasmania, Legislative Council, Government Administration Committee 'B', *Special Report on Resolution to Commence Inquiry*, <https://www.parliament.tas.gov.au/ctee/council/TermsofReference/DST%20ToR.pdf>.

<sup>13</sup> Parliament of Tasmania, Legislative Council, Government Administration Committee 'A', 'Submissions now open for new inquiry into health outcomes and services in rural and remote Tasmania', media release, 30 January 2021, <https://www.parliament.tas.gov.au/ctee/Council/Media/GAA%20RUR/gaa.inq.rur.med.210130.embargoedmediarelease.jm.001.pdf>.

<sup>14</sup> Parliament of Tasmania, Legislative Council, Government Administration Committee 'A', *Terms of Reference*, [https://www.parliament.tas.gov.au/ctee/Council/TermsofReference/Rural%20Health%20Services%20in%20Tasmania%20TOR\\_updated.pdf](https://www.parliament.tas.gov.au/ctee/Council/TermsofReference/Rural%20Health%20Services%20in%20Tasmania%20TOR_updated.pdf).

## 2 Australian health system

### 2.1 Introduction

The Australian health system is a complex mix of programs and services. It includes:

- primary health care services – general practitioners (GPs) and allied health services
- secondary health care services – public and private hospitals
- tertiary health care services – referred medical services, including specialist services.

Many health services are paid for, and delivered by, the Australian or State and Territory Governments, while others are managed by private or not-for-profit organisations.

These services are supported and delivered by a range of health professionals including doctors, nurses, allied health professionals, specialists and administrative staff. Together these professionals make up the health workforce.<sup>15</sup>

The below diagram outlines the Australian health system, with primary health care services taking a central role as the ‘gatekeeper’ to the rest of the system.

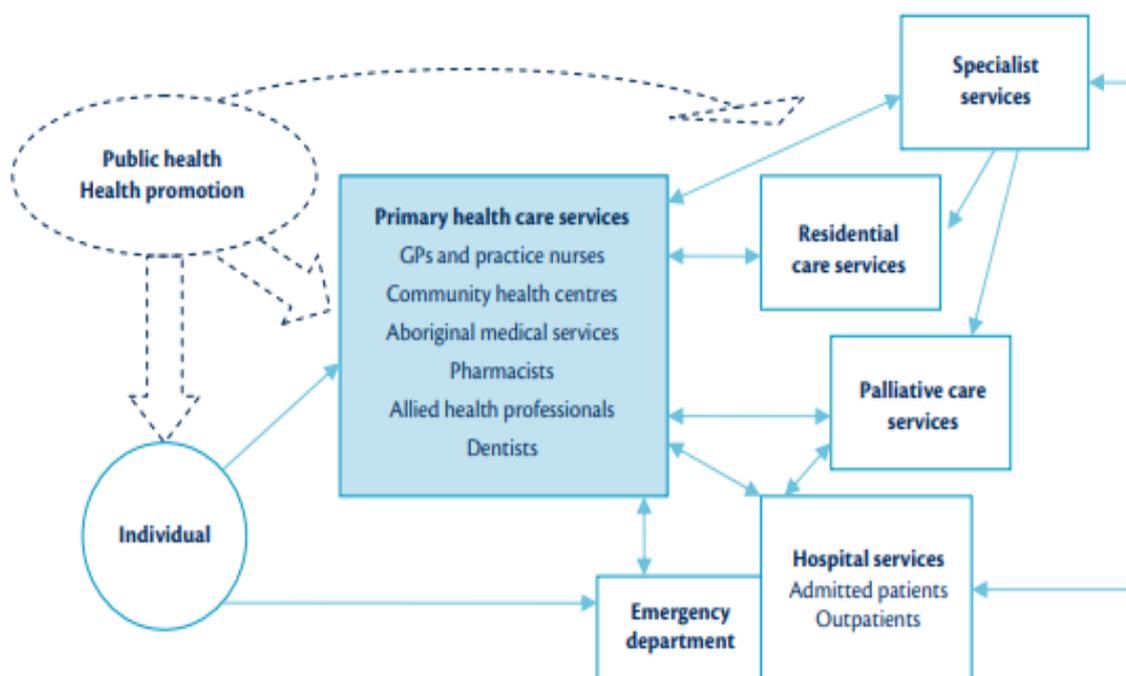


Figure 1 – Australian health system: a simplified framework; source AIHW, *Review and evaluation of Australian information about primary health care: a focus on general practice 2008*.

Australians can access healthcare through the public sector via Medicare, where healthcare is free or subsidised at the point of use, or through the private sector, where the patient pays for a health service when they access it. People may also purchase private health insurance to cover some, or all, of the costs of accessing healthcare through the private sector.

<sup>15</sup> Australian Government, Australian Institute of Health and Welfare (AIHW), ‘Australia’s health 2020: in brief’, July 2020, <https://www.aihw.gov.au/getmedia/2aa9f51b-dbd6-4d56-8dd4-06a10ba7cae8/aihw-aus-232.pdf.aspx?inline=true>, p 35.

## 2.2 Commonwealth and State responsibilities

The *National Health Reform Agreement 2020-2025* (NHRA) recognises that the responsibility for health is shared between the Australian and State Governments. The NHRA also recognises that all governments have a responsibility to ensure that systems work together effectively and efficiently to produce the best outcomes for people, including interfaces between health, aged care and disability services, regardless of their geographic location.<sup>16</sup>

The Australian Institute of Health and Welfare (AIHW) describes the Australian health system as:

... a complex mix of service providers and other health professionals from a range of organisations—from Australian and state and territory governments and the non-government sector. Collectively, they work to meet the physical and mental health care needs of Australians.<sup>17</sup>

### 2.2.1 Australian Government responsibilities – funding and systems management

The Australian Government funds primary health care, private specialist care, aged care and supports for people with permanent and significant disability.<sup>18</sup>

The Australian Government is responsible for:

- system management and support, policy and funding for GP and primary health care services including lead responsibility for Aboriginal and Torres Strait Islander Community Controlled Health Services (CCHS)
- maintaining Primary Health Networks (PHNs) to promote coordinated GP and primary health care service delivery and service integration
- working with each State and with PHNs on system-wide policy and State-wide planning for GP and primary health care
- supporting and regulating private health insurance to enable an effective private health sector and patient choice
- planning, funding, policy, management and delivery of the national aged care system
- continuing to focus on reforms in primary care that are designed to improve patient outcomes and reduce avoidable hospital admissions.<sup>19</sup>

The Australian Government is also responsible for:

- regulating the provision of services under the NDIS
- funding the Medicare Benefits Schedule (MBS) to ensure equitable and timely access to affordable primary health care and specialist medical services
- funding the Pharmaceutical Benefits Scheme (PBS) to ensure timely and affordable access to safe, cost-effective and high-quality medicines

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<sup>16</sup> Queensland Health, submission 39, p 5; National Health Reform Agreement 2020-2025, <https://www.health.gov.au/initiatives-and-programs/2020-25-national-health-reform-agreement-nhra>.

<sup>17</sup> Australian Government, AIHW, 'Health system overview', <https://www.aihw.gov.au/reports/australias-health/health-system-overview>.

<sup>18</sup> Australian Government, submission 75, p 2.

<sup>19</sup> Queensland Health, submission 39, p 5.

- affordable aged care services so that people needing this care can access it when required, regardless of geographic location.<sup>20</sup>

In the 2021-22 federal budget, the Australian Government allocated \$98.3 billion<sup>21</sup> (16.7 per cent of total expenditure)<sup>22</sup> on health expenditure, consisting of:

- \$37.6 billion on medical services and benefits
- \$29.1 billion on medical benefits, which mostly comprises Medicare expenditure
- \$6.7 billion for private health insurance expenses incurred by the Australian Government
- \$25.5 billion on assistance to the states for public hospitals,<sup>23</sup> including all admitted services, delivery of hospital services in the home, and emergency department services<sup>24</sup>
- \$15.2 billion on pharmaceutical benefits and services, with \$14.4 billion for the PBS.<sup>25</sup>

### **2.2.2 Queensland Government responsibilities – public hospital system and managing public health activities**

The Queensland Government is responsible for:

- providing health and emergency services through the public hospital system
- system management of public hospitals
- taking a lead role in managing public health activities.<sup>26</sup>

Queensland Health's total expenditure on health in 2021-22 is \$29.797 billion.<sup>27</sup> The expenditure was split as follows:

- acute inpatient care – 47.1 per cent
- emergency care – 9.6 per cent
- mental health and alcohol and other drug services – 10.3 per cent
- outpatient care – 11.5 per cent

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<sup>20</sup> Queensland Health, submission 39, p 5.

<sup>21</sup> Australian Government, *Budget 2021-22, Budget Strategy and Outlook, Budget Paper No. 1*, May 2021, [https://budget.gov.au/2021-22/content/bp1/download/bp1\\_2021-22.pdf](https://budget.gov.au/2021-22/content/bp1/download/bp1_2021-22.pdf), p 171.

<sup>22</sup> Australian Government, *Budget 2021-22, Budget Overview*, May 2021, [https://budget.gov.au/2021-22/content/download/glossy\\_overview.pdf](https://budget.gov.au/2021-22/content/download/glossy_overview.pdf), p 57.

<sup>23</sup> Australian Government, *Budget 2021-22, Budget Strategy and Outlook, Budget Paper No. 1*, May 2021, [https://budget.gov.au/2021-22/content/bp1/download/bp1\\_2021-22.pdf](https://budget.gov.au/2021-22/content/bp1/download/bp1_2021-22.pdf), p 173.

<sup>24</sup> Australian Government, *Budget 2021-22, Budget Strategy and Outlook, Budget Paper No. 1*, May 2021, [https://budget.gov.au/2021-22/content/bp1/download/bp1\\_2021-22.pdf](https://budget.gov.au/2021-22/content/bp1/download/bp1_2021-22.pdf), p 173.

<sup>25</sup> Australian Government, *Budget 2021-22, Budget Strategy and Outlook, Budget Paper No. 1*, May 2021, [https://budget.gov.au/2021-22/content/bp1/download/bp1\\_2021-22.pdf](https://budget.gov.au/2021-22/content/bp1/download/bp1_2021-22.pdf), p 172. In addition, \$479 million will be spent on immunisation and \$323 million on veterans' pharmaceutical benefits.

<sup>26</sup> Queensland Health, submission 39, p 5.

<sup>27</sup> Queensland, Department of Health, *Annual Report 2020-21*, September 2021, [https://www.health.qld.gov.au/\\_\\_data/assets/pdf\\_file/0030/1115877/Department-of-Health-Annual-Report-2020-2021.pdf](https://www.health.qld.gov.au/__data/assets/pdf_file/0030/1115877/Department-of-Health-Annual-Report-2020-2021.pdf), p 10.

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

- prevention, primary and community care – 14.3 per cent
- ambulance services – 3.1 per cent
- sub and non-acute care – 4.1 per cent.<sup>28</sup>

The Australian and State Governments are jointly responsible for funding for public hospital services and preventative services (eg cancer screening schemes), registering and accrediting health professionals, funding palliative care, national mental health reform and responding to national health emergencies.<sup>29</sup>

The following table outlines the respective responsibilities of the Australian and State Governments:

Commonwealth responsibilities	State responsibilities
Medicare Benefits Schedule (MBS)	Managing and administering public hospital system
Pharmaceutical Benefits Scheme (PBS)	Delivering preventive services (eg breast cancer screening and immunisation programs)
Supporting and regulating private health insurance	Funding and managing community and mental health services
System management, support and funding of GPs and primary health care services, including lead responsibility for CCHSs	Public dental clinics
Maintaining PHNs to promote coordinated GP and primary healthcare service delivery and integration	Ambulance and emergency services
Planning, funding, management, regulation and delivery of national aged care system (eg residential care and home care)	Patient transport and subsidy schemes
Australian Institute of Health and Welfare (AIHW) – collecting and publishing health and welfare information	
Maintaining the number of doctors in Australia (through Commonwealth-funded university places) and ensuring they are distributed equitably	
National immunisation program	
Therapeutic Goods Administration	

*Table 1 - Commonwealth and State and Territory responsibilities, source Australian Government, Department of Health, <https://www.health.gov.au/about-us/the-australian-health-system>; Queensland Health, submission 39.*

<sup>28</sup> Queensland, Department of Health, 'Annual Report 2020-21', September 2021, [https://www.health.qld.gov.au/\\_\\_data/assets/pdf\\_file/0030/1115877/Department-of-Health-Annual-Report-2020-2021.pdf](https://www.health.qld.gov.au/__data/assets/pdf_file/0030/1115877/Department-of-Health-Annual-Report-2020-2021.pdf), p 10.

<sup>29</sup> Australian Government, Department of Health, <https://www.health.gov.au/about-us/the-australian-health-system>.

## 2.3 Medicare

Australia's health system is underpinned by Medicare, the Australian Government-funded universal health insurance scheme. Medicare provides free, or subsidised, health care services at the point of use to Australian and New Zealand citizens, permanent residents in Australia, and people from countries with 'reciprocal agreements'.<sup>30</sup> Medicare comprises:

- **Health insurance benefits** – paid by the Australian Government in accordance with the MBS either directly to health care providers (referred to as bulk-billing) or in the form of a refund to patients who receive health care services from private providers, including GPs, specialists, allied health professionals and diagnostic testing and imaging services
- **Pharmaceutical Benefits Scheme** – which subsidises the price of many prescription medications
- **Free public hospital services** – funded jointly via formal agreements between the Australian Government and States and Territory Governments.<sup>31</sup>

Medicare is funded by the Australian Government through taxation revenue, including a Medicare Levy (2 per cent of people's taxable income) and the Medicare Levy Surcharge (MLS).<sup>32</sup>

People may have to pay the MLS, if they earn over a certain income and do not have the appropriate level of private hospital insurance.<sup>33</sup>

The MLS seeks to incentivise people to purchase private patient hospital cover and use the private hospital system, to reduce demand on the public system. The MLS of 1 per cent, 1.25 per cent and 1.5 per cent is levied on taxable income<sup>34</sup> on single people who earn \$90,000 a year or a family who earns \$180,000 a year.<sup>35</sup>

The Australian Government incentivises young people to purchase private health insurance through lifetime health cover (LHC) loading. People who have not taken out and maintained private patient

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<sup>30</sup> Parliament of Australia, Parliamentary Library, 'Medicare - Background Brief', October 2004, [https://www.aph.gov.au/About\\_Parliament/Parliamentary\\_Departments/Parliamentary\\_Library/Publications\\_Archive/archive/medicare](https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/Publications_Archive/archive/medicare); Australian Government, AIHW, *Health system overview*, July 2020, <https://www.aihw.gov.au/reports/australias-health/health-system-overview>.

<sup>31</sup> B Harris, M Craike, R Dunkin, R Calder, 'Is Medicare Fair? ii. The distribution of Medicare benefits across the cities and country', Mitchell Institute, Policy issues paper no. 3-2019, Victoria University, Melbourne, 2019, p 6.

<sup>32</sup> Australian Government, AIHW, 'Health system overview', <https://www.aihw.gov.au/reports/australias-health/health-system-overview>; Australian Government, Services Australia, 'About Medicare', December 2021, <https://www.servicesaustralia.gov.au/about-medicare?context=60092>; Australian Government, Services Australia, 'Medicare and tax', <https://www.servicesaustralia.gov.au/medicare-and-tax?context=60092>.

<sup>33</sup> Australian Government, Services Australia, 'Medicare and tax', <https://www.servicesaustralia.gov.au/medicare-and-tax?context=60092>.

<sup>34</sup> The MLS is also levied on total reportable fringe benefits and any amount on which family trust distribution tax has been paid.

<sup>35</sup> Australian Government, Australian Tax Office, 'Medicare levy surcharge', <https://www.ato.gov.au/Individuals/Medicare-and-private-health-insurance/Medicare-levy-surcharge/>.

hospital cover from the year they turn 31 pay a 2 per cent LHC loading on top of their premium for every year they are aged over 30, if they decide to take out hospital cover later in life.<sup>36</sup>

## 2.4 Private health insurance

While the public health system in Australia is a universal health care system that delivers health care for most Australians, the private health system provides further options and also covers items which are not covered by Medicare.<sup>37</sup>

Private health insurance offers coverage for out-of-pocket fees and private providers, aims to give greater choice of providers (particularly in hospitals) and faster access to non-emergency services, and rebates for selected services. Private health insurance may include coverage for hospital care, general treatment, or ambulance services.<sup>38</sup>

The current demand for, and coverage of, private health insurance in Queensland is discussed in more detail in Chapter 6 of this report.

## 2.5 Health system funding

The Australian health system is funded by a variety of sources. About two-thirds of spending is funded by the Australian (42 per cent) and State and Territory Governments (27 per cent). Non-government sources, including private health insurance providers and individuals, fund the rest.

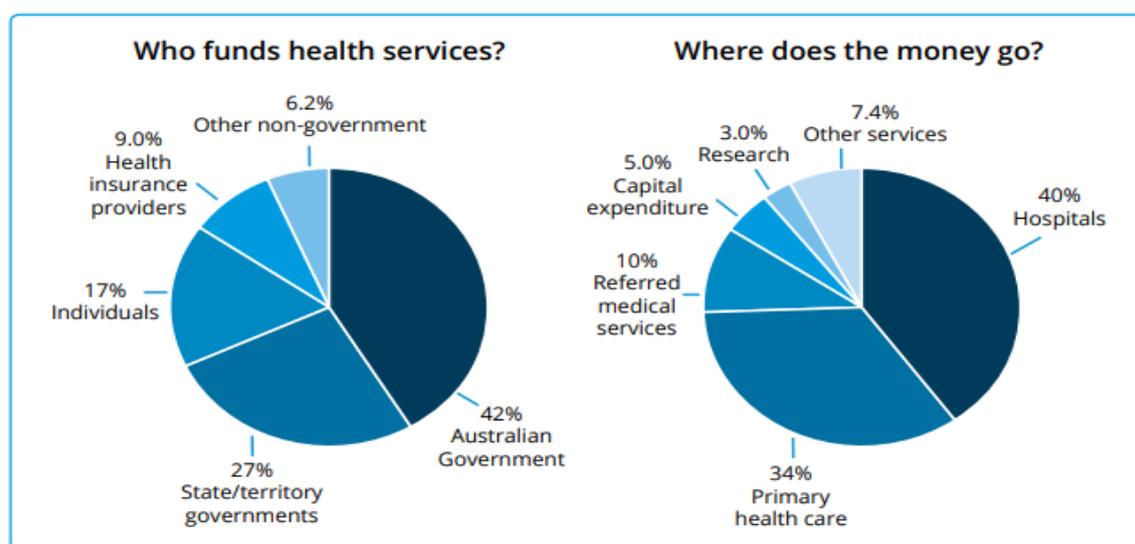


Figure 2 - Australian health system funding, 2017-18, source AIHW, *Australia's Health 2020: in brief*

<sup>36</sup> Australian Government, Australian Tax Office, 'Lifetime health cover', <https://www.ato.gov.au/Individuals/Medicare-and-private-health-insurance/Private-health-insurance-rebate/Lifetime-health-cover/>.

<sup>37</sup> Australian Government, [https://www.privatehealth.gov.au/health\\_insurance/what\\_is\\_covered/index.htm](https://www.privatehealth.gov.au/health_insurance/what_is_covered/index.htm).

<sup>38</sup> The Commonwealth Fund, Lucinda Glover, *International Health Care System Profiles: Australia*, <https://www.commonwealthfund.org/international-health-policy-center/countries/australia#universal-coverage>.

The NHRA provides that the Australian Government funds 45 per cent of ‘efficient growth’ in public hospital services, with the states and territories funding the remaining 55 per cent.<sup>39</sup>

Accordingly, in theory, the Australian Government should fund a portion of any increase in the use of public hospital services. However, national growth in Australian Government funding for public hospital services is capped at 6.5 per cent per year, including both price and volume growth. Queensland Health stated that:

With health price inflation increasing as a result of COVID-19, the funding cap means that in future years the Australian Government is likely to fund little if any of the growth in public hospital services arising from the increase in the public market share.<sup>40</sup>

Queensland Health stated that it is critical that the Australian Government waive the funding cap to ensure that it pays for a share of the increase in public hospital services. Queensland Health also stated:

... given that the Commonwealth would still only fund 45 per cent of the increase in public market share without the cap, there may also be a case for the Commonwealth to transfer a portion of the savings from lower private health insurance rebates and increased revenue from the Medicare levy surcharge to the States for reinvestment in the public hospital system.<sup>41</sup>

The Queensland Nurses and Midwives’ Union (QNMU) recommended the introduction of a permanent shared 50-50 commonwealth-state funding model for public hospitals and removal of the 6.5 per cent per annum cap on the efficient growth of activity based services for 2022-2023 to 2024-2025 financial years.<sup>42</sup>

#### Committee comment

This report provides a summary of the issues raised by submitters and witnesses about the adverse impact that significant gaps in the provision of primary and allied health care, aged care services and NDIS care services have had on Queensland’s public health system. These impacts include:

- an increase in presentations at public emergency departments, including lower acuity presentations, mental health presentations and presentations from aged care services – discussed at section 4.2 of this report
- an increase in potentially preventable hospitalisations and avoidable hospitalisations due to a lack of aged care and NDIS services – discussed at sections 4.3 and 4.4 of this report
- older patients becoming long-stay patients in public hospitals – discussed at section 4.5 of this report
- people with a disability becoming long-stay patients – discussed at section 4.6 of this report.

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<sup>39</sup> Australian Medical Association, ‘Public hospitals: Cycle of crisis,’  
[https://www.ama.com.au/sites/default/files/2021-10/Public%20hospitals\\_Cycle%20of%20crisis\\_online%20%281%29.pdf](https://www.ama.com.au/sites/default/files/2021-10/Public%20hospitals_Cycle%20of%20crisis_online%20%281%29.pdf), p 25.

<sup>40</sup> Submission 39, p 17.

<sup>41</sup> Submission 39, p 17.

<sup>42</sup> Submission 69, p 27.

During the Inquiry, the committee was also informed of the impact that the reduction in private health insurance coverage, or the uptake of 'junk policies', has had on the Queensland public health system (discussed at Chapter 6 of this report).

The committee notes that as a consequence of these impacts the Queensland public health system has become the provider of 'last resort', in many circumstances, adding to the burden on the system and resulting in growth in the market share of the public health system.

The committee considers that the current funding model, including the cap of 6.5 per cent per year on funding for public hospitals, does not ensure that the Australian Government pays its fair share of the rising costs to the Queensland public health system.

Accordingly, the committee recommends that the Australian Government agrees to remove the 6.5 per cent funding growth cap and adopt a 50/50 contribution model between the Australian and State and Territory Governments for the funding of the public hospital system.

**Recommendation 1 – Removal of funding cap and adoption of 50/50 contribution funding model for public hospital system**

The committee recommends that the Australian Government agrees to:

- remove the current 6.5 per cent per annum growth cap on Australian Government funding for public hospitals
- adopt a 50/50 contribution model between the Australian and State and Territory Governments for the funding of the public hospital system.

### 3 Queensland's public health system

#### 3.1 Introduction

The Queensland public health system comprises:

- public hospitals
- community-based services
- subsidised services provided by some private practitioners.

The Minister for Health and Ambulance Services has overall responsibility for Queensland's public health system through Queensland Health and 16 Hospital and Health Boards.<sup>43</sup>

Public health services in Queensland are provided through 16 Hospital and Health Services (HHSs):

Cairns and Hinterland	Metro South
Central Queensland	North West
Central West	South West
Children's Health Queensland	Sunshine Coast
Darling Downs	Torres and Cape
Gold Coast	Townsville
Mackay	West Moreton
Metro North	Wide Bay

*Table 2 - List of Hospital and Health Services in Queensland, source Queensland Health, About Hospital and Health Services, <https://www.health.qld.gov.au/system-governance/health-system/hhs/about>*

These are statutory bodies, each governed by a Hospital and Health Board. Some public health services are also provided by private providers.

Queensland Health is responsible for the overall management of the public health system in Queensland, including monitoring the performance of HHSs. Service agreements are negotiated between Queensland Health and each HHS. The service agreement determines the services that the department will purchase from the HHS and how much it will pay for the provision of these services (ie the level of funding to be provided).<sup>44</sup>

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<sup>43</sup> Queensland Health, 'Queensland Health organisational structure, <https://www.health.qld.gov.au/system-governance/health-system/managing/org-structure>.

<sup>44</sup> Queensland Health, Queensland Health Organisational structure, <https://www.health.qld.gov.au/system-governance/health-system/managing/org-structure>.

### 3.2 Demands on the public health system

Queensland Health has described the Queensland public health system as ‘being stretched due to a broad range of factors and interdependencies, many of which sit outside Queensland Health’s control or remit’.<sup>45</sup>

Queensland Health advised that in 2021, compared to the previous year, there was a:

- 15.4 per cent increase in public emergency department presentations
- 11.2 per cent increase in patients requiring resuscitation or acute care
- 5.4 per cent increase in the number of ambulance arrivals to emergency departments
- 6.9 per cent increase in emergency surgeries.<sup>46</sup>

Queensland Health stated that ‘All indications point to these pressures continuing this financial year’. As an example, Queensland Health advised that ‘between July and October 2021 our public emergency department presentations increased again by 6.6 per cent’.<sup>47</sup>

The committee notes that the Queensland public health system faces a number of challenges and demands, including:

- a rapidly increasing population – Queensland has the fastest population growth of all states and territories – Queensland’s current population of 5.2 million is projected to reach over 6.22 million in 2036 (a 20 per cent increase)<sup>48</sup>. By 2066, Queensland’s population is expected to be between 7.8 million and 11.5 million<sup>49</sup>
- an ageing population – the number of Queenslanders aged over 65 is projected to more than double from 631,000 in 2020 to 1.301 million by 2036 (an increase of 106 per cent). The number of Queenslanders aged over 85 is projected to increase from 90,324 in 2020 to 200,569 by 2036 (an increase of 122 per cent)<sup>50</sup>
- an increase in people suffering complex and chronic illness (eg arthritis, back pain, cardiovascular disease, respiratory diseases, cancer and diabetes – account for 4 of the top 5 causes of death in 2019) and mental health conditions<sup>51</sup>

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<sup>45</sup> Submission 39, p 3.

<sup>46</sup> Public briefing transcript, Brisbane, 29 November 2021, p 2.

<sup>47</sup> Public briefing transcript, Brisbane, 29 November 2021, p 2.

<sup>48</sup> Queensland Treasury, ‘Queensland population counter’, <https://www.qgso.qld.gov.au/statistics/theme/population/population-estimates/state-territories/qld-population-counter>.

<sup>49</sup> Queensland Government Statistician’s Office, ‘Queensland Government population projections’, 2018 edition: Queensland, <https://www.qgso.qld.gov.au/issues/2671/qld-government-population-projections-2018-edn.pdf>.

<sup>50</sup> Queensland Government Statistician’s Office, ‘Queensland Government population projections’, 2018 edition: Queensland, <https://www.qgso.qld.gov.au/issues/2671/qld-government-population-projections-2018-edn.pdf>.

<sup>51</sup> Joint submission from health charities and non-government organisations, submission 41, p 1.

- increased consumer expectations and demands for responsiveness – eg there is a strong expectation that all Queenslanders should have access to services 24 hours a day, 365 days a year
- being a highly-decentralised state – approximately 40.4 per cent of Queenslanders live outside of major cities, with almost 38 per cent living in regional areas
- a high proportion of First Nations people who suffer complex co-morbidities and reduced health outcomes and life expectancy – more than 25 per cent of Australia’s First Nations people live in Queensland
- the cost of running the health system is expected to continue to increase – as a share of gross domestic product, health spending is projected to increase from 4.6 per cent in 2021-22 to 6.2 per cent in 2060-61.<sup>52</sup>

### 3.3 COVID-19 pandemic

Queensland’s public health system has also been impacted significantly by the COVID-19 pandemic.

Since the first cases of COVID-19 were recorded in Australia in January 2020, Australian and State and Territory health systems have responded with a range of measures to limit the spread of the disease and treat those affected including:

- new or repurposed treatment facilities
- procurement of additional protective equipment
- testing facilities
- contact tracing and quarantine systems (including hotel quarantine)
- pop-up and drive-through facilities established to allow widespread testing
- the delivery of the vaccination program.<sup>53</sup>

Following a decision by National Cabinet, non-urgent elective surgeries were suspended from 26 March 2020.<sup>54</sup>

While this Inquiry does not specifically examine the impacts of the COVID-19 pandemic, the committee acknowledges its impacts on both the Australian and Queensland public health systems.

In its submission to the Inquiry, Queensland Health acknowledged that health system pressures have been exacerbated by the direct effects of COVID-19, including the backlog resulting from the pandemic and the need to maintain hospital readiness.<sup>55</sup> It stated:

While Queensland’s residents and health system are resilient, the added complexity of COVID-19 has resulted in rising costs, forced changes to workforce and models of care, and most significantly, is taking its toll on the mental health and wellbeing of our population.<sup>56</sup>

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<sup>52</sup> Australian Government, Treasury, *2021 Intergenerational Report*, June 2021, [https://treasury.gov.au/sites/default/files/2021-06/p2021\\_182464.pdf](https://treasury.gov.au/sites/default/files/2021-06/p2021_182464.pdf), p 92.

<sup>53</sup> Australian Government, AIHW, ‘COVID-19: looking back on health in 2020’, <https://www.aihw.gov.au/reports-data/australias-health-performance/the-impact-of-covid-19-on-australias-health-system>.

<sup>54</sup> Hon Scott Morrison MP, Prime Minister of Australia, ‘Elective Surgery’, media release, 25 March 2020.

<sup>55</sup> Submission 39, p 6.

<sup>56</sup> Submission 39, p 3.

### 3.3.1 A backlog of care

Following the advice of the National Cabinet to suspend elective surgery during 2020, on 8 January 2022, the Minister for Health and Ambulance Services, Hon Yvette D'Ath MP postponed all non-urgent elective surgeries in Queensland public hospitals until 1 March 2022. The Minister for Health and Ambulance Services stated 'non-urgent elective surgeries is an unfortunate but necessary step to ensure Queenslanders can continue to access urgent and critical healthcare if and when they need it'.<sup>57</sup>

The AIHW advised that the long-term health effects of cancelling or postponing non-urgent elective surgeries are not yet known,<sup>58</sup> and reported that 'the number of patients being treated from Australia's public hospital elective surgery waiting lists increased during 2020–21 as the hospitals worked to clear a backlog left by COVID-19 suspensions the previous year'.<sup>59</sup>

### 3.3.2 Increased hospitalisations and presentations in emergency departments

The AIHW reported that with the outbreak of COVID-19 in February 2020, the number of emergency department presentations decreased by 1.4 per cent compared to 2018–19 and attributed this decrease to the influence of COVID-19 restrictions and the changes made to health care provision.

In contrast, in 2020-21, the number of presentations to emergency departments increased 6.9 per cent compared to 2019–20, despite ongoing restrictions to health care due to the ongoing COVID-19 pandemic.<sup>60</sup>

The Pharmacy Guild noted the challenges to the public health system due to the pandemic included 'increased hospitalisations and ICU requirements, effects of 'long-COVID', furloughing of staff, and the suspension or delay of screening programs and chronic disease management'.<sup>61</sup>

Queensland Health's performance was inevitably impacted as a result of the extra pressures resulting from the pandemic. Queensland Health stated that:

While Queensland has an excellent public health system, these pressures have inevitably led to some decline in performance metrics relating to patient off-stretcher times and the percentage of emergency department and elective surgery patients seen within clinically recommended times.<sup>62</sup>

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<sup>57</sup> Queensland Government, 'Non-urgent elective surgeries postponed', media release, 8 January 2022.

<sup>58</sup> Australian Government, AIHW, 'COVID-19: looking back on health in 2020', <https://www.aihw.gov.au/reports-data/australias-health-performance/the-impact-of-covid-19-on-australias-health-system>.

<sup>59</sup> Australian Government, AIHW, 'Public hospitals worked to clear elective surgery backlog during 2020–21', media release, 22 January 2022.

<sup>60</sup> Australian Government, AIHW, 'Emergency department care', <https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care>.

<sup>61</sup> Submission 45, p 2.

<sup>62</sup> Submission 39, p 6.

### *3.3.2.1 Increased presentation in emergency departments as a result of mental health impacts*

According to the AIHW, in September 2020, the number of mental health services delivered was 14.5 per cent higher than in the same period in September 2019.<sup>63</sup>

Similarly, Brisbane South PHN commented that 'the COVID-19 pandemic has had a considerable impact on demand for mental health services and has accelerated work to improve the coordination and delivery of services'.<sup>64</sup>

Queensland Health also recognised the mental health impacts of the pandemic and noted the increased demand on the public health system, advising:

The impact of the COVID-19 pandemic response measures has resulted in significant increased and unmet demand reported by adult and child youth public mental health, alcohol and other drug services. Referrals for mental health community treatment services has increased, especially for adolescents whose presentations with eating disorders almost doubled in 2020-21. Service capacity limits of current models are putting additional pressure on the public hospital system, leading to longer waiting times, shorter periods of service and an intensity of service insufficient to meet consumer needs.<sup>65</sup>

### **3.3.3 Impact on the health workforce and models of care**

Disruptions to the healthcare workforce and to the delivery of healthcare resulted from the introduction of border restrictions to manage the spread of the COVID-19 pandemic and the complexities associated with treating COVID-19 infected patients in hospital.

The border restrictions imposed in response to the COVID-19 pandemic disrupted workforce supply chains and exposed gaps in medical workforce distribution across specialities and geographic locations. Queensland Health advised:

... staffing and skills shortages across nursing and midwifery, allied health, First Nations workforce and mental health workforce are adversely affecting delivery of primary health, aged care and NDIS supports in the community. This is increasing patient flow into public hospitals, impacting resources available for patients requiring acute care and imposing additional strain on hospital staff.<sup>66</sup>

The health workforce issues caused by the COVID-19 pandemic are addressed in detail in Chapter 5 of this report.

In terms of the impacts arising from treating patients suffering from COVID-19 in public hospitals, the Australian Medical Association (AMA) foreshadowed impacts on the Australian healthcare workforce including:

- healthcare staff capacity will decrease because 3.6 to 11.5 per cent or 13,000 - 42,500 staff will be furloughed by COVID-19 at the peak after opening up (steady level of staff absent on any day including doctors, nurses and ancillary staff)

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<sup>63</sup> Australian Government, AIHW, 'COVID-19: looking back on health in 2020', <https://www.aihw.gov.au/reports-data/australias-health-performance/covid-19-and-looking-back-on-health-in-2020#Increased%20use%20of%20mental%20health%20services%20during%20COVID-19%20pandemic>.

<sup>64</sup> Submission 30, p 6.

<sup>65</sup> Submission 39, p 7.

<sup>66</sup> Submission 39, p 3.

- lost staff time in adhering to PPE protocols.<sup>67</sup>

In addition, Queensland Health attributed changes to models of care and additional costs to the complexities associated with dealing with the COVID-19 pandemic.<sup>68</sup>

Committee comment

The committee notes that the pressures on the public health system have been exacerbated by the COVID-19 pandemic, which has had significant impacts on Queensland's public health system.

The committee appreciates the thousands of Queensland Health staff who worked tirelessly in providing testing, sampling, supporting quarantine arrangements, administering vaccinations and treating patients infected with COVID-19 and the personal risks they faced in providing this care.

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<sup>67</sup> Australian Medical Association, *Public hospitals: cycle of crisis*, 2021  
<https://www.ama.com.au/sites/default/files/2022-03/Public%20hospitals%20-%20cycle%20of%20crisis.pdf>, p 4.

<sup>68</sup> Submission 39, p 3.

## 4 Impact of the provision of primary, allied and private health care, aged care and National Disability Insurance Scheme care services on the Queensland public health system

In addition to the factors discussed in Chapter 3 of this report, the Queensland public health system has been impacted by the provision of services for which the Australian Government is responsible for funding, planning and delivering, namely:

- primary and allied health services
- private health care
- aged care services
- NDIS care services.

The Inquiry terms of reference task the committee with examining the impacts that the availability and accessibility of these services have on the Queensland public health system.

During its inquiry, the committee heard evidence from submitters and witnesses about a number of issues affecting the provision of primary and allied health care, aged care and the NDIS that fell outside the terms of reference.

All of these issues have not been addressed directly in this report, however, the submissions and transcripts of the committee's public briefings and hearings are publicly available and may inform any future, broader inquiries into these issues.

This report focuses on the Inquiry's terms of reference and outlines the committee's findings in that regard. In doing so, it draws on the submissions received by the committee and the evidence provided at its public hearings across Queensland, and makes a number of recommendations aimed at resolving current issues and reducing impacts on the public health system.

### 4.1 A 'stretched' public health system

Queensland Health advised that Queensland's public health system is 'being stretched' due to gaps in primary and allied health care, the interface with aged care and NDIS services and the need for an adequate and skilled workforce.<sup>69</sup>

Queensland Health advised these gaps have two major impacts on Queensland's public health system:

- Queensland Government stepping in as a direct provider of primary health care, especially in rural and remote areas
- the lack of accessible and affordable primary health care puts additional pressures on the Queensland public hospital system, through:
  - patients presenting to emergency departments, in instances where it would be more appropriate and cost-effective for them to see a GP
  - a worsening or deterioration in their underlying health conditions leading to potentially preventable hospitalisations.<sup>70</sup>

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<sup>69</sup> Submission 39, p 3.

<sup>70</sup> Submission 39, p 13.

#### **4.1.1 Queensland Health – ‘provider of last resort’**

A significant number of submitters and witnesses referred to the Queensland public health system being the ‘provider of last resort’.<sup>71</sup>

Queensland Health stated this is particularly true in rural and remote locations, as well as some regional areas, where Australian Government funded primary care services are limited or not available.<sup>72</sup> Dr Wakefield, former Director-General, Queensland Health, stated that:

The Queensland government is often the provider of last resort for primary care services, especially in rural and regional areas. In 2020-21, it is estimated we spent about \$160.6 million on these services. The bulk-billing rate for a standard GP consultation is \$39.10. As a past GP myself, I can tell you that it is very hard to keep in business when you are supposed to deliver good health care for \$39. The average cost for an emergency department presentation, by comparison, is \$729.<sup>73</sup>

Health Workforce Queensland (HWQ) referred to ‘... fundamental policy failures / challenges that are leading to a self-perpetuating cycle of primary care, disability and aged care failures. When these services fail, Queensland Health must become the provider of last resort for these communities’.<sup>74</sup>

## **4.2 Emergency department presentations**

Emergency departments are a vital part of the Queensland public health system. They provide care for people who require urgent, and often life-saving, medical attention.

### **4.2.1 Lower urgency presentations to emergency departments**

During its inquiry, the committee heard that the current state of primary health care, in particular availability and access to services, has led to an increase in low acuity, or lower urgency presentations, to emergency departments.<sup>75</sup>

The AIHW defines lower urgency emergency department presentations as presentations at formal public hospital emergency departments where the person:

- had a type of visit to the emergency department of Emergency presentation
- was assessed as needing semi-urgent care (triage category 4 – should be seen within 1 hour) or non-urgent care (triage category 5 – should be seen within 2 hours)
- did not arrive by ambulance, or police or correctional vehicle
- was not admitted to hospital and did not die.<sup>76</sup>

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<sup>71</sup> Submissions 2, 16, 25, 39 and 48. Public hearing transcripts: Brisbane, 29 November 2021, pp 4-6; Logan, 10 February 2022, p 4; Brisbane, 21 February 2022, p 2; Longreach, 4 March 2022, pp 2, 7, 17.

<sup>72</sup> Submission 39, p 4.

<sup>73</sup> Public briefing transcript, Brisbane, 29 November 2021, p 3.

<sup>74</sup> Submission 25, p 7.

<sup>75</sup> Submissions 13, 47, 50, 48, 69 and 70.

<sup>76</sup> Australian Government, AIHW, ‘Use of emergency departments for lower urgency care: 2015-16 to 2018-19’, <https://www.aihw.gov.au/reports/primary-health-care/use-of-ed-for-lower-urgency-care-2018-19/contents/lower-urgency-care/summary>.

The AIHW found that, in 2018-19, there were 406,057 lower urgency care presentations in Queensland, representing 26.4 per cent of emergency department presentations in that year.<sup>77</sup>

The Royal Australian College of General Practitioners (RACGP) stated that, in 2020-21 there were over 1.8 million presentations to emergency departments in Queensland, 10.3 per cent of which were deemed non-urgent (category 5) and 32.1 per cent deemed semi-urgent (category 4) presentations. RACGP considered that these presentations could have been handled by a GP.<sup>78</sup>

RACGP compared the cost of a non-urgent emergency presentation (estimated at \$540), with a 40-minute GP consultation which costs \$111.50.<sup>79</sup>

Figure 3 shows the number of emergency department presentations who were ‘walk-ins’, as a proportion of total presentations. The graph shows a steady increase in the number of ‘walk-ins’ over the last ten years and an increase in ‘walk-ins’ as a proportion of total presentations from 2019-20 to 2020-21.

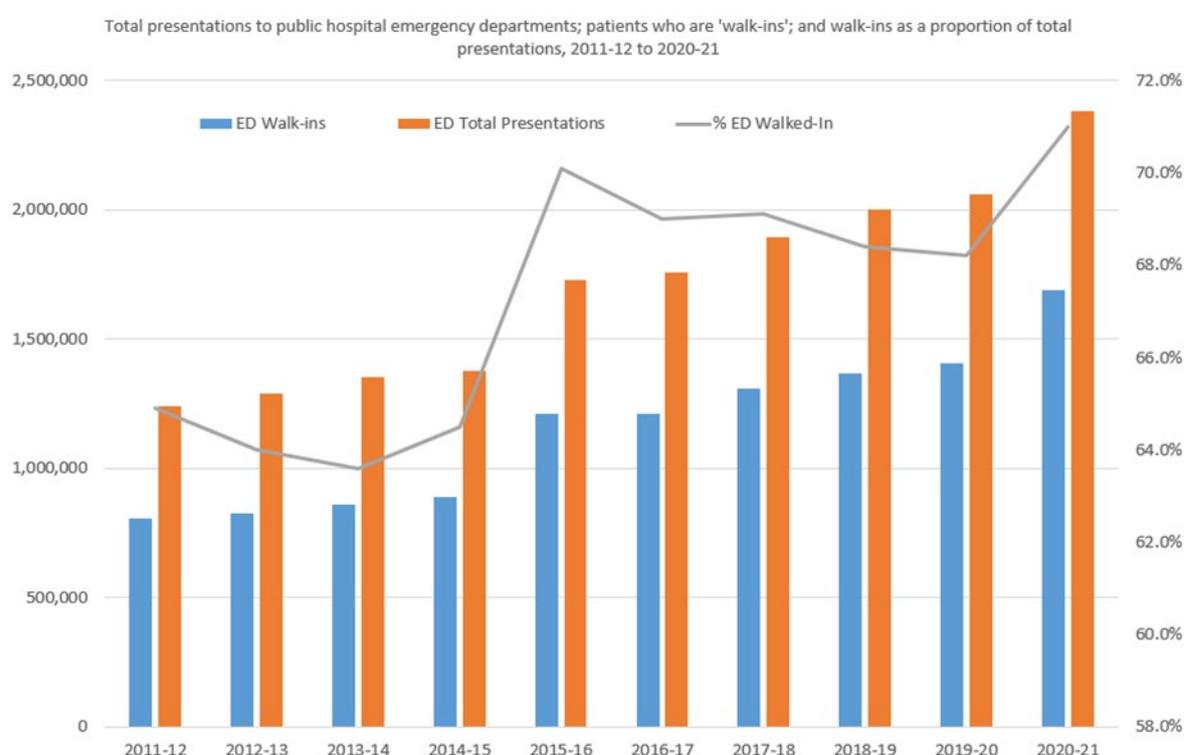


Figure 3 - Total presentations to public hospitals in Queensland; patients who are 'walk-ins'; and 'walk-ins' as a proportion of total presentations; source Queensland Health, response to questions on notice – ED walk-ins, 7 December 2021.

<sup>77</sup> Australian Government, AIHW, 'Use of emergency departments for lower urgency care: 2015-16 to 2018-19', <https://www.aihw.gov.au/reports/primary-health-care/use-of-ed-for-lower-urgency-care-2018-19/contents/lower-urgency-care/summary>.

<sup>78</sup> Submission 73, p 5.

<sup>79</sup> Submission 73, p 5.

The committee heard that many people present to emergency departments for health conditions that may be managed more appropriately and effectively in a different health care setting, eg a General Practice or community walk-in clinic.<sup>80</sup> For example, the Australian College of Rural and Remote Medicine (ACRRM) stated:

Given that [MBS] rebates have not kept up with increasing costs for patients and the increasing ability for practices to absorb the shortfall, this imbalance will eventually drive patients to cheaper options like an emergency department'.<sup>81</sup>

The United Workers Union (UWU) noted that patients present at emergency departments rather than wait weeks for an appointment with the few accessible GPs who bulk bill.<sup>82</sup> The Community Nurse Service, Bundaberg, provided the following example:

Emergency departments across Queensland are the backstop for anyone in the community who needs an emergency or a planned catheter change if they cannot access this elsewhere or cannot afford privately for this to be completed. The Queensland public health system is affected by the lack of continence services, because these people or their carers eventually find the workload or expense of dealing with these problems too much of a burden, resulting in an admission and possibly eventual residential care.<sup>83</sup>

Townsville HHS explained the impact on the services they provide to the public:

Last financial year our emergency department presentations increased to 91,920 at Townsville University Hospital, an average of 251 people a day and an 8.2 per cent increase on the previous year. About 30 per cent of those presentations are admitted to hospital. Our patients tell us that getting access to general practice is difficult, which often drives them to seek the emergency department. This is made even more difficult by the lack of afterhours availability.<sup>84</sup>

It also highlighted the difficulty patients have in accessing primary care:

Speaking to my colleagues in the emergency department, they tell me that, of the 50 or so general practices in our community, about six operate after 6 pm and only one operates after 9 pm, and it is in that order of magnitude. The private hospital emergency department operates from 7 am until 11 pm and patients incur a fee-for-service for their attendance. Our total surgical operations— both emergency and elective—grew by 6½ per cent year on year last year. Primarily, that was due to 1,345 additional elective, not emergency, procedures—which was a growth of 16 per cent. We also outsource to the private sector and grew that by 49 per cent for public procedures. Outpatient services increased by three per cent.<sup>85</sup>

The issue of the accessibility of GP services, in particular bulk-billing and after-hours services, is discussed further at section 5.2 of this report.

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<sup>80</sup> Submissions 36, 47, 50 and 73.

<sup>81</sup> Submission 13, p 5.

<sup>82</sup> Submission 36, p 8.

<sup>83</sup> Public hearing transcript, Bundaberg, 2 March 2022, p 12.

<sup>84</sup> Public hearing transcript, Townsville, 9 February 2022, p 3.

<sup>85</sup> Townsville HHS, public hearing transcript, Townsville, 9 February 2022, p 3.

The committee heard that lower acuity presentations at emergency departments are also more prevalent in regional, rural and remote areas. For example:

- 48.7 per cent of presentations in the area covered by Western Queensland PHN were classified as lower urgency care in 2018-19<sup>86</sup>
- 50 per cent of presentations in the Mackay HHS area were considered category 4 or 5 in 2020-21 – a nine per cent increase compared to 2019-20.<sup>87</sup>

A recent study led by Dr Yaqoot Fatima, a researcher at James Cook University (JCU) and the University of Queensland (UQ), found that:

Utilisation of ED [emergency department] services is increasing rapidly, with national data showing that around 35 per cent of ED attendances are for less urgent problems. In rural communities, the number of people using the ED for less urgent problems is up to 70 per cent.<sup>88</sup>

The study found that the top three presenting diagnoses were viral infections, upper respiratory infections and wound care.<sup>89</sup>

A high proportion of these types of presentations occur after hours (ie on Sundays, public holidays, before and after business hours on weekdays and weekends), which may reflect the lack of access to GP services after hours in Queensland (as discussed in section 5.2 of this report).<sup>90</sup>

However, Dr Fatima's study data suggests that while about half of all Category 4 and 5 (lowest urgency) attendances met the agreed definition of GP-appropriate problems, about half of the Category 4 and 5 presentations were during normal work hours when GP services would have been available.<sup>91</sup>

Similarly, the Pharmaceutical Society of Australia (PSA) noted that, in 2018-19, 70 per cent of non-urgent cases presented to the emergency department between the hours of 9:00 am and 7:00pm, meaning they could have readily accessed pharmacists in community pharmacies for their non-urgent health care.<sup>92</sup>

According to Queensland Health, in 2018-19, there were 406,000 lower urgency emergency department presentations in Queensland. Dr Wakefield, former Director-General, Queensland Health, stated that:

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<sup>86</sup> Australian Government, AIHW, Use of emergency departments for lower urgency care: 2015-16 to 2018-19, <https://www.aihw.gov.au/reports/primary-health-care/use-of-ed-for-lower-urgency-care-2018-19/contents/lower-urgency-care/summary>.

<sup>87</sup> QRRPHN, submission 70, p 6.

<sup>88</sup> Australian Institute of Tropical Health and Medicine, 'Emergency departments used for non-urgent cases', <https://www.aithm.jcu.edu.au/emergency-departments-used-for-non-urgent-cases/>.

<sup>89</sup> Australian Institute of Tropical Health and Medicine, 'Emergency departments used for non-urgent cases', <https://www.aithm.jcu.edu.au/emergency-departments-used-for-non-urgent-cases/>.

<sup>90</sup> Australian Government, AIHW, Use of emergency departments for lower urgency care: 2015-16 to 2018-19, <https://www.aihw.gov.au/reports/primary-health-care/use-of-ed-for-lower-urgency-care-2018-19/contents/lower-urgency-care/summary>.

<sup>91</sup> Australian Institute of Tropical Health and Medicine, 'Emergency departments used for non-urgent cases', <https://www.aithm.jcu.edu.au/emergency-departments-used-for-non-urgent-cases/>.

<sup>92</sup> Submission 47, p 6.

... over a quarter of all of our emergency department presentations, at least at some level, could and should be provided in a community setting—if it was available, free at the point of care and accessible to people. Many of these occur after hours or in rural areas, and they reflect a lack of primary and GP services at these times or locations.<sup>93</sup>

Queensland Health advised that given the average cost of an emergency department presentation is \$729, it is clear that more appropriate funding of GP consultations by the Australian Government would reduce demand and cost on the public health system, leading to a more sustainable and cost-effective health system.<sup>94</sup> Queensland Health stated:

There is a strong case for the Commonwealth to fund the full cost of GP-type presentations to emergency departments. Not only would this lead to more equitable funding arrangements, it would drive reforms to primary health care policy and funding models that provide the right care, at the right time in the right setting.<sup>95</sup>

### Committee comment

The committee acknowledges the impact and financial cost that lower urgency presentations have, not only on public emergency departments, but also on patients and their health outcomes.

The committee notes that these types of presentations, which could be more appropriately addressed by GPs in primary health care or community settings, represented over a quarter of emergency department presentations in Queensland in 2018-19. The committee also notes the cost of addressing a non-urgent emergency presentation (estimated at \$540), compared to a 40-minute GP consultation which is \$111.50.

The committee recommends that given its responsibility for the funding and delivery of primary health care services, the Australian Government should fund the cost incurred by the Queensland public health system of lower acuity presentations to emergency departments, which could have been more appropriately dealt with in a primary care or community setting.

The committee considers that this approach would lead to more equitable funding arrangements and drive reforms to primary health care policy and funding models.

**Recommendation 2 – Australian Government to pay fair share of cost of lower acuity emergency department presentations**

The committee recommends that the Australian Government funds the costs incurred by the Queensland public health system of lower acuity presentations to emergency departments, which could have been more appropriately dealt with in a primary care setting.

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<sup>93</sup> Public briefing transcript, Brisbane, 29 November 2021, p 3.

<sup>94</sup> Submission 39, p 15.

<sup>95</sup> Submission 39, p 15.

#### 4.2.2 Increase in mental health presentations to emergency departments

The Queensland Mental Health Commissioner stated that ‘The impact of our current unbalanced [mental health] system can be seen through blockages in our emergency departments’. The Commissioner stated:

Reliance on ED [emergency department] intervention can be considered a sign of system failure. Earlier responses are required to prevent and intervene when mental health challenges arise. Too often the first-time people present for help is to an emergency department, often via ambulance services or accompanied by the police.

This additional pressure is exacerbated by the fact Queensland has the lowest per capita spending of any state on public mental health services. Queensland has also the lowest number of mental health inpatient beds per capita in Australia, and people who can’t get help in the community often end up in crisis at an ED.<sup>96</sup>

The Australian Psychological Society (APS) referred to a dramatic increase in mental health presentations at emergency departments.

APS stated ‘Colloquially named the ‘canary in the coalmine’; increases in presentations to emergency departments are signals that the mental health system is not coping as patients typically have no other avenue of support’.<sup>97</sup>

QNMU noted that, in 2019-20, mental health-related presentations to public emergency departments was 4.1 per cent and this figure has been steadily rising over a number of years.<sup>98</sup>

Central Queensland HHS referred to:

... an exponential growth in young people presenting to emergency departments with suicide ideations. The seeking of acute public mental health should be the very last resort for these consumers, but rather it is the first port of call because there are very few services and significant waiting times in the private and public sector, and when they can access services there is considerable out-of-pocket expense due to the gaps in the Medicare benefits scheme.<sup>99</sup>

#### Committee comment

The committee notes the impact that the increasing number of mental health presentations has on the public health system, which has increased notably due to the impacts of the COVID-19 pandemic.

The committee shares the concerns of submitters and witnesses that for many people with a mental health condition their first contact, and step towards treatment, is via an emergency department.

The committee encourages the Mental Health Select Committee to consider this issue, in detail, during its inquiry and to include recommendations for systemic reform to the mental health system at a national level to improve care for those people with a mental health issue and reduce the burden on the Queensland public health system.

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<sup>96</sup> Submission 44, p 6.

<sup>97</sup> Submission 33, p 1.

<sup>98</sup> Submission 69, p 36; Australian Government, AIHW, 2021, ‘Mental health services in Australia’, <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/hospital-emergency-services>.

<sup>99</sup> Public hearing transcript, Rockhampton, 3 March 2022, p 3.

#### 4.2.3 Presentations at emergency departments from residential aged care facilities

Queensland Health advised that, in 2020-21, there was a total of 39,358 ambulance transfers (Code 1 and 2) from residential aged care facilities (RACFs) to Queensland Health hospital emergency departments – an 8.2 per cent increase from the previous year.<sup>100</sup>

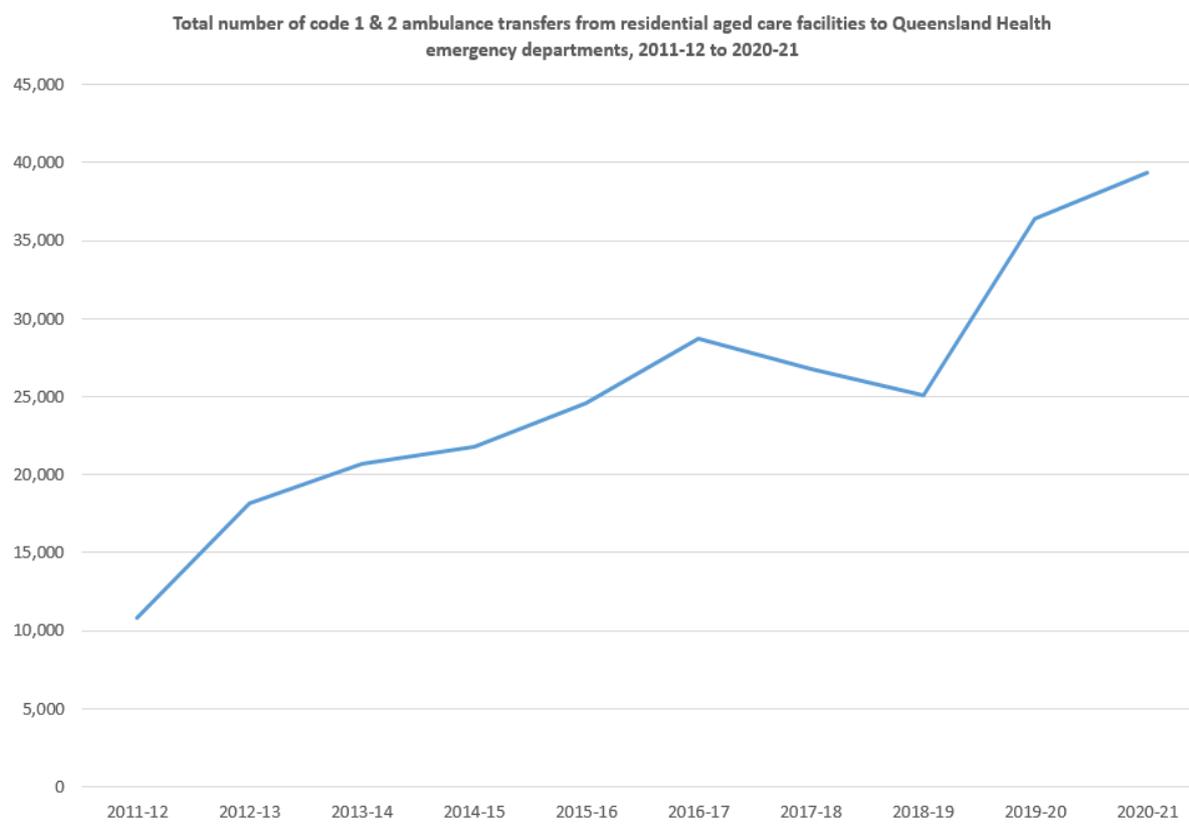


Figure 4 - Total number of code 1 and 2 ambulance transfers from RACFs to Queensland Health emergency departments; source Queensland Health, response to question on notice – Ambulance transfers residential aged care, 7 December 2021.

Figure 4 demonstrates that the number of Code 1 and 2 ambulance transfers from RACFs to public emergency department per year has increased significantly from 2018-19 (25,000) to 2021 (almost 40,000).

QNMU advised that it is also apparent that many residential aged care providers ‘default to sending their residents to hospital when the care they need is something you would expect to receive from an RN [registered nurse] or a GP in an aged care facility’.<sup>101</sup> A QNMU member informed the committee:

We see many residential aged-care residents being sent to the ED [emergency departments] department at all hours. That is mainly because there is not a registered nurse on each shift. There are unlicensed and untrained workers in the service and clearly they are not able to make that clinical judgement and they do not have the expertise to manage somebody who perhaps might have dementia or delirium on top of the dementia, so they tend to panic and dial triple 0 and send them to the hospital—quite rightly I might

<sup>100</sup> Submission 39, p 6.

<sup>101</sup> Submission 69, p 21.

add. However, there should be a registered nurse on each shift, and I draw your attention to that which has been happening lately.

Since January 2021, the lowest monthly presentations of category 4 triage have been 392 ranging to a high of 493 presentations per month, with an average of over 400 per month and a total of 5,789 presentations of category 4 in 2021 to the end of January this year. Category 5 lowest monthly figures have been 243 with a high of 346 and a total monthly figure of 3,676 up to January 2022. That is an average presentation of about 285 category 5s monthly. That has an impact on the service.<sup>102</sup>

QNMU referred to research which shows that nearly 37 per cent of Australian aged care residents over 65 were taken to an emergency department for treatment at least once in 2018-19.<sup>103</sup> QNMU advised that aged care residents are being sent to emergency departments for procedures, such as:

- catheter changes
- intravenous fluids (IV)
- basic wound reviews
- unitary tract infections.<sup>104</sup>

In relation to catheter changes, UWU stated that:

It is a pretty simple procedure. During their training all nurses will have learned how to do it. Simply due to probably some skill degradation and policies in particular facilities, they have said they cannot do that procedure and the patient must be taken to hospital. Or they just simply do not have enough time. It might be an urgent catheter change if they have some urinary retention or a catheter is blocked. The longer it is blocked and the more the retention is there, the greater the risk of infection. They will sit and wait for an ambulance to get there. Obviously it is a lower priority call in the initial instance, and given our current demand they might wait some time for that. That patient could have had that problem resolved there in the nursing home, but they end up going to hospital and sitting on a stretcher for a couple of hours when the hospital system is under strain.<sup>105</sup>

QNMU stated that 'if there was the right skill mix and number of RNs [registered nurses] employed at residential aged care facilities these could be addressed within the facility'.<sup>106</sup> These issues, and the reported lack of access to GPs in RACFs, are discussed at section 7.3 of this report.

#### Committee comment

The committee notes the continued increase in the number of emergency department presentations from RACFs, and the impact they are having on Queensland's public hospitals.

The committee is concerned by the figures and statistics shared by submitters and witnesses, for example that over a third of RACF residents in Australia, over 65 years old, had been taken to an emergency department at least once in 2018-19.

As outlined above, and in further detail in Chapter 7 of this report, a significant number of these issues could have been dealt with at RACFs, if there was sufficient access to primary and allied health care within RACFs (improved models of care), in particular GPs and registered nurses.

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<sup>102</sup> Shaun Cram, QNMU Member, public hearing transcript, Mossman, 8 February 2022, pp 11-12.

<sup>103</sup> Submission 69, p 21.

<sup>104</sup> Submission 69, p 21.

<sup>105</sup> Public hearing transcript, Brisbane, 21 February 2022, p 22.

<sup>106</sup> Submission 69, p 21.

It could be argued that, in transferring their residents to emergency departments for treatments that could have been dealt with by a GP or registered nurse, RACF owners are transferring their costs to the public health system.

The Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee made a number of recommendations in its Report No. 33, 56th Parliament – Aged care, end-of-life and palliative care aimed at addressing issues in the aged care system. The committee notes that the Australian Government has not responded to those recommendations.

The committee has made a number of recommendations in this report calling on the Australian Government to respond to those recommendations as a matter of urgency.

### **4.3 Potentially preventable hospitalisations**

The committee heard that service gaps in primary and allied health care are leading to potentially preventable hospitalisations (PPHs).<sup>107</sup>

The AIHW describes PPHs as specific hospital admissions that potentially could have been prevented by the provision of appropriate preventive health interventions and early disease management in primary care and community-based care settings (including by GPs, medical specialists, dentists, nurses and allied health professionals).<sup>108</sup>

The AIHW reported that, in 2017-18, 748,000 admissions in public and private hospitals were classified as PPHs across Australia.<sup>109</sup> UWU noted that this accounted for 1 in 5 hospital admissions.<sup>110</sup>

Queensland Health advised that, in 2019-20, there was a total of 174,839 PPHs in Queensland, representing 6.6 per cent of all separations – 152,948 episodes were in public hospital, at a total cost of \$1.164 billion.<sup>111</sup>

PPH rates are seen as indicators of the effectiveness of non-hospital care. The rate of PPHs may reflect the level of access to primary health care, as well as sociodemographic factors and health behaviours. There are 22 conditions for which hospitalisation is considered potentially preventable, across three broad categories: chronic; acute and vaccine-preventable conditions.<sup>112</sup>

Queensland Health advised PPHs vary significantly in line with access to primary health care services and are highest for Aboriginal and Torres Strait Islander people and people in rural and remote areas.<sup>113</sup> The Queensland Rural and Remote Primary Health Networks (QRRPHN) noted that:

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<sup>107</sup> Submissions 39, 47, 48, 50, 51, 61, 65 and 71.

<sup>108</sup> Australian Government, AIHW, Disparities in potentially preventable hospitalisations across Australia, 2012-13 to 2017-18, <https://www.aihw.gov.au/getmedia/20bc5bf9-d46c-40a7-96c1-d632a1d448bc/aihw-hpf-50.pdf.aspx?inline=true>.

<sup>109</sup> Australian Government, AIHW, Disparities in potentially preventable hospitalisations across Australia, 2012-13 to 2017-18, <https://www.aihw.gov.au/getmedia/20bc5bf9-d46c-40a7-96c1-d632a1d448bc/aihw-hpf-50.pdf.aspx?inline=true>.

<sup>110</sup> Submission 36, p 4.

<sup>111</sup> Submission 39, p 16.

<sup>112</sup> Australian Government, AIHW, Disparities in potentially preventable hospitalisations across Australia, 2012-13 to 2017-18, <https://www.aihw.gov.au/getmedia/20bc5bf9-d46c-40a7-96c1-d632a1d448bc/aihw-hpf-50.pdf.aspx?inline=true>.

<sup>113</sup> Submission 39, pp 16-17.

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.<sup>114</sup>

PSA stated that 12 per cent of all hospital admissions and 20 to 30 per cent of hospital admissions, in those aged over 65 years of age, are medication related. While this figure is nationwide, it provides an indication of the magnitude of harm that Queenslanders are experiencing.<sup>115</sup>

PSA referred to research into medication-related hospital admissions which showed that between 15 and 61 per cent of hospitalisations may have been avoided had a process of care to improve medication management been utilised.<sup>116</sup> PSA also referred to evidence that suggests that medication management reviews undertaken by pharmacists can lead to reduced levels of hospitalisations for people in the community who are at high risk of medication-related hospital admissions.<sup>117</sup>

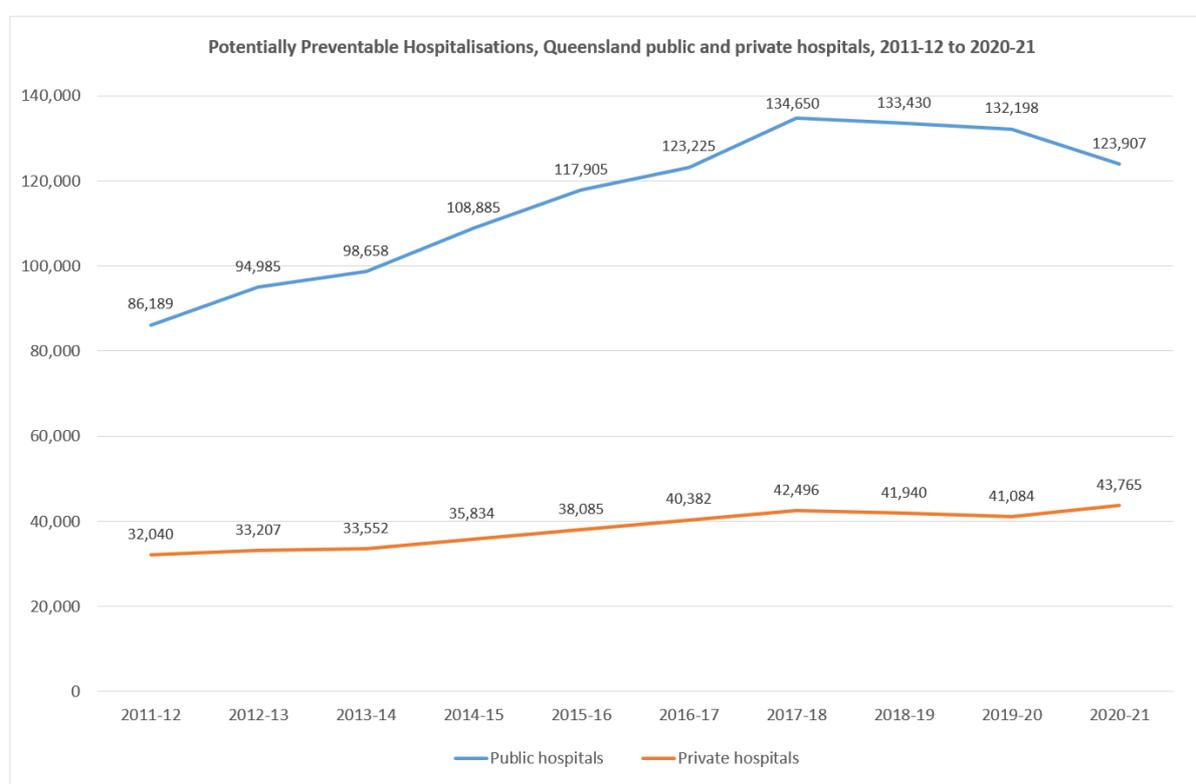


Figure 5 - Potentially preventable hospitalisations - 2011-21 to 2020-21, source Queensland Health response to question on notice – potentially preventable hospitalisations, 7 December 2021.

<sup>114</sup> Submission 70, p 5.

<sup>115</sup> Submission 47, p 3.

<sup>116</sup> Submission 47, p 3; LM Kalisch, GE Caughey, JD Barratt, EN Ramsay, G Killer, AL Gilbert, et al. ‘Prevalence of preventable medication-related hospitalizations in Australia: an opportunity to reduce harm’. *International Journal for Quality in Health Care*, 2012; 24(3):239-49.

<sup>117</sup> Submission 47, p 3; L Roughhead, S Semple, E Rosenfeld. ‘Literature review: Medication safety in Australia’. Sydney, Australian Commission on Safety and Quality in Health Care, 2013.

Committee comment

Over the last decade, the number of PPHs at public hospitals has increased by over 43 per cent - from 86,189 in 2011-22 to 123,907 in 2020-21.

The committee notes that this comes at a significant cost to the public health system – with PPHs costing the public health system approximately \$1.164 billion in 2019-20 alone.

As acknowledged by the AIHW, the rates of PPHs are seen as an indicator of the effectiveness of non-hospital care and the accessibility and availability of other health care, such as primary and allied health care services.

In this report, the committee has made a number of recommendations aimed at improving access to primary and health care, increased investment in early intervention and preventive health care and the use of innovative models of care.

The committee recommends that the Australian Government funds the full cost to the public health system of PPHs to incentivise the Australian Government’s uptake of reforms to primary health care policy and funding models aimed at reducing PPHs.

**Recommendation 3 – Australian Government to pay fair share of cost of potentially preventable hospitalisations**

The committee recommends that the Australian Government funds the cost of potentially preventable hospitalisations in Queensland’s public hospitals in order to incentivise reforms to primary health care policy and funding models aimed at reducing potentially preventable hospitalisations.

#### **4.4 Avoidable hospitalisations due to lack of aged care and NDIS services**

During its inquiry, the committee heard about the significant impact on the Queensland public health system of avoidable admissions to public hospitals due to a lack of aged care services.<sup>118</sup>

The Royal Commission into Aged Care Quality and Safety (Royal Commission) noted that hospitalisations are widely understood to be important indicators for monitoring the quality of aged care services, particularly RACFs.<sup>119</sup>

AMA estimates that, Australia-wide, 27,569 hospital admissions per year from RACFs are potentially preventable at an annual cost of \$312 million.<sup>120</sup>

The Royal Commission noted that publicly available information about hospitalisations is very limited. However, the Royal Commission produced a dataset, which showed that a large number of people in permanent residential aged care, aged 65 years or more, are hospitalised, some for reasons that are potentially preventable. The Royal Commission found that, in 2018-19, across Australia:

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<sup>118</sup> Public briefing and hearing transcripts, Brisbane, 29 November 2021, pp 3-5; Brisbane, 8 December 2021, pp 2, 15; Logan 10 February 2022, p 2; Brisbane, 21 February 2022, p 5.

<sup>119</sup> Royal Commission into Aged Care Quality and Safety, ‘Hospitalisations in Australian Aged Care: 2014/15-2018/19’, Research Paper 18, February 2021, p 1.

<sup>120</sup> AMA, *Putting health care back into aged care*, 2021, p 9.

- 36.9 per cent of residents presented to an emergency department at least once
- 31.1 per cent of residents were admitted to a public hospital at least once (increasing to approximately 37 per cent when private hospitals admissions are included)
- residents received 9.1 days of care in public hospitals per 1,000 resident days (increasing to approximately 11.5 days when private hospital stays are included).<sup>121</sup>

The Royal Commission found that the most common reasons for hospital admissions were respiratory disease, injuries, circulatory disease, dialysis and symptoms and signs.<sup>122</sup>

Metro South HHS referred to an increase in preventable hospitalisations for:

... things like cellulitis, for example, or a UTI— have certainly increased. They are non-acute/subacute type presentations. The largest proportion are in people aged over 65. What Metro South has done, alongside some other areas, is establish a program called CAREPACT, which actually liaises with aged care and Queensland Ambulance to try to provide timely health advice so that aged-care facilities can provide in-home care. One of the great achievements has been how to keep people in aged care who may be COVID-positive but otherwise okay, otherwise well, but also then to monitor their functioning so that we can admit them as soon as possible. It is reducing the time they may otherwise spend in hospital.<sup>123</sup>

The Australian Physiotherapy Association (APA) referred to the impact that falls have on older people, including avoidable admissions to hospital:

Most falls at an aged-care facility are not like a fall for us, where you might dust yourself off and have a small ache or pain. They present as considerable time in hospital. The small real value of a half-hour to an hour physio appointment, whether that is once a week or once a fortnight, compared with upwards of \$2,000 per day in a hospital—it is a small cost. For a fall that results in a fractured hip we are talking about operations and we are talking about a possible two-week stay in hospital which could very much have been prevented. It is mentioned in the report about how preventable they are with regular ongoing strength maintenance and physiotherapy input.<sup>124</sup>

As noted by QNMU, RACFs are experiencing financial and or staffing shortages and as a result the Queensland Government will be called upon to act to provide these services in the local affected communities. QNMU stated that:

It is not technically their [Queensland Health] responsibility to do so, but such systems failures demand urgent action and unfortunately given Queensland Health is all too often the major health service provided in many communities in Queensland, it will fall to Queensland Health to fill the void.

If the federal government, as funder and regulator, continues to fail to take responsibility, the impact on Queensland's public health system will be immense as it tries to deal with an increasing and ageing population, coupled with growing health care needs.<sup>125</sup>

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<sup>121</sup> Royal Commission into Aged Care Quality and Safety, 'Hospitalisations in Australian Aged Care: 2014/15-2018/19', Research Paper 18, February 2021, p 1.

<sup>122</sup> Royal Commission into Aged Care Quality and Safety, 'Hospitalisations in Australian Aged Care: 2014/15-2018/19', Research Paper 18, February 2021, p 1.

<sup>123</sup> Public hearing transcript, Logan, 10 February 2022, p 2.

<sup>124</sup> Public hearing transcript, Brisbane, 21 February 2022, pp 10-11.

<sup>125</sup> Submission 69, p 18.

In relation to NDIS services, Queensland Health advised that many presentations to emergency departments and acute psychiatric admissions are due to NDIS providers relinquishing support as they are unable to manage a participant’s escalating behaviours of concern. Queensland Health stated:

Participants are regularly relinquished to emergency departments by NDIS providers and families when they can no longer cope, where NDIS-funded supports have failed or when the participant has depleted their plan funding.<sup>126</sup>

Queensland Health explained that ‘This has significant impacts on the wellbeing of these participants, and on the health system’.<sup>127</sup>

Issues in relation to access and availability of aged care and NDIS care services are discussed further at Chapters 7 and 8 of this report.

#### 4.5 Older patients becoming long-stay patients in public hospitals

The committee heard that once in the hospital system, older persons needing aged care services face a significant risk of becoming long-stay patients whilst awaiting adequate aged care supports whether in the home or in RACFs.<sup>128</sup>

Queensland Health advised that, on 24 November 2021, approximately 175 older patients remained in a public health setting waiting for Australian Government aged care supports despite being medically ready for discharge, at a cost of \$2,011 bed day cost. Queensland Health advised that:

In reality, the costs are even higher, given the complex needs of some patients who may require nurse specialists, multiple beds, or increased security in the hospital. This cost is substantially more than hospitals receive in revenue for the patients’ care and a patient with extremely high care needs can cost the health system up to \$20,000 per day.<sup>129</sup>

Date	Number of Long-stay older patients	Median days	Average days
28 October 2020	231	48	112
25 November 2020	234	48	88
24 February 2021	289	62	103
26 May 2021	312	42	81
25 August 2021	325	47	111
24 November 2021	272	43	111

*Table 3 - Long-stay older patients - length of stay, source Queensland Health, response to questions on notice - Long stay patients, 7 December 2021.*

<sup>126</sup> Submission 39, p 26.

<sup>127</sup> Submission 39, p 26.

<sup>128</sup> Public briefing and hearing transcripts: Brisbane, 29 November 2021, p 4; Cairns, 7 February 2022, p 2; Mossman, 8 February 2022, p 14; Townsville, 9 February 2022, p 2; Brisbane, 21 February 2022, pp 25-26; Bundaberg, 2 March 2022, p 2; Rockhampton, 3 March 2022, p 7.

<sup>129</sup> Queensland Health, response to question taken on notice – Long stay patients, 7 December 2021, p 9.

Queensland Health advised that, as at 24 November 2021, the highest barrier to discharge was waiting for a RACF bed (63.6 per cent). Queensland Health noted that the current cohort of older patients waiting for aged care is costing over \$350,000 per day.<sup>130</sup>

Townsville HHS explained the difficulties in its region:

For the elderly in our hospital awaiting placement, we find there are two fundamental insufficiencies. One is that there are just not enough residential beds available in our community to meet the demand. Secondly, there are not the places that can care for those with complex needs, specifically those who are quite high-care individuals with multiple, complex behavioural elements that need settings that cater for dementia, challenging behaviours, wandering and some gender specific environments for successful transition for them and other residents. We also struggle with a lack of GPs to service residential aged-care environments and that is another frequent barrier for placement.<sup>131</sup>

The Together Union stated that ‘Because of failings in the aged care and disability systems, hospitals are warehousing people who should be moved out of acute beds’. The Together Union called for the Australian Government to ‘step up and fix these problems’.<sup>132</sup>

Central Queensland HHS also highlighted the issue of older patients waiting in acute beds for an aged-care placement, stating:

Today there are 42 people across Central Queensland hospitals, but primarily here in Rockhampton, waiting for a residential aged-care facility bed and four people in acute beds here in Rockhampton Hospital awaiting the finalisation of their NDIS package. They are not medically or acutely unwell, they simply do not have anywhere else to go. The longer these people stay in hospital, the more likely it is that, despite the very best of care, they will fall, they will develop a pressure injury or they will simply pick up a nosocomial infection that can deteriorate both their cognitive and functional capability. For some people the lack of aged-care beds here in Central Queensland results in them living in Rockhampton Hospital for months. Two years ago I led a review on the growth requirements for aged-care beds in Central Queensland. The available evidence at the time described an immediate shortage of around 190 aged-care residential beds across Central Queensland and that will escalate if we do nothing to 2,000 beds short by 2036. Without any future investment it looks quite bleak.<sup>133</sup>

Queensland Health’s submission confirmed these impacts:

Discharge delays divert resources away from patients who need acute care. In addition, unnecessarily prolonged hospitalisations are associated with adverse patient outcomes including deconditioning, institutionalisation, hospital acquired infection and the psychological distress that comes from being forced to live in a hospital bed unnecessarily.<sup>134</sup>

The Northern Queensland PHN explained the impact of limited access to GPs and its impact on the public health system, stating:

Limited access to general practitioners results in poor discharge rates. If you have patients within your system in your specialist outpatients department who need to be discharged back into the community

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<sup>130</sup> Submission 39, p 24.

<sup>131</sup> Public hearing transcript, Townsville, 9 February 2022, p 2.

<sup>132</sup> Submission 46, p 4.

<sup>133</sup> Public hearing transcript, Rockhampton, 3 March 2022, p 2.

<sup>134</sup> Submission 39, p 24.

into primary care—in Mackay I have 33 per cent of our practices closed to new patients— they cannot be discharged, so your flows are disrupted quite significantly.<sup>135</sup>

Committee comment

The committee acknowledges the impacts that delays in discharging older people, who are medically ready to be discharged from hospital, has on the public health system. The committee notes that many of these patients could be more appropriately cared for in aged care settings and that unnecessarily prolonged hospitalisations may lead to adverse patient outcomes, such as deconditioning and hospital acquired infections.

The committee shares submitters' calls for the Australian Government to address these issues given its responsibility for funding and regulating the aged care system. Accordingly, the committee recommends that the Australian Government puts in place arrangements for Queensland's HHSs to be reimbursed for the cost of excessive length of patient stay in hospitals caused by a lack of access to aged care services.

**Recommendation 4 – Australian Government to reimburse costs of excessive long-stay patients due to delays in accessing aged care services**

The committee recommends that the Australian Government establishes arrangements for Queensland's Hospital and Health Services to be reimbursed for the cost of excessive length of patient stays in public hospitals caused by a lack of access to aged care services.

The committee accepts that the issue of older patients becoming long-stay patients can only be addressed through increased collaboration and co-ordination between the various agencies and services at the interface between the aged care and health systems.

The committee notes that the Australian and Queensland Governments have taken action to support the discharge of older patients, who are medically ready, from hospital. These initiatives include HHSs directly funding more additional aged care beds in areas, Queensland Health's Long-Stay Rapid Response initiative and the Australian Government's Transition Care Program. These initiatives are discussed further at section 7.4 of this report.

The committee recommends that the Australian and Queensland Governments collaborate to improve discharge arrangements and post-hospitalisation care planning (including the timely completion and availability of discharge documents) between public hospitals, allied and primary health service providers, residential aged care facilities and providers of other aged care services, such as home care packages, to reduce the number of older persons becoming long-stay patients in public hospitals.

**Recommendation 5 – Collaboration to improve hospital discharge arrangements (older patients)**

The committee recommends that the Australian and Queensland Governments collaborate to improve discharge arrangements and post-hospitalisation care planning (including the timely completion and availability of discharge documents) between public hospitals, allied and primary health service providers, residential aged care facilities and providers of other aged care services, such as home care packages, to reduce the number of older persons becoming long-stay patients in public hospitals.

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<sup>135</sup> Public hearing transcript, Brisbane, 8 December 2021, p 18.

#### 4.6 People with a disability becoming long-stay patients in public hospitals

Queensland Health advised that inadequate access to NDIS supports is also contributing to unnecessarily prolonged hospitalisations.<sup>136</sup> Queensland Health also stated that ‘In the event of NDIS market, administrative or provider failure, the public health system has become the default provider of last resort’.<sup>137</sup>

The Australian Government also acknowledged that:

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 extended stay in hospital when one or more of their support needs cannot readily be met in the community.<sup>138</sup>

As at 24 November 2021, there were 235 long-stay patients occupying Queensland Health beds awaiting disability supports at a cost of around \$472,000 per day.<sup>139</sup> The highest reported barriers to discharge for long-stay young patients were NDIS-related administrative delays in:

- access and planning (31.5 per cent)
- availability of supported individual living (13.2 per cent)
- complex medical requirements (7.7 per cent).<sup>140</sup>

Date	Number of Long-stay younger patients	Median days	Average days
28 October 2020	190	176	375
25 November 2020	208	172	348
24 February 2021	286	175	330
26 May 2021	237	155	312
25 August 2021	238	99	266
24 November 2021	235	125	282

*Table 4 - Long-stay younger patients, source Queensland Health, response to questions on notice - Long-stay patients, 7 December 2021.*

The committee notes that these are patients who are medically ready for discharge but cannot transition to the community because they do not have access to the appropriate disability supports or accommodation.

<sup>136</sup> Submission 39, p 27.

<sup>137</sup> Submission 39, p 25.

<sup>138</sup> Submission 75, p 18.

<sup>139</sup> Queensland Health, submission 39, p 27.

<sup>140</sup> Queensland Health, submission 39, p 6; Queensland Health, response to question on notice – Long-stay patients, 7 December 2021, p 8.

At the public briefing, Queensland Health provided an example of an NDIS patient who was unable to obtain suitable disability care accommodation and as a result stayed in hospital unnecessarily for seven months and cost the public health system \$2 million:

Tommy was admitted to hospital in December 2020, when he was 18 years old. I spent quite a bit of time back and forth with the provider HHS, with the departmental people, trying to resolve the situation for Tommy and with Tommy. Tommy had a breakdown in his disability residential accommodation and support arrangements. As is often the case, because the hospital is the provider of last resort, he ended up in hospital. He did not need hospital and a hospital was not the right place for him, but there was nowhere else to go. Due to the risks that he posed to himself, other patients and staff during this admission, he needed 24/7 security and one-on-one nursing support. Tommy had significant behavioural challenges which were exacerbated by being in hospital.

A lack of NDIS policy flexibility, a poor provider market and poorly structured disability accommodation pricing all contributed to the discharge delays that Tommy experienced. There were many meetings and many attempts to try to get an appropriate place for Tommy. Tommy was discharged successfully in July 2021. I am pleased to say that, according to his mum, he is now thriving in his new home environment—after seven months of unnecessary admission and with his hospital stay costing over \$2 million to the healthcare system. Fundamentally, though, we failed Tommy as a society. Sometimes administrative matters can have a huge impact on people’s experience and outcomes.<sup>141</sup>

Cairns and Hinterland HHS also provided an example of one NDIS patient enduring an 11-month hospital stay, stating ‘... 11 months in hospital is 22 rehab admissions, so 22 people could have been receiving rehab during that period’.<sup>142</sup>

Gold Coast HHS provided the following information about long-stay patients:

We can see that we have a range of patients from 35 days up to and including sometimes two years. In the last three years we have made great efforts to reduce the length of stay so that we are not having patients in for 12 months or 24 months. However, we do continue to get some patients like that.<sup>143</sup>

Whereas, Metro-South HHS contrasted long stays for patients waiting for aged care with those waiting for NDIS placements:

What we find is that, when talking about the number of days a bed is occupied, we have a higher number of people waiting for aged-care beds but a lower number of days they wait, so the volume is important. It is the reverse for people who are National Disability Insurance Scheme participants. There is a lower number but they wait much longer. We have some who can wait—it is very uncomfortable—a year.<sup>144</sup>

Queensland Health advised that delays in discharging long-stay patients awaiting disability supports have significant implications and adverse outcomes for people with a disability, including deconditioning, institutionalisation, hospital acquired infection and psychological distress. Such delays also impact on the public health system and divert resources away from patients who need acute care.<sup>145</sup>

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<sup>141</sup> Public briefing transcript, Brisbane, 29 November 2021, p 5.

<sup>142</sup> Public hearing transcript, Cairns, 7 February 2022, p 3.

<sup>143</sup> Public hearing transcript, Gold Coast, 10 February 2022, p 2.

<sup>144</sup> Public hearing transcript, Logan, 10 February 2022, p 4.

<sup>145</sup> Submission 39, p 28.

Queensland Health contended that the National Disability Insurance Agency (NDIA) does not have a financial incentive to prevent participants remaining in hospital longer than is medically required:

This is because a person is receiving their care and supports from the health system when they should be getting these supports through the NDIS, but have not yet gained access to the Scheme or have not been able to secure an appropriate support provider or level of plan funding. Also, if a participant is admitted to hospital, any accommodation payments under their NDIS plans are paused.<sup>146</sup>

These issues are discussed further in Chapter 8 of this report.

#### Committee comment

The committee notes that the median number of days that younger patients, who are medically ready for discharge, remain in hospital due to a lack of access to NDIS care is significantly higher than that experienced by older patients awaiting aged care.

The committee shares the submitters' concerns about the significant implications and adverse outcomes that these delays in hospital discharge have on people with a disability, including deconditioning, institutionalisation, hospital acquired infection and psychological distress.

The committee notes that the NDIA has responsibility for operating and administering the NDIS, including ensuring that NDIS participants have access to appropriate support.

The committee, therefore, recommends that the Australian Government commits to the NDIA reimbursing Queensland's HHSs for excessive length of patient stays caused by delays in accessing NDIS care services.

**Recommendation 6 – National Disability Insurance Agency to reimburse costs of excessive long-stay patients due to delays in accessing services**

The committee recommends that the Australian Government commits to the National Disability Insurance Agency reimbursing Queensland's Hospital and Health Services for excessive length of patient stays in hospital caused by delays in accessing National Disability Insurance Scheme care services.

#### **4.7 General comments about hospital discharge arrangements**

During its inquiry, submitters and witnesses raised a number of general issues with the committee about hospital discharge arrangements and communication between GPs and hospitals.

At the public hearing in Longreach, the committee was informed about the hospital discharge issues experience by people who are transferred from rural and remote areas to hospitals in regional cities.

The committee heard of a patient who had broken their leg and been taken to Rockhampton Hospital by the Royal Flying Doctors and then discharged at 1:00 am in the morning and could not get back to Longreach.<sup>147</sup>

Ms Simone Thomason advised that she:

... had an example this morning where I was talking to one of the staff members whose husband was flown out. He was asked to leave very early in the morning and he said, 'But I got flown out. I don't know how to get back. How will I get back?' Arguably, he played devil's advocate: he did know how to get back

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<sup>146</sup> Submission 39, p 28.

<sup>147</sup> Mr Lachlan Millar MP, public hearing transcript, Longreach, 4 March 2022, p 25.

because he actually had some knowledge, but he also wanted to see how that system was working. So he said, 'I need discharge planning. I need a social worker to help me find somewhere,' and then that actually fell into place. However, not everybody will say that for themselves. They will not stand up for themselves because they do not feel they are able to.<sup>148</sup>

Ms Thomason also referred to the limitations of the current patient travel and accommodation allowances, advising:

You only get so much on patient travel as well. You only get \$60 towards accommodation at night too, so if that person was discharged and a train did not go for three days, you have to advocate as to why they should pay for those three days and it would be \$60 a night. You cannot get anywhere for \$60 a night. Then you have to get your food. Ground transport is another one. It is difficult. Socioeconomics plays a big part in people's health.<sup>149</sup>

At its public hearing in Logan, the committee was informed of the issues caused by delays in receiving discharge summaries from hospitals. Inala Primary Care stated:

My bigger concern is actually discharge. Queensland Health has a target to send us a discharge summary within 28 days—28 days—of the patient leaving hospital. Patients often leave hospital with medications that they might only need to take for three days, five days or 10 days and then they are supposed to discontinue it. If we do not even know they have presented to hospital, been admitted and had a medication change, and we do not get the discharge summary back for 28 days—and let me tell you, it is often more like three months—how do we know to contact that patient, get them in, educate them about the new medication they are on or take them off a medication they are only supposed to take short-term?<sup>150</sup>

At the public hearing in Townsville, Dr Michael Clements, Chair, RACGP, referred to the New Zealand system for sharing information in respect of Specialist Outpatient Services and Referrals between public and private health practitioners and specialists. Dr Clements advised:

One of the other things that we have proposed and that works in New Zealand—and, again, we can learn a lot from them—is a communication path between GPs and the hospitals. Many of the times that I refer and many of our doctors refer into the hospital we are just asking a question: is this woman's intermenstrual bleeding a problem? Should we investigate further? What tests should I order? Is this person's hip arthritis of such a bad severity that they might need a hip replacement? At the moment I cannot ask that question of an orthopaedic surgeon or a gynaecologist. In New Zealand I can send a secure message to the gynaecologist at the hospital and ask them the same question and then they have a turnaround of, I think it is, 48 hours and I will get a response, so we can even stop those referrals in the first place. There are solutions out there but we cannot use them due to systems and confidentiality and processes and silos in terms of funding. One of the comments when I suggested at a local hospital about being able to email a gynaecologist I was told, 'If our gynaecologist spends half a day answering your emails we don't get any funding for that so, no, we're still going to require you to refer them into us.' So remember that your funding tools are actually one of the barriers.<sup>151</sup>

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<sup>148</sup> Public hearing transcript, Longreach, 4 March 2022, p 26.

<sup>149</sup> Public hearing transcript, Longreach, 4 March 2022, p 25.

<sup>150</sup> Public hearing transcript, Logan, 10 February 2022, p 16.

<sup>151</sup> Public hearing transcript, Townsville, 9 February 2022, p 10.

Committee comment

The committee notes the concerns raised by submitters and witnesses about the issues experienced with the current discharge arrangements at hospitals.

The committee recommends that Queensland Health, in collaboration with the HHSs, reviews the current hospital discharge practices, especially in relation to patients who have been transferred long distances to attend the hospital and delays in producing discharge summaries.

The committee also encourages the Queensland Government to review the allowances paid to patients on discharge to ensure that they cover reasonable travel and accommodation costs.

**Recommendation 7 – Queensland Health to collaborate with Hospital and Health Services to review hospital discharge practices**

The committee recommends that Queensland Health, in collaboration with the Hospital and Health Services, reviews the current hospital discharge practices, especially in relation to patients who have been transferred long distances to attend hospital and to improve processes to produce discharge summaries.

The committee also encourages Queensland Health to explore the New Zealand system for sharing information between hospitals and GPs, in a timely and confidential manner, as a way to reduce duplication and improve discharge arrangements in regional, rural and remote areas of Queensland.

#### **4.8 Decline in private health insurance coverage resulting in increased demand for public health services**

Queensland Health advised that a decline in private health insurance coverage is contributing to increased demand for Queensland Health services, stating ‘This is true for most Queensland regions and medical specialties, including elective admissions and obstetrics’.<sup>152</sup>

Central Queensland HHS advised:

Over the past 10 years the private health insurance coverage across Central Queensland has decreased well below state and national coverage levels and sits below 38 per cent. Also with that, the available private practitioners have dwindled. The result is frequent and potentially preventable attendances at emergency departments, increased outpatient appointments and the increased number of admissions and longer lengths of stay. From a patient’s perspective this is a very difficult and at times uncomfortable journey. In the best instance is a four-hour wait in a noisy emergency department, at worst it is sitting in a hospital corridor whilst ambulance trolleys are pushed past and staff in full PPE shuffle by.<sup>153</sup>

QNMU noted that some patients continue to use the public health care system regardless of having private health insurance. QNMU considered that this may indicate:

- a lack of coherence in the insurance policy
- excessive medical fees not covered by insurance arrangements
- a perceived higher quality and specialisation of public hospitals compared to private hospitals
- proximity of public health services.<sup>154</sup>

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<sup>152</sup> Submission 39, p 17.

<sup>153</sup> Public hearing transcript, Rockhampton, 3 March 2022, p 2.

<sup>154</sup> Submission 69, p 25.

Queensland Health stated that:

There remains considerable uncertainty around the likely level of the future public market share with a combination of several factors contributing to the outlook, including private health insurance levels, public sector funding, and the availability of private hospital providers.<sup>155</sup>

The committee notes that, in the last seven years, the public hospital market share has increased from 58.5 per cent in 2013-14 to 63.4 per cent in 2020-21, an increase of 4.9 percentage points. Dr Wakefield, former Director-General, Queensland Health explained that:

The key fact is that over the past five years insurance coverage has dropped from 45 per cent to 40 per cent or thereabouts. That is 250,000 Queenslanders who no longer have private health insurance. Moreover, less than 40 per cent of all the insured persons now have a policy which some would call junk policies. That policy requires multiple co-payments, up-front payments and has exclusions. I have spoken to patients and clinicians in this regard. Patients come into the hospital and say, 'I don't want to use my private insurance because it's going to cost me.'<sup>156</sup>

In South East Queensland, the market share shift to the public sector has been 5 percentage points from 56 per cent in 2013-14 to 61 per cent in 2020-21. The market share for elective admissions has increased from 38.5 per cent to 45.9 per cent; an increase of 7.4 percentage points in the last seven years.<sup>157</sup>

Queensland Health contended that a strong example of the shift to public hospitals is demonstrated in the public market shares for obstetrics, stating:

I note the Courier-Mail article on obstetrics on the weekend, which mentioned a lady who had spent \$20,000 out of pocket on obstetric care. The mind boggles. That is someone with private insurance.

One of the key rationales for the federal government's support for private health insurance is that it reduces pressure on our public hospital system, but the changes we have seen in private health insurance are actually contributing to service demand increase across most regions and medical specialties. If we turn to obstetrics, which has traditionally been a strong area of private care, the share of work in the public sector has increased from 72 per cent to 78 per cent. Conversely, the private sector has fallen from 28 per cent to 22 per cent of the market. We are not seeking to get more market share here.

Private sector volumes over this period have fallen from a peak of 17,156 births in 2013-14 to 13,005 births to 2020-21. There is a significant shift of pregnant mums into the public sector for birthing and antenatal care. The falls in volume are likely to challenge the viability—and they are challenging the viability—of some of the private providers, as we saw with closure at the Gladstone private hospital, which further exacerbates the pressure on the public system and reduces choice for regional communities. If you have private health insurance there now, your ability to access it and choose a doctor is gone. Similar pressures exist for lots of the smaller towns' private hospitals.<sup>158</sup>

The committee notes that these changes have also affected the viability of some private hospitals. For instance, in 2019 Mercy Health and Aged Care announced it would close the Mater Private Hospital in Gladstone. The hospital was purchased by Queensland Health in April 2020.<sup>159</sup>

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<sup>155</sup> Submission 39, p 17.

<sup>156</sup> Public briefing transcript, Brisbane, 29 November 2021, p 4.

<sup>157</sup> Queensland Health, submission 39, p 17.

<sup>158</sup> Public briefing transcript, Brisbane, 29 November 2021, p 4.

<sup>159</sup> Queensland Health, submission 39, p 17.

Queensland Health advised that the decline in private health insurance coverage leads to reduced costs for the Australian Government through lower private health insurance rebates and increased revenue through the MLS. The consequent increase in the public market share leads to increased pressure on the public hospital system and increased expenditure by the State Government.<sup>160</sup>

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<sup>160</sup> Submission 39, p 17.

## 5 Primary and allied health care

### 5.1 Introduction

Primary health care is the cornerstone and ‘frontline’ of the Australian health system. Primary care is typically the first point of contact an individual with a health concern has with the health system.<sup>161</sup>

The primary health care system is based primarily on Medicare on a fee-for-service basis. It guarantees all Australians (and some overseas visitors) access to a wide range of health and hospital services at low or no cost. Primary health care professionals include:

- GPs
- nurses and midwives
- nurse practitioners
- allied health professionals – including regulated professions (eg occupational therapists, osteopaths, pharmacists, physiotherapists and psychologists) and self-regulated professionals (eg speech pathologists, dietitians, exercise physiologists and social workers)<sup>162</sup>
- dentists
- Aboriginal and Torres Strait Islander health professionals.

These professionals provide primary health care across a range of settings, including general practices, community health centres, allied health practices, and increasingly is also delivered via telehealth and video consultations. They often work in multidisciplinary health teams to provide specialised support to suit an individual’s needs.

Primary health care includes health promotion, prevention, early intervention, treatment of acute conditions, and management of chronic conditions.<sup>163</sup>

The AIHW noted that primary health care, particularly general practice, is traditionally seen as the ‘gateway’ to the wider health system. Through assessment and referral, individuals are directed both from one primary care service to another, and from primary care services to secondary and tertiary services, eg specialist, hospital and palliative care services.<sup>164</sup>

Under the NHRA, the Australian Government is responsible for system management and support, policy and funding for general practice and primary healthcare services, including lead responsibility for Aboriginal and Torres Strait Islander community controlled health services (CCHSs).<sup>165</sup>

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<sup>161</sup> Queensland Mental Health Commission, submission 44, p 7.

<sup>162</sup> Australian Government, Department of Health, ‘About allied health’, <https://www.health.gov.au/health-topics/allied-health/about>.

<sup>163</sup> Queensland Health, submission 39, p 7.

<sup>164</sup> Australian Government, AIHW, *Review and evaluation of Australian information about primary health care: a focus on general practice*, 10 December 2008, p 2.

<sup>165</sup> Australian Government, submission 75, p 6; Queensland Health, public briefing transcript, Brisbane, 29 November 2021, pp 2-3.

## 5.2 Accessibility and availability of primary and allied health care

A number of submitters highlighted the importance of quality primary health care. The Queensland Primary Health Network (QPHN) acknowledged that a stronger primary health system plays a critical role in reducing demand on the hospital system.<sup>166</sup> The Australian Government recognised that:

Effective primary health care can improve health outcomes at a lower cost than hospital and secondary care and helps to avoid unnecessary hospitalisations. Countries with strong primary health care systems have better health outcomes.<sup>167</sup>

RACGP stated that ‘evidence shows that a well-supported general practice sector will result in efficiencies for primary and secondary care, and the broader healthcare system’. However, failure to invest adequately in general practice will result in continued increases in overall healthcare costs.<sup>168</sup>

According to QNMU access to quality primary health care is associated with: increased access to health services; better problem recognition and diagnostic accuracy; a reduction in avoidable hospitalisations; better health outcomes; lower suicide rates and higher life expectancy.<sup>169</sup>

Research has demonstrated that well-supported and appropriately funded primary care can:

- improve patient outcomes
- lower mortality rates
- lowers hospital admissions
- reduce the burden on tertiary care
- improve patient experience of health
- lower infant mortality rates
- improve quality of life
- decrease the use of more expensive health services.<sup>170</sup>

Whilst noting that the ‘Provision of high quality primary health care is challenging across Queensland’, QPHN advised that in 2020-21, Queensland’s primary health care providers had greater population coverage and delivered more services per capita, than the average for other states and territories.<sup>171</sup>

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<sup>166</sup> Submission 65, p 9.

<sup>167</sup> Australian Government, Department of Health, *Future focused primary health care: Australia’s Primary Health Care 10 Year Plan 2022-2032 – Consultation Draft*, October 2021, p 4.

<sup>168</sup> Submission 73, p 5.

<sup>169</sup> Submission 69, p 6.

<sup>170</sup> S Leiyu, ‘The Impact of Primary Care: A focused review’, Cairo, Scientifica 2012.

<sup>171</sup> Submission 65, p 2.

QPHN noted that:

In the financial year 2020-21 Queensland general practices provided Medicare subsidised care to around 86 per cent of the resident population in Queensland. A lot of Queenslanders are accessing care through their GPs. In terms of allied health, only about 39 per cent of the resident population accessed allied health services. It is certainly not as accessible as general practice. Compared to the previous year, general practice services had increased by about four per cent. Allied health services had increased by 14 per cent, which is disturbing because it is still pretty low. That is well above population growth. Primary health care is doing the heavy lifting in terms of the provision of health care in Queensland.<sup>172</sup>

QPHN noted that these figures exceed the national average for both GPs and allied health professionals.<sup>173</sup>

Queensland Health advised, however, that limited access to GPs and bulk-billing practices and support for ongoing allied health services is adding to the demand on Queensland's public health system.<sup>174</sup>

During the Inquiry, submitters and witnesses raised significant concerns about the availability of, and access to, quality primary and allied health care, including:

- lengthy wait times for patients to see a GP, sometimes several weeks or months, and in some cases patients are not able to see a GP
- a lack of GPs in communities and General Practices 'closing their books to new patients', particularly in regional, rural and remote parts of Queensland
- the limited availability of GPs providing after hours services or conducting home visits
- a lack of access to ongoing allied health services, particularly to treat chronic conditions
- difficulties in accessing psychologists or psychiatrists, due to increased demand resulting from the COVID-19 pandemic, with patients waiting for 6 - 12 months for appointments.<sup>175</sup>

Queensland Health advised that 'All the best healthcare systems in the world have a really strong primary and family care system at their heart' and 'Queensland has difficulty sustaining our public health system without this effective, sustainable primary care that caters for all our regions and citizens'.<sup>176</sup>

Queensland Health advised that the lack of access to appropriate primary health care services, whether intentionally or not, has created significant gaps and resulted in cost-shifting from the Australian Government to the State Governments and an increasing burden on the public health system.<sup>177</sup>

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<sup>172</sup> Public hearing transcript, Brisbane, 8 December 2021, p 17.

<sup>173</sup> Submission 65, p 3.

<sup>174</sup> Submission 39, p 3.

<sup>175</sup> Submissions 28, 33, 39, 40, 65 and 70.

<sup>176</sup> Public briefing transcript, 29 November 2021, p 2.

<sup>177</sup> Submission 39, p 13.

### 5.2.1 Access and availability of general practitioners

A number of individuals have shared with the committee their personal stories of the lengthy waiting times they experienced in accessing a GP, while some patients advised that they could not access a GP in their community at all.

A number of stakeholders also shared case studies and patient testimonies with the committee. The committee thanks these individuals and stakeholders for sharing their experiences. A few examples of these experiences are outlined below.

One individual stated that:

I find it harder and harder to get an appointment with a doctor on the island, waiting for 4 weeks to get a phone consultation, this is unacceptable, please help our ageing population.<sup>178</sup>

A mother of three, stated:

... it took 7 months to get a GP after moving here and now you have to know weeks in advance if you're going to be sick and need an appointment. As someone who suffers from vertigo on and off driving off the island to find care is not always an option.<sup>179</sup>

Mr Bill Allison, a witness at the committee's public hearing in Mossman, stated:

One of the difficulties here is getting to see your local GP. It is almost impossible. I have been seeing a female GP for about 17 years ... It usually takes me three or four weeks to get in to see her. If it is really urgent she will try to get me in if she can, otherwise I have to go to the hospital. My grandchildren—I have two young ones, one aged three and another aged seven—usually have to go to hospital with minor things because we cannot see a GP. It puts pressure on the hospital system obviously.<sup>180</sup>

Ms Elizabeth Moret, a witness at the public hearing on Bribie Island, stated:

I want to address also the lack of GPs, particularly during COVID. Looking for a new one was really hard. When you went through their websites, they were all not taking new patients. I had a recent look and some of that seems to have disappeared, but we have not yet made that transition. Currently we go 75 kilometres each way to our old GP when we need to get some sort of medical attention. Luckily we have not had colds or the flu, because you do not want to travel that far. Over the 35 years I have been going to this one clinic I have noticed that they have gone through a number of GPs, and as time has progressed there seems to be less and less choice within the clinic itself as they move on. There are fewer choices and it is hard to find a GP that you can relate to and discuss your issues with.<sup>181</sup>

Mr Shaun Cram, a member of the QNMU, stated:

The community are waiting about two weeks to get in to see a GP. It has been made worse by the COVID pandemic. GPs have been offering vaccinations, of course, and that takes them away from GP work.<sup>182</sup>

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<sup>178</sup> Submission 63, p 4.

<sup>179</sup> Submission 63, p 10.

<sup>180</sup> Public hearing transcript, Mossman, 8 February 2022, p 18.

<sup>181</sup> Public hearing transcript, Bribie Island, 9 December 2021, p 31.

<sup>182</sup> Public hearing transcript, Mossman, 8 February 2022, p 17.

Mr Nicholas Lentakis, State Council Delegate for the UWU, considered:

Accessing GPs is difficult. Even for people who have long-term GPs, trying to get a GP appointment, whether they bulk-bill or not—it does not matter if you are willing to pay—is becoming almost impossible. We are talking weeks in advance now.<sup>183</sup>

Some submitters stated they had to travel outside their communities to see a GP, with a Mission Beach-based submitter stating ‘for the second time in 5 years we are without a GP and have to travel to Tully or Innisfail for any medical treatment’.<sup>184</sup>

Other submitters stated they had ‘to drive to Brisbane to see a doctor’ from the Pumicestone electorate,<sup>185</sup> advising that:

We moved to Bribie Island almost a year ago and can't get into any local GP. This means we need to travel back to our previous GP which is about 75 mins each way and about 120K return. Please fix this as it is not sustainable.<sup>186</sup>

When asked whether she felt she could access her local GP surgeries, the Service Manager of the Tableland Community Link Association Inc, replied, ‘not if you are a new person, no, and even to get a general appointment is very difficult’.<sup>187</sup>

One submitter highlighted the challenges of finding a bulk-billing GP for their son, an NDIS user:

My son is on a DSP [Disability Support Pension] and is an NDIS customer. It is ridiculous that there are no GPs (that I could find) in his area (Yeronga) that will see him at a bulk billed rate. For someone with chronic health problems and limited income this is a substantial barrier to health care.<sup>188</sup>

Another submitter highlighted the challenges of being taken on as a new patient and finding a bulk-billing GP:

I have health issues as does my youngest son. Not one GP on the island will take on new patients and few bulk bill. Please, for the sake of my sanity, the safety of myself and my child, get this change happening! We're a family of six and have never had such difficulties anywhere else we've lived before.<sup>189</sup>

#### *5.2.1.1 Regional differences in accessing primary health care across Queensland*

The committee heard the lack of access and availability of GPs impacts all Queensland communities, including metropolitan and outer metropolitan areas. For example, Metro North HHS stated:

The current community demand far outstrips the available primary and private allied healthcare resources in our area. This means that the acute public hospital sector and community sector are seeing and treating the outcomes of this lack of early and consistent primary and allied health care. This can manifest in frequent attendance at the emergency department, increased outpatient appointments, increased number of admissions and longer lengths of stay. From a patient’s perspective, this is a very difficult and at times uncomfortable journey and—as much as I hate to discuss finances—a very expensive

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<sup>183</sup> Public hearing transcript, Brisbane, 21 February 2022, p 21.

<sup>184</sup> Ms Caryn Quinn, submission 11, p 1.

<sup>185</sup> Submission 63, p 10.

<sup>186</sup> Submission 63, p 4.

<sup>187</sup> Public hearing transcript, Cairns, 7 February 2022, p 25.

<sup>188</sup> Submission 5, p 1.

<sup>189</sup> Submission 63, p 10.

journey compared to one provided by the primary healthcare provider who is consistent, trusted and knows the patient, their family and the nuances of their healthcare presentations.<sup>190</sup>

QPHN noted that, in general, outer metropolitan areas have fewer GPs, so patients have to wait longer for appointments.

QPHN stated that GPs, in outer metropolitan areas, have little choice but to work longer hours, to see as many patients as possible, even though they are treating patients with complex needs that require more effort and resources to manage. QPHN stated that access to other specialists and allied health professionals is also reduced, with lower numbers and little bulk billing available. Therefore, GPs are required to manage more complex patients with little support.<sup>191</sup>

The committee notes that the viability of practices is reduced, as the population is reliant on bulk-billing, with a reduced capacity to pay for care. The reluctance of GPs to work in outer metropolitan areas means that there is little back up or support to spread the load and reduce burn-out.<sup>192</sup>

The committee acknowledges the issues experienced in metropolitan and certain outer-metropolitan areas, however, the committee notes that regional, rural and remote areas are disproportionately impacted by the lack of access to quality primary and allied health care.

#### 5.2.1.2 Access to primary and allied health care in regional, rural and remote areas

The AIHW reports that people living in remote and very remote areas generally have poorer access to health services than people in regional areas and major cities, have lower rates of bowel, breast and cervical cancer screening and higher rates of PPHs.<sup>193</sup>

Queensland Health highlighted the disparity in numbers of GPs serving metropolitan areas and rural and remote communities, advising that, in 2020, there was:

- one GP for every 767 people in metropolitan areas (eg Brisbane, Gold Coast, Ipswich)
- one GP for every 1,160 people in small rural towns (eg Ingham and Condamine)
- one GP for every 1,429 people in remote communities (eg Cape Tribulation and Cloncurry).<sup>194</sup>

Queensland Health advised that poorer access to primary care services is also demonstrated by the differential in the per capita MBS spend across regions in Queensland. For example, in 2018-19, Western Queensland PHN had the lowest MBS spend per capita at \$977, one third lower than the Gold Coast where the MBS spend per capita was \$1,467.<sup>195</sup>

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<sup>190</sup> Public hearing transcript, Bribie Island, 9 December 2021, p 2.

<sup>191</sup> Submission 65, p 4.

<sup>192</sup> QPHN, submission 65, p 4.

<sup>193</sup> Australian Government, AIHW, 'Rural & remote health', October 2019, p13-23, <https://www.aihw.gov.au/getmedia/838d92d0-6d34-4821-b5da-39e4a47a3d80/Rural-remote-health.pdf.aspx?inline=true>.

<sup>194</sup> Submission 39, p 13.

<sup>195</sup> Submission 39, p 13.

The Rural Doctors Association of Queensland (RDAQ) referred to a report from the Mitchell Institute at Victoria University, which found that ‘the distribution of Medicare funds does not match areas’ needs’ and ‘Medicare benefits are not evenly distributed between cities and country areas’.<sup>196</sup> The report found that:

- people in major cities receive an average amount of Medicare dollars (\$1.00)
- people in inner regional areas receive a little more than the average amount of Medicare dollars (\$1.04)
- people in outer regional areas receive a little less than the average amount of Medicare dollars (94c)
- people in remote areas receive a less than the average amount of Medicare dollars (75c)
- people in very remote areas receive a lot less than the average amount of Medicare dollars (56c).<sup>197</sup>

The AIHW reports regularly on the poorer health outcomes for rural, regional and remote communities, including:

- higher mortality rates and lower life expectancy
- higher reported rates of high blood pressure, diabetes, and obesity
- higher death rates from chronic disease
- an increased prevalence of mental health problems
- higher rates of alcohol abuse and smoking
- poorer dental health.<sup>198</sup>

The committee acknowledges the challenges experienced by people living in regional, rural and remote parts of Queensland in accessing health care services. The AIHW reports that these challenges are caused by multiple factors, including their geographical location, low population density, limited infrastructure and higher costs of delivering health care in regional, rural and remote areas.<sup>199</sup>

HWQ also referred to ‘multifactorial barriers to addressing the health and wellbeing of remote, rural and regional Queenslanders’, including: significant health workforce shortages; thin markets and lack of viability of practices; and patient out of pocket costs.<sup>200</sup> HWQ stated that these barriers ‘all contribute to a fragile and increasingly failing health system and workforce environment’.<sup>201</sup>

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<sup>196</sup> Public hearing transcript, Longreach, 4 March 2022, p 14

<sup>197</sup> B Harris, M Craike, R Dunkin, R Calder, ‘Is Medicare Fair? ii. The distribution of Medicare benefits across the cities and country’, Mitchell Institute, Policy issues paper no.3 – 2019, Victoria University, Melbourne, p 11.

<sup>198</sup> RACGP, submission 73, p 1; Australian Government, Department of Health, ‘Annual Medicare statistics 2019–20’, Canberra, 2020; Australian Government, AIHW, ‘Rural & remote health’, October 2019, p 9/23, <https://www.aihw.gov.au/getmedia/838d92d0-6d34-4821-b5da-39e4a47a3d80/Rural-remote-health.pdf.aspx?inline=true>.

<sup>199</sup> Australian Government, AIHW, *Australia’s health*, 2018, <https://www.aihw.gov.au/reports/australias-health/australias-health-2018/contents/table-ofcontents>.

<sup>200</sup> Submission 25, p 4.

<sup>201</sup> Submission 25, p 4.

QPHN noted that providing primary health care services in remote areas is difficult, with people living in remote areas less likely to have a GP nearby. QPHN noted that many primary health care services in remote areas are provided by remote area nurses or Aboriginal Health Practitioners, meaning that less funding is available through the MBS.<sup>202</sup>

The committee notes that, in rural and remote areas, facilities are generally smaller, have less infrastructure and provide a broader range of services to a more widely distributed population than in cities. The Queensland Mental Health Commissioner also noted that rural and remote populations rely more on GPs to provide health care services, due to less availability of local specialist services.<sup>203</sup>

As noted by HWQ, a well-resourced general practice sector is, therefore, essential in regional, rural and remote areas, stating that general practice is ‘... essential to addressing both the sustainability of healthcare services and improving the health outcomes of people living in remote and rural Queensland’.<sup>204</sup>

Submitters highlighted, however, that many regional, rural and remote areas do not have sufficient access to GPs.<sup>205</sup> ACRRM stated that AIHW research indicates that:

... people living in outer regional areas are 2.5 times more likely to report having access to a General Practitioner as a barrier to accessing care compared with their urban counterparts, and residents in remote areas are up to six times more likely to report this as a barrier.<sup>206</sup>

The joint submission from health charities and non-government organisations (Joint Submission) stated regional, rural and remote areas of Queensland:

... experience poor access to quality and timely healthcare with issues including waiting longer to see a GP, having to travel longer distances to receive treatment, lack of continuity of care, shortages of clinicians, clinics closing and lack of facilities for critical services.<sup>207</sup>

The committee was advised that an increasing number of primary care practices in rural, regional and remote communities are not taking new patients or have closed their doors, for example:

- 33 per cent of general practices in Mackay are not taking on new patients<sup>208</sup>
- one practice in Roma has closed and another is for sale, with six GP vacancies<sup>209</sup>
- five practices have closed in Cairns in the last 12 months, with a six GP practices closing recently.<sup>210</sup>

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<sup>202</sup> Submission 65, p 5.

<sup>203</sup> Australian Government, AIHW, ‘Rural & remote health’, October 2019, p13-23, <https://www.aihw.gov.au/getmedia/838d92d0-6d34-4821-b5da-39e4a47a3d80/Rural-remote-health.pdf.aspx?inline=true>; submission 44, p 7.

<sup>204</sup> Submission 25, p 1.

<sup>205</sup> Submissions 39, 70; Central Queensland HHS, public hearing transcript, Rockhampton, 3 March 2022, p 2.

<sup>206</sup> Submission 13, p 3.

<sup>207</sup> Submission 41, p 8.

<sup>208</sup> Public hearing transcript, Brisbane, 8 December 2021, p 19.

<sup>209</sup> Queensland Rural and Remote Primary Health Networks, submission 70, p 5.

<sup>210</sup> Northern Queensland PHN, public hearing transcript, Brisbane, 8 December 2021, p 19.

Northern Queensland PHN advised that:

Health Workforce Queensland have cited to us 70 registered vacancies for allied health in Queensland, 19 for primary care nursing and 97 for GP vacancies. The Central and Western Queensland PHN provided me with data yesterday. They have 27.5 GP vacancies and 21.9 nurse vacancies and nearly 19—some of these are FTE halves—allied health professional vacancies.<sup>211</sup>

Central Queensland HHS advised that their region has ‘a significant lack of general practitioners, and particularly bulk-billing GPs, which in turn places greater pressure on our emergency departments.’<sup>212</sup>

ACRRM stated that the:

... National Rural Health Alliance research has indicated that there is at least a \$2 billion underspend per capita in rural and remote areas across Australia just on Medicare rebates alone per year. That money is disseminated. Obviously Queensland has a significant percentage of that, being the largest distributed population base across rural and remote areas in Australia.<sup>213</sup>

QPHN noted that services are often provided by visiting practitioners, or expensive locum providers, rather than resident health practitioners, because attracting health practitioners to remote areas can be very challenging.<sup>214</sup> These issues are discussed further in section 5.6 of this report.

RDAQ noted that:

In some towns, that shortfall is made up of other federally funded organisations like RFDS. For example, some small communities, such as Birdsville, have RFDS as their general practice and they are federally funded so that does not come up as Medicare dollars. But it does come with its own issues. Because they cannot bill Medicare, they cannot trigger some of the other services that are available. For example, if a patient wants to access some of the mental health programs that are available and the psychologists that are Medicare rebated, they need to have a care plan billed, but RFDS are not able to bill a mental health care plan because they are not Medicare funded.<sup>215</sup>

Dr Steve Saleras, JCU, outlined his concerns:

... that the current crisis in general practice and the catastrophe in rural general practice will mean that Queensland Health ends up, by default, being the providing organisation. The fire hose of money that currently goes into Queensland Health will not be enough. The Queensland and Australian economies cannot pay for hospitals to deal, often very poorly, with health issues that need to be addressed in the primary health system. It is really bad for my patients and my friends and family.<sup>216</sup>

The committee also heard about the lack of access to allied health services in regional, rural and remote areas. For example, Cairns and Hinterland HHS advised:

Compared to the rest of the state, there is a low volume of allied health services in Cairns and hinterland and a significant lower volume in the Far North if you take in the Torres Strait as well. It is well documented that without the access to primary care there is often a high burden of chronic disease and

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<sup>211</sup> Public hearing transcript, Brisbane, 8 December 2021, p 19.

<sup>212</sup> Public hearing transcript, Rockhampton, 3 March 2022, p 2.

<sup>213</sup> Public hearing transcript, Brisbane, 8 December 2021, p 42.

<sup>214</sup> Submission 65, p 6.

<sup>215</sup> Public hearing transcript, Longreach, 4 March 2022, p 17.

<sup>216</sup> Public hearing transcript, Mossman, 8 February 2022, p 6.

mental health related illnesses, and these in turn can lead to frequent ED presentations and multiple admissions to hospital as well as prolonging people's length of stay within hospital.<sup>217</sup>

Torres and Cape HHS stated that allied health services are limited in the Cape and Torres regions, advising that an under-resourced workforce has resulted in:

- long waiting lists for allied health services
- limited outreach to communities in the region
- prioritisation of allied health services.

The committee notes that this has led to patients with primary prevention, disability and rehabilitation needs not being met. Torres and Cape HHS noted that there are very few private providers in the region and for some allied health services Queensland Health is the only provider in the region.<sup>218</sup>

QPHN acknowledged that access to particular allied health services is problematic with conveniently located, low cost or bulk billed diabetes education, dietetics, pulmonary rehabilitation, occupational therapy, mental health nursing and psychology services particularly difficult, however need for these services is high.<sup>219</sup>

Wide Bay HHS advised that its region had quite limited post-acute services, advising that:

Once people are discharged from hospital, they might need follow-up care by allied health services in the community or other primary health services. That is quite limited in the Wide Bay region as well and that can result in people becoming unwell and re-presenting to hospital sooner than we would like.<sup>220</sup>

### *5.2.1.3 State provision of primary health care in rural and remote areas*

The committee notes that Queensland Health plays a very active role in providing primary health care services as a 'provider of last resort' in rural and remote areas that are under-serviced or not serviced by private GPs.

Queensland Health advised that while there is access to MBS revenue for some of these services, the vast bulk of this expenditure is funded by Queensland Health.<sup>221</sup>

The committee heard that HHSs have maintained primary health care support to rural and remote areas through a variety of interim solutions, including:

- locum doctor engagement
- outsourced medical models to private providers
- telehealth support
- medical officer rotations from other Queensland Health facilities.<sup>222</sup>

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<sup>217</sup> Public hearing transcript, Cairns, 7 February 2022, p 2.

<sup>218</sup> Submission 2, p 1.

<sup>219</sup> Submission 65, p 3.

<sup>220</sup> Public hearing transcript, Bundaberg, 2 March 2022, p 3.

<sup>221</sup> Submission 39, pp 13-15.

<sup>222</sup> Queensland Health, submission 39, p 13.

Queensland Health stated that, in many cases, HHSs directly provide primary healthcare services as the provider of last resort. QRRPHN acknowledged that in a number of rural and remote places, the General Practice is operated by the public health system.<sup>223</sup>

In 2020-21, it is estimated that Queensland Health spent about \$161.2 million on primary healthcare services, including \$61.7 million in Torres and Cape HHS.<sup>224</sup> Queensland Health commented that only a small proportion of this expenditure would have been recovered from the Australian Government.<sup>225</sup>

Queensland Health advised that in some locations, such as Biggenden, Richmond and Theodore, it established GP clinics in rural locations where there is no private GP or where the previous GP has retired or left. In such instances, a non-specialist senior medical officer (SMO) employed by Queensland Health would work part-time at the GP clinic in addition to working at the public hospital.<sup>226</sup>

Generally, the SMO works under a granted private practice arrangement, and the patients are considered to be patients of the SMO, not of Queensland Health. The SMO would be able to bulk-bill the patients to the MBS. Depending on the employment arrangements, the MBS revenue may be retained by the SMO or may be assigned to Queensland Health in exchange for attraction and retention allowances.<sup>227</sup>

Central West HHS advised there are currently no private GPs in the Central West region, providing the following details:

There are four practices across the four hubs—Winton, Longreach, Barcaldine and Blackall—and for probably at least 10 years now there has not been a private general practitioner as such. The Central West Hospital and Health Service runs those private practices. There are a couple of different arrangements, without going too far down a rabbit hole, but certainly the Central West health service actually supplies the primary care to the general practices. Of the doctors, there are 22½ FTE senior medical officers across the Central West, and they are all general practitioners by trade—‘rural generalist’ I think is the catch phrase these days. Those doctors work across both the acute space in the hospital and also in general practice. The general public would probably not know the difference, that there is not a private GP. They are seeing GPs who are GPs by training and they have the usual general practice relationship that patients would have.<sup>228</sup>

#### 5.2.1.4 Exemption under Health Insurance Act 1973 (Cth)

The committee notes that, in some small locations, Queensland Health is able to claim MBS benefits for primary healthcare services provided to public patients under the Council of Australian Governments (COAG) section 19(2) exemptions initiative. This is an exemption from section 19(2) of the *Health Insurance Act 1973* (Cth), and is designed to improve primary health care in small rural communities with an identified general practitioner district workforce shortage.

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<sup>223</sup> Submission 70, p 6.

<sup>224</sup> Submission 39, p 14.

<sup>225</sup> Submission 39, p 14.

<sup>226</sup> Submission 39, p 14.

<sup>227</sup> Submission 39, p 14.

<sup>228</sup> Public hearing transcript, Longreach, 4 March 2022, p 2.

This initiative provides for exemptions to allow eligible sites to claim against the MBS for primary healthcare services provided in emergency departments and outpatient clinic settings. The exemption is only available in locations classified as MM5 (small rural towns), MM6 (remote communities) and MM7 (very remote communities) in the Modified Monash Model (MMM).<sup>229</sup>

Queensland Health advised that the exemption enables MBS rebates to be claimed for state-remunerated primary health care services—that is public non-admitted, non-referred primary care services.

The revenue generated from these initiatives is to be used to enhance primary care services at the sites where the revenue is generated. For a site to gain a COAG Section 19(2) exemption, a local negotiation and implementation plan must be completed and forwarded to the Australian Government for review. It is a prerequisite that no local private practitioner will be materially affected by the granting of the exemption.<sup>230</sup>

According to Queensland Health, the MBS benefits are generally insufficient to cover costs of HHS' providing primary health care, given the high cost of service delivery in rural locations and because services are bulk-billed. Hence, Queensland Health is required to fund the additional costs.<sup>231</sup>

The committee notes that there are currently 51 active sites in Queensland, including localities such as Childers, Hughenden and Longreach, operating under an exemption under section 19(2) of the *Health Insurance Act 1973* - with MBS revenue of \$6.0 million in 2020-21.<sup>232</sup>

#### 5.2.1.5 Rural and Remote Medicare Benefits Scheme

The Rural and Remote Medical Benefits Scheme (RRMBS) also enables listed sites to bulk-bill for primary healthcare services in eligible communities which have a significant Aboriginal and Torres Strait Islander population and whose members have little or no access to services through the private sector.

The committee notes that MBS revenue from the RRMBS was \$11.1 million in 2020-21. Again, the revenue generated from these initiatives is to be used to enhance primary care services at the site.<sup>233</sup>

Queensland Health commented that while the RRMBS is a very welcome initiative, in many remote Aboriginal and Torres Strait Islander communities Queensland Health operates primary healthcare clinics led by a nurse practitioner and/or Aboriginal and Torres Strait Islander health practitioner, with a medical officer visiting on a periodic basis.

Queensland Health also explained that nurse practitioners and allied health workers have only limited access to the MBS, especially in the absence of a supervising medical practitioner.<sup>234</sup>

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<sup>229</sup> The Modified Monash Model defines whether a location is a city, rural, remote or very remote.

<sup>230</sup> Queensland Health, submission 39, p 15.

<sup>231</sup> Submission 39, pp 13-15.

<sup>232</sup> Submission 39, p 15.

<sup>233</sup> Queensland Health, submission 39, p 15.

<sup>234</sup> Submission 39, p 15.

### 5.2.2 Access to mental health care

The Australian Government funds the primary mental health system, consisting of GPs, private psychologists and psychiatrists through the MBS, the NDIS and components of the non-government sector. The Queensland Government funds public community and hospital services and some non-government services for those people who do not qualify for the NDIS.<sup>235</sup>

The Australian Productivity Commission's Mental Health Inquiry report demonstrated the substantial cost of mental illness to the Australian economy and provided compelling evidence of the cost and benefits of reform, estimating mental illness is conservatively costing the Australian economy about \$200-220 billion per year – or between \$550 million and \$600 million per day.<sup>236</sup>

The Australian Productivity Commission noted that GPs are the 'first port of call' for many people when they first experience symptoms of mental ill-health; with at least one in five people consulting a GP about their mental health; and one in eight GP consultations relating to mental health problems in 2018-19.<sup>237</sup>

A significant number of submitters acknowledged the considerable impact that the COVID-19 pandemic had on demand for mental health services.<sup>238</sup>

The Australian Medical Association Queensland (AMAQ) stated that patients are unable to source appointments with psychologists or psychiatrists for 6 - 12 months, noting that 'GPs are caring for these patients as they have nowhere else to go'.<sup>239</sup> APS stated that:

Evidence suggests that the longer a patient waits to seek and receive treatment, the greater the risk of a condition becoming chronic, taking longer to resolve, or being associated with poorer outcomes – which is likely to cost our health service more in the long run.<sup>240</sup>

APS provided the committee with data based on a survey of its members in September 2021. The survey results included:

- 91 per cent of psychologists reported seeing an increase in wait times from March 2020, with 65 per cent reporting dramatically increased wait times
- 61 per cent of psychologists have a wait list of more than three months, or are not taking on new clients
- 76 per cent of psychologists would be willing to take on new clients who live in other states, territories and locations via telehealth.<sup>241</sup>

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<sup>235</sup> Queensland Mental Health Commission, submission 44, p 5.

<sup>236</sup> Queensland Mental Health Commission, submission 44, p 3; Australian Government, Productivity Commission, *Mental Health Inquiry report*, November 2020, p 9.

<sup>237</sup> Australian Government, Productivity Commission, *Mental Health Inquiry report*, November 2020.

<sup>238</sup> Submissions 28, 30, 33, 39, 40, 65 and 70.

<sup>239</sup> Submission 28, p 1.

<sup>240</sup> Submission 33, p 1.

<sup>241</sup> Submission 33, p 1.

Brisbane South PHN referred to:

... waiting times were up to six months, if you could get in there at six months. Therefore, we had to build a community response that attracted people who wanted to practise as psychologists. We have specialist areas where the bulk-billing nature is one that is causing the issues.<sup>242</sup>

The Queensland Mental Health Commissioner welcomed the Australian Government's \$2.3 billion investment in mental health and suicide prevention, including Head to Health community mental health centres and a temporary increase in MBS-funded private mental health sessions from 10 to 20 sessions a year.<sup>243</sup>

The Queensland Mental Health Commissioner noted that additional government funding was necessary to address 'long-term, chronic underfunding', stating that:

Australian Government investment is especially necessary to build a diverse range of community-based services, including for the 'missing middle' who are people whose mental health challenges are too complex for the primary health system but not complex enough for the state acute system. These people regularly fall through the gaps in the patchwork of services.<sup>244</sup>

#### 5.2.2.1 COVID-19 pandemic measures – telehealth and increase in MBS-fund mental health sessions

APS called for the retention of telehealth psychology sessions and the additional 10 subsidised sessions, made available under Medicare during the COVID-19 pandemic.<sup>245</sup>

However, the Queensland Mental Health Commissioner considered that:

... funding 10-20 mental health sessions a year has exacerbated workforce pressures as there hasn't been a corresponding increase in the number of clinicians to do this work. It has just divided their time among fewer people, increasing wait times and frustrations for people needing support.<sup>246</sup>

Queensland Health agreed that:

... expanding those 10 Medicare funded psychology sessions to 20, all that has done is increase queues—  
... There is no doubt that the evidence suggests that now you have to wait a long time to get in because people now have 20 sessions and the psychologists are full, bearing in mind that also there are out-of-pockets with that. Again, I think for people who are in dire straits, that is not necessarily going to work for them.<sup>247</sup>

The Queensland Mental Health Commissioner acknowledged that state-funded HHSs are the 'safety net Queenslanders rely on'. The Commissioner recognised, however, that these services are stretched beyond capacity which impacts on their ability to provide timely and effective care to people who need it.<sup>248</sup>

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<sup>242</sup> Public hearing transcript, Logan, 10 February 2022, pp 12-13.

<sup>243</sup> Submission 44, p 5.

<sup>244</sup> Submission 44, p 5.

<sup>245</sup> Submission 33, pp 1-2.

<sup>246</sup> Queensland Mental Health Commission, submission 44, p 5.

<sup>247</sup> Public briefing transcript, Brisbane, 29 November 2021, p 17.

<sup>248</sup> Submission 44, p 5.

In addition, the Queensland Network of Alcohol and Other Drugs Agency (QNADA) noted that barriers to primary care, including practitioners playing a role in preventative health, screening, assessment and referrals of issues relating to alcohol and other drug use:

... places pressure on the Queensland public health system. For example, failing to identify and respond to potential problems early (eg through brief intervention) can lead to more serious problems downstream. It also limits service availability in primary care, such as opioid dependence treatment, with stigma contributing to a lack of willingness to complete the training required to deliver these services.<sup>249</sup>

#### 5.2.2.2 Queensland Government investment in mental health responses

The Queensland Mental Health Commissioner noted that the Queensland Government is making significant investment in innovative and contemporary responses that enable crisis responses outside of the emergency department and hospital systems, including:

- co-responder models
- mental health consultation and liaison models
- crisis outreach
- safe spaces
- the Crisis Stabilisation Unit.<sup>250</sup>

The Queensland Mental Health Commissioner recommended that 'These tertiary system responses are supported and should be scaled up and expanded'.

In relation to the mental health co-responder model, UWU commented that:

The mental health co-responder model has been exceptional. It is probably one of the better things we have done over the past 18 months to two years for two reasons. One, we have a mental health coordinator in the communications centre. Some patients of ours will call us 40 times a day and it is the same thing. With those that we know, they will have what we call a caution note on their address or phone number. It will simply say 'refer to the mental health coordinator'. They will have a chat with them, usually de-escalate them and calm them down and go with that. Therefore, we do not need to attend.<sup>251</sup>

#### 5.2.2.3 Requirement for early intervention and solutions

The Queensland Mental Health Commissioner stated that earlier solutions are required to prevent people experiencing acute distress wherever possible. He advised that primary and secondary interventions across the spectrum of human services, which are the remit of the Australian Government and the Queensland Government, should be scaled up and expanded, including:

- improved step-down models
- social and affordable housing and accommodation
- psychosocial supports
- community clinical support
- supports to assist people back into the community

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<sup>249</sup> Submission 37, p 4.

<sup>250</sup> Submission 44, p 6.

<sup>251</sup> Public hearing transcript, Brisbane, 21 February 2022, p 26.

- early intervention services before people require treatment in hospital.<sup>252</sup>

The Queensland Mental Health Commissioner also considered that pressure on the public health system in the mental health area could be eased by providing options for social prescribing for the primary health care sector.<sup>253</sup>

Social prescribing is the practice where health professionals, including GPs, have the resources and infrastructure to link patients with social services – or even social groups – in a bid to address the social determinants contributing to poor health and stave off the epidemic of loneliness and social isolation.

The committee notes the Community Support and Services Committee's recent report on its *Inquiry into social isolation and loneliness in Queensland* recommended the implementation of a state-wide trial of social prescribing.<sup>254</sup>

The committee notes that the Mental Health Select Committee will be considering issues relating to access and availability of mental health services as part of its inquiry.

### **5.2.3 Accessing culturally appropriate primary health care for First Nations people**

The Australian Government funds a range of activities, through the Indigenous Australians' Health Program (IAHP). These activities 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 committee notes that IAHP's primary health care activity provides grants for primary care services, including services delivered by CCHSs, 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* (Cth), CCHSs can also access MBS billing while receiving primary health care funding through the IAHP.<sup>255</sup>

The Australian Government advised that it 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 IAHP, which supports 32 organisations across Queensland, including 27 CCHSs.<sup>256</sup>

Queensland Health noted, however, that First Nations peoples have relatively low rates of MBS usage. Queensland Health advised that accessible and culturally appropriate primary health care services for First Nations peoples are critical to achieving the Government's commitment to close the gap in life expectancy between Indigenous and non-Indigenous Australians by 2031.<sup>257</sup>

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<sup>252</sup> Submission 44, pp 6-7.

<sup>253</sup> Submission 44, p 8.

<sup>254</sup> Community Support and Services Committee, Report No. 14, 57<sup>th</sup> Parliament – *Inquiry into social isolation and loneliness in Queensland*, 6 December 2021, p 85.

<sup>255</sup> Australian Government, submission 75, p 6.

<sup>256</sup> Submission 75, p 4.

<sup>257</sup> Submission 39, p 7.

To illustrate this issue, Queensland Health gave the example of preventable chronic disease, which continues to be a major contributor to the Aboriginal and Torres Strait Islander health gap:

While health assessments are available at no cost to patients, in 2016, only 35.7 per cent of First Nations peoples in Queensland received a (MBS item 715) health check to screen for chronic disease risk factors and maintain health. This reflects a range of barriers including lack of knowledge by GPs and First Nations peoples themselves, the fact that mainstream GP practices may not collect Indigenous status information for all patients and the fact that there is no requirement for GPs to bulk bill for the health check. MBS item 715 should also focus not just on the annual health check but be expanded to encourage appropriate follow up processes, referrals, treatment and care planning to target prevention and delaying disease progression.<sup>258</sup>

Dr John Wakefield, former Director-General, Queensland Health advised:

Preventable chronic disease continues to be a major contributor to the First Nations health gap. The expansion and uptake of chronic disease checks, continuity of care and chronic disease management needs to be incentivised through Medicare, along with enabling First Nations people choice of access, especially in rural and remote settings. The role of investment in service planning and capacity building for Aboriginal and Torres Strait Islander community controlled health organisations has largely been undertaken by the state. For example, in 2020 services for primary health on Palm Island transitioned to the Palm Island Community Company, a reform led solely by Queensland. All these significant gaps place an additional burden on our public hospital system.<sup>259</sup>

QNMU advised that First Nations peoples face barriers to accessing health care including cost, experiences of discrimination, and poor communication with health care practitioners. QNMU stated that this has impacted the health and life expectancy of First Nations people identified in the *Closing the Gap Report 2020* where there has been limited progress against the life expectancy target. QNMU contended that delivering culturally sensitive primary health care must be appropriate to the unique culture, language and circumstances of First Nations people.<sup>260</sup>

Queensland Health acknowledged that the Australian Government has sought to address gaps through PHNs and through other programs such as support for Aboriginal and Torres Strait Islander Community-Controlled Health Organisations. However, Queensland Health considered that these programs are not sufficient to overcome the market failures arising from the MBS system.<sup>261</sup> These issues are discussed in more detail in section 5.4 of this report.

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<sup>258</sup> Submission 39, pp 7-8.

<sup>259</sup> Public briefing transcript, Brisbane, 29 November 2021, p 3.

<sup>260</sup> Submission 69, p 6.

<sup>261</sup> Submission 39, pp 7-8.

### 5.3 Australian Government funding and reporting

The Australian Government stated that it has made continuing investments to strengthen primary health care, referring to the ‘\$700 million in the 2021-22 Budget which built on \$1.6 billion over three previous Budget updates’. The Australian Government advised that measures included support for general practice, after hours care, allied health, mental health and the rural workforce.<sup>262</sup>

The Australian Government stated that it also 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.<sup>263</sup>

#### Committee comment

The committee notes that this is a considerable amount of funding, however, as noted in this report, problems persist in relation to availability, accessibility and affordability of the quality primary and allied health care that Queenslanders deserve.

To ensure that the policies and funding of the Australian Government are truly making a difference to health outcomes in Queensland, the committee recommends that the Australian Government establishes rigorous and transparent methods to assess the availability, accessibility and affordability of primary and allied health care across Queensland.

The committee considers that the Australian Government should report on these assessments publicly on a regular basis, broken down by each PHN region in Queensland.

#### **Recommendation 8 – Assessment and increased transparency of the availability and accessibility of primary and allied health care**

The committee recommends that the Australian Government:

- establishes rigorous and transparent methods to assess the availability, accessibility and affordability of primary and allied health care across Queensland
- publishes the results of the assessments on a regular basis, broken down by each Primary Health Network region in Queensland.

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<sup>262</sup> Submission 75, p 7.

<sup>263</sup> Submission 75, p 7.

#### 5.4 Medicare Benefits Scheme

The Australian Government is responsible for funding general practice and primary healthcare services through the MBS. The MBS is a list of the medical services for which the Australian Government provides a Medicare rebate, to provide patients with financial assistance towards the costs of the medical services.<sup>264</sup>

The MBS sets out the 'schedule fee' for each service to determine the amount of the patient rebate.<sup>265</sup> Patient rebates are provided for the following services:

- consultation fees for GPs and specialists
- diagnostic tests and procedures, which are medical services needed to treat illnesses, including diagnostic imaging and pathology tests
- most surgical and other therapeutic procedures
- eye tests performed by optometrists
- some surgical procedures performed by approved dentists and specified dental care services for eligible children
- specified items under the Cleft Lip and Palate Scheme
- specified allied healthcare services for chronically ill people who are managed by their GP.<sup>266</sup>

Each professional service in the MBS is allocated a unique item number, as well as an item descriptor, which outlines the service requirements.<sup>267</sup>

The schedule fee is a fee-for-service, as set by the Australian Government, and may differ from a health professional's actual fee which they are free to determine.

Some health professionals offer 'bulk billing', where a person does not have to pay for their medical service at the point of use. Instead, the health professional accepts a fee equal to the Medicare rebate as full payment for the service.<sup>268</sup>

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<sup>264</sup> Submission 75, p 6.

<sup>265</sup> Australian Government, *An MBS for the 21<sup>st</sup> Century, Recommendations, Learnings and Ideas for the Future, Medicare Benefits Schedule Review Taskforce*, Final Report to the Minister for Health, December 2020, p 16.

<sup>266</sup> Australian Government, *An MBS for the 21<sup>st</sup> Century, Recommendations, Learnings and Ideas for the Future, Medicare Benefits Schedule Review Taskforce*, Final Report to the Minister for Health, December 2020, p 16.

<sup>267</sup> Australian Government, *An MBS for the 21<sup>st</sup> Century, Recommendations, Learnings and Ideas for the Future, Medicare Benefits Schedule Review Taskforce*, Final Report to the Minister for Health, December 2020, p 17.

<sup>268</sup> Australian Government, Services Australia, 'Bulk billing', December 2021, <https://www.servicesaustralia.gov.au/bulk-billing?context=60092>.

If the practitioner charges a fee that is higher than the rebate, the patient must pay the full cost of the service before claiming the rebate from the Government. The gap between the fee and the patient-rebate is borne by the consumer as an 'out-of-pocket' cost.<sup>269</sup>

If a person's medical costs exceed a certain level in a calendar year, they may be able to benefit from the Medicare safety net, which offers higher rebates for health services after their expenditure on healthcare has exceeded a pre-determined threshold.<sup>270</sup>

#### **5.4.1 Issues with the current system**

Queensland Health advised that 'many Queenslanders do not have access to timely and affordable primary health care through the MBS system'.<sup>271</sup> The committee was informed that there are currently significant gaps in MBS funded primary health care services due to:

- the MBS' focus on episodic treatment for acute conditions, rather than provision of holistic person-centred care for ongoing conditions
- limited support under the MBS for allied health and nurse specialist services, inhibiting the use of multidisciplinary teams to treat patients with chronic conditions
- the indexation of Medicare rebates not keeping pace with costs of providing primary health care, leading to increasing out of pocket costs for patients
- barriers in accessing culturally appropriate care for First Nations people
- the MBS not incentivising GPs to practise in rural and remote areas
- insufficient incentives under the MBS for GPs to service people in RACFs or to conduct after-hours visits.<sup>272</sup>

This section of the report discusses these issues in further detail.

#### **5.4.2 Fee-for-service scheme, focuses on episodic care**

Queensland Health, and other submitters, highlighted that the MBS schedule, whilst including some chronic disease management items, is focussed on episodic care.<sup>273</sup> Queensland Health considered this is to the detriment to the provision of holistic, ongoing person-centred care required to meet current and future health needs.<sup>274</sup>

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<sup>269</sup> Australian Government, *An MBS for the 21<sup>st</sup> Century, Recommendations, Learnings and Ideas for the Future, Medicare Benefits Schedule Review Taskforce*, Final Report to the Minister for Health, December 2020, p 16.

<sup>270</sup> Australian Government, Services Australia, 'Medicare Safety Nets', December 2021, <https://www.servicesaustralia.gov.au/medicare-safety-nets>; Australian Government, Services Australia, 'What are the thresholds', January 2022, <https://www.servicesaustralia.gov.au/what-are-medicare-safety-nets-thresholds?context=22001>.

<sup>271</sup> Submission 39, pp 7-8.

<sup>272</sup> Queensland Health, submission 39, p 3; also see submissions 13, 17, 21, 40, 41, 42, 48, 49, 50, 51, 61, 65, 66 and 69.

<sup>273</sup> Submissions 21, 39, 40, 42 and 65.

<sup>274</sup> Submission 39, p 8; also see submissions 40, 42 and 65.

Dr Wakefield, former Director-General, Queensland Health, commented that the MBS:

... is still designed, really, for a 20<sup>th</sup> century, break-fix model of episodic treatment of acute conditions rather than being set up to provide holistic, person centred care for chronic disease for a population which often requires longer consultations and a multidisciplinary team to wrap around and support the care to an individual.<sup>275</sup>

QPHN considered that 'fee-for-service funding doesn't support effective team-based care or chronic disease management', stating:

People present to providers with symptoms and the practitioner looks for a medical cause for the symptoms and recommends a course of treatment. There is little capacity to understand the underlying social determinants of health and possible social prescriptions for care.<sup>276</sup>

Similarly, Brisbane North PHN stated that:

General practice is funded on a fee-for-service basis. Largely what that drives is volume rather than value. I think there is limited ability for general practice to provide what is required in terms of comprehensive care for chronic and complex conditions in the community. ... the funding model supports episodic rather than chronic and complex care.<sup>277</sup>

Dr Heather McNamee, from Care and Sexual Health Service stated that 'Fee-for-service is not an efficient way to run any health service, particularly one where prevention should be of major focus and in the era of COVID where telehealth has become a part of normal practice'.<sup>278</sup> Dr McNamee advised that:

A fee-for-service model lends itself to overservicing and is not health-outcome driven. A GP working in a 24-hour clinic offering fast, often substandard care can easily earn a lot more than a GP with a regular patient base offering holistic and preventative care. The current funding model leads itself to a two-tier primary care system where, if you want a decent GP who can afford to spend the necessary time with you, you will have to pay.<sup>279</sup>

Queensland Health stated that the MBS needs to transition to a contemporary system which caters to the needs of today's consumers in order to ensure:

- high quality, safe and accessible primary health care to an ageing population who are living longer – both independently at home and in residential aged care facilities
- integrated, coordinated, and ongoing care for chronic conditions and multiple morbidities, including through multi-disciplinary care
- increased mental health and wellbeing support
- consumers feel empowered and have the support/tools to take control of their own health management.<sup>280</sup>

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<sup>275</sup> Public briefing transcript, Brisbane, 29 November 2021, p 2.

<sup>276</sup> Submission 65, p 6.

<sup>277</sup> Public hearing transcript, Brisbane, 8 December 2021, p 17.

<sup>278</sup> Public hearing transcript, Mossman, 8 February 2022, p 1.

<sup>279</sup> Public hearing transcript, Mossman, 8 February 2022, p 1.

<sup>280</sup> Submission 39, p 8.

### 5.4.3 Market-driven model

Queensland Health advised that, as Medicare is based on a private provider market, it is subject to significant market failure and does not incentivise services for many groups who are disadvantaged from a health perspective, such as First Nations peoples, people in rural and remote communities and many regional centres, and people in aged care.<sup>281</sup>

Queensland Health, highlighted one of the drawbacks of the market-driven model, stating:

If the private provider chooses not to set up shop in a town, there is no provider, no service and no billing to Medicare. With insufficient funding and policy settings this exacerbates inequity, impacting on our most vulnerable Queenslanders. Unfortunately, it is significantly rural, remote and regional communities that this significantly underservices. Many areas do not have access to GPs at all, and the MBS benefits per capita are much lower in rural and remote areas.<sup>282</sup>

Dr Will Cairns expressed his reservations about the current market system, stating:

It is a cautionary tale from the United States that reflects their health system, but you can see things here. The one-line quote that struck me when I read this book was— ‘Free market competition does not and cannot deliver socially acceptable health care.’<sup>283</sup>

#### 5.4.3.1 *Impact on rural and remote communities – thin markets*

The committee notes that, in general, MBS items attract the same rate of payment in rural and remote areas, as they do in urban areas.

Submitters, such as HWQ and ACRRM, stated that the market-driven, fee-for-service model adversely impacted rural and remote communities.<sup>284</sup> HWQ noted that the ‘fee for service’ funding model does not focus on the needs of the community or support the unique business and workforce challenges in remote and rural areas.<sup>285</sup>

In addition, ACRRM stated that Medicare funding is commonly not sufficient to sustain the high costs of operating general practice and the rural Practice Incentives Program (PIP) is generally viewed as critical to practice viability.<sup>286</sup>

QRRPHN considered that the rigid design of the current MBS model is impacting on the sustainability of rural and remote general practices and primary care providers. QRRPHN stated that ‘It neither reflects the unique requirements of rural and remote practitioners, nor provides adequate remuneration for practices located in regions with much higher costs than metropolitan practices’.<sup>287</sup>

ACRRM advised that clinicians who invest in local practices must accept a considerable lack of capacity to grow their business and considerable vulnerability to small changes in the local population which may render their otherwise healthy business, unviable and unsellable.<sup>288</sup>

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<sup>281</sup> Submission 39, p 7.

<sup>282</sup> Public briefing transcript, Brisbane, 29 November 2021, p 2.

<sup>283</sup> Public hearing transcript, Townsville, 9 February 2022, p 18.

<sup>284</sup> Submissions 13 and 25.

<sup>285</sup> Submission 25, p 5.

<sup>286</sup> Submission 13, p 5.

<sup>287</sup> Submission 70, p 9.

<sup>288</sup> Submission 13, p 5.

QPHN stated that the small-scale businesses and private practices that make up primary health care in Australia are no longer sustainable outside of inner metropolitan areas and are not enabled to operate in ways that meet contemporary community needs.<sup>289</sup>

#### 5.4.3.2 *First Nations people*

Queensland Health referred to the MBS creating barriers in accessing culturally appropriate care for First Nations peoples, stating that the MBS 'does not incentivise services for many groups who are disadvantaged from a health perspective, such as First Nations peoples'.<sup>290</sup>

The committee notes the special direction issued to permit CCHSs to access Medicare billing (see section 5.2.3 of this report).<sup>291</sup>

The Institute for Urban Indigenous Health (IUIH) stated that the MBS is not structured in a way that supports the delivery of high-quality and culturally safe care for its clients and does not fund the full suite of services it needs to provide its patients. IUIH advised:

Our clients often have complex comorbidity, requiring extensive time and skill from a GP, nurse, health worker and other allied health professionals. The MBS does not cover many of the costs associated with enabling this care.<sup>292</sup>

IUIH stated that continuation of MBS for telehealth, allied health, mental health and specialist care and supplementation of health grant funding through the Section 19:2 Directions under the *Health Insurance Act 1973* (Cth) is also critical to CCHS' ability to provide integrated person-centred care and to achieve the Closing the Gap targets.

IUIH stated that:

Indigenous people are currently not benefiting from the same levels of universal access to Medicare as non-Indigenous Australians. Targeted health grant funding available through the Commonwealth's Indigenous Australians' Health Program (IAHP) and state/territory grant programs are insufficient to provide the level of service responses required to accelerate closing the health gap.<sup>293</sup>

QPHN also advised that many primary health care services in remote areas are provided by remote area nurses or Aboriginal Health Practitioners, meaning that less funding is available through the MBS.<sup>294</sup>

IUIH stated that 'MBS rebates should be evidence-based and reflect the time and effort required of all health practitioners to meet the patients' needs, particularly of Aboriginal and Torres Strait Islander people with complex comorbidity'.<sup>295</sup>

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<sup>289</sup> Submission 65, p 6.

<sup>290</sup> Submission 39, pp 3 and 7.

<sup>291</sup> Australian Government, Department of Health, 'Access to Medicare and pharmaceutical benefits for Aboriginal and Torres Strait Islander people', <https://www.health.gov.au/health-topics/aboriginal-and-torres-strait-islander-health/primary-care/medicare-and-medicines>.

<sup>292</sup> Submission 21, p 14.

<sup>293</sup> Submission 21, p 14.

<sup>294</sup> Submission 65, p 6.

<sup>295</sup> Submission 21, p 15.

#### 5.4.3.3 Introduction of Rural Bulk Billing Incentives

ACRMM advised that the recent introduction of rural loadings for a limited number of MBS items is a welcome, important and potentially game-changing innovation.<sup>296</sup>

The committee notes that the Rural Bulk Billing Incentives, which commenced on 1 January 2022, provide higher benefits to regional, rural and remote doctors to bulk bill children under 16 years and concession card holders.

The incentive is based on the Modified Monash Model (MMM) geographical classification system (MM 1 is inner metropolitan areas and MM 7 is very remote). The new incentives are:

- 150 per cent higher in MM 2 areas
- 160 per cent higher in MM 3 to 4 areas (\$10.40 per eligible consultation)
- 170 per cent higher in MM 5 areas (\$11.05 per eligible consultation)
- 180 per cent in MM 6 areas (\$11.70 per eligible consultation)
- 190 per cent in MM 7 areas (up to \$12.35 per eligible consultation).<sup>297</sup>

#### 5.4.3.4 Further action to recognise requirements of rural and remote areas

Several submitters called for further reform to the MBS to reflect the unique requirements of delivering primary and allied health services in rural and remote areas.<sup>298</sup>

HWQ stated that 'the current funding models do not work in thin markets such as rural and remote'. HWQ called for the Australian Government to revisit how these services are funded and delivered.<sup>299</sup>

Exercise and Sport Science Australia (ESSA) advised that, in comparison, the NDIS offers increased remuneration for service provision in remote areas (MM 6) and very remote areas (MM 7), stating:

Services provided in remote locations attract 40% more funding than services delivered in metropolitan and regional areas, while services provided in very remote locations attract 50% more funding than services delivered in metropolitan and regional areas.<sup>300</sup>

Similarly, RDAQ suggested that:

We also think that Medicare rebates in general should be indexed to your rurality. We have got a good modified Monash model that indexes rurality and the costs go with that so why not index Medicare rebates according to that? You would suddenly get a lot more GPs in Mount Isa if they are getting increased Medicare rebates per consultation.<sup>301</sup>

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<sup>296</sup> Submission 13, p 6.

<sup>297</sup> Australian Government, Department of Health, 'Rural Bulk Billing Incentives', <https://www.health.gov.au/initiatives-and-programs/rural-bulk-billing-incentives>.

<sup>298</sup> Submissions 25, 61 and 70.

<sup>299</sup> Submission 25, p 7.

<sup>300</sup> Submission 61, p 24.

<sup>301</sup> Public hearing transcript, Longreach, 4 March 2022, p 15.

RDAQ stated that:

Medicare rebates are not just frozen; they have never been indexed to inflation, let alone make up for increased operating costs, the increase in consumables, IT et cetera. That is a step up again in rural areas. Bulk-billing is impossible in rural areas in a private general practice. It is impossible to make that sustainable and to get GPs into a community in the long run. There is no incentive through the Medicare system. The Medicare rebates for most consultations are the same whether you are in the middle of Brisbane or the middle of Mount Isa, and we all know that the cost of living and also the cost of running a business are much greater in these areas.<sup>302</sup>

QRRPHN recommended that a blended funding model be introduced for rural, regional and remote service providers that recognises the additional costs and challenges of delivering primary health services in these areas.<sup>303</sup>

#### **5.4.4 Medicare rebate freeze, bulk-billing and out-of-pocket expenses**

The Australian Government froze indexation on all Medicare services from July 2013 to July 2017.

The committee notes that while some services, such as GP bulk-billing incentive payments, were lifted in July 2017, followed by standard GP and other specialist consultations in July 2018, other Medicare services did not have their freezes removed until July 2020.

The University of Queensland, Faculty of Medicine (UQ Faculty of Medicine) explained that 'Medicare rebates increased by 1.2 to 2.5% per year between 1995 and 2021, at a time when the Consumer Price Index increased by 3% per year, until they were frozen completely'.<sup>304</sup>

##### *5.4.4.1 Sustainability of General Practices*

A number of submitters highlighted the impact that the Medicare freeze had on the sustainability of general practices.<sup>305</sup> For example, QPHN stated that the freeze reduced the profitability of businesses.<sup>306</sup> RACGP noted that:

The costs to provide general practice care, including practice and staffing costs, increase year on year, and successive government have not matched these increases in the patient rebates provided by Medicare.<sup>307</sup>

AMAQ stated that the 'Medicare rebates (and the freeze) do not reflect the cost of providing General Practice services' and 'these constraints put at risk the viability of private general practice and are likely to lead to more pressure on already overwhelmed hospitals'.<sup>308</sup>

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<sup>302</sup> Public hearing transcript, Longreach, 4 March 2022, p 14.

<sup>303</sup> Submission 70, p 9.

<sup>304</sup> Submission 14, p 3.

<sup>305</sup> Submissions 13, 14, 25, 28, 73 and 65.

<sup>306</sup> Submission 65, p 6.

<sup>307</sup> Submission 73, p 4.

<sup>308</sup> Submission 28, p 1.

UQ Faculty of Medicine concurred, stating that the Medicare freeze ‘... has undoubtedly compromised the viability of many general practices, especially in areas of socioeconomic disadvantage, which includes rural communities’.<sup>309</sup>

RACGP advised that the growing gap between the cost of providing care and the Medicare rebate, combined with high external pressure for GPs to bulk bill all services, has had a significant impact on general practice sustainability.<sup>310</sup> RACGP estimated that full-time GPs have lost \$109,000 in total income from 2015-2020, as a result of the Medicare freeze, with the cumulative value of lost indexation for general practice MBS rebates estimated at over \$1.5 billion.<sup>311</sup>

RACGP provided the following information as regards the Medicare freeze:

Most general practices have either had to react to the Medicare freeze by seeing more patients per hour—and that is where you get the so-called six-minute medicine label—or they start charging privately.  
...

If Medicare was indexed to CPI from when it was first created, it would be \$85 right now. We know that at the moment the Medicare rebate is \$38, which falls short by \$40. We know the average patient out-of-pocket cost over the last five years has increased from an average of about \$21 or \$22 per consult to \$41 per consult, so it is just going to keep going up. I pay rental and that goes up every year. I pay staff and that goes up every year.<sup>312</sup>

ACRRM stated that ‘many practices have not recovered from the freeze on MBS rebates’.<sup>313</sup> HWQ outlined the ongoing impacts of the Medicare rebate freeze, stating:

General practices are still playing catch up from the Medicare rebate freeze. They are paying more for their practices, staff, medical products, utilities and just about anything else that goes into running a medical service but the rebates still are not adequate, particularly for rural and remote where economies of scale cannot be supported.<sup>314</sup>

ACRRM stated that ‘insufficient funding of Medicare disproportionately impacts the viability and attractiveness of providing medical services in rural and remote areas’.<sup>315</sup> ACRRM stated:

The viability of rural general practices is limited to the capacity of the patients within their geographic catchment to pay an out of pocket contribution to their care cost. They do not have the flexibility to grow their business by offering niche (cosmetic, sports medicine, skin cancer etc.) services to attract a broader pool of patients. They are also more likely to have a patient pool of low socio-economic status with less capacity or willingness to pay gap fees and who are more reliant on Medicare rebates to fund their health care costs.<sup>316</sup>

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<sup>309</sup> Submission 14, p 3.

<sup>310</sup> Submission 73, p 4.

<sup>311</sup> Submission 73, p 4.

<sup>312</sup> Public hearing transcript, Townsville, 9 February 2022, p 12.

<sup>313</sup> Submission 13, p 5.

<sup>314</sup> Submission 25, p 7.

<sup>315</sup> Submission 13, p 5.

<sup>316</sup> Submission 13, p 5.

#### 5.4.4.2 *Reduced bulk-billing options*

Queensland Health advised that the Medicare freeze also reduced incentives for GPs to bulk-bill and led to them providing services that are higher cost, stating:

At \$39.10 for a standard GP consultation Medicare rebate, increasing out of pocket costs for many patients are having to bridge the divide between the Commonwealth Government's rebate and the real cost of providing medical services, impacting on the viability of general practice.

Around 88 per cent of GP non-referred attendances in Queensland were bulk billed in 2020-21. For those services that were not bulk billed, the average patient contribution per service was \$42.08 creating significant impediments and disincentives to visit the GP.<sup>317</sup>

Inala Primary Care explained that as a practice operating in one of Queensland's poorest suburbs, patient poverty limits its ability to cross-subsidise bulk-billed operations. It described the special requirements of its patient cohort and the need to introduce fees for its patients:

... in November we introduced a \$20 fee on Saturday mornings. We need to aim for five per cent mixed billing by the end of the financial year and 10 per cent within 18 months to even be able to pay our rent. Our practice bulk-bills in an area with above state and national prevalence for every condition—with 32 per cent of our patients using five or more medications and 53.5 per cent having two or more chronic conditions. This is not a six-minute-medicine cohort. Prior to the Medicare freeze, it was common for GPs to schedule four patients per hour. The majority of practices have moved to six, with many in our immediate catchment routinely seeing 10 to 12. Six-minute medicine is a direct response to the financial pressures practices face, meaning we can no longer spend time with patients.<sup>318</sup>

The Indigenous Wellbeing Centre (IWC) stated that:

We have been banging on about it for a long time. We are probably the largest practice in the area [Bundaberg]. We bulk-bill Indigenous patients and we bulk-bill under-16-year-olds and pensioners, but everyone else pays because we only receive limited funding and the rest we generate. Realistically, in today's society no-one in this region is really going to survive on bulk-billing and trying to provide a quality service. I will put it that way. Yes, there is a six-minute service that you spoke about earlier; that is correct. That is the way Medicare is designed. It is not necessarily designed to compensate quality. That is what is missing and that is what is required for this region.<sup>319</sup>

According to the Australian Government, in 2020-21, over 35 million MBS-subsidised GP services were provided in Queensland at a cost of \$1.8 billion. It advised that 'of these services, 88.1 per cent were bulk-billed, which is in line with the national average'.<sup>320</sup>

However, UWU noted that Queensland's bulk billing rate of 88.1 per cent is below the national average of 88.8 per cent. It commented that the lack of local bulk billing GPs in Rockhampton, for example, has adversely impacted on the local emergency department.<sup>321</sup>

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<sup>317</sup> Submission 39, p 12.

<sup>318</sup> Public hearing transcript, Logan, 10 February 2022, p 14.

<sup>319</sup> Public hearing transcript, Bundaberg, 2 March 2022, p 9.

<sup>320</sup> Submission 75, p 4.

<sup>321</sup> Submission 36, p 4.

UWU also advised that ‘health costs rose 39% over the decade to 2020, while the Medicare rebate for a GP consultation increased only 12%’. UWU stated that ‘this gap contributes to a low-service, high turnover model of GP care and forces GPs to forego bulk billing for many of their patients’.<sup>322</sup>

Bill Allison drew a comparison between what a GP receives via bulk-billing compared to other services, stating:

A bulk-billing doctor I think gets \$38. Someone from Cairns charged me \$190 to spend 10 minutes to fix my garage door. My doctor would spend a minimum of 15 to 20 minutes seeing me. Every time I go there she gives me a thorough check over. She does not rush me.<sup>323</sup>

#### 5.4.4.3 Increased out-of-pocket costs

IUIH referred to the recent *The Health of the Nation 2021 Report*, which found that the average patient out-of-pocket costs for all GP non-referred attendance increased by 49 per cent over the past decade, and the value of MBS patient rebates continued to decline.<sup>324</sup> RACGP stated that ‘without reasonable increases to MBS rebates, out-of-pocket costs to patients will increase so that practices can remain viable’.<sup>325</sup>

RACGP advised that in 2012 a patient attending their GP paid an average of \$27.65 out-of-pocket and in 2021 that patient pays \$41.12. Meanwhile, the MBS rebate has only increased from \$34.90 to \$38.75 over that same period. RACGP stated that the average patient out-of-pocket cost is higher than the Medicare rebate, has been since 2018 and will continue to grow.<sup>326</sup>

QPHN acknowledged that ‘The current MBS billing model and the freeze on Medicare has made it quite unsustainable in rural and remote areas to have universal bulk-billing’.<sup>327</sup>

A significant number of submitters stated that out-of-pocket expenses and the lack of bulk-billing deterred people from accessing the treatment they require.<sup>328</sup>

The AIHW reported that, in 2016-17, 34 per cent of patients nationwide with GP visits incurred out-of-pocket expenses, including 37.8 per cent in Northern Queensland PHN and 36.2 per cent in Western Queensland PHN. Nationwide, 4.1 per cent of people who needed to see a GP delayed or did not see a GP due to cost.<sup>329</sup>

HWQ observed that the community, given the option of paying fee-for-service or MBS gap for private allied health services or GP services, unsurprisingly will choose ‘free’ Queensland Health services.<sup>330</sup>

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<sup>322</sup> UWU, submission 36, p 4.

<sup>323</sup> Public hearing transcript, Mossman, 8 February 2022, p 18.

<sup>324</sup> Submission 21, p 14; RACGP, *The Health of the Nation 2021*, Summary Report, p 10.

<sup>325</sup> Submission 73, p 4; RACGP, *General Practice: Health of the Nation 2021*, Melbourne 2021.

<sup>326</sup> Submission 73, p 4; RACGP, *General Practice: Health of the Nation 2021*, Melbourne 2021.

<sup>327</sup> Public hearing transcript, Brisbane, 8 December 2021, p 18.

<sup>328</sup> See, for example, submissions 25, 38 and 69.

<sup>329</sup> Australian Government, AIHW, ‘Patients’ out-of-pocket spending on Medicare services’, 2016-17, <https://www.aihw.gov.au/reports/health-welfare-expenditure/patient-out-pocket-spending-medicare-2016-17/data>.

<sup>330</sup> Submission 25, p 7.

HWQ advised that GP practices in rural and remote areas are unable to rely solely on bulk-billing and patients are having to pay higher out-of-pocket costs which can be challenging for lower socio-economic communities. This in turn places higher pressure on state-funded emergency departments with rises in Category 4 and 5 and GP-type presentations.<sup>331</sup>

QNMU stated that:

We are seeing non-urgent patients presenting to emergency departments as they are either not wanting to pay out-of-pocket costs to see a GP who charges higher than the Medicare rebate or cannot get into a bulk-billed medical centre in a convenient timeframe.<sup>332</sup>

The committee notes that delaying treatment exacerbates underlying health conditions and may result in avoidable emergency department presentations and preventable hospital admissions. See Chapter 4 of this report.

#### **5.4.5 After-hours services and home visits**

The Australian Government advised that it 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 PHN After-Hours Program and \$30.8 million through healthdirect.<sup>333</sup>

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

For example, Wide Bay HHS stated:

There are very limited after-hours health services available at GP practices and things. That is quite limited, so the only place to go is the hospital and that certainly leads to increased presentations.<sup>334</sup>

Inala Primary Care advised:

GPs have absolutely no incentive to work extended hours. Penalty rates apply for nursing and reception staff but the bulk-billed rate remains the same. We ran Saturday morning clinics at a loss before we introduced a moderate out-of-pocket expense. GPs operate from sizeable premises, meaning occupancy costs have been impacted by rising property prices. In addition, staff working under awards receive regular pay increments. These are still insufficient to attract highly qualified skilled nurses to perform the chronic disease and care coordination work to keep patients out of hospital.<sup>335</sup>

North Queensland PHN stated:

I would suggest that GPs cannot do a home visit. They are absolutely at capacity. What is happening with the bulk-billing is, if you are getting \$39—I think it is \$38.90 or something—for a bulk-bill, if you are delivering high-quality primary care, which 95 per cent to 99 per cent of our practices are, you are seeing four to six patients an hour. That is \$144 an hour that the GP walks away with. He has to pay his public

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<sup>331</sup> Submission 25, p 7.

<sup>332</sup> Submission 69, p 29.

<sup>333</sup> Submission 75, p 8.

<sup>334</sup> Public hearing transcript, Bundaberg, 2 March 2022, p 3.

<sup>335</sup> Public hearing transcript, Logan, 10 February 2022, p 14.

indemnity insurance, he has to do his education and training, and the practice then gets the other part of that.

When it comes to sustainability for that model when you do not have large numbers in rural and remote areas, you just cannot. You will go broke and you will not be there. These are private businesses. These are professionals. I do not think you would see another professional like a lawyer earning those sums of money. That is not to include all of the additional work and travel that does not get covered.<sup>336</sup>

Dr Maureen Mitchell, a palliative medicine specialist on the Sunshine Coast, advised that ‘GP remuneration for home visits does not cover the cost of service provision, nor the travel time to reach our more isolated patients’.<sup>337</sup>

Dr Cynthia Jackson, JCU, stated:

We do home visits. I have been on a home visit this morning. It took me an hour. For that hour I might get \$60 and of that I pay a facility fee and I pay my tax. I do that at a loss and I do it because I know my community. If I were in a city, I could be part of a deputising service and just do after-hours or home visits and it is quite lucrative. The whole demographic in country areas is different. We need to be looking at how we pay those practitioners to do the job they are actually doing.<sup>338</sup>

Queensland Health advised that, in the years prior to 2018, the gap in after-hours care was increasingly filled by medical deputising services. These services are designed to provide general practice services for and on behalf of a patient’s regular practice. The Approved Medical Deputising Services (AMDS) program enables non-vocationally recognised GPs to access MBS benefits for providing after-hours services on behalf of other doctors. Queensland Health advised that this helps them get general practice experience, while ensuring people can access health care after-hours.<sup>339</sup>

The committee notes that MBS items for the provision of urgent after-hours primary care were reviewed in 2017. Following the review, on 1 March 2018, the Australian Government reduced the fees payable to non-vocational recognised GPs for urgent services provided between 6:00pm and 11:00pm in metropolitan areas from \$129.80 to \$100, and then to \$90 from 1 January 2019. This fee has since increased to \$93.65 from 1 July 2021.

Queensland Health advised that ‘since these changes the total number of after-hours services has declined significantly, from 505,122 services in 2017 to 369,225 services in 2018’.<sup>340</sup> Queensland Health noted that AIHW data from 2018-19 shows areas with lower access to GPs after-hours services have higher rates of emergency department presentations across all triages – see figure 6 below.

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<sup>336</sup> Public hearing transcript, Brisbane, 8 December 2021, p 19.

<sup>337</sup> Submission 20, p 8.

<sup>338</sup> Public hearing transcript, Bundaberg, 2 March 2022, p 24.

<sup>339</sup> Submission 39, pp 12-13.

<sup>340</sup> Submission 39, pp 12-13.

PHN Name	Estimated resident population	GP subtotal - After-hours No. of services	GP subtotal - After-hours Services per 100 people	ED Presentations	ED Presentations per 100 people
Brisbane North	1,024,570	463,806	45.27	307,041	29.97
Brisbane South	1,163,504	604,381	51.94	360,701	31.00
Gold Coast	621,929	382,275	61.47	166,337	26.75
Darling Downs and West Moreton	577,853	243,755	42.18	255,172	44.16
Western Queensland	62,400	15,054	24.12	73,334	117.52
Central Queensland, Wide Bay, Sunshine Coast	862,892	220,476	25.55	394,992	45.78
Northern Queensland	698,068	253,120	36.26	373,853	53.56
<b>Queensland</b>	<b>5,011,216</b>	<b>2,182,867</b>	<b>43.56</b>	<b>1,931,430</b>	<b>38.54</b>

Figure 6 - Number of GP after-hours services compared with emergency department presentations, source Queensland Health, response to questions on notice – After-hours GPs thin markets, 7 December 2021.

#### 5.4.6 Availability of MBS item numbers for essential services in rural and remote areas

RDAQ advised that the Department of Health had removed MBS items for services that are essential in a rural context, stating:

Last year they took out the item number for GPs to read an ECG. We run the hospital here so if I have a patient with chest pain I can send them to the hospital, which is me as well, but Medicare does not fund me to read the ECG.<sup>341</sup>

RDAQ added that the federal Medicare advisory committee is heavily weighted with urban practitioners. RDAQ stated:

When they look at case examples, they really only consider the urban situation where there is a cardiologist at the hospital down the road who can look at an ECG for a patient. They are likely to be transferred to a specialist hospital. There has not been a consideration of rural areas in a lot of these changes and there has been overbilling.

Whenever Medicare billing exists, there are places—especially corporates and especially in the city—that take advantage of it. From the rural doctors’ point of view, we think that these Medicare items should be reinstated for rural and remotes—not necessarily across the board.<sup>342</sup>

#### Committee comment

The committee notes that the lack of health care providers in rural and remote areas, and some outer metropolitan areas, means that services are often delivered differently than in urban, metropolitan areas.

The committee recommends that the Queensland Government requests that the Medicare Benefits Schedule Review Advisory Committee reverse the removal of MBS items for services that are essential in a rural, remote and outer metropolitan context, including reading an electrocardiogram (ECG), and review whether any other MBS items should be added to assist the provision of quality primary and allied health care in these settings.

<sup>341</sup> Public hearing transcript, Longreach, 4 March 2022, p 14.

<sup>342</sup> Public hearing transcript, Longreach, 4 March 2022, p 14.

**Recommendation 9 – Medicare Benefits Scheme funding for services that are essential in regional, rural and remote areas and identified outer metropolitan areas of need**

The committee recommends that the Queensland Government requests that the Medicare Benefits Schedule Review Advisory Committee reinstates immediately Medical Benefits Scheme items for services that are essential in regional, rural and remote areas and identified outer metropolitan areas of need, including reading an electrocardiogram (ECG), and reviews whether any other items should be added to assist the provision of quality primary and allied health care in these settings.

#### 5.4.7 Ongoing allied health care

The Australian Government advised that, in 2021-22, 3.3 million MBS-subsidised allied health care services were delivered in Queensland, 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 Queensland in line with average national rates, at 99.7 per cent and 94.6 per cent respectively.<sup>343</sup>

The committee notes, however, that the MBS provides only limited support for ongoing allied health services to manage chronic conditions. Patients with a chronic disease or terminal condition can only currently access benefits for allied health services, if they have a:

- General Practitioner Management Plan (GPMP) – via the patient’s usual medical practitioner
- Team Care Arrangement (TCA) – a multidisciplinary approach – involving the patient’s usual medical practitioner and at least two collaborating health or care providers.<sup>344</sup>

A GPMP or TCA must be completed by the patient’s usual medical practitioner. To be eligible for a GPMP or TCA, a patient must have had a chronic disease (eg cancer, diabetes or kidney disease) for at least six months or have a terminal medical condition.<sup>345</sup>

Patients can then receive a total of five allied health visits over a calendar year (ten for Aboriginal and Torres Strait Islander peoples).<sup>346</sup>

Queensland Health stated that GPMP and TCA schemes are problematic for both consumers, and allied health practitioners in private practice, particularly in rural and remote communities, because:

... it is reliant on an available, stable GP workforce that also understands allied health access and availability in the consumer’s location. It also employs a reactive approach to health management, as opposed to a preventative approach.<sup>347</sup>

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<sup>343</sup> Submission 75, p 4.

<sup>344</sup> Australian Government, Services Australia, ‘Chronic disease GP Management Plans and Team Care Arrangements’, <https://www.servicesaustralia.gov.au/chronic-disease-gp-management-plans-and-team-care-arrangements>.

<sup>345</sup> Australian Government, Services Australia, ‘Chronic disease GP Management Plans and Team Care Arrangements’, <https://www.servicesaustralia.gov.au/chronic-disease-gp-management-plans-and-team-care-arrangements>.

<sup>346</sup> Queensland Health, submission 39, pp 9-10.

<sup>347</sup> Submission 39, pp 9-10.

A number of submitters and witnesses, including individual allied health professionals and representative associations, considered that the limit of five visits was not sufficient to manage ongoing chronic conditions.<sup>348</sup> For example, IMPACT Community Health Service stated that:

They might get three podiatry, one diabetes education and one dietitian. Our dietitian is usually only getting one of those care plan visits and that severely limits her capacity to provide comprehensive care and services to people because their ability to pay for private services is limited.<sup>349</sup>

Similarly, ESSA advised that:

Five sessions is not enough to treat someone with a chronic condition, particularly when it has to be delivered as a multidisciplinary item. We talked at length about diabetic patients here this morning. They cannot see the dietician, the exercise physiologist and the podiatrist in five sessions, so it needs to be realistic.<sup>350</sup>

The Joint Submission stated that the current cap of five allied health sessions per year is 'insufficient to provide effective care to people living with chronic health issues'.<sup>351</sup> The APA agreed, stating that the five sessions '... has never been enough to provide comprehensive care'.<sup>352</sup>

Queensland Health stated:

As a patient is likely to require input from more than one allied health profession for their chronic disease, this means that they are only able to access one to three visits for each profession they need to see, which is inadequate to address the multiple co-morbidities associated with the chronic disease.<sup>353</sup>

Submitters, including Diabetes Queensland, ESSA, the Joint Submission and APA, advocated for a significant increase in the current total of Medicare-funded consultations.<sup>354</sup> ESSA recommended that the number of permitted visits be increased from 5 to 10 or 12 and an expansion of the services covered by the schemes, stating:

The government cannot determine that these items are having great outcomes because you are not going to get an outcome. We might see a person once. You are not going to get any outcomes, let's be honest. We have asked that they be increased to 10 or 12 sessions to actually have any meaningful outcome. We have also been advocating for expansion. For example, there is a lot of evidence around exercise and mental health, yet we cannot access services for those people. The process to go through is ridiculously long, yet the evidence is there.<sup>355</sup>

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<sup>348</sup> Submissions 39, 42, 51, 57 and 61.

<sup>349</sup> Public hearing transcript, Bundaberg, 2 March 2022, p 18.

<sup>350</sup> Public hearing transcript, Brisbane, 21 February 2022, p 17.

<sup>351</sup> Submission 41, p 11.

<sup>352</sup> Submission 57, p 4.

<sup>353</sup> Submission 39, pp 9-10.

<sup>354</sup> Submissions 41, 42, 57, 61 and 71.

<sup>355</sup> Public hearing transcript, Brisbane, 21 February 2022, p 17.

Allied Health Professions Australia (AHPA) considered that the current MBS approach is ‘at best piecemeal and episodic’, stating:

Only a few allied health treatments are funded under the Medicare Benefits Schedule (MBS). The MBS is not designed for treatment of chronic and complex physical and mental illnesses, because it provides funding for only a limited number of fixed-time appointments and requires patients to fund significant out of pocket costs, meaning that some of the most vulnerable people will not get treatment at all. Similarly, very low rates of funding for allied health treatment of veterans often make provision of these services unviable.<sup>356</sup>

Queensland Health stated:

Patients may also be out of pocket up to several hundred dollars for the gap between the Medicare benefit and the amount charged by allied health practitioners, because the Medicare benefit does not reflect the cost to the allied health practitioner to provide services.<sup>357</sup>

Queensland Health advised that the MBS rebate is approximately \$55 for a minimum 20-minute appointment, meaning that an individual is likely to be out-of-pocket by \$250 to \$300 for their five allied health visits. As a result, even with the MBS subsidy, Queensland Health considered that primary care allied health services are unaffordable for many patients and these patients are often referred to a Queensland Health specialist outpatient clinic.<sup>358</sup>

Similarly, Occupational Therapy Australia (OTA) stated that the ‘... individualised funding that is available through the MBS [for allied health care] is often inadequate for clients with complex health needs and/or chronic and progressive conditions’. OTA stated ‘... the cost of care not funded by the MBS falls back on clients, many of whom do not have capacity to independently fund the health care they need’.<sup>359</sup>

Health and Wellbeing Queensland noted that allied health led models of care provide a cost-effective approach to increasing health service demands. They also considered that the current GPMP and TCA schemes inadequately support those living with chronic conditions and do not support those at risk of developing a chronic condition. Health and Wellbeing Queensland stated:

Medicare rebated chronic disease management plan does not adequately reimburse allied health care providers to provide sustainable business revenue. Providers are often required to charge a gap fee for financial viability thereby limiting access for low socioeconomic population groups. The eligibility criteria for chronic disease management plans are not clearly defined contributing to inconsistent application across primary health care providers.<sup>360</sup>

On 1 November 2021, the Department of Health made a number of changes to the MBS. These changes enable a Medicare benefit to be paid where allied health practitioners participate in case conferences to manage the care of certain patients.<sup>361</sup>

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<sup>356</sup> Submission 42, p 2.

<sup>357</sup> Submission 39, pp 9-10.

<sup>358</sup> Submission 39, pp 9-10.

<sup>359</sup> Submission 17, p 5.

<sup>360</sup> Submission 58, p 4.

<sup>361</sup> Australian Government, Department of Health, ‘MBS Online – Medicare Benefits Schedule’, <http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/news-211101>.

Queensland Health, and submitters, raised concerns about the changes.<sup>362</sup> Queensland Health considered that the update failed to address the inadequacy of funding for allied health services for chronic diseases to provide effective treatment and multidisciplinary care.<sup>363</sup> Queensland Health stated:

While the introduction of new MBS item numbers that allow MBS reimbursement for allied health practitioners to participate in case conferences is a positive step, Commonwealth funding for primary allied health care remains inadequate to meet community needs. Many consumers who are receiving care from allied health professionals do not meet the strict criteria for reimbursement of the new items (General Medical Services – Allied Health Case Conference) which are limited to patients who are already under an approved management plan and only if the case conference is initiated and includes the GP or medical specialist.<sup>364</sup>

OTA stated ‘... there must be greater access to allied health through MBS items, with Chronic Disease Management and other allied health MBS items enhanced to meet the varying needs of clients’.<sup>365</sup>

Queensland Health expressed the view that the above issues in relation to access to ongoing allied health services impact on the viability of private allied health services, compounding a lack of choice and access in the private sector for consumers and adding additional burden on the public sector.<sup>366</sup> Queensland Health stated that ‘these patients are often then referred to a Queensland Health specialist outpatient clinic in order to access services’.<sup>367</sup>

Brisbane North PHN agreed stating that ‘a lot of GPs will refer into the hospital and health service as a way to get affordable allied health for people with chronic and complex conditions’.<sup>368</sup>

OTA considered that innovate models of care and funding (block/blended/pooled) must be introduced to support wider access to allied health services.<sup>369</sup> The issue of MBS funding reforms is discussed in more detail at section 5.4.

#### Committee comment

The committee notes the benefits to patients that can be realised through access to ongoing allied health care, particularly for those people who are suffering chronic conditions, such as cancer, diabetes, kidney diseases and strokes.

With the increase in the number of Queenslanders suffering from chronic disease, the committee notes that the requirement to access these services will become greater in the future.

The committee, therefore, recommends that the Australian Government reviews the current limit of five MBS funded allied health visits per annum.

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<sup>362</sup> Submissions 17 and 39.

<sup>363</sup> Submission 39, p 10.

<sup>364</sup> Submission 39, pp 9-10.

<sup>365</sup> Submission 17, p 5.

<sup>366</sup> Submission 39, pp 9-10.

<sup>367</sup> Submission 39, pp 9-10.

<sup>368</sup> Public hearing transcript, Brisbane, 8 December 2021, p 21.

<sup>369</sup> Submission 17, p 5.

**Recommendation 10 – Increased number of Medicare Benefits Scheme-funded allied health visits**

The committee recommends that the Australian Government reviews the current limit of five Medicare-funded allied health visits per annum, under the General Practitioner Management Plans or Team Care Arrangements, to ensure that patients have appropriate access to allied health care to manage ongoing chronic conditions.

The committee also recommends that the Australian Government reviews the current requirement for GPMP and TCA to be completed by GPs. The committee considers that GPMP or TCAs could be completed by allied health professionals, freeing-up GP time to see other patients.

**Recommendation 11 – Improving accessing to allied health services**

The committee recommends that the Australian Government reviews the current requirement for general practitioners to complete General Practitioner Management Plans or Team Care Arrangements, with a view to enabling appropriately qualified allied health professionals to undertake this task to increase efficiencies and promote patient access to allied health care.

#### **5.4.8 Access to MBS funding for nurse and midwifery professions**

QNMU and Queensland Health recommended that the Australian Government reviews the MBS to assist nurses and midwives to work to their full scope of practice and provide valuable services to the community, including where medical-led models of care are unsustainable.<sup>370</sup>

QNMU considered that the fact that the MBS funding model continues to prescribe that health practitioners within the multidisciplinary team are deemed to have provided care ‘for and on behalf’ of a medical practitioner, ‘diminishes and limits the important role they play in delivering primary health care’.<sup>371</sup>

QNMU called for increased access to the MBS to recognise nurses and midwives are equal and valued members of the health care team and to cover the delivery of all nursing and midwifery services.<sup>372</sup>

The Australian College of Nursing (ACN) noted that the limited funding support offered by the MBS for nurse practitioners and registered nurses is restricting access to nursing care in the community. ACN, therefore, advocated for increased access to the MBS for nurse practitioners and advanced practice nurses.<sup>373</sup>

Dr McNamee, General Practitioner, Care and Sexual Health Service, highlighted the inefficiencies of the current system, stating:

Nurses have the skills and they have the abilities, but in general practice in Australia you just cannot use them. Even something as silly as a childhood vaccination, which nurses do, there is this ridiculous thing goes on where the GP has to go out and sort of wave at the baby. So you just go and say to the mum, ‘You right? All good? Yep’, if they do not need another check-up and they do not need anything else done. And that is for Medicare. That is to make it legal under Medicare.

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<sup>370</sup> Submission 39 and 69.

<sup>371</sup> Submission 69, p 9.

<sup>372</sup> Submission 69, p 27.

<sup>373</sup> Submission 66, p 3.

I work in a public clinic at the moment where our nurses basically see patients independently and we are there for backup and questions and prescriptions for the more complex patients. But they are basically trained in their area, which is sexual health, and most of our patients are seen by nurses and not doctors. It is easy logistically to make it work. The issue is Medicare and the item number.<sup>374</sup>

Ms Linda Kirby, a nurse practitioner, commented on the restrictions she faces:

The restrictions I face as a nurse practitioner with MBS funding and PBS prescribing provide an absolute hotbed for the breakdown in continuity of care and directly entrench the barriers to health care for my clients.<sup>375</sup>

Ms Kirby added:

... that there was an MBS change recently in relation to the funding for IUD insertions for GPs. As a nurse practitioner, I do exactly the same training that GPs do to insert Mirenas and IUDs. I do the same training to put in Implanons and in script writing—the exact same training—however I have no MBS billing number. I have one billing code that I can use, and that is just a consultation. Whilst there have been many studies—and I am sure my colleagues before me have discussed that—and multiple papers written about the holistic nature and the care that nurse practitioners can give, those changes would mean that I could see someone, give them some contraception and they could come back and see me at any stage. It is fantastic. It is good to see that the MBS is trying to catch up and trying to get GPs on board with allowing us to insert them, but I think we have about a six per cent rate of using long-acting contraception and it is a barrier. Nurse practitioners can do these things.

These limitations related to the MBS and the PBS really demonstrate that the laws and the regulations are not in step with industry and patient needs. The industry is tying itself up with red tape instead of utilising an already willing, capable and highly skilled workforce to the best of its ability to provide equitable, accessible and holistic health care.<sup>376</sup>

Mrs Sandra Ilett, a nurse continence specialist, advised the committee of the issues she experienced in providing catheter and continence services. Mrs Ilett stated:

When I first started work as a sole provider, I did try to access some help or guidance through my local primary health network but it became fairly obvious from the lack of response that I really did not fit their model, so I stopped trying to access help. I do not have a Medicare provider number. That is the big issue. If I had a Medicare provider number, no problem.<sup>377</sup>

HWQ recommended a review of MBS item numbers for allied health and nurse practitioners would also support further viability of private practice in rural and remote areas.<sup>378</sup>

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<sup>374</sup> Public hearing transcript, Mossman, 8 February 2022, p 3.

<sup>375</sup> Public hearing transcript, Rockhampton, 3 March 2022, pp 19-20.

<sup>376</sup> Public hearing transcript, Rockhampton, 3 March 2022, p 20.

<sup>377</sup> Public hearing transcript, Bundaberg, 2 March 2022, p 16.

<sup>378</sup> Submission 25, p 6.

#### 5.4.9 Reforms to the MBS and the funding of primary and allied health care

RACGP stated that ‘GPs consistently rank Medicare rebates and creating new funding models for primary care as the highest priority health policy issues for government action’.<sup>379</sup>

AMAQ stated ‘fund primary care appropriately and more patients will be healthier, have less hospital visits and enjoy continuity of care’.<sup>380</sup>

HWQ stated that incremental increases in funding to GP services will not improve the quality of the Australian health care system, instead calling for ‘fundamental funding reforms for general practice and the way primary health care services are delivered is vital if we are to see significant reform’.<sup>381</sup>

AMAQ called for the MBS to be simplified and Medicare rebates to be reviewed. AMAQ considered that the last review, undertaken between 2015 and 2020, did not adequately address the cost of providing services.<sup>382</sup> AMAQ recommended that the GP practice owners, who understand the practicalities and cost of providing medical care, should be included on all review panels.<sup>383</sup>

Submitters, including QPHN, QNMU, QRRPHN and JCU, recommended that new models of funding primary health care be investigated to incorporate blended payments, performance based and pooled funding, allowing for innovation and locally responsive models of care.<sup>384</sup>

QPHN considered this would ‘allow primary health care provision to escape from the constraints of the fee for service paradigm and enable the development of truly patient centred approaches to delivering primary health care’.<sup>385</sup> JCU stated that a blend of funding would balance payment for service with value and outcomes that enable team-based care.<sup>386</sup> QRRPHN considered that blended funding would ‘recognise the additional costs and challenges of delivering primary health services’ in rural, regional and remote areas.<sup>387</sup>

RACGP considered that the Australian Government’s *Primary Health Care 10 Year Plan* (the 10 Year Plan), launched in August 2019, is a critical opportunity to improve the lives of all Australians through achievable and cost-effective reforms and investments in primary care.<sup>388</sup>

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<sup>379</sup> Submission 73, p 4; RACGP, ‘General Practice: Health of the Nation Reports 2018-2021’, Melbourne.

<sup>380</sup> Submission 28, p 3.

<sup>381</sup> Submission 25, p 7.

<sup>382</sup> Submission 28, p 2.

<sup>383</sup> Submission 28, p 2.

<sup>384</sup> Submissions 65, 68, 69 and 70.

<sup>385</sup> Submission 65, p 6.

<sup>386</sup> Submission 68, p 3.

<sup>387</sup> Submission 70, p 8.

<sup>388</sup> Submission 73, p 4; RACGP, ‘General Practice: Health of the Nation Reports 2018-2021’, Melbourne.

RACGP noted that many of the recommendations put forward by the 10 Year Plan Steering Group are 'a step in the right direction'. RACGP highlighted the need to modernise Medicare to reflect the cost of providing care, with initial reforms including:

- improved MBS rebates for longer consultations
- structure Medicare funding to reward time invested in preventive and secondary care in the community, rather than disproportionately funding/rewarding tertiary care and surgical procedures that are required as chronic diseases approach severe or end-stage
- removal of rebate differentiation between MBS items based on provider status
- focus on the provision of holistic comprehensive care rather than single-disease MBS item numbers.<sup>389</sup>

RACGP also highlighted the need to introduce blended payment funding models that support the provision of high-quality care to patients with complex conditions, in addition to MBS rebates.

The committee notes that the 10 Year Plan Steering Group has recommended that, over time, funding models be blended and tailored to provide the right balance of incentives to achieve person centred, high quality, integrated primary health care.<sup>390</sup>

#### Committee comment

The committee notes that the Australian Government's indexation of MBS fees for service have not kept pace with real increases in practice costs since Medicare began, contributing to increasing levels of out-of-pocket costs and a decrease in bulk-billing options.

The committee agrees with the RACGP that MBS reforms and the creation of new funding models for primary care is one of the highest priority health policy issues for the Australian Government. During the Inquiry, submitters and witnesses have raised a number of issues with the current MBS system that need to be addressed – see section 5.4 of this report.

The committee recommends that the Australian Government, as part of the *Primary Health Care 10 Year Plan* process, reviews the current MBS system and commit to reforming the method of funding primary and allied health care. The review should consider the following issues:

- the reversal of the impact of the Medicare rebate freeze and ensuring that Australian Government funding of primary and allied health increases year-on-year at least in line with the Consumer Price Index
- the introduction of blended payments and performance based and pooled funding to promote innovative models of care and a greater focus on early intervention and preventive care
- how to ensure a focus on person-centred, high quality, holistic and integrated care, including facilitating longer GP consultations and the use of multidisciplinary teams
- the funding of counselling services under the MBS
- the removal of rebate differentiation between MBS items based on provider status

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<sup>389</sup> Submission 73, p 4.

<sup>390</sup> Australian Government, Department of Health, 'Future focused primary health care: Australia's Primary Health Care 10 Year Plan 2022-2032 – Consultation Draft', October 2021, p 12.

- how to ensure that patients have appropriate access to allied health care to manage ongoing chronic conditions
- incentives for GPs to provide after-hours services and conduct home visits by ensuring that they are appropriately recompensed for the service
- incentives for GPs to provide primary care in aged care settings, including after-hours services
- incentives to optimise the delivery of primary and allied health services in rural and remote areas and outer metropolitan areas of need
- incentives to promote the teaching and training of health professionals in primary and allied health care settings
- the funding of nurses, nurse practitioners and midwives to work to their full scope of practice (eg nurse continence specialists), and provide valuable services to the community in a primary care setting.

**Recommendation 12 – Review and comprehensive reform of the Medicare Benefits Scheme**

The committee recommends that the Australian Government, as part of the *Primary Health Care 10 Year Plan* process, reviews the current Medicare Benefits Scheme system and commits to reforming the method of funding primary and allied health care. The review should consider the following issues:

- the reversal of the impact of the Medicare rebate freeze and ensuring that Australian Government funding of primary and allied health increases year-on-year at least in line with the Consumer Price Index
- the introduction of blended payments and performance based and pooled funding to promote innovative models of care and a greater focus on early intervention and preventive care
- how to ensure a focus on person-centred, high quality, holistic and integrated care, including facilitating longer general practitioner consultations and the use of multidisciplinary teams
- the funding of counselling services under the MBS
- the removal of rebate differentiation between MBS items based on provider status
- how to ensure that patients have appropriate access to allied health care to manage ongoing chronic conditions
- incentives for general practitioners to provide after-hours services and conduct home visits by ensuring that they are appropriately recompensed for the service
- incentives for general practitioners to provide primary care in aged care settings, including after-hours services
- incentives to optimise the delivery of primary and allied health services in rural and remote areas and outer metropolitan areas of need
- incentives to promote the teaching and training of health professionals in primary and allied health care settings
- the funding of nurses, nurse practitioners and midwives to work to their full scope of practice (eg nurse continence specialists), and provide valuable services to the community in a primary care setting.

## 5.5 Health workforce

The Australian Government is responsible for ensuring that Australia has the health workforce necessary to improve the health and wellbeing of all Australians.<sup>391</sup> The Australian Government advised that it ‘... makes substantial investments to support a primary health care system to keep Australians healthy and reduce demand for hospital services’.<sup>392</sup>

In Australia, the health workforce comprises the following health professions:

- nurses and midwives – largest group in the registered health workforce – 334,000 nurses and midwives in 2018
- allied health professionals – 133,400 allied health professionals in 2018
- medical practitioners (commonly known as doctors, including physicians and surgeons) – 98,400 in 2018
- dental practitioners – 20,600 in 2018.<sup>393</sup>

The First Nations health workforce, including Aboriginal and Torres Strait Islander health workers and Aboriginal and Torres Strait Islander health practitioners, play a vital role in improving the health outcomes of First Nations people.<sup>394</sup>

### 5.5.1 Significant challenges of health workforce shortages

Since 2018, the Health Workforce needs assessment survey, conducted by HWQ, has identified significant health workforce gaps, particularly in regional, rural and remote areas.<sup>395</sup> QPHN referred to this as a ‘workforce crisis’ in primary healthcare in Queensland.<sup>396</sup>

Queensland Health advised there are currently significant challenges in maintaining a sufficient workforce to meet increasing demands for public health services. The committee notes that these workforce pressures have been exacerbated by the COVID-19 pandemic with disruption to supply chains exposing issues with health workforce distribution across specialities and geographic locations.<sup>397</sup>

The committee notes that these challenges have resulted in health workforce shortages, including skills shortages, and the maldistribution of health workers across geographic locations. Queensland Health advised that this is having a significant impact on the delivery of primary health care.<sup>398</sup>

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<sup>391</sup> Queensland Health, submission 39, p 32.

<sup>392</sup> Submission 75, p 9.

<sup>393</sup> Australian Government, AIHW, ‘Australia’s health 2020 – in brief’, 2020, <https://www.aihw.gov.au/getmedia/2aa9f51b-dbd6-4d56-8dd4-06a10ba7cae8/aihw-aus-232.pdf.aspx?inline=true>.

<sup>394</sup> Australian Government, Department of Health, About the Aboriginal and Torres Strait Islander health workforce, <https://www.health.gov.au/health-topics/indigenous-health-workforce/about>.

<sup>395</sup> Public briefing transcript, Brisbane, 29 November 2021, p 3.

<sup>396</sup> Submission 65, p 6.

<sup>397</sup> Queensland Health, submission 39, p 32.

<sup>398</sup> Submission 39, p 3; public briefing transcript, Brisbane, 29 November 2021, p 2.

Health Consumers Queensland stated:

Workforce shortages and an inappropriate spread of workforce means that we do see waits such as three-week waits for GPs across too many areas of Queensland and then the flow-on effect of a lack of early intervention, prevention and care that is needed in a timely way. Also we see a lack of cultural representation in our workforce: Aboriginal and Torres Strait Islander people in roles right across the system, people from culturally and linguistically diverse backgrounds and people in local, rural and remote communities.<sup>399</sup>

QRRPHN noted that health workforce shortages in regional and rural areas contribute to avoidable emergency department presentations, where patients have been unable to access primary care services in the community.<sup>400</sup> Queensland Health stated that this ‘... has a direct effect on patient flow into public hospitals, impacting the resources available for treatment of patients requiring acute care and imposing additional strain on hospital staff’.<sup>401</sup>

### 5.5.2 Nursing and midwifery workforce

Submitters, including the HWQ, ACN and QNMU, referred to an imminent and acute shortfall in the number of nurses and midwives.<sup>402</sup> ACN stated that Australia is expected to experience an estimated shortage of over 100,000 nurses by 2025.<sup>403</sup>

QNMU referred to HWQ predictions that population health trends, combined with an ageing workforce and poor retention rates will lead to a shortfall of 85,000 nurses by 2025 and 123,000 nurses by 2030.<sup>404</sup>

#### 5.5.2.1 *Recruitment, training and retention*

ACN noted that while there are a significant number of students studying to become nurses, new graduates are experiencing a lack of vacancies and challenges entering the workforce due to poor transition practice.<sup>405</sup> Similarly, HWQ highlighted the need to attract and support early career nurses and graduates into practice nursing.<sup>406</sup>

QNMU highlighted the issue of an unsustainable workload and staff burnout, stating:

Increasing workloads, understaffed shifts, double shifts and regular overtime are becoming normalised and are leading to staff burning out. Workforce planning is desperately needed to support exhausted nurses and midwives and other health practitioners. For many, their existing workload has been on top of the COVID-19 response which has involved testing, tracing, screening, isolating, vaccinating and treating the disease. These workload problems aren’t new, but they have been exposed and exacerbated by the COVID-19 pandemic.<sup>407</sup>

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<sup>399</sup> Public hearing transcript, Brisbane, 8 December 2021, p 12.

<sup>400</sup> Submission 70, p 6.

<sup>401</sup> Submission 39, p 32.

<sup>402</sup> Submissions 25, 66 and 69.

<sup>403</sup> Submission 66, p 3.

<sup>404</sup> Submission 69, p 31.

<sup>405</sup> Submission 66, p 3.

<sup>406</sup> Submission 25, p 1.

<sup>407</sup> Submission 69, p 31.

Other submitters noted the remuneration disparity between the public and private sector. Inala Primary Care noted that:

Nurses can earn 40 per cent more in the public system. Without chronic disease support, more patients are referred to public services. Bundled payments, which reflect patient need, or chronic disease care planning payments, which reflect patient complexity, are long overdue. Increases to the workforce incentive payment—which pays practices for their nurses—are urgently required to ensure general practice is a career path that nurses will embrace.<sup>408</sup>

Central West HHS highlighted the need for a greater focus on recruitment and retention, advising:

It is not just about retention; it is recruiting, retaining and how we can keep people here on a long-term basis. For my team, they are mainly specialty nurses. They have a special interest or they have had ongoing study and they bring that specialty to support our community—whether it is cancer care, palliative care, chronic diseases or child health especially. It is extremely challenging to recruit those staff to come out here, even from an agency point of view. I have tried different methods and I have had some very successful methods, working in partnership with Metro North, of people wanting to come out here for a taste and they are still here two years on with their families. They love the lifestyle and they can grow professionally out here. They may have come here as a grade 6 clinical nurse and they are going into a grade 7 job and they can embrace and share their knowledge and expertise out here. That is probably one of our greatest challenges here—that is, recruiting and retaining staff—but I think grabbing people from metros has been a good partnership.<sup>409</sup>

Central West HHS also referred to the importance of partnerships with universities, stating:

We also have nurse graduate programs with the universities. We partner with them for their placements. We have just had an increase of 16 graduates for the HHS start in February. Do not quote me on the numbers, but I think at least six or seven of those students came out here on a placement, loved it and applied. It is word of mouth, it is someone knows somebody or someone went to school with somebody and it is the lifestyle.<sup>410</sup>

QNMU called for increased training places for nurses and midwives, supported by increased clinical educators and graduate program places to support the transition, stating:

The transition from student to RN or midwife involves many changes in roles and responsibilities. And yet, nurses and midwives are not required to undertake transition programs, nor are there coordinated, formalised graduate programs, unlike their medical colleagues.<sup>411</sup>

QNMU considered that new graduates need support and a period of structured transition when first employed as a nurse or midwife, in order to progressively develop their clinical skills and confidence.<sup>412</sup>

JCU considered that the current three-year training program for nurses and midwives is inadequate and completely out of step with nursing training across the world and in other health professions in

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<sup>408</sup> Public hearing transcript, Logan, 10 February 2022, p 14.

<sup>409</sup> Public hearing transcript, Longreach, 4 March 2022, p 5.

<sup>410</sup> Public hearing transcript, Longreach, 4 March 2022, p 5.

<sup>411</sup> Submission 69, p 30.

<sup>412</sup> Submission 69, p 30.

Australia. JCU stated that a minimum four-year program was required, which would allow significantly more hours of supervised clinical placement.<sup>413</sup>

QNMU noted that while increasing the number of nursing and midwifery students is one solution, it does not address the problem of the three year gap before new graduate nurses are ready to enter the workforce.<sup>414</sup>

QNMU recommended that the Queensland Government take the following steps to address the nurse and midwifery workforce shortages:

- conduct research on future health needs and patient preferences, based on current health and disease trends, demographics, population growth and ageing to determine where health care needs will be and the scope of practice of the health practitioners required to meet those needs
- support growth of innovative nursing and midwifery models of care and other health practitioners that will enhance the ongoing sustainability and safety of our public health system
- address nursing and midwifery workforce shortages through the development of a comprehensive workforce plan for Queensland
- once the workforce needs are determined, assist in developing nationally consistent vocational education and training (VET) tertiary courses that will meet health care needs, in partnership with education providers, so that student intake and completion rates can be commensurate with anticipated need
- provide incentives and supports and targeted recruitment for health workers to practice/work in regional, rural, and remote areas and continue to monitor the effectiveness of these strategies for a longer-term rural health workforce
- growing the workforce in non-acute health settings including mental health, midwifery and aged care to shift health care out of acute hospitals
- lobby the Australian Government to ensure private sector minimum wages and conditions are adequate and appropriate in order to attract and retain nurses and midwives.<sup>415</sup>

The issues of nurses and midwives working to their full scope of practice to deliver innovative models of care is also discussed in further detail at section 9.5 of this report.

### **5.5.3 Medical workforce – a shortage of general practitioners**

Queensland Health advised that the COVID-19 pandemic has disrupted workforce supply chains and exposed gaps in medical workforce distribution across specialities, in particular, general practice, and geographical locations.<sup>416</sup>

During the Inquiry, the committee heard that Australia was facing a critical undersupply of GPs.<sup>417</sup> A recent Deloitte Access Economics *General Practitioner Workforce Report 2019* found that Australia

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<sup>413</sup> Submission 68, p 18.

<sup>414</sup> Submission 69, p 30.

<sup>415</sup> Submission 69, pp 33-34.

<sup>416</sup> Submission 39, p 3.

<sup>417</sup> Submissions 14, 65; public hearing transcripts: Brisbane, 8 December 2021, pp 28-30; Bribie Island, 9 December 2021, p 31; Mossman, 8 February 2022, p 2; Townsville, 9 February 2022, p 26; Gold Coast,

is heading for a significant undersupply of GPs in both urban and rural areas by 2030. The report highlights that:

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

The report advised that ‘the number of new general practitioners entering the market will not keep pace with increasing demand for healthcare’.<sup>418</sup>

RACGP also noted that the nature of the GP workforce and workload is changing, advising that:

- the average number of hours worked by GPs per week is declining
- there is an increasing proportion of female GPs – who are more likely to work part time, and who also on average spend more time with their patients
- there has been an increase in the proportion of long GP consultations due to the prevalence of chronic disease and co-morbidities meaning GPs see fewer patients in a standard workday.

RACGP stated that a combination of these factors means that a greater headcount of GPs will be required to provide the same full-time equivalent (FTE) workforce and a larger FTE workforce will be needed in the future.<sup>419</sup>

RACGP stated that ‘a decline in specialist GP numbers will have a devastating impact on the health of the nation’, advising that:

If patients cannot access appropriate care in the right setting at the right time from their specialist GP, the delay in care will result in poorer health outcomes, and more patients will end up in an emergency department, causing higher government expenditure.<sup>420</sup>

During the Inquiry, submitters and witnesses highlighted a number of causes and contributing factors to the GP workforce shortage, including:

- the impact of an ageing GP workforce
- fewer medical graduates choosing to specialise in General Practice.

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10 February 2022, p 12; Brisbane, 11 February 2022, p 63; Bundaberg, 2 March 2022, p 10; Rockhampton, 3 March 2022, p 2.

<sup>418</sup> Deloitte Access Economics, *General Practitioner workforce report 2019*, Cornerstone Health Pty Ltd, November 2019, Foreword, ii.

<sup>419</sup> Submission 73, p 2; A Scott, *The future of the medical workforce*, ANZ–Melbourne Institute health sector report, Melbourne Institute of Applied Economic and Social Research, University of Melbourne, 2019; Department of Health, *GP workforce statistics: 2001–02 to 2018–19*, Canberra, 2020; University of Melbourne and Monash University, *Medicine in Australia: Balancing Employment and Life*, MABEL Wave 10 survey, Melbourne, 2019; Australian Government, AIHW, *Australia’s health 2018*, Australia’s health series no. 16. AUS 221, Canberra; Department of Health, Medicare Australia, *Medicare Item Reports*, Canberra, 2020.

<sup>420</sup> Submission 73, p 2.

The committee notes that these issues are disproportionately felt in regional, rural and remote areas. These issues are discussed further at section 5.6 of this report.

#### 5.5.3.1 *An ageing GP workforce*

QPHN noted that Australia has an ageing health workforce, which will be further diminished as senior GPs retire, leaving no alternative care pathway for their patients.<sup>421</sup> QRRPHN advised that the average age of GPs in Queensland is 50.4 years<sup>422</sup> and the RACGP has reported that the proportion of GPs over the age of 65 has increased from 11.6 per cent in 2015 to 13.3 per cent in 2019.<sup>423</sup>

RACGP stated that ‘with almost 40% of GPs aged over 55, the government must invest in our future GP workforce’.<sup>424</sup>

ACRRM highlighted that this issue is more pronounced in the rural GP workforce, advising that:

The average age for a GP working in a rural or remote area continues to be over 50, with an increasing number in the over-60 age group who will be looking to retire or at least reduce their workloads over the coming years.<sup>425</sup>

Submitters, such as QRRPHN and Cairns and Hinterland HHS, stated that 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.<sup>426</sup>

ACRRM acknowledged that there were larger numbers of GPs in the younger aged groups; however, it considered that the challenge would be retaining the experienced doctors, who are close to retirement within the workforce to ensure they can provide health care services and train the next generation.<sup>427</sup>

#### 5.5.3.2 *Fewer medical graduates choosing a career in General Practice*

RACGP stated that ‘the future workforce supply [of GPs] is in jeopardy’, as the ‘... number of medical graduates choosing to enter GP training each year has stagnated’. RACGP’s *General Practice: Health of the Nation 2021* report found that:

- only 15.2 per cent of final year students are listing general practice as their first preference specialty (the lowest since 2012)
- eligible applications for GP training dropped by 22 per cent between 2015 and 2020
- unfilled rural GP training places increased from 10 per cent (65 places) in 2018 to 30 per cent (201 places) in 2020-12.<sup>428</sup>

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<sup>421</sup> Submission 65, p 3.

<sup>422</sup> Submission 70, p 4.

<sup>423</sup> RACGP, *General Practice: Health of the Nation 2021*, Melbourne, Victoria, 2021, <https://www.racgp.org.au/health-of-the-nation/president-s-message>.

<sup>424</sup> Submission 73, p 2; see also Productivity Commission, *Report on Government Services 2021*, Canberra, 2021.

<sup>425</sup> Submission 13, p 3.

<sup>426</sup> Submission 70; Cairns and Hinterland HHS, public hearing transcript, Cairns, 7 February 2022, p 2.

<sup>427</sup> Submission 13, p 3.

<sup>428</sup> Submission 73, p 2; RACGP, *General Practice: Health of the Nation 2021*, Melbourne, Victoria, 2021; RACGP and Department of Health, unpublished GP registrar intake data, 2018 to 2020, January 2020.

Submitters agreed that for medical graduates a career in general practice is increasingly seen as less desirable.<sup>429</sup> RACGP stated:

The AMA released a survey last week showing that only 15 per cent of medical students are thinking about general practice or have the intent to move to general practice. That is down from roughly 50 per cent back in its heyday and most of those doctors are now choosing to work in hospitals and are thinking of training in general surgery and as emergency physicians and anaesthetics. There is an absolute oversupply of most of those specialties, particularly in the Brisbane region and the inner city areas. We need to see investment and reward for moving into general practice.<sup>430</sup>

QPHN noted that the number of new GP registrars declined by almost 20 per cent from 2016 to 2019. QPHN considered that this decline was due to:

- a lack of career progression
- low financial remuneration
- an undervaluing of the profession
- a lack of flexibility to enable part-time work and provide after-hours support.<sup>431</sup>

Other submitters considered that the decline in interest in becoming a GP was due to:

- new GPs having different expectations of how and where they wish to work<sup>432</sup>
- medical graduates increasing preferencing careers in specialities, other than general practice, due to greater training opportunities, collegial support and work life balance.<sup>433</sup>

For example, ACRRM stated that the ‘younger generation of doctors have differing priorities and lifestyle expectations to their forebears’, with many less interested in running a private business and placing a higher priority on allocating time for family and other interests. HWQ also noted the ‘... declining motivations of the future medical workforce to run their own business and participate in often onerous call arrangements’.<sup>434</sup>

ACRRM added that private general practice does not necessarily offer many of the benefits of public employment, including sick leave; designated holiday periods; transferability of entitlements; and study and other professional leave.<sup>435</sup> ACRRM also considered that:

... the impact of decades of under-funding and undermining of the role of private general practice has resulted in this speciality becoming less attractive to medical students and junior doctors and threatened the viability of existing practices.<sup>436</sup>

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<sup>429</sup> Submissions 13, 65, 70, and 73; public hearing transcripts: Brisbane, 8 December 2021, p 21; p 7; Mossman, 8 February 2022, pp 1-2; Townsville, 9 February 2022, p 7.

<sup>430</sup> Public hearing transcript, Townsville, 9 February 2022, p 7.

<sup>431</sup> Submission 65, p 7.

<sup>432</sup> Submissions 13, 25, and 65.

<sup>433</sup> QPHN, submission 65, p 4.

<sup>434</sup> Submission 25, p 5.

<sup>435</sup> Submission 13, p 4.

<sup>436</sup> Submission 13, p 5.

A recent article in the Courier-Mail reported on claims by General Practice Registrars Australia that the critical shortage of GPs in Queensland 'is being fuelled by a lack of maternity and paternity leave for general practitioner registrars'.<sup>437</sup>

HWQ agreed that general practice has become less appealing as a career choice for medical graduates, noting the disparity in pay rates for GPs compared to state government salaried doctors.<sup>438</sup> In this regard, RACGP advised that:

About 20 or 15 years ago, doctors who left a hospital job to move into private general practice got a pay rise; right now it is a pay cut. One of the trainees that I have at the island practice was getting about \$150,000 on a public health servant salary, which is pretty good, but the basic pay under the GP terms and conditions is \$90,000, so they suffer a significant cut to then choose general practice. You can see some of the barriers we are fighting against.<sup>439</sup>

### 5.5.3.3 Australian Government's responsibility for ensuring adequate medical workforce

The committee notes that the Australian Government is responsible for various levers to influence the medical health workforce in a number of ways, including through:

- funding programs and incentive payments to improve the supply of medical professionals throughout Australia
- increasing or decreasing the number of overseas trained doctors through the immigration portfolio
- restrictions on Medicare provider numbers (eg requirements for overseas trained doctors) and foreign graduates of accredited medical schools to serve in rural, regional and remote locations for a period under the *Health Insurance Act 1973* (Cth), including the Distribution Priority Areas (DPA) scheme
- funding for Commonwealth Supported Places (CSPs) for university students to study medicine.<sup>440</sup>

The Inquiry terms of reference specifically task the committee with considering the Australian Government's definition of the Commonwealth Distribution Priority Areas (DPA) and the availability of medical training places at Queensland universities, compared to other jurisdictions. These issues are discussed at sections 5.7 and 5.9 of this report.

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<sup>437</sup> The Courier-Mail, 'Lack of maternity and paternity leave behind critical shortages of GPs in Queensland', doctors say, 28 March 2022, p 1.

<sup>438</sup> Submission 25, p 5.

<sup>439</sup> Public hearing transcript, Townsville, 9 February 2022, p 7.

<sup>440</sup> Queensland Health, submission 39, p 32.

#### 5.5.4 Allied health workforce

Submitters, such as Associate Professor Ray Bange OAM, noted that allied health professionals represent more than a quarter of the health workforce.<sup>441</sup>

Allied health professionals play a key part in primary care and the prevention, management and treatment of chronic disease, leading to a reduction in preventable hospitalisations.

As with other health workforce professions, submitters reported that Queensland is experiencing an allied health workforce shortage.<sup>442</sup>

The committee notes that allied health professions have significant workforce gaps in regional, rural and remote areas, particularly psychology, social work, occupational therapy and speech pathology. These issues are discussed in section 5.6.

Allied Aged Care (AAC) advised that Queensland has fewer allied health workers than other states, with a 2020 survey demonstrating that Queensland had only 2,037 allied health (employees and contractors) out of 12,603 for all respondents of Australia.

AAC stated that Queensland has only 16 per cent of Australia's allied health workforce, despite making up 20 per cent of Australia's population. As a comparison, Victoria has 3,881 allied health workers (31 per cent of Australia's workforce), despite only having 28 per cent of Australia's population.<sup>443</sup>

Queensland Health advised that Jobs Queensland has estimated an anticipated jobs growth of between 20 per cent and 25 per cent for allied health professions by 2024.<sup>444</sup>

The committee notes that the COVID-19 pandemic has further increased demand for the allied health workforce within Queensland, with public health services reporting failure to secure locums and permanent staff and an increase in extended vacancies.

Metro South HHS referred to the challenge of shortages in certain allied health professions, stating:

I think the challenges are that there are not enough allied health professionals in some of the professions. That has been well established for a very long period. In prosthetics and orthotics, for example, there are severe shortages and in podiatrists. I am a psychologist so I know that for psychologists there has been an increase in the number of MBS sessions in response to COVID. That has been great for people already under the care of a psychologist, but it has actually been a huge barrier to access for new referrals.<sup>445</sup>

##### 5.5.4.1 *Competition from the NDIS*

AHPA referred to the competition created by the NDIS for allied health professionals and the wage differences between the NDIS and MBS funding, advising that:

One of the reasons the NDIS has become an area of choice for people to go into is that NDIS actually pays a living wage. MBS and DVA do not. Private health insurance is a struggle. It is due to the market. People are going into NDIS because they can actually afford to feed their families by doing NDIS work, whereas the other funding systems do not necessarily do that; it is a really hard slog. They also do not have to

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<sup>441</sup> Submission 50, p 9.

<sup>442</sup> Submissions 21, 32, 39, 52 and 61.

<sup>443</sup> Submission 52, p 8.

<sup>444</sup> Submission 39, p 34.

<sup>445</sup> Public hearing transcript, Logan, 10 February 2022, p 6.

charge gap fees in NDIS so the participants are more likely to turn up so they actually get paid. That has made a substantial difference.<sup>446</sup>

Similarly, IWC highlighted that the increase in participants accessing the NDIS is placing an ever-growing demand on allied health professionals and services, which is impacting on the availability for non-NDIS funded clients to access regular allied health services.<sup>447</sup>

#### 5.5.4.2 Issues with training and lack of clinical placements

AHPA and APA highlighted issues with the training of allied health professionals and the lack of subsequent clinical placements outside of the public hospital system. AHPA stated that:

Part of the problem with training is not so much that people are not interested in going into careers; the pipeline is driven by access to clinical placements, and the lion's share of clinical placements is a burden on the public health system. We actually need more allied health to be going into primary care, to be going into aged care, where they are really needed. Almost all of the training places are in the public hospital system, which puts a huge burden on the public hospital system and it does not actually produce the training that we need to have people moving into areas like disability or aged care because it does not actually support that.<sup>448</sup>

APA advised that:

It is a very real issue at the moment with physiotherapy because there is not a student billing code. For primary care physios, it just costs you more money to take a student. Whilst there are thousands of physio practices that will take students, and certainly ours does, it is not a sustainable model. In a lot of cases, unless there is a vested interest that a particular owner has in training somebody to enter that workforce to replace them, which is quite rare, unfortunately the students do not get exposure to that because there is not that model in place. That model exists in the public health system, where students will treat daily a case load of patients depending on the ward or in an outpatient setting.<sup>449</sup>

#### 5.5.4.3 Lack of understanding of scope and role of allied health

HWQ advised that the scope and role of allied health practitioners in primary health is not always well defined or governed, and often not understood or utilised effectively within health services or the community. HWQ stated that the:

Lack of clarity of allied health roles, clinical silos, lack of clarity around HHS appointed positions, and the underutilisation of co-commissioning and funding pools of private allied health practitioners has resulted in inadequate integration of allied health staff into local teams.<sup>450</sup>

HWQ recommended that system changes needed to be made to:

- leverage existing workforce data to understand local priorities for allied health workforce and to look at opportunities to collate nationally consistent data sets for allied health
- identify existing workforce initiatives and gaps within the allied health career life-cycle, from promoting health careers, training, ongoing professional development through to succession planning

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<sup>446</sup> Public hearing transcript, Brisbane, 21 February 2022, p 7.

<sup>447</sup> Submission 23, p 4.

<sup>448</sup> Public hearing transcript, Brisbane, 21 February 2022, p 7.

<sup>449</sup> Public hearing transcript, Brisbane, 21 February 2022, p 12.

<sup>450</sup> Submission 25, p 2.

- work collaboratively to develop joined-up ‘pathways’ which attract, train and support allied health professionals
- address gaps in workforce pathways through collaborative initiatives using pooled funding where appropriate. HWQ considered that co-commissioning and fund pooling appear best suited to support the private/public business mix that will make the allied health workforce sustainable and accessible.<sup>451</sup>

### 5.5.5 Mental Health and Alcohol and Other Drugs workforce

The committee notes that a number of recent reports and strategies, including the draft National Mental Health Workforce Strategy, Productivity Commission report into mental health and proposed National Alcohol and Other Drugs Workforce Development Strategy have all identified significant national shortfalls across the mental health, alcohol and other drugs (MHAOD) workforce.

APS noted that the demand for mental health services has markedly increased since 2020, yet the psychological workforce has not grown to meet this demand. APS advised that ‘Australia has 35% of the required psychological workforce’.<sup>452</sup>

The Cancer Council Queensland stated that workforce capacity for psychological services is impacting mental health services across the state, observing that it:

... is now common for psychologists to cease accepting new referrals (either for a period or indefinitely). Prior to the COVID-19 pandemic, only one in 100 psychologists were unable to accept new patients, whereas it is now reported to be one in five. Psychologists who are still able to accept new referrals often have long wait times of up to 6 months.<sup>453</sup>

The issue of availability and access to mental health services is discussed, in detail, in section 5.2.2 of this report.

Queensland Health stated that the Australian Government, states and territories and training providers have complementary roles to play in addressing causes of the shortfalls in the mental health workforce.<sup>454</sup> Queensland Health identified the following causes:

- ageing of the existing workforce
- insufficient pre-entry and post-graduate exposure to MHAOD training
- stigma associated with MHAOD consumers and careers.<sup>455</sup>

Queensland Health advised that action is required to address shortfalls in the mental health workstreams of psychiatry, psychology, mental health nursing, Aboriginal and Torres Strait Islander health workers and lived experience (peer) workforce. The specialist alcohol and other drugs workforce is also insufficient to meet existing demand for services and requires enhancements.<sup>456</sup>

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<sup>451</sup> Submission 25, p 3.

<sup>452</sup> Submission 33, p 1.

<sup>453</sup> Submission 40, p 3.

<sup>454</sup> Submission 39, p 35.

<sup>455</sup> Submission 39, p 35.

<sup>456</sup> Submission 39, p 35.

The Queensland Mental Health Commissioner highlighted the issues caused by an ageing mental health workforce, stating:

Research by the Drug and Alcohol Nurses of Australasia (DANA) into the alcohol and other drugs nursing workforce cohort of people aged 65-74 found that this aged group has doubled since 2013, this age group is working past the traditional retirement age.

The workforce in all disciplines is ageing workforce overall, the current estimate this that 16 per cent of the alcohol and other drug clinical workforce in Queensland is aged 55 and over and almost 70 per cent of the workforce is female, meaning that a significant segment of the workforce will reach retirement age or move to part-time work over the next 10 years.<sup>457</sup>

The Commissioner also stated that allied health graduates are entering the workforce without the required skills to work in alcohol and other drugs requiring the State-funded services to provide on-the-job training and in-house professional development.<sup>458</sup>

APS also recommended the following initiatives to support the psychological workforce, which in turn will ease the pressure on the Queensland public health system:

- the revitalisation of the 2010 APS 'Find a psychologist' virtual waiting room – Australia's largest searchable database for private psychologists
- providing support and incentives to address the shortage of psychologists working in the public sector
- ensuring paid employment pathways for provisional psychologists in both public and private settings
- ensuring clear pathways for a paid graduate workforce in the public care sector and eligibility to work in private practice
- improving funding for psychological qualifications for tertiary students and offering scholarships to encourage students to practice psychology, particularly in rural and remote settings, including the expansion of the Workforce Incentive Program to include psychology practices in regional, rural and remote areas
- incentivising supervised, federally funded placements which are critical to the skill development required in psychological training
- initiatives to increase the diversity of post-graduate psychology courses, including subsidising or re-branding post-graduate courses to ease the cost burden on higher education providers
- ensuring adequate funding is provided to address current gaps in healthcare for Aboriginal and Torres Strait Islander people, including a focus on training Aboriginal and Torres Strait Islander people to become primary healthcare workers.<sup>459</sup>

The Queensland Mental Health Commissioner highlighted the importance of ensuring a systemic workforce approach, rather than a focus on specific disciplines, as changes made in one part of the workforce will affect other parts. The Commissioner stated:

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<sup>457</sup> Submission 44, p 12.

<sup>458</sup> Submission 44, p 12.

<sup>459</sup> Submission 33, p 2.

Any additional investment must be underpinned by a comprehensive and innovative workforce strategy to meet demand, cut wait times and reduce pressure on the public system.<sup>460</sup>

The committee notes that the Australian Productivity Commission's Mental Health Inquiry report made several recommendations, including:

- finalising the National Mental Health Workforce Strategy
- increasing the number of psychiatrists
- improving training on medications and non-pharmaceutical interventions
- supporting and increasing the peer workforce
- stigma reduction programs in initial and continuing education for all health professionals
- promoting mental health as a career option.<sup>461</sup>

The Queensland Mental Health Commissioner also recommended that consideration be given to building the capability of the non-clinical and non-mental-health workforce to work in a trauma-informed, healing-aware way across all population groups to maximise the potential to address mental distress early, before it requires specialised intervention.<sup>462</sup>

#### **5.5.6 First Nations workforce**

The committee notes that First Nations peoples are underrepresented across all health workforces and professional streams. Queensland Health stated that renewed approaches are needed to:

- increase the supply of First Nations peoples entering the health sector
- support the career mobility and development of existing First Nations peoples working in the health system
- remove barriers for the creation of regional integrated workforces between Queensland Health and the primary health care sector.<sup>463</sup>

The committee considers that more needs to be done by all governments to increase the First Nations health workforce. Queensland Health is progressing the development of a First Nations Health Workforce Strategy for Action for Queensland jointly with the Queensland Aboriginal and Islander Health Council.

Queensland Health advised that this is the first time a joint workforce strategy is being developed for Aboriginal and Torres Strait Islander people across the health system. The strategy will be released in mid-2022 and focuses on removing the barriers and obstacles that have prevented the achievement of our state and national workforce targets.<sup>464</sup>

Further, amendments to the Hospital and Health Boards Act Regulation 2012 require HHSs to increase First Nations peoples' workforce representation to be at least commensurate with local population

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<sup>460</sup> Submission 44, p 13.

<sup>461</sup> Australian Government, Productivity Commission, *Mental Health Inquiry report*, November 2020, pp 64-83.

<sup>462</sup> Submission 44, p 13.

<sup>463</sup> Submission 39, p 35.

<sup>464</sup> Submission 39, p 35.

size across every stream/category and every level. This will require HHSs to agree targets accordingly and undertake regional health workforce planning with the CCHS and other healthcare providers.<sup>465</sup>

Northern Queensland PHN highlighted the need:

... to really focus on a First Nations workforce. It takes many, many years to develop a workforce and we simply do not have enough Indigenous clinicians and leaders. We need to be building that workforce so that we can provide culturally appropriate care to our First Nations colleagues.<sup>466</sup>

Sam Mills, a QNMU member working in the Cape and Torres Strait region, advised:

What could go a long way to address the issues in remote Indigenous communities like the Torres Strait? Building a nursing workforce would be a big step forward as well as building models of care that utilise appropriate nursing positions, like the nurse practitioners and diabetes educators. While I say that, I would underline the fact that it is imperative to increase the Indigenous nursing workforce. The bit we have done around COVID speaks to that. We would deliver services a lot better than the non-Indigenous ones could deliver in communities because (inaudible). It is important to establish pathways to facilitate First Nations nurses positions across all levels—at the DON, at the EDON, at the CNCs and the nurse unit managers—where we could make a difference in directing services. At the moment there are barriers for us to get there as nurses.<sup>467</sup>

Central West HHS advised that:

At the moment as part of the health equity strategy, we are building our First Nations workforce. We can certainly say that we have made great leaps in that in the last couple of years and we are getting more health workers in place. We have Indigenous nurses as well who are able to really make some ground there, and we also just recently appointed an Indigenous medical officer here in Longreach.<sup>468</sup>

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<sup>465</sup> Submission 39, p 35.

<sup>466</sup> Public hearing transcript, Cairns, 7 February 2022, p 11.

<sup>467</sup> Public hearing transcript, Brisbane, 21 February 2022, p 28.

<sup>468</sup> Public hearing transcript, Longreach, 4 March 2022, p 4.

## 5.6 Health workforce shortages in regional, rural and remote areas

As outlined above, regional, rural and remote areas of Queensland are experiencing workforce shortages across all health professions.

HWQ advised that since 2018, its annual *Health Workforce Needs Assessment* surveys<sup>469</sup> have demonstrated a gradual increase in the primary care service and workforce gap ratings across all services and workforce groups in remote and rural areas. HWQ stated that this suggests:

... that there are considerable concerns among primary care staff and practice managers in remote and rural Queensland about primary care services and the availability of primary health care workforce.<sup>470</sup>

QRRPHN considered that the 'availability of health workforce is the single biggest contributing factor to access to primary care in Queensland's rural and remote communities'.<sup>471</sup>

### 5.6.1 General practitioners

Submitters, including HWQ, JCU, UQ Faculty of Medicine, ACRRM and QRRPHN, referred to the fragility of the GP workforce in remote, rural and regional Queensland, as demonstrated by:

- an increasing workforce maldistribution and shortages
- increasing GP closures
- greatly reduced access to GP registrars
- a disproportionately adverse impact of the COVID-19 pandemic and associated restrictions on international and domestic travel on regional, rural and remote areas due their heavy reliance upon International Medical Graduates (IMGs) and expensive locums to fill gaps in the health workforce
- a continued high turnover and reliance on visiting and outreach medical centres
- low, or often no, access to bulk-billing services outside of the public health system
- increased wait times for GP appointments.<sup>472</sup>

The committee notes that these factors have created a significant shortfall and increased demand for primary health care practitioners in rural, regional and remote Queensland. HWQ noted that these challenges and barriers place increasing pressure on local emergency departments.<sup>473</sup>

Cairns and Hinterland HHS shared a sobering statistic with the committee, advising that there are currently 97 vacancies for GPs in the North Queensland PHN region and 27 vacancies for allied health practitioners.<sup>474</sup> QRRPHN further advised that in the West Queensland PHN region there are 38 GP, 22 nurse and 30 allied health positions currently vacant.<sup>475</sup>

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<sup>469</sup> Health Workforce Queensland, 'Health Workforce Needs Assessment', [www.healthworkforce.com.au/hwna](http://www.healthworkforce.com.au/hwna).

<sup>470</sup> Submission 25, p 1.

<sup>471</sup> Submission 70, p 3.

<sup>472</sup> Submissions 13, 14, 25, 68 and 70.

<sup>473</sup> Submission 25, p 5.

<sup>474</sup> Public hearing transcript, Cairns, 7 February 2022, p 2.

<sup>475</sup> Submission 70, p 4.

### 5.6.1.1 *Australian medical graduates less likely to work in rural and remote areas*

Submitters, such as ACRRM, UQ Faculty of Medicine, IWC, HWQ and QRRPHN, considered that Australian medical graduates are unwilling to work in rural and remote areas.<sup>476</sup> ACRRM stated that:

Australian trained medical graduates today are less likely to work either as general practitioners or in rural communities compared to graduates in previous decades and rural areas continue to remain substantially dependent on International Medical Graduates doctors, who comprise almost half of the general practitioner workforce in rural areas.<sup>477</sup>

QPHN stated that practitioners are concerned about both professional factors, such as a lack of support, professional isolation, financial viability of their practice and career progression, as well as non-professional factors such as connection with family and friends, work or education for family members, and accommodation availability.<sup>478</sup>

IWC stated that:

There is very little incentive to attract Australian trained doctors to regional towns. Previously there was financial incentives, but this is now very limited and it does not recognise or incentivise doctors to move to less remote places where there continues to be doctor shortages.

GP income is often lower in regional towns due to these towns being lower socioeconomic, with more bulk billing and patients less willing to pay for services with an out of pocket or no Medicare rebate.

GPs in regional and rural towns like ours, are often under more pressure and have more responsibility with patient care due to a lack of public hospital specialist departments and an unwillingness for patients to travel to the bigger cities for medical care. Similarly, there is a lack of private specialists with patients less willing or able to pay for private specialist care.<sup>479</sup>

Dr Jackson, JCU, advised:

It is very difficult to attract someone to a regional centre such as Rockhampton, Bundaberg or even Hervey Bay if they really have no prospect of any difference in income to someone who is working in the middle of Sydney or the middle of Brisbane who has an awful lot more support networks in place.<sup>480</sup>

### 5.6.1.2 *Reliance on International Medical Graduates and expensive locums*

A number of submitters, including JCU, Griffith University and Queensland Health, noted that workforce gaps in regional, rural and remote areas have historically been filled by international medical graduates (IMG)s and expensive locums.<sup>481</sup>

JCU noted that Australia had been importing medical labour to supplement domestic supply at about the same rate as it has produced domestic graduates (up to 3,000 per year).<sup>482</sup>

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<sup>476</sup> Submissions 13, 14, 23, 25 and 70.

<sup>477</sup> Submission 13, p 3.

<sup>478</sup> Submission 65, p 6.

<sup>479</sup> Submission 23, p 3.

<sup>480</sup> Public hearing transcript, Bundaberg, 2 March 2022, p 23.

<sup>481</sup> Submissions 39, 68; Griffith University, public hearing transcript, Brisbane, 8 December 2021, p 24.

<sup>482</sup> JCU, response to questions on notice, 7 March 2022, p 5.

These submitters raised concerns about the over-reliance on IMGs in rural and remote areas, who often return to metropolitan areas once their restrictions expire.<sup>483</sup> Further information about the restrictions placed on IMGs and the DPA classification system is included at section 5.9.

For example, UQ Faculty of Medicine stated that when restrictions on practice are lifted, many IMGs relocate to the city, resulting in the rural community once again having a shortfall in GPs and stated that ‘This reliance is not a satisfactory or sustainable long-term model’.<sup>484</sup>

Dr Jackson, JCU, highlighted the issues arising from relying on an IMGs workforce, stating:

The problem with depending on an IMG workforce in rural areas is that you are taking people who are unfamiliar with the culture, unfamiliar with rural people, and putting them in largely less supervised situations where they really are a fish out of water and expecting them to want to stay. I do not particularly think there is a lot of virtue in trying to force longer durations of service from international medical graduates. It is by necessity a stopgap measure—one we have used to date and one we probably will need to continue to use just to fill workforce. I do not think that should be our long-term view. We have enough domestic graduates. We need to work to see where we are recruiting those students and junior doctors from so that we can retain them in areas they want to be in. We want doctors who actually come to an area, stay in a community and get that longevity and that history with the community and patients. We do not want people who come for two years or five years; we want people to live there.<sup>485</sup>

Similarly, Central Queensland HSS stated:

One of the challenges we have had, particularly in medicine, is an ongoing reliance on international medical graduates. Therefore, we have people who are often tied to a visa and, as soon as that changes, there is a movement on.<sup>486</sup>

The Healthlink Family Medical Centre also raised issues in relation to the reliance on IMGs in Townsville, stating that:

The problem for Townsville is we can recruit them to Townsville and we generally retain them while they are studying to qualify for their exams, but as soon as they have the GP qualification that allows them to be a permanent resident and then 90 per cent of them want to live in a capital city.<sup>487</sup>

JCU also noted that:

Australia’s continued reliance on international labour to prop up medical services in the regions and the intersection of this with Australian Government GP training arrangements means that taxpayers are in effect funding IMGs to complete GP fellowship training in regional Australia and then who usually go on to work in major cities.<sup>488</sup>

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<sup>483</sup> Submissions 14 and 68; Central Queensland HHS, public hearing transcript, Rockhampton, 3 March 2022, p 5.

<sup>484</sup> Submission 14, p 1.

<sup>485</sup> Public hearing transcript, Bundaberg, 2 March 2022, p 24.

<sup>486</sup> Public hearing transcript, Rockhampton, 3 March 2022, p 5.

<sup>487</sup> Public hearing transcript, Townsville, 9 February 2022, p 29.

<sup>488</sup> Submission 68, p 16.

UQ Faculty of Medicine raised the issue of IMGs not becoming embedded in communities, stating:

Whilst many overseas trained doctors do work in General Practice when they first arrive in Queensland, many do not become embedded in the community in which they work, with their families often living in metropolitan locations.<sup>489</sup>

Section 5.10 of this report discusses a number of recommendations and options aimed at recruiting, training and retaining a regional, rural and remote health workforce.

### **5.6.2 Nurses and midwives**

JCU noted that, despite an increase in interest in becoming a nurse or midwife, the profession faced a continuing challenge of retaining nurses in regional, rural and remote areas beyond three years after graduation. JCU stated:

The increasing acuity of the healthcare environment, workforce shortages, the physically and emotionally demanding nature of nursing work in RRR [Regional, Rural and Remote] contexts as well as the longer working hours as compared to their city counterparts, contribute to this attrition. In addition, the nursing workforce is ageing, with the average age of nurses in RRR older than that in the cities. This, combined with attrition in the early career year's results in an ongoing shortage of qualified nurses for RRR locations.<sup>490</sup>

JCU also raised issues about the cost of nursing and midwifery professional experience placements, noting that rural and remote clinical placements are more expensive than urban placements. They called for a review of the charges associated with nursing and midwifery experience placements, along with an increase in funding to support the cost of delivering high quality nursing and midwifery education.<sup>491</sup>

In addition, JCU called for an expansion of nursing training places in regional, rural and remote areas and increased support for nurses, once they are qualified, including ongoing fit-for-purpose continuing professional development.<sup>492</sup>

### **5.6.3 Allied health professionals**

Queensland Health advised that the health, disability and aged care sectors project continued strong demand for the allied health workforce, with geographic maldistribution of the allied health workforce being a long-standing issue, particularly in rural and remote areas.<sup>493</sup>

Queensland Health advised that access to most allied health professions decreases with rurality. For example, national practitioner registration data in 2019 showed that communities classified as Very Remote in the Modified Monash Model have fewer than half the full-time equivalent pharmacists per capita compared to Metropolitan locations, and for podiatry and occupational therapy it is closer to a third.<sup>494</sup>

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<sup>489</sup> Submission 14, p 1.

<sup>490</sup> Submission 68, p 6.

<sup>491</sup> Submission 68, p 6.

<sup>492</sup> Submission 68, p 6.

<sup>493</sup> Submission 39, p 34.

<sup>494</sup> Submission 39, pp 34-35.

The Joint Submission stated that ‘the current allied health workforce is poorly distributed and too small to meet patient needs’.<sup>495</sup>

HWQ’s *Health Workforce Needs Assessment* survey has consistently identified allied health professions as having significant workforce gaps in regional, rural and remote areas, particularly:

- psychology
- social work
- occupational therapy
- speech pathology.<sup>496</sup>

QRRPHN stated that:

In terms of allied health services, across our catchment we have lower availability of allied health hours than in other parts of Queensland, and that applies across many of the different allied health disciplines, for example podiatry, psychologists and dental. Those are just a few of the disciplines where we have shortages. However, one of the biggest priorities for us is around mental health and access to psychologists and other relevant allied health clinicians.<sup>497</sup>

Similar to the experience with attracting Australian-trained GPs, AAC noted that younger physiotherapists, for example, ‘... wanted to work in inner city hospitals and clinics, rather than with older people, and in regional Queensland’.<sup>498</sup>

A representative from Services for Australian Rural and Remote Allied Health (SARRAH) commented on his own practice, stating that ‘After a three-year battle we made the heartbreaking decision to close our local Chinchilla service due to ongoing recruitment and retention issues’.<sup>499</sup> SARRAH also shared its concerns about the potential closure of its Toowoomba service, stating that:

I am at a point where I am really worried about our Toowoomba services too. We already have extensive waitlists, particularly for speech and OT. We are only two hours from Brisbane, so it is a very attractive city and a great place to live, but just in the last few weeks we have lost four of our speech pathologists and one of our OTs, all of whom left because they had to relocate back to metro areas for family support reasons or because they have been headhunted to Brisbane or the Gold Coast due to the national workforce shortage.<sup>500</sup>

Torres and Cape HHS highlighted the lack of private providers of allied health services in their area, stating that:

I could literally count on one hand the number of private providers providing services across this whole cape and Torres region. They are mostly fly-in fly-out. It is by necessity; it is obviously very expensive to get up here and to stay up here.<sup>501</sup>

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<sup>495</sup> Submission 41, p 11.

<sup>496</sup> Queensland Health, submission 39, p 34; Health Workforce Queensland, submission 25, p 2.

<sup>497</sup> Public hearing transcript, Cairns, 7 February 2022, p 10.

<sup>498</sup> Submission 52, p 4.

<sup>499</sup> Public hearing transcript, Brisbane, 8 December 2021, p 4.

<sup>500</sup> Public hearing transcript, Brisbane, 8 December 2021, p 4.

<sup>501</sup> Public hearing transcript, Brisbane, 21 February 2022, p 2.

Torres and Cape HHS stated that:

As the provider of last resort, we do provide a multidisciplinary team. We have to prioritise our patient load. For instance, we have one occupational therapist and one speech therapist in any of our hubs. We have two physios in some places but the waiting lists are longest for physiotherapy, dietetics and for podiatry. We prioritise our case load which means there are long waits to get access to some of the professions.<sup>502</sup>

#### *5.6.3.1 Importance of rural-based training and placements*

JCU stated that, as with GPs, its experience confirms that training allied health students in regional, rural and remote locations 'increases the likelihood of their working in these locations after graduation'.<sup>503</sup>

HWQ concurred stating that 'The single most significant factor predicting long term rural practice was early career rural practice'. HWQ called for improved capacity for allied health students to undertake rural based training and an expansion of rural placement opportunities particularly in the primary care setting.<sup>504</sup>

HWQ considered that expanding the allied health rural generalist pathway could provide another means to deliver wrap-around support to new graduates and early career professionals.<sup>505</sup>

However, JCU noted that there are multiple barriers to supporting the education of a fit-for-purpose regional, rural and remote allied health workforce, including:

- students on clinical placements having to meet the costs of accommodation and living expenses, with accommodation being difficult to find and expensive (eg \$3,000 for accommodation for a five week placement)
- the expense of travel to and from regional, rural and remote areas
- loss of income from casual work when on placement
- high turnover of allied health staff, which impacts the capacity of a service to have students on placement.<sup>506</sup>

JCU called for financial support to enable more and longer rural undergraduate allied health clinical placements.<sup>507</sup>

As with their urban counterparts, JCU noted that clinical placements tend to fall onto Queensland Health facilities due to the current rules around students providing services in private practice. JCU stated that 'This results in a relative lack of involvement of the private sector in allied health clinical placements and reliance on Queensland Health facilities for placements'.<sup>508</sup>

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<sup>502</sup> Public hearing transcript, Brisbane, 21 February 2022, p 2.

<sup>503</sup> Submission 68, p 8.

<sup>504</sup> Submission 25, p 3.

<sup>505</sup> Submission 25, p 3.

<sup>506</sup> Submission 68, p 7; public hearing transcript, Townsville, 9 February 2022, p 23.

<sup>507</sup> Submission 68, p 7; public hearing transcript, Townsville, 9 February 2022, p 23.

<sup>508</sup> Submission 68, p 8.

JCU, Centre for Rural and Remote Health – Emerald, stated:

The health services need to be resourced to be able to undertake teaching and research. In partnership with the universities, we need to have the student accommodation and the teaching facilities. If there are funds pooled by state, Commonwealth and community organisations, this is entirely possible—not only possible, but desirable.<sup>509</sup>

JCU also called for increased support for ongoing fit-for-purpose continuing professional development (CPD) to support allied health professional’s scope of practice and account for the barriers that they face when accessing CPD, including the significant cost of travel and the requirement for locum cover when they are not practising.<sup>510</sup>

SARRAH gave the following warning at the public hearing in Brisbane:

If we keep doing what we are doing, our regional, rural and remote workforce will keep deteriorating in both quality and quantity when there are already critical issues. The further you are from metro areas, the more those allied health workforce issues—it is like a magnifying glass on the problems.<sup>511</sup>

### 5.6.3.2 Barriers to recruitment and retention

A number of submitters, including HWQ and SARRAH highlighted the challenges experienced in regional, rural and remote areas in recruiting and retaining allied health professions.<sup>512</sup> SARRAH advised that:

Workforce issues with regard to allied health such as recruitment, retention problems, skills gaps, high turnover, attrition due to burnout and mental health issues—especially markedly in regional, rural and remote areas—are not a new thing. I feel that we are on the brink of disaster right now because of a nationwide shortage.<sup>513</sup>

HWQ noted that despite numerous initiatives over recent decades, persisting rural allied health workforce challenges remain a key factor limiting access to allied health services in rural and remote communities.<sup>514</sup> These factors include:

- a lack of supervision and professional development opportunities
- concerns about deskilling
- a perceived lack of rural training experience, including education and qualifications in rural and remote practice
- concerns that time in a rural role will limit career progression
- supportive work environment
- capacity to work to full scope of practice
- role and recognition of allied health in the wider healthcare system.<sup>515</sup>

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<sup>509</sup> Public hearing transcript, Rockhampton, 3 March 2022, p 13.

<sup>510</sup> Submission 68, p 8.

<sup>511</sup> Public hearing transcript, Brisbane, 8 December 2021, p 4.

<sup>512</sup> Submission 25, p 2.

<sup>513</sup> Public hearing transcript, Brisbane, 8 December 2021, p 3.

<sup>514</sup> Submission 25, p 2.

<sup>515</sup> Submission 25, pp 2-3.

Queensland Health stated that Australian Government leadership is required to address key challenges in the allied health workforce pipeline, including:

- policy, regulatory and resourcing strategies to facilitate the rapid intake and deployment of overseas-trained allied health professionals, particularly to regional areas as border restrictions allow
- revision of the number and distribution of university training places as well as the focus of course curriculum to ensure alignment to community, aged care and disability service demands for key allied health professions (such as physiotherapy, podiatry, speech pathology, social work, and occupational therapy).<sup>516</sup>

Torres and Cape HHS raised the issue of a lack of accommodation for allied health professionals in rural areas, stating:

For us as a health service it is a major issue to provide housing for our allied health professionals. In their award they are entitled to housing. This is an ongoing issue for us as a health service. When we are looking to expand our workforce, which is much needed, then housing is a huge issue. You mentioned Thursday Island. It is chock-a-block. We are really battling with housing or accommodation for workers up there and the so-called population because obviously it drives up the demand and makes it more difficult for locals as well.<sup>517</sup>

JCU argued that the Queensland Government should consider recommending greater incentives and practical support for health students undertaking training in locations of workforce need, such as improved accessibility and affordability of student accommodation and reduced fees and levies for placement of students in those locations.<sup>518</sup>

These suggestions, and other initiatives aimed at incentivising health professionals to work in regional, rural and remote areas are discussed in more detail at section 5.10 of this report.

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<sup>516</sup> Submission 39, pp 34-35.

<sup>517</sup> Public hearing transcript, Brisbane, 21 February 2022, p 2.

<sup>518</sup> Public hearing transcript, Cairns, 7 February 2022, p 17.

## 5.7 Availability of medical training places at Queensland universities

The committee notes that there are broadly three types of medical training places available at medical schools in Australia:

- **Commonwealth Supported Places (CSPs)** – places at medical schools that are subsidised by the Australian Government – students that receive a CSP are only required to pay a fraction of the tuition fee (the Student Contribution Amount) and are guaranteed an internship in Australia on graduation.

Within the CSP category, the Australian Government also offers Bonded Medical Places, which aim to address the shortage of medical doctors in regional, rural and remote areas. In exchange for a medical place, participants must, once graduated, agree to work in an area of workforce shortage for one to six years.<sup>519</sup>

- **Domestic full-fee places** – offered to students who do not obtain a CSP, or students applying to medical programmes that do not offer a CSP – students are required to pay full tuition fees and do not receive a government subsidy. Domestic full-fee paying students may not be guaranteed an internship, once they have graduated.
- **International places** – many Australian medical schools have varying numbers of reserved places for international students – due to factors such as eligible visas, it may be more challenging for international students to secure an internship in Australia after graduating compared to domestic students.<sup>520</sup>

### 5.7.1 Commonwealth Supported Places for professional entry medical education

Commonwealth Supported Places for professional entry medical education (CSPs) are determined by the Commonwealth Minister for Education and administered by the Commonwealth Department of Education Skills and Employment (DESE) under the *Higher Education Support Act 2003* (Cth).

The Australian Government regulates the number of medical CSPs at universities based on the clinical training capacity, projected workforce requirements and the impact on the health budget.<sup>521</sup>

Decisions by the Minister for Education on the number and distribution of medical school places is made in consultation with the Commonwealth Minister for Health and their State and Territory counterparts. This is in recognition of the link between medical graduate numbers, labour demand and availability of opportunities for employment as first year graduates (interns) in public hospitals.<sup>522</sup>

University funding of medical CSPs is reflected in triennium Funding Agreements between the Australia Government and the relevant medical schools.<sup>523</sup> DESE advised that the education portfolio

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<sup>519</sup> Australian Government, Department of Health, 'Bonded Medical Places (BMP) Scheme', [https://www.health.gov.au/initiatives-and-programs/bonded-medical-places-scheme?utm\\_source=health.gov.au&utm\\_medium=callout-auto-custom&utm\\_campaign=digital\\_transformation](https://www.health.gov.au/initiatives-and-programs/bonded-medical-places-scheme?utm_source=health.gov.au&utm_medium=callout-auto-custom&utm_campaign=digital_transformation).

<sup>520</sup> Medify, 'Types of Medical Student Places Offered and Degrees Conferred', <https://www.medify.com.au/medical-admissions-guide/step-one/medical-student-places-degrees>.

<sup>521</sup> Australian Government, Department of Education, Skills and Employment, correspondence, 20 December 2021, p 1.

<sup>522</sup> JCU, responses to questions on notice, 7 March 2022, p 1.

<sup>523</sup> JCU, responses to questions on notice, 7 March 2022, p 1.

subsidises tuition costs for medicine through the Commonwealth Grant Scheme (CGS). DESE advised that in 2021, universities will receive an estimated \$363.4 million in CGS funding for the delivery of CSPs in medicine.<sup>524</sup> DESE advised that:

Medical education policy is currently considered in a context of a forecast oversupply of around 7,000 doctors by 2030, along with an ongoing shortage of doctors working in regional and remote communities. The Government's key policy focus is to improve rural doctor supply, involving initiatives in both the Education and Health portfolios.<sup>525</sup>

In addition to the overall cap on medical CSPs, each university's CGS Funding Agreement limits the number of domestic students that may graduate from medical courses each year.<sup>526</sup>

#### 5.7.1.1 *Number of CSPs allocated to medical schools*

The committee notes that the number of commencing domestic enrolments in Australian medical schools is used as a proxy for the allocated medical CSPs per year, noting that first year enrolments in medical programs are typically a little larger than final year enrolment numbers because of attrition.<sup>527</sup>

The below graph shows the number of domestic medical students enrolled by state and territory from 2015 to 2019. Over this period, the number of domestic medical enrolled students has remained fairly static.

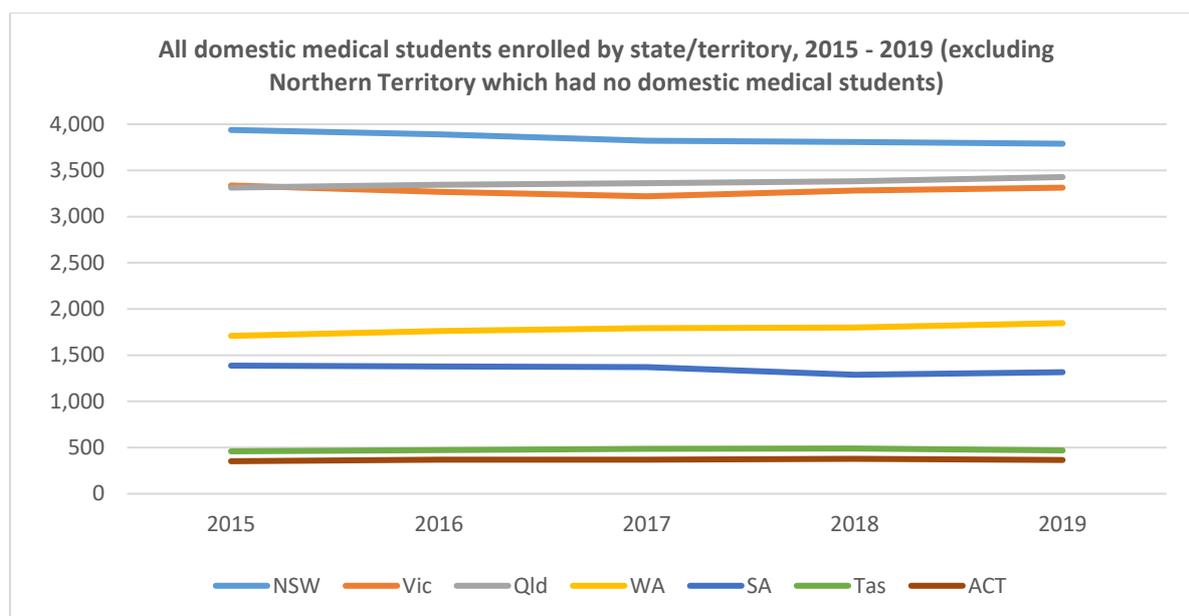


Figure 7 - All medical students enrolled by state and territory, 2015-2019, source data from the Department of Education, Skills and Employment, Student Data for 2015-2019, <https://www.dese.gov.au/higher-education-statistics/student-data>

<sup>524</sup> Australian Government, Department of Education, Skills and Employment, correspondence, 20 December 2021, p 2.

<sup>525</sup> Australian Government, Department of Education, Skills and Employment, correspondence, 20 December 2021, p 1.

<sup>526</sup> Australian Government, Department of Education, Skills and Employment, correspondence, 20 December 2021, p 2.

<sup>527</sup> JCU, responses to questions on notice, 7 March 2022, p 1.

The below chart shows the percentage of domestic medical students enrolled in each state and territory in 2019. New South Wales (NSW) had the largest percentage of domestic medical students with 26.1 per cent, followed by Queensland (23.6 per cent) and Victoria (22.8 per cent). Western Australia, South Australia, Tasmania and the Australian Capital Territory (ACT) each have less than a 15 per cent share.

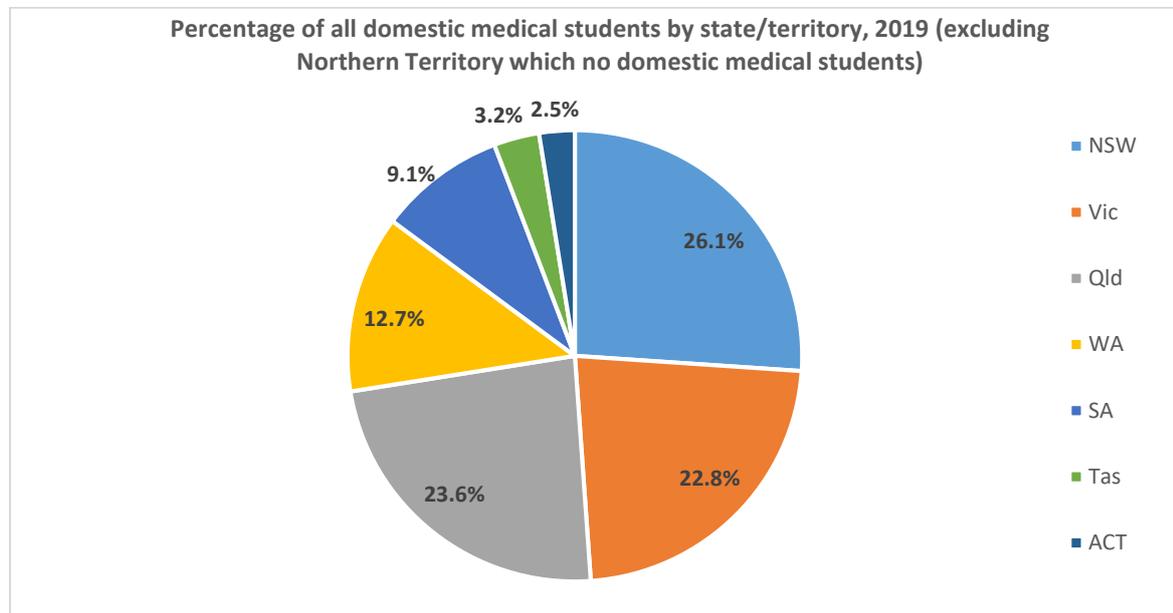


Figure 8 - Percentage of all domestic medical students by state and territory 2019, data from the Department of Education, Skills and Employment, Student Data, Student Data for 2019, <https://www.dese.gov.au/higher-education-statistics/student-data>

Figure 9 shows the number of domestic medical students per 100,000 population. On this basis, Queensland ranks fifth, behind Tasmania, ACT, South Australia and Western Australia, but ahead of Victoria and NSW.

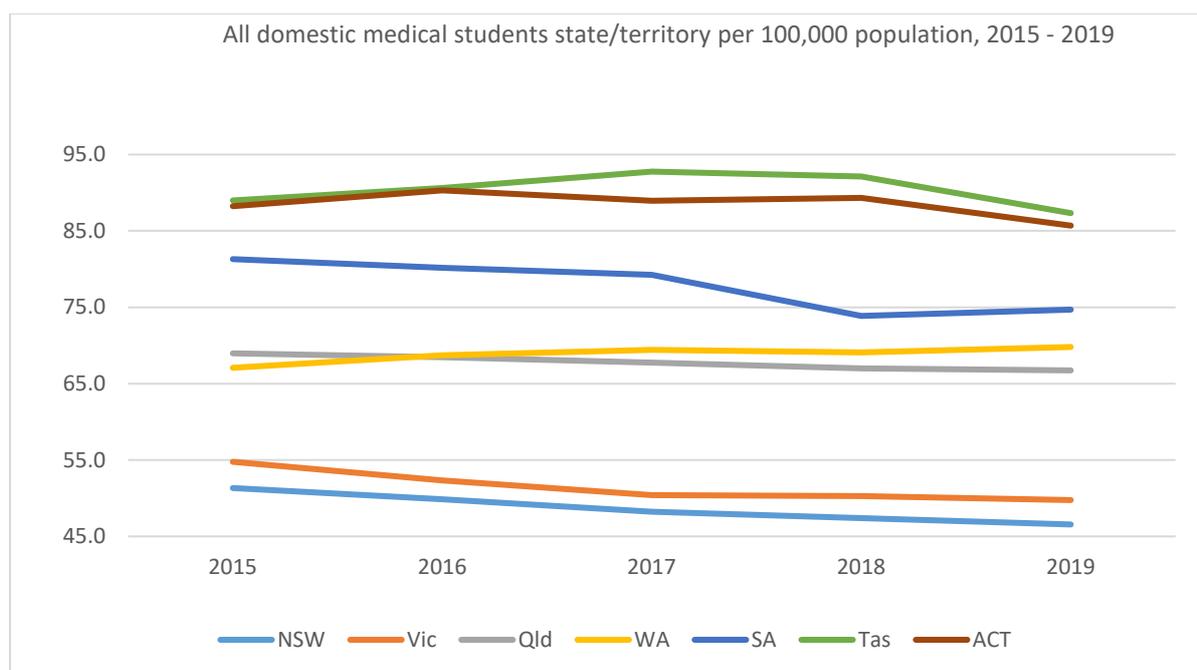


Figure 9 - All domestic medical students per 100,000 population, 2015-2019, source data from the Department of Education, Skills and Employment, Student Data, Student Data for 2015 – 2019, <https://www.dese.gov.au/higher-education-statistics/student-data> and from the Australian Bureau of Statistics, National, state and territory population, <https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/mar-2021>

The committee notes that in 2021 to 2023, Queensland’s share of CSPs will fall behind both NSW and Victoria. In 2021, 13,461 medical CSPs were allocated across Australian university medical schools. Of this allocation, Queensland ranks third (2,784 CSPs), across three medical schools (University of Queensland, JCU and Griffith University). NSW is ranked first (3,748 CSPs) across 7 medical schools and Victoria is ranked third (3,005 CSPs) across 3 medical schools.<sup>528</sup>

The CSP places allocated to medical schools in Australia in 2021 to 2023 is outlined in the Table 5.

<sup>528</sup> Australian Government, Department of Education, Skills and Employment, correspondence, 20 December 2021, p 1.

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

University	Total CSPs - 2021	Total CSPs - 2022	Total CSPs - 2023
<b>New South Wales</b>			
University of New England	300	300	300
University of Newcastle	535	534	533
University of Sydney	904	901	898
University of New South Wales	1189	1187	1185
University of Wollongong	279	276	276
Western Sydney University	504	503	502
Charles Sturt University	37	74	111
<b>Total</b>	<b>3,748</b>	<b>3,775</b>	<b>3,805</b>
<b>Victoria</b>			
Deakin University	518	516	514
Monash University	1485	1474	1465
University of Melbourne	1002	994	991
<b>Total</b>	<b>3,005</b>	<b>2,984</b>	<b>2,970</b>
<b>Queensland</b>			
Griffith University	783	796	794
James Cook University	920	918	916
University of Queensland	1081	1078	1075
<b>Total</b>	<b>2,784</b>	<b>2,792</b>	<b>2,785</b>
<b>Western Australia</b>			
Curtin University	399	448	487
University of Notre Dame Australia	638	636	634
University of Western Australia	817	814	811
<b>Total</b>	<b>1,854</b>	<b>1,898</b>	<b>1,932</b>
<b>South Australia</b>			
Flinders University	443	442	441
University of Adelaide	802	800	798
<b>Total</b>	<b>1,245</b>	<b>1,242</b>	<b>1,239</b>
<b>Tasmania</b>			
University of Tasmania	465	465	465
<b>Australian Capital Territory</b>			
The Australian National University	360	360	360
<b>Australian Total</b>	<b>13,461</b>	<b>13,516</b>	<b>13,556</b>

Table 5 - Commonwealth Supported Places for Australian medical schools, 2021-2022, source data from the Department of Education, Skills and Employment, Higher education providers' 2021-2023 funding agreements, <https://www.dese.gov.au/collections/higher-education-providers-2021-2023-funding-agreements>

The DESE advised that, in 2021, Queensland universities are permitted to graduate a total of 610 domestic medical students under the CGS Funding Agreements limits. This compares to 767 medical graduates in NSW, 747 medical graduates in Victoria and 477 medical graduates in Western Australia.<sup>529</sup>

#### 5.7.1.2 *Re-distribution of Medical CSPs to Charles Sturt University, NSW*

The 2018-19 Federal Budget established a redistribution pool of 60 commencing medical CSPs every three years to address ‘emerging medical priorities’.<sup>530</sup>

In 2019, the DESE released its *Discussion Paper – redistribution pool of medical places*, which outlined a number of options for a mechanism to redistribute current medical CSPs.<sup>531</sup>

In October 2020, DESE wrote to universities with medical CSPs to advise that 32 medical CSPs were being reallocated to Charles Sturt University (CSU) in 2021 to establish a new rural medical school program at Orange, NSW, in partnership with Western Sydney University (CSU Program).<sup>532</sup> In addition, DESE guaranteed an additional 7 medical CSPs for CSU – creating a total of 39 CSPs.<sup>533</sup>

The CSU program is part of an Australian Government ‘Murray Darling Medical Schools Network’ (MDMSN) initiative. As well as the CSU program, MDMSN includes Australian Government funding to support the establishment, or expansion, of regionally-based satellite medical programs from the University of Sydney, the University of New South Wales, Monash University and the University of Melbourne.<sup>534</sup> The committee notes that no additional funding has been granted to Queensland.

JCU advised that the initial 32 medical CSPs that were re-allocated for the CSU Program from other medical schools are pipelined through to 2025, representing a transfer of 160 medical CSPs in total. JCU stated that the advice from DESE is that approximately 1 per cent of places are being taken from all medical schools with over 100 CSP enrolments per year.<sup>535</sup>

The committee notes that, in total, 35 medical CSPs will be transferred from Queensland medical schools to CSU in NSW.

Queensland Health stated that the UQ Faculty of Medicine, JCU and Griffith University have been negatively and financially impacted by the Australian Government’s decision.<sup>536</sup> JCU stated that the impact of this is not immaterial, advising that it will lose 2 CSPs each year from 2021 for a total of 10 CSPs by 2025 (with corresponding lost revenue per annum).<sup>537</sup>

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<sup>529</sup> Australian Government, Department of Education, Skills and Employment, correspondence, 20 December 2021, attachment.

<sup>530</sup> Australian Government, Department of Education, Skills and Employment, correspondence, 20 December 2021, p 1.

<sup>531</sup> Australian Government, Department of Education, Skills and Employment, Discussion Paper – redistribution pool of medical places, 2019.

<sup>532</sup> Australian Government, Department of Education, Skills and Employment, correspondence, 20 December 2021, p 1.

<sup>533</sup> JCU, responses to questions on notice, 7 March 2022, p 1.

<sup>534</sup> JCU, responses to questions on notice, 7 March 2022, p 1.

<sup>535</sup> JCU, responses to questions on notice, 7 March 2022, p 2.

<sup>536</sup> Submission 39, pp 32-33.

<sup>537</sup> JCU, responses to questions on notice, 7 March 2022, p 2.

### 5.7.2 Producing a local, rural and remote medical workforce

A number of submitters and witnesses agreed that there is no need to encourage more people to apply for medical training places.<sup>538</sup> As Professor David Ellwood, Griffith University, put it ‘we have thousands more applicants than we can ever take; they are academically very suitable’.<sup>539</sup>

ACRRM highlighted that the doubling of the number of Australian medical graduates has led to an oversupply of doctors in urban areas, but has done little to address shortages in rural Australia’.<sup>540</sup> ACRRM considered that any move to increase these intakes will simply result in more junior doctors remaining in larger centres and either choosing a career in a speciality other than general practice, or looking to increase their income through over-servicing.<sup>541</sup>

As outlined in section 5.6 of this report, workforce gaps in regional, rural and remote areas have historically been filled by IMGs and expensive locums. However, the COVID-19 pandemic and the associated international and domestic travel restrictions have severely limited Queensland’s access to IMGs and locums. JCU stated that ‘the COVID-19 pandemic and its impact on international and domestic labour movement has highlighted the underlying deficiency in medical labour supply, especially in the regions and in Queensland’.<sup>542</sup>

JCU noted that, of all the States and Territories, Queensland has historically been the most reliant on imported medical labour to support medical workforce supply over the last two decades.<sup>543</sup>

Griffith University also noted the looming shortage of junior medical officers in the system, stating:

... that has come about because of the inability of international graduates to come into the country over the past two years. Every year a number of junior medical places in public hospitals are occupied by graduates primarily from Europe and the UK. Of course, those people have not been coming in for the past two years so there is concern that there is a looming shortage, that the medical schools in Queensland are not producing enough graduates to fill all of the places and certainly that that will be exacerbated once the shortage because of a lack of international graduates becomes apparent.<sup>544</sup>

Submitters agreed that the solution to the current GP workforce shortages is to create a local, rural and remote medical workforce.<sup>545</sup> JCU stated ‘the single most important priority in health workforce reform is to build a substantial pipeline of domestic health professional graduates who willingly pursue RRR [Regional, Rural and Remote] careers’.<sup>546</sup> UQ Faculty of Medicine stated that:

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<sup>538</sup> Submission 13, Professor David Ellwood, Head of School of Medicine and Dentistry and Dean of Medicine, Griffith University, public hearing transcript, Brisbane, 8 December 2021, p 25.

<sup>539</sup> Public hearing transcript, Brisbane, 8 December 2021, p 25.

<sup>540</sup> Submission 13, p 3.

<sup>541</sup> Submission 13, p 7.

<sup>542</sup> JCU, responses to questions on notice, 7 March 2022, p 5.

<sup>543</sup> JCU, responses to questions on notice, 7 March 2022, p 5.

<sup>544</sup> Public hearing transcript, Brisbane, 8 December 2021, p 24.

<sup>545</sup> Submissions 14, 68 and 73.

<sup>546</sup> Submission 68, p 4.

It is evident that we need to not only grow our skilled workforce to deliver primary care health services, but to also find ways to train and retain medical practitioners and their families in these under-served areas, in order to future-proof the health workforce for years to come.<sup>547</sup>

Both GP colleges referred to evidence that suggests there are two drivers that influence GPs to choose to work in rural and remote areas:

- the quality and duration of their rural training experience
- growing up, or spending considerable time living, in a rural or remote community.<sup>548</sup>

UQ Faculty of Medicine agreed stating that ‘the longer a medical learner remains in a region during their medical education and training, the more likely they are to remain in that region’.<sup>549</sup>

ACRRM, and other submitters, also referred to strong evidence that medical students from a rural background are far more likely to return to rural practice.<sup>550</sup> ACRRM stated that initiatives such as Rural Clinical Schools, longitudinal rural placements, and providing junior doctors with a positive exposure to rural general practice, will encourage these students and doctors to return to providing high-quality generalist care within rural and remote communities.<sup>551</sup>

JCU stated that, in its experience, the most cost-effective solutions for delivering a health workforce for regional, rural and remote locations is through the vertical integration of education and training that is based in and designed for the needs of regional Australia from admission to university through to professional clinical practice and beyond.<sup>552</sup>

### **5.7.3 Medical training in a regional and rural setting**

The committee notes that JCU currently has the only medical program in Australia that delivers fully integrated medical training from entry to medical school through to Fellowship as a specialist GP in a regional and rural setting.

The committee notes that the University of Queensland, with its regional partners, is also currently undertaking two initiatives aimed at growing a regional and remote primary health workforce.

Griffith University also offer students the opportunity, in years 3 and 4 of their study, to participate in the Rural Longlook Program through its Rural Clinical School. The program is conducted in partnership with Rural Medical Education Australia, and has sites in various regional, rural and remote areas, including Goondiwindi, Warwick, Toowoomba, Stanthorpe, Palm Island, Jandowae, Miles, Kingaroy, Dalby and Beaudesert.<sup>553</sup>

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<sup>547</sup> Submission 14, p 1.

<sup>548</sup> Submissions 13 and 73; J Ogden, S Preston, RL Partanen, R Ostini, P Coxeter, ‘Recruiting and retaining general practitioners in rural practice: systematic review and meta-analysis of rural pipeline effects’, *Medical Journal of Australia* 2020, 213 (5): 228-236.

<sup>549</sup> Submission 14, p 2.

<sup>550</sup> See, for example, submissions 13 and 23.

<sup>551</sup> Submission 13, p 7.

<sup>552</sup> Submission 68, p 4.

<sup>553</sup> Griffith University, Health for rural communities, Rural Clinics, <https://www.griffith.edu.au/griffith-health/school-medicine-dentistry/learning-teaching/rural-clinics>.

Griffith University offers a Rural Pathway program aimed at encouraging early engagement of Griffith Medical students in possible pathways in rural medicine.<sup>554</sup>

#### 5.7.3.1 *James Cook University medical program*

The committee notes that the establishment of JCU's medical program in 2000 was a landmark – the first in Australia to be entirely located in a regional area and to be based in tropical north Queensland.<sup>555</sup> As noted above, JCU's medical program offers a fully integrated approach from entry to medical school to Fellowship.

JCU advised that around 70 per cent of students admitted to the JCU medical program are of non-metropolitan origin. They stated that the medical course provides extensive rural clinical placement in an inspiring regionally based education and training experience.<sup>556</sup>

JCU advised that as a result of the program design, the majority of its medical graduates (around 75 per cent) go on to work outside of major cities and around half pursue training and careers as GPs or Rural Generalists (RGs).<sup>557</sup>

The committee notes that, in 2016, JCU became the only university in Australia to also deliver the Australian Government funded Australian General Practice Training (AGPT) program.<sup>558</sup> JCU stated that its General Practice Training program has training offices based in 14 towns across regional Queensland.<sup>559</sup>

JCU advised that seven years ago it responded to a tender to deliver general practice training across 90 per cent of Queensland, stating that it:

... implemented a model of highly distributed, locally based and embedded training across a very large network. We have 14 local points of presence in towns and communities where general practice training is delivered. In about half of those we also fully integrate the medical student and other health professional student education and training in small rural towns and communities—in larger settings such as Mackay, for instance, and smaller settings like Mount Isa, Atherton, Roma, the Wide Bay and beyond Rockhampton. It is bringing people together and having that critical mass, including the multiprofessional focus.<sup>560</sup>

Since 2016, JCU has produced 696 qualified GP Fellows in the North Western Queensland GP training region, an area that covers 90 per cent of the state of Queensland.<sup>561</sup> JCU's graduate tracking research shows that:

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<sup>554</sup> Rural Medical Education Australia, 'Rural Stream', <https://ruralmeded.org.au/courses/rural-stream/>.

<sup>555</sup> JCU, submission 68, p 12.

<sup>556</sup> Submission 68, p 12.

<sup>557</sup> Submission 68, p 12.

<sup>558</sup> Submission 68, p 13.

<sup>559</sup> JCU, General Practice Training, 'Our training region', <https://www.jcugp.edu.au/about-us/our-training-region/>. JCU training offices are located in the following regions: Cairns Coast; Cape and Torres Strait; Central Queensland; Central West; Mackay; North West; South West; Sunshine Coast; Townsville' Tablelands; Wide Bay and Rural Gympie and Sunshine Coast.

<sup>560</sup> Public hearing transcript, Townsville, 9 February 2022, p 22.

<sup>561</sup> Submission 68, p 13.

- two thirds of JCU-trained GP Fellows have stayed on in the North Western Queensland region after completing their training
- 60 per cent of JCU-trained GP Fellows are working in remote and regional locations
- of those who both graduated with a medical degree from JCU and who also completed GP training with JCU, 92 per cent go on to work in remote and regional locations after Fellowship.<sup>562</sup>

#### 5.7.3.2 *University of Queensland – medical pathways*

UQ Faculty of Medicine, with its regional partners, is undertaking the following two initiatives aimed at growing the regional and rural primary health care workforce in Queensland:

- Wide Bay and Central Queensland Regional Medical Pathway (WB-CQ RMP)
- Darling Downs – South West Medical Pathway (DD-SW MP).

UQ Faculty of Medicine stated that:

These medical pathways will provide and support an end-to-end pre-medical, medical education and vocational training pathway (from completion of secondary school to completion of vocational training to Fellowship) in the Central Queensland, Wide Bay, Darling Downs and South West regions of Queensland.<sup>563</sup>

The Rural Clinical School, UQ Faculty of Medicine referred to:

... the beginning of the pathway of the journey to becoming a GP and the importance of educating medical students for their whole medical program in the regions. It is also important to recruit students for these regional based programs from those same regions. We hope that more of them will become the junior doctors and then subsequently the GPs that these communities particularly need.<sup>564</sup>

UQ Faculty of Medicine stated that access to medical services will be improved through the focused development of a sustainable, 'home grown' medical workforce who are committed to living and working in regional, rural and remote Australia and specifically across the Central Queensland, Wide Bay, Darling Downs and South West regions.<sup>565</sup>

The committee notes that under the pathways, local students from these areas will be able to undertake their undergraduate studies with a regionally based university and then complete the four years of the UQ Medical Degree program in the rural and regional communities, which are served by the UQ Rural Clinical School.<sup>566</sup>

UQ Faculty of Medicine stated that support during prevocational and vocational training will be provided by the UQ Regional Training Hubs (RTHs):

- Regional Training Hub Central Queensland (RTHCQ)<sup>567</sup>

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<sup>562</sup> Submission 68, p 13.

<sup>563</sup> Submission 14, pp 1-2.

<sup>564</sup> Public hearing transcript, Brisbane, 11 February 2022, p 18.

<sup>565</sup> Submission 14, p 2.

<sup>566</sup> Submission 14, p 2.

<sup>567</sup> University of Queensland, Rural Clinical School, 'Central Queensland', <https://rcs.medicine.uq.edu.au/regional-training-hubs/central-queensland>.

- Regional Training Hub Wide Bay (RTHWB)<sup>568</sup>
- Regional Training Hub Southern Queensland (RTHSQ).<sup>569</sup>

UQ Faculty of Medicine advised that these RTHs are ideally placed to take on a larger role in facilitating place-based GP vocational training within the Regional Medical Pathway and Medical Pathway footprints, ensuring the pathway to rural and regional GP is maintained.<sup>570</sup>

#### **5.7.4 Additional Commonwealth Supported Places to grow a reliable domestic pipeline of medical practitioners**

Queensland Health recommended that the Australian Government review its investment in the medical workforce in Queensland, including increasing the CSPs allocation to Queensland medical schools, to aid the creation of reliable domestic pipeline of medical practitioners to work in rural and remote parts of Queensland.<sup>571</sup>

RACGP also supported increasing the number of rural-origin students in medical school and increasing exposure to rural general practice in undergraduate and graduate medical courses.<sup>572</sup>

Both JCU and UQ Faculty of Medicine have requested additional CSPs to support their regional medical training pathways. The JCU, Centre for Rural and Remote Health, stated:

I heard you ask the question today about whether we need more training places, and the answer is yes. We know that, if we are able to take on more in the north and in the west, we can deliver a workforce. For those health professional courses that are capped, we absolutely need more training places.<sup>573</sup>

At the public hearing in Brisbane on 8 December 2021, Griffith University advised:

The number of medical training places is determined by the Commonwealth. There are capacity issues in relation to the number of placements we can put into public hospitals, but I think the medical deans would generally agree that we have not reached capacity, we have not reached a natural saturation point, so we can certainly increase the number of places if the Commonwealth would fund them.<sup>574</sup>

...

Yes, we could certainly cope with more places. I think the number of places has to be linked to the availability of training spots, but with the expansions happening at Logan Hospital and the plans for the new Coomera hospital I think there is certainly capacity growing within the system and I think we need to take advantage of that. It makes sense that we train more of our own rather than import lots of international graduates.<sup>575</sup>

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<sup>568</sup> University of Queensland, Rural Clinical School, 'Wide Bay', <https://rcs.medicine.uq.edu.au/regional-training-hubs/wide-bay>.

<sup>569</sup> University of Queensland, Rural Clinical School, Southern Queensland, <https://rcs.medicine.uq.edu.au/regional-training-hubs/southern-queensland>

<sup>570</sup> Submission 14, p 2.

<sup>571</sup> Submission 39, pp 32-33.

<sup>572</sup> Submission 73, p. 2.

<sup>573</sup> Public hearing transcript, Rockhampton, 3 March 2022, p 13.

<sup>574</sup> Public hearing transcript, Brisbane, 8 December 2021, p 24.

<sup>575</sup> Public hearing transcript, Brisbane, 8 December 2021, p 24.

JCU stated that in order to address the ongoing shortfall in the regional, rural and remote health care workforce, it requires additional support, including a significant increase in the number of CSPs in medical schools.<sup>576</sup>

JCU advised that additional CSPs will allow it to offer its full medical program in three regional locations, thus increasing access to medical training for students from regional, rural and remote Queensland, stating that:

Given our success in supplying health professionals who go on to work in regional, rural and remote communities, we would encourage the committee to recommend supporting the expansion of health professional education outside of South-East Queensland, including JCU's bid for an increase in Commonwealth supported places for our medical program.<sup>577</sup>

UQ Faculty of Medicine stated that it is planning for 90 medical students to experience all four years of their medical program in regional centres and surrounding rural communities. They advised that by the time the CQ-WB RMP and DD-SW MP are fully operational, the rural and regional communities in the UQ footprint will be supporting the learning of 360 students at any one time compared to approximately 170 on year-long placements currently.<sup>578</sup>

UQ Faculty of Medicine stated that to offer these pathways more CSP medical places were needed.<sup>579</sup>

The committee notes that the UQ Faculty of Medicine applied for an allocation of 30 CSPs from the re-distribution pool from 2023 onwards (up to a total of 120 CSPs). The UQ Faculty of Medicine intended to match these additional 30 CSPs with 30 CSPs from its existing CSP allocation each year, for the CQ-WB RMP. UQ Faculty of Medicine also stated that it would be requesting an additional 15 CSPs for each of the four years aligned to the DD-SW MP.<sup>580</sup>

UQ Faculty of Medicine stated:

These additional places would make a significant difference to achieving the goals of the Stronger Rural Health Strategy, including Junior Doctor training program and streamlined pathways to General Practice Fellowship. UQ's new Medical Program has a strong emphasis on Primary Care, which aims to encourage more graduates to choose GP as their career preference.<sup>581</sup>

At the public hearing on 11 February 2022, UQ Faculty of Medicine provided an update, advising that they had not been provided with the requested additional CSPs. The committee was informed that the UQ Faculty of Medicine:

... are moving our CSPs out of the metro site to the regions. We had asked for a fifty-fifty split—that is, we would move 15 of UQ's Commonwealth supported places to the three regional programs, and we were hoping that the Commonwealth would provide the other 50 per cent. All up it would be 45, but initially it would be 15 for Rockhampton and 15 for Bundaberg. That is out of the redistribution pool that the Commonwealth had. Our understanding is that there are still 28 places—I am not 100 per cent sure

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<sup>576</sup> Submission 68, p 2.

<sup>577</sup> Public hearing transcript, Cairns, 7 February 2022, p 17.

<sup>578</sup> Submission 14, p 2.

<sup>579</sup> Submission 14, p 2.

<sup>580</sup> Submission 14, p 2.

<sup>581</sup> Submission 14, p 2.

of that—that had to be redistributed. We felt that our model was a great place for those to go to. We put in a submission and we received a response that that is not going to happen at this point in time.<sup>582</sup>

UQ Faculty of Medicine advised it would need to fund all of the new rural pathway programs out of its existing CSPs, advising:

That puts a strain on our program based out of Brisbane as well as being able to make this sustainable. Obviously there are concerns. There will have to be tight management financially to make it a sustainable model, but we are committed to it and we will make it work. It is going to be a bit challenging, but, at the same time, it is important work to be done. We hope that there might be other opportunities for funding to support growing that medical workforce in areas where there is acute shortage, particularly Central Queensland, Wide Bay and the south-west, which, as we know, is short of medical staff.<sup>583</sup>

JCU noted that the case for additional regional medical CSPs would be assisted by the Queensland Government providing clear advice to the Australian Government that it would support employment for the additional domestic graduates – particularly in the regions.<sup>584</sup>

The DESE advised that the Department of Health is currently working with states and territories on the development of the National Medical Workforce Strategy 2021 to 2031. The DESE advised that the Australian Government has deferred any decisions on the further allocation or redistribution of medical places, including assessment of proposals for new schools, until the National Workforce Strategy has been finalised.<sup>585</sup>

#### Committee comment

The evidence clearly demonstrates that the best way for Queensland to create a rural and remote medical workforce is to grow its own by educating medical students from a rural background in a rural setting and ensuring a quality rural training experience.

The committee supports the JCU medical program, UQ's rural and regional pathway programs and Griffith University's Rural Longlook Program and Rural Pathway Program, as excellent examples of this approach.

Given the importance of building a local, rural and regional medical workforce, the committee recommends that the Australian Government allocates additional CSPs to JCU, UQ and Griffith University Medical Programs to enable them to continue, and expand, their programs, pathways and courses aimed at ensuring a sustainable regional, rural and remote workforce.

#### **Recommendation 13 – Additional Commonwealth Supported Places for medical programs**

The committee recommends that the Australian Government allocates additional Commonwealth Supported Places to the James Cook University, University of Queensland and Griffith University medical programs to enable them to continue, and expand, their programs, pathways and courses aimed at ensuring a sustainable regional, rural and remote medical workforce.

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<sup>582</sup> Public hearing transcript, Brisbane, 11 February 2022, p 19.

<sup>583</sup> Public hearing transcript, Brisbane, 11 February 2022, pp 19-20.

<sup>584</sup> JCU, responses to questions on notice, 7 March 2022, p 5.

<sup>585</sup> Australian Government, Department of Education, Skills and Employment, correspondence, 20 December 2021, p 2.

In addition to the current the medical programs, at UQ, JCU, Griffith University and Bond University, the committee considers that there is scope to extend the existing facilities at Cairns, Rockhampton and Toowoomba to establish university and TAFE-supported Schools of Medicine for primary and allied health services. The committee, therefore, recommends that the Australian and Queensland Governments collaborate to investigate the feasibility of establishing Schools of Medicine at these locations to support the training of medical students in major Queensland regional centres.

**Recommendation 14 – Australian and Queensland Governments to investigate feasibility of establishing schools of medicine in major regional centres**

The committee recommends that the Australian and Queensland Governments collaborate to investigate the expansion of facilities and operations at Cairns, Rockhampton and Toowoomba with a view to establishing university and TAFE supported Schools of Medicine for primary and allied health services.

## 5.8 Australian General Practice Training program

In Australia, medical graduates must achieve a GP fellowship in order to practise as a GP. The Australian General Practice Training program (AGPT) delivers postgraduate vocational training for medical graduates wishing to pursue a career in general practice.<sup>586</sup>

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 currently has two RTOs:

- General Practice Training Queensland (GPTQ) is responsible for South East Queensland which includes Brisbane, Gold Coast and Darling Downs, and West Moreton District
- JCU which is responsible for North Western Queensland.<sup>587</sup>

The AGPT program provides full-time, on-the-job training for Australian and overseas-trained doctors who want to specialise in general practice. Training is delivered in accordance with the curriculum and standards set by the two accredited training colleges – RACGP and ACCRM.<sup>588</sup>

There are two training pathways under the AGPT program:

- General pathway – registrars on this pathway can nominate where they train, electing either a full year in one location or two, six month placements in different locations – there is no requirement to undertake a rural placement unless the registrar is pursuing a Fellowship of Advanced Rural General Practice<sup>589</sup>
- Rural pathway – registrars on the rural pathway must spend their community-based training time in a rural or remote location (MM2 to MM7).<sup>590</sup>

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<sup>586</sup> Australian Government, submission 75, p 10.

<sup>587</sup> Australian Government, submission 75, p 10.

<sup>588</sup> JCU, response to question on notice, 7 March 2022, p 2.

<sup>589</sup> General Practice Training Queensland, 'The AGPT General Pathway', <https://www.gptq.qld.edu.au/our-program/agpt-general-pathway/>.

<sup>590</sup> General Practice Training Queensland, 'The AGPT Rural Pathway', <https://www.gptq.qld.edu.au/our-program/agpt-rural-pathway/>.

GP registrars who undertake training placements in rural and remote locations may be eligible for payments under the General Practice Rural Incentives Program (GPRIP).<sup>591</sup>

The Australian Government's Workforce Incentive Program (WIP) also aims to address a shortage of medical staff in rural areas. It offers doctors working in rural and remote areas an additional annual payment between \$4,500 and \$60,000, depending on your location and years of service.<sup>592</sup>

Medical graduates on the AGPT program train towards achieving one of the following fellowships:

- Fellowship of the Australian College of Rural and Remote Medicine (FACRRM)
- Fellowship of the Royal Australian College of General Practitioners (FRACGP)
- FRACGP and Fellowship of Advanced Rural General Practice (FARGP).<sup>593</sup>

After receiving one of the above fellowships, a medical graduate can register with the Medical Board of Australia and work as a GP anywhere in Australia.<sup>594</sup>

### 5.8.1 Reforms to the training program

In 2017, the Honourable Greg Hunt MP, Minister for Health, announced that the AGPT program would transition to a 'college-led' GP training model.

RACGP and ACRRM have now resumed full leadership of almost all core college functions from the Department of Health. These colleges are now directly responsible for:

- selection of candidates and selection policy
- accreditation of training providers and through them, training posts
- managing formative and summative assessment
- remedial support of GP trainees (registrars) in difficulty.<sup>595</sup>

From 2023, the colleges will also be responsible for the direct delivery of the AGPT program:

- ACRMM will deliver the FACRMM
- RACGP will deliver the FRACGP and FARGP.

QPHN referred to recent evidence that shows that the number of GPs starting their registrar training had decreased by 20 per cent by 2016. QPHN noted that the planned reforms to GP training, including a transition to college-led training, aims to better equip new doctors with more comprehensive skills to work in a range of settings.<sup>596</sup>

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<sup>591</sup> General Practice Training Queensland, 'The Australian General Practice Training Program', <https://www.gptq.qld.edu.au/our-program/agpt-program-2/>.

<sup>592</sup> General Practice Training Queensland, 'Why go rural?', <https://www.gptq.qld.edu.au/rural-medicine-2/>

<sup>593</sup> General Practice Training Queensland, 'The Australian General Practice Training Program', <https://www.gptq.qld.edu.au/our-program/agpt-program-2/>.

<sup>594</sup> General Practice Training Queensland, 'The Australian General Practice Training Program', <https://www.gptq.qld.edu.au/our-program/agpt-program-2/>.

<sup>595</sup> JCU, response to question on notice, 7 March 2022, p 2.

<sup>596</sup> Submission 65, p 7.

JCU supports the proposition that GP colleges should receive public funds to develop and maintain a core set of national learning resources for GP registrars and professional development for GP supervisors.<sup>597</sup> However, they consider that the Australian Government's failure to distinguish between the quality and capacity of a national GP training system on the one hand, and producing more GPs in, and for, regional communities is a major policy shortcoming.<sup>598</sup>

QRRPHN also raised the importance of ensuring adequate preparation and training of medical professions for a long-term career in rural and remote areas.<sup>599</sup>

JCU stated that:

The national and international evidence is clear that this [the production of a regional and rural GP workforce] requires a comprehensive 'pipeline' approach to training, integrated across the medical training continuum and located in and responsive to the regional context.<sup>600</sup>

JCU noted that 'achieving rural workforce distribution is also not a core function for accredited medical colleges'.<sup>601</sup>

JCU's view was that a comprehensive review of GP training arrangements is required to clarify overarching policy objectives and to inform future GP training program design. JCU noted that it is highly unusual for an Australian Government program of the size of the AGPT program to not have undergone an external review for value and impact in its two decades of operation.<sup>602</sup>

### **5.8.2 Potential adverse impact on the number of general practitioners practising in rural and remote areas**

JCU noted that the Australian Government is currently considering bids from the RACGP and ACCRM to directly deliver GP training, including across regional Queensland.<sup>603</sup>

As the AGPT program design will be largely unreformed, JCU considers that the components of the program that 'create barriers to sustainable GP workforce in the regions will be retained'. JCU provided the following example:

... the current 50:50 division of training opportunities into desirable "General Pathway" GP training places and the so-called "Rural Pathway" training places that international medical graduates (IMGs) are obliged to take up (along with domestic medical graduates who miss out on a flexible place). Queensland does poorly out of this split, with 62% of its allocation of commencing GP training places designated as Rural Pathway places, compared to 47% in New South Wales.

It is JCU's view that this sort of 'conscription-style' approach to GP training is outdated and has manifestly failed. Australia's continued reliance on international labour to prop up regional medical services and the intersection of this with AGPT conscription to train regionally means that Australian taxpayers are in

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<sup>597</sup> JCU, response to question on notice, 7 March 2022, p 3.

<sup>598</sup> JCU, response to question on notice, 7 March 2022, p 3.

<sup>599</sup> Submission 70, p 4.

<sup>600</sup> JCU, response to question on notice, 7 March 2022, p 3.

<sup>601</sup> JCU, response to question on notice, 7 March 2022, p 3.

<sup>602</sup> JCU, response to question on notice, 7 March 2022, p 3.

<sup>603</sup> JCU, response to question on notice, 7 March 2022, p 3.

effect funding IMGs to complete GP fellowship training in regional Australia, who then usually go on to work in major cities.<sup>604</sup>

JCU stated that this is evidenced by the fact that while the stock of qualified GPs has been growing at about 2.9 per cent per annum, two thirds of the increase in numbers have been in major Australian cities and nine out of 10 of those are IMGs.

Meanwhile, as outlined in section 5.5.3 of this report, interest in a GP career among domestic graduates is at an historical low – 16 per cent among final year medical students and 16 per cent among junior doctors in their first or second year after graduation. JCU stated that ‘General Practice in Australia is steadily becoming a career that is taken up by IMGs working in the cities.’<sup>605</sup>

JCU considered that their model of integrated regionally-based medical education and training – extending from entry to medical school to junior doctor training and GP vocational training has been ‘highly successful and represents best practice’.<sup>606</sup>

The committee notes that this has been acknowledged by the Australian Government who have indicated a continuing role for JCU in the future of GP training in Queensland in partnership with RACGP and ACRRM. JCU advised that ACRRM has agreed to collaborate with JCU; however, RACGP have indicated this is not their intention.<sup>607</sup>

RACGP advised that ‘New and significant investment in training GP registrars is needed’. RACGP noted that ‘While no single change to the training program will be the solution, action is needed to put general practice training on equal, or greater, footing with other medical speciality training programs’.<sup>608</sup>

JCU stated that according to a RACGP briefing on 23 February 2022, the RACGP intends to close down local GP training offices in Mackay, Bundaberg, Hervey Bay, Gympie, Roma, Longreach, Emerald, Mount Isa, the Atherton Tablelands and Thursday Island. JCU stated that instead, RACGP intends to base its Queensland training in the greater Brisbane area and limit regional activities to scaled-back operations in a few regional cities: Townsville, Cairns, Rockhampton and Toowoomba.<sup>609</sup>

JCU considered that ‘If implemented, this would be a major disruption to integrated local training delivery arrangements in Queensland that are currently provided by JCU’.<sup>610</sup> In summary, JCU considered that proposed changes in GP training are likely to have the following impacts:

- from 2023, the visibility and local support for GP training pathways in many regional, rural and remote Queensland towns will end
- the successful ‘end-to-end’ training model from medical school through to GP training that JCU has deployed across remote, rural and regional Queensland will be disrupted

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<sup>604</sup> JCU, response to question on notice, 7 March 2022, p 3.

<sup>605</sup> JCU, response to question on notice, 7 March 2022, p 3.

<sup>606</sup> JCU, response to question on notice, 7 March 2022, p 3.

<sup>607</sup> JCU, response to question on notice, 7 March 2022, p 4.

<sup>608</sup> Submission 73, p 2.

<sup>609</sup> JCU, response to question on notice, 7 March 2022, p 4.

<sup>610</sup> JCU, response to question on notice, 7 March 2022, p 4.

- the impact of the closures and disruption of GP training pathways will be felt most in smaller rural and remote locations, with loss of skilled local personnel and training facilities
- over time, the GP workforce for primary care practices across remote, rural and regional Queensland will be destabilised
- a reduced GP workforce supply will result in lower primary care sector capacity and practice closures and will inevitably drive-up client presentations to Queensland Health facilities.<sup>611</sup>

JCU recommended that the Queensland Government indicate to the Australian Government:

- support for JCU's vertically-integrated, regionally-based model of GP training in regional Queensland
- an expectation that GP training in smaller regional, rural and remote Queensland towns should continue
- Queensland Government's preference to continue local collaboration with JCU in regional GP training, along with a strong role for GP colleges.<sup>612</sup>

#### Committee comment

The committee recommends that the Australian Government undertakes a comprehensive review of the AGPT program, in the context of the Primary Health Care 10 Year Plan and *National Medical Workforce Strategy 2021-2031* to ensure that the delivery of GP training achieves the objective of creating a sustainable GP workforce in rural and remote areas.

#### **Recommendation 15 – Review of the Australian General Practice Training program**

The committee recommends that the Australian Government undertakes a comprehensive review of the Australian General Practice Training program, in the context of the *Primary Health Care 10 Year Plan* and the *National Medical Workforce Strategy 2021-2031*, to ensure that the delivery of general practice training achieves the objective of creating a sustainable general practice workforce in rural and remote areas.

The committee notes the achievements of JCU's GP training model, with 60 per cent of JCU-trained GP Fellows now working in remote and regional locations. These figures demonstrate that the model is helping to create the sustainable rural and remote medical workforce that is required.

The committee notes that the ACCRM has committed to collaborate with JCU on the delivery of regional GP training. The committee recommends that the Australian Government consults with the RACGP to ensure that GP training continues to take place in smaller regional, rural and remote Queensland towns, with the collaboration of JCU in the delivery of the training.

#### **Recommendation 16 – Continued collaboration with James Cook University in delivery of Australian General Practice Training program**

The committee recommends that the Australian Government commits to continuing the existing collaboration with James Cook University, which has ensured that general practice training takes place in smaller regional, rural and remote Queensland towns, once responsibility for the delivery of training is transferred to the relevant colleges.

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<sup>611</sup> JCU, response to question on notice, 7 March 2022, p 4.

<sup>612</sup> JCU, response to question on notice, 7 March 2022, p 4.

## 5.9 Distribution Priority Areas

On 1 July 2019, the Australian Government introduced the Distribution Priority Area (DPA) classification system, replacing the Districts of Workforce Shortage (DWS) Assessment Areas for GPs and Bonded Doctors.<sup>613</sup>

The Australian Government uses the DPA to identify locations with a shortage of medical practitioners, including rural areas and communities, and facilitates the placement of primary care doctors subject to location restrictions, such as IMGs and Australian doctors participating in the Bonded Medical Programs.<sup>614</sup>

IMGs are required to work in a location identified as a DPA to access a Medicare provider number under section 19AB of the *Health Insurance Act 1973* (Cth).<sup>615</sup> IMGs must work in the location for a minimum of 10 years, depending on how rural and remote the area is where the IMG practises.<sup>616</sup>

The Australian Government stated that the DPA ‘... helps to compare relative shortages of GPs between communities, as most communities appear to self-identify that they have a shortage of GPs’.<sup>617</sup>

The DPA is linked to the Modified Monash Model (MMM) (a geographical classification scheme which measures the remoteness of a location).<sup>618</sup> The MMM defines whether a location is a city, rural, remote or very remote location based on a scale from 1 to 7. MM 1 is a major city and MM 7 is very remote.<sup>619</sup>

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 they were receiving benchmark level GP services.<sup>620</sup>

The Department of Health advised that the benchmark for each GP catchment is determined based on the composition of their communities, considering their demographics, including their age, sex and Socio-Economic Indexes for Areas (an assessment of the welfare of communities created by the Australian Bureau of Statistics).<sup>621</sup>

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<sup>613</sup> RACGP, submission 73, p 3.

<sup>614</sup> RACGP, submission 73, p 3; Queensland Health, submission 39, p 33.

<sup>615</sup> RACGP, submission 73, p 3; Queensland Health, submission 39, p 33.

<sup>616</sup> Australian Government, Department of Health, ‘10-year moratorium and scaling’, <https://www.health.gov.au/health-topics/doctors-and-specialists/what-we-do/19ab/moratorium>.

<sup>617</sup> Submission 75, p 10.

<sup>618</sup> The Modified Monash Model is how the Department of Health defines whether a location is a city, rural, remote or very remote. The model measures remoteness and population size on a scale of Modified Monash (MM) category MM 1 to MM 7. MM 1 is a major city and MM 7 is very remote.

<sup>619</sup> Queensland Health, submission 39, p 33.

<sup>620</sup> Australian Government, Department of Health, ‘Distribution Priority Area’, <https://www.health.gov.au/health-topics/rural-health-workforce/classifications/dpa>.

<sup>621</sup> Australian Government, Department of Health, ‘Distribution Priority Area’, <https://www.health.gov.au/health-topics/rural-health-workforce/classifications/dpa>.

The DPA has the following automatic rules:

- MM 1 (inner metropolitan areas) are automatically deemed non-DPA
- MM 5 to 7 are automatically deemed DPA
- all of the Northern Territory is automatically deemed DPA.<sup>622</sup>

Other areas are classified as DPA when the level of health services for the population does not meet a service benchmark. The average level of health services under MM 2 is the benchmark for a DPA.<sup>623</sup>

The Australian Government advised that a community or practice can apply for special consideration if they are not an area categorised as a DPA. Applications are assessed based on advice from the Distribution Working Group.<sup>624</sup>

The DPA system applies only to general practice; other specialties continue to be assessed under the DWS system, although this was under review in 2021.<sup>625</sup>

### 5.9.1 Adverse impact of Distribution Priority Areas classification system

During its inquiry, submitters highlighted the adverse impact that the DPA system has had on the availability of GPs in certain areas, including certain outer-metropolitan and regional areas.<sup>626</sup>

Queensland Health stated that:

As the DPA redistribution policy has taken effect, GP catchment areas have gained and lost DPA status. The system allocates a three-year classification period. Areas such as Mackay for example, have recently lost their DPA status thereby rendering them unable to employ IMGs in their general practices. As a result, many general practices in the area have stopped taking new patients due to doctor shortages which makes it extremely difficult for new people to the area to access primary care.<sup>627</sup>

Queensland Health noted that of the MM 3 to 7 locations in Queensland, there are four non-DPAs in the entire State (Beaudesert, Dalby, Gatton, and Maryborough). In addition, there are several MM 2 areas that are non-DPA which include Cairns, Townsville, Hervey Bay, towns within the Sunshine Coast Hinterland, and towns between the Gold Coast and Logan.<sup>628</sup>

RACGP stated that:

Geographic reclassification affected an estimated 7,000 GPs. In May 2020, 261 locations that were previously a DWS became fully or partially non-DPA. Practices affected by changes to DPA classification were only able to appeal if the change had affected recruitment of an international medical graduate (IMG) that had already commenced. This meant that these locations could no longer recruit IMGs or

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<sup>622</sup> Australian Government, Department of Health, 'Distribution Priority Area', <https://www.health.gov.au/health-topics/rural-health-workforce/classifications/dpa>.

<sup>623</sup> Australian Government, Department of Health, 'Distribution Priority Area', <https://www.health.gov.au/health-topics/rural-health-workforce/classifications/dpa>.

<sup>624</sup> Submission 75, p 10.

<sup>625</sup> RACGP, submission 73, p 3.

<sup>626</sup> Submissions 13, 25, 39, 63, 65 and 70.

<sup>627</sup> Submission 39, p 33.

<sup>628</sup> Submission 39, p 33.

those in Bonded Medical Programs which exacerbated doctor shortages for these communities. It also impacted practice viability with reduced access to bulkbilling incentives.<sup>629</sup>

QRRPHN referred to a 'failure of the Distribution Priority Area (DPA) system to properly respond to local needs'.<sup>630</sup> QRRPHN told the committee the DPA:

... is causing great angst throughout the sector. The 19(2) exemption, which the federal government has just done a review of, is not doing what it was meant to do. It is not making more primary care accessibility and workforce. It is causing some problems with workforce distribution. There is also the MBS billing models and the utilisation of the Modified Monash Model for rural classification. The example I will give is Mackay. We are classed as outer regional the same as Toowoomba. Toowoomba is one hour from Brisbane. We are four hours from Townsville and a 12-hour drive from Brisbane.<sup>631</sup>

HWQ noted that there are many towns in regional areas who are not classified as a DPA even though they have an under-supply of GPs.<sup>632</sup>

At the public hearing on Bribie Island, Ningi Doctors advised that:

... unless you were quite rural you could not get people in from overseas. Where we are, which is not considered rural at all, just over the bridge, we had no ability to get people from overseas. We had to replace our overseas trained doctors with other doctors from overseas who were already in Australia, so it means we have to poach them from another practice and the pool is getting smaller. That was all to do with visas and overseas trained workers coming into Australia.<sup>633</sup>

Cairns and Hinterland HSS stated that:

We know that Cairns is excluded from the GP prioritisation area at the moment, yet we still see shortages across general practices within our metro centres and this is exacerbated even more as we move outside of Cairns.<sup>634</sup>

QPHN and RACGP noted that the loss of DPA status had significantly impacted the ability of practices in larger regional and outer metropolitan areas, such as the Sunshine Coast and Gold Coast, to maintain their GP workforce and resulted in practices closing their books to new patients.<sup>635</sup>

RACGP referred to modelling in 2019 which forecast a shortfall of 7,535 full-time GPs or 31.7 per cent in urban areas by 2030.<sup>636</sup> QPHN stated that the DPA system has:

... significantly impacted the ability of practices in these regions to maintain their GP workforce. Most General Practices would be willing to expand their services, however they don't meet the criteria for Distribution Priority Area (DPA) classification which presents a barrier to recruitment and maintaining a stable workforce. As a result, most practices have closed their books to new patients.<sup>637</sup>

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<sup>629</sup> Submission 73, p 3.

<sup>630</sup> Submission 70, p 4.

<sup>631</sup> Public hearing transcript, Brisbane, 8 December 2021, p 18.

<sup>632</sup> Submission 25, p 8.

<sup>633</sup> Public hearing transcript, Bribie Island, 9 December 2021, p 11.

<sup>634</sup> Public hearing transcript, Cairns, 7 February 2022, p 3.

<sup>635</sup> Submissions 65 and 73.

<sup>636</sup> Submission 73, p 3.

<sup>637</sup> Submission 65, p 7.

The Member for Pumicestone stated that the DPA model ‘... is failing the people of Pumicestone, especially our elderly and most vulnerable’. The Member for Pumicestone considered that:

The emphasis of the Distribution Priority Area model on geographic proximity to metropolitan centres does not take into account the reality that Pumicestone residents find it very much harder to access GP services in a timely way than people who may live even 30km closer to Brisbane, and that distance alone is not a pure measure of geographic isolation.

Below-average incomes, limited public transport options, a high proportion of elderly residents who can no longer drive and the location of multiple Pumicestone communities as the final destination on regional connector roads increases the isolation of Pumicestone residents far beyond the actual distances involved.<sup>638</sup>

The Member for Pumicestone stated that the current DPA model fails to give consideration to the complex health needs and socio-economic factors that place an extreme strain on GP services in Pumicestone. The Member stated that ‘The needs of the Pumicestone community are starkly different to the inner metro areas that share the same Distribution Priority Area classification’.<sup>639</sup>

HWQ stated that the recent automatic classification of MM 3 – 7 as DPAs was welcomed by many towns, however, they noted that the more towns that have DPA status, reduces the potency of this lever to attract workforce to those most in need, such as MM 5-7 areas.<sup>640</sup>

### 5.9.2 New exceptional circumstances review

On 2 September 2021, the Honourable, Dr David Gillespie MP, the Federal Minister for Regional Health announced a new exceptional circumstance review for the DPA classification to help regional and rural areas respond to unforeseen workforce and population changes which may be impacting access to local GP services.

Under the scheme, anyone in a non-DPA area, such as a GP clinic, can apply for an assessment. An important step in the assessment process is applicants working with, and having the support of, the Rural Workforce Agency (RWA) in their state or territory.

Once an applicant has worked with their RWA, they can submit to the Distribution Working Group for a review of an area’s non-DPA status. If approved, an area will be eligible to access additional programs for that year to support recruitment of a broader pool of doctors.<sup>641</sup>

The committee notes that the Australian Government has also announced a formal review of the DPA indicator.<sup>642</sup>

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<sup>638</sup> Submission 63, pp 1-2.

<sup>639</sup> Submission 63, p 2.

<sup>640</sup> Submission 25, p 8.

<sup>641</sup> Australian Government, Ministers, Department of Health, ‘Distribution Priority Areas exceptional circumstances review for GPs’, media release, <https://www.health.gov.au/ministers/the-hon-dr-david-gillespie-mp/media/distribution-priority-areas-exceptional-circumstances-review-for-gps>.

<sup>642</sup> Australian Government, Ministers, Department of Health, ‘Distribution Priority Areas exceptional circumstances review for GPs’, media release, <https://www.health.gov.au/ministers/the-hon-dr-david-gillespie-mp/media/distribution-priority-areas-exceptional-circumstances-review-for-gps>.

### 5.9.3 Calls for reform to the Distribution Priority Areas classification system

Submitters, including AMAQ, QPHN, QRRPHN, HWQ and Queensland Health, called for the Australian Government's definition of DPAs to be reviewed.<sup>643</sup>

For example, QRRPHN stated that '... 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 health care'.<sup>644</sup>

QPHN recommend that the DPA should be determined on a need basis, to reduce the impact on GP recruitment in outer metropolitan areas, with a longer term move to regional flexibility and place-based solutions.<sup>645</sup>

Queensland Health noted that the DPA does not take into account medical locum or fly-in-fly out workforces which may go into communities. Queensland Health noted that the COVID-19 pandemic demonstrated that a reliance on temporary/transient workforce (and a disruption to this supply) can impact access to primary care and other medical services.

Queensland Health considered that the DPA would be more effective if it considered supply side factors, rather than just the provision of services in community.<sup>646</sup>

HWQ stated that the move from DWS to the DPA has made access to the IMG workforce more complex and restrictive.<sup>647</sup> HWQ called for DPA calculations to be made publicly available and transparent, with clear details about the influence of each component on the statistical aspect of the DPA decision. They considered that this would better inform local communities, community leaders and DPA process applicants.<sup>648</sup>

HWQ stated that different levers or mechanisms are required to address workforce challenges in outer metro/MM1 that do not compete or overtake the greater need for rural and remote medical workforce.<sup>649</sup>

IUIH stated that any policy decisions related to DPAs should consider the specific context of the CCHS sector, particularly in urban areas, to ensure any unintended consequences are avoided that may impact on service delivery or staffing options.<sup>650</sup>

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<sup>643</sup> Submissions 25, 28, 39 and 70.

<sup>644</sup> Submission 70, p 4.

<sup>645</sup> Submission 65, p 10.

<sup>646</sup> Submission 39, p 33.

<sup>647</sup> Submission 25, p 5.

<sup>648</sup> Submission 25, p 8.

<sup>649</sup> Submission 25, p 8.

<sup>650</sup> Submission 21, p 15.

Committee comment

The committee notes the adverse impact that the recent changes to the DPA have had on Queensland communities, particularly those in regional cities, such as Mackay, Townsville and Cairns, or outer metropolitan areas, such as Brisbane and Logan.

The committee acknowledges submitters' concerns that the DPA does not consider the local health needs of a community and its current access to primary health care. The committee also notes the calls for a move to a system which provides regional flexibility and place-based solutions to the identification of priority areas with GP shortages.

Accordingly, the committee recommends that the Australian Government reviews the mechanism for addressing shortages of medical practitioners in specific communities and replace the Distribution Priority Areas classification system with a fit-for-purpose scheme that recognises supply side factors and local community health needs.

**Recommendation 17 – Review and replacement of the Distribution Priority Areas classification system**

The committee recommends that the Australian Government reviews the mechanism for addressing shortages of medical practitioners in specific communities and replaces the Distribution Priority Areas classification system with a fit-for-purpose scheme that recognises supply side factors and local community health needs.

The committee also considers that there should be greater transparency in relation to the assessment criteria and factors that lead to decisions under the DPA, including applications for the new exceptional circumstance review. The committee considers that these decisions, and the reasons for them, should be made publicly available.

**Recommendation 18 – Accountability and transparency of the Distribution Priority Areas classification system**

The committee recommends that the Australian Government publishes, as soon as practicable, details of the factors considered, and how decisions are made, under the Distribution Priority Areas classification system, including decisions on applications for the new exceptional circumstances review, to improve transparency and accountability and better inform local communities and applicants.

### **5.10 Recruiting, training and retaining a regional, rural and remote health workforce**

The committee notes that primary care providers servicing regional, rural and remote communities, and certain outer metropolitan areas of need, are subject to additional pressures and professional challenges than their counterparts in metropolitan areas.

A number of these issues are discussed in section 5.5 of this report. QRRPHN summarised the challenges and pressures, as follows:

- professional isolation and a lack of financial sustainability of practicing in rural and remote areas
- a lack of supporting health services in the primary care ‘team’, eg 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
- poorer health status of rural and remote communities compared to metropolitan areas, resulting in more complex care
- the coordination and navigation of state, private and federally funded outreach type services further compound the complexity of rural and remote health services delivery.<sup>651</sup>

Due to these challenges, QRRPHN stated that 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.<sup>652</sup> Dr Jackson, JCU, stated that attracting health professionals to work in rural and remote areas is not just about remuneration, advising:

I think it is so multifactorial. I know that you have asked a couple of other people here today. I really do think there is a critical mass effect. You are quite right: you just cannot keep throwing money at it, because it is not just money; it is lifestyle. There are lots of things that come with that. There is availability of decent accommodation. There is internet access, which is abysmal. I can say as a business owner that trying to run a business on the internet service we have in Childers is diabolical. It is a matter of your overtime, the hours you are working, being on call every night, everyone in the community knowing who you are, getting asked medical questions all the time down the street.<sup>653</sup>

The committee was informed about a number of current initiatives and recommendations aimed at enhancing the rural and remote workforce. These included:

- increasing support for health professionals that are undertaking study and training in rural communities to cover the additional costs, eg:
  - scholarships and bursaries to train in rural communities
  - reduced fees and levies for placements
  - travel expenses
  - provision of accessible and affordable accommodation

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<sup>651</sup> Submission 70, p 6.

<sup>652</sup> Submission 70, p 6.

<sup>653</sup> Public hearing transcript, Bundaberg, 2 March 2022, p 24.

- initiatives to support health professionals to experience extended placements in rural settings and compensation to entice them to work in rural, regional and remote areas
- increased support, adequate compensation and access to professional development for rural supervisors and private clinics to encourage and increase engagement in the training of health professionals, including increased funding for compensation
- a shared workforce model – for example, in Clermont, the Mackay HHS is working with primary care to implement a shared workforce model. Under this model GPs have a lighter, shared workload across primary and acute care. GPs operate 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<sup>654</sup>
- streamline credentialing processes, so that it is easier for GPs from other areas to locum in rural communities to fill gaps
- providing greater incentives, rebates, and scholarships for rural GPs to gain and maintain additional skills to benefit their community, including both procedural (eg surgery, anaesthetics, obstetrics, emergency) and non-procedural (eg mental health, paediatrics, palliative care) skills
- encouraging a whole-of-community approach to settle GPs into rural communities, eg supporting health professionals to find accommodation, childcare or education options for their children and work for their partner.<sup>655</sup>

In relation to the lack of student accommodation, JCU advised:

What has happened over maybe a 20-year period is that Queensland Health, along with other state and territory government health departments, have tended to extract themselves from the business of providing accommodation on site such as student quarters and so on. Mostly we have seen a loss of stock that is available. That said, we have some fabulous local partnerships with our hospital and health services in different areas where we have been able to secure and co-invest in accommodation, but it is a rate-limiting set. It is particularly rate limiting for allied health and nursing students. I think we will often see quite significant inequities in access to supported accommodation for a nursing student who might be undertaking a placement in a town where that town may well benefit from that person's employment the following year but these students may find that they are looking to stay in a caravan park and what is more they also have to forgo their part-time job back in town that they are using to sustain themselves.<sup>656</sup>

In relation to financial incentives for GPs to practice in rural and remote areas and the potential lack of remuneration incentivises in regional cities, Dr Jackson, JCU, stated that:

Depending on your level of rurality, you will get an annual payment, depending on how long you have served in that community. The problem with some of the larger regional areas is that, under the Modified Monash classification, they are level 2. Level 2 is sort of this grey zone. It sort of comes in and goes out—it depends on what is in political play at the time—as to whether level 2 areas attract any sort of rural retention payments at all. At the moment I do not believe they do. I think your rural retention payments are starting at Modified Monash 3. Certainly Modified Monash goes up to level 7 for the really remote areas of Queensland. It is very difficult to attract someone to a regional centre such as Rockhampton,

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<sup>654</sup> QRRPHN, submission 70, p 5.

<sup>655</sup> Submissions 13, 23, 25, 70, 73; Central West HHS, public hearing transcript, Longreach, 4 March 2022, p 7; James Cook University, Murtupuni Centre for Rural and Remote Health, public hearing transcript, Longreach, 4 March 2022, p 20.

<sup>656</sup> Public hearing transcript, Townsville, 9 February 2022, p 23.

Bundaberg or even Hervey Bay if they really have no prospect of any difference in income to someone who is working in the middle of Sydney or the middle of Brisbane who has an awful lot more support networks in place.<sup>657</sup>

RDAQ and Rural Health Management Services remarked that historically GPs used to be part of the hospital workforce. Rural Health Management Services stated that GPs acted:

... as visiting medical officers or doing some ED [emergency department] shifts and doctors from the hospital would work in ED. We have had a number of areas where specialists from within the hospital system will also work in general practice and provide clinics to patients in general practice. It is that mentorship and support and collegiate approach that we have to bring back. People come to work where they are respected and where they are valued and where there is an integrated system. At the moment the hospital does one thing and primary care does another thing. If primary care fails, which it is, then the impact is all on the hospital system because patients cannot get seen so they either get well without intervention or they end up very, very sick.<sup>658</sup>

Rural Health Management Services stated that:

It is now very difficult for GPs to work within a hospital setting or to have interaction at a higher level with the acute care services. It is very rare that allied health professionals also work in a sessional way or have a part-time appointment within the hospital setting. Those positions are very doable but they are very rare. They usually arise because of a relationship between the two people at the time, not because it is a policy change about encouraging that. There are some workforce issues and some legalities that I am sure could be easily worked out to allow that to happen if that leadership came from a government level down. We want to see more planning. We want to see a plan for Rockhampton health services. We want to see a plan for Rockhampton aged-care services. We want to see integration, collaboration and innovation at a local level.<sup>659</sup>

Rural Health Management Services also commented that:

It is the same for the hospital doctors coming out and being able to cut down to 0.8 or 0.6 (FTE) and do productive work in general practice. It is much harder to have a part-time appointment now than it ever used to be. Having a GP obstetrician who is available to work two days a week—due to the process, the credentialing, the lack of respect for when they get there, it is just easier to not do it. We need to go back to having the whole workforce respected and being able to work together, and you as political leaders can set that. You can start having those conversations.<sup>660</sup>

RDAQ stated that they are seeing a reduction in GPs who are permitted to have visitation or admitting rights in rural towns, advising:

It does not make any sense to reduce the already-small workforce in rural places and it does not make any sense to cut out the most experienced people in town, who also are the ones most known to the patients. In a perfect system, our state health system should not just allow private GPs admitting rights but should really thoroughly encourage it.<sup>661</sup>

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<sup>657</sup> Public hearing transcript, Bundaberg, 2 March 2022, p 23.

<sup>658</sup> Public hearing transcript, Rockhampton, 3 March 2022, pp 7-8.

<sup>659</sup> Public hearing transcript, Rockhampton, 3 March 2022, p 8.

<sup>660</sup> Public hearing transcript, Rockhampton, 3 March 2022, p 11.

<sup>661</sup> Public hearing transcript, Longreach, 4 March 2022, p 16.

Committee comment

The committee notes submitters' and witnesses' comments about the difficulties in attracting and retaining health professionals to work in regional, rural and remote areas, and ensuring that they stay long term in those areas. The committee notes that identified outer metropolitan areas of need also experience similar issues.

The committee recommends that the Australian Government considers the above recommendations and initiatives, as part of its *Primary Health Care 10 Year Plan* and the recommended National Health Workforce Strategy (see recommendation 22), to ensure that a comprehensive, long-term strategy is in place to create a sustainable health workforce in rural and remote Queensland and identified outer metropolitan areas of need.

**Recommendation 19 – Initiatives to promote recruitment, training and retention of a regional, rural, remote health workforce**

The committee recommends that the Australian Government considers the recommendations and initiatives contained in this report about recruiting, training and retaining a health workforce to service regional, rural, remote areas and identified outer metropolitan areas of need, as part of its *Primary Health Care 10 Year Plan* and the recommended National Health Workforce Strategy (recommendation 22), to ensure that a comprehensive, long-term strategy is in place to create a sustainable health workforce in these areas.

The committee also recommends that the Australian and Queensland Governments review the current visa requirements, and offers and packages available, to encourage more primary and allied health specialists, doctors and aged care workers to regional, rural and remote areas of Queensland and increase their length of tenure in these areas.

**Recommendation 20 – Australian and Queensland Government to review visa requirements and offers and packages available to encourage health professionals to work in regional, rural and remote areas**

The committee recommends that the Australian and Queensland Governments review the current visa requirements, and offers and packages available, to encourage more primary and allied health specialists, doctors and aged care workers to regional, rural and remote areas of Queensland and increase their length of tenure in these areas.

In addition, the committee recommends that the Australian and Queensland Governments, in partnership, consult with individual HHSs to provide capital investment for affordable and accessible accommodation for medical, allied health and nursing students to use during their studies and placements in rural and remote areas, as part of a broader accommodation strategy.

**Recommendation 21 – Capital investment in accommodation for students**

The committee recommends that the Australian and Queensland Governments, in partnership, consult with individual Hospital and Health Services, to provide capital investment for affordable and accessible accommodation for medical, allied health and nursing students to use during their studies and placements in rural and remote areas, as part of a broader accommodation strategy.

### 5.11 Calls for a National Health Workforce Strategy

In 2013, the Australian Government established Health Workforce Australia (HWA) to deliver a national, coordinated approach to health workforce reform, with the overall goal of building a sustainable health workforce for Australia.<sup>662</sup> The committee notes that the HWA was abolished in 2015.

JCU stated that health professional workforce planning, implementation and delivery must be situated within an overall national primary health care policy framework and be managed in the long term as a whole-of-government priority.<sup>663</sup>

JCU stated that:

Substantial reform is required across the suite of Commonwealth and State Health Workforce programs as they apply to primary care and community practice, including General Practice, and rural health workforce. This reform must address the entire training continuum from undergraduate through to ongoing professional development once health practitioners are fully qualified.

The confusing array of overlapping programs aimed at addressing workforce challenges in RRR [Regional, Rural and Remote] locations needs to be consolidated and aligned and a clear joint commonwealth and state outcomes frameworks developed.<sup>664</sup>

The Australian Government advised that the *National Medical Workforce Strategy*, which 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 Australian Government stated that *National Medical Workforce 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:

- collaboration on planning and design
- rebalance supply and distribution
- reform the training pathway
- building the generalist capability of the medical workforce
- a medical workforce that is supported to thrive and train and work flexibly.<sup>665</sup>

The Australian Government stated that, in addition to these priority areas, the *National Medical Workforce Strategy* will consider three other cross cutting issues: supporting the Aboriginal and Torres Strait Islander workforce and improving cultural safety; changing models of care; and doctor wellbeing.<sup>666</sup>

The Australian Government advised that issues such as geographic distribution, collaborative workforce planning and flexibility in training and education for Australia's medical workforce will be

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<sup>662</sup> QNMU, submission 69, p 31.

<sup>663</sup> Submission 68, p 3.

<sup>664</sup> Submission 68, p 17.

<sup>665</sup> Submission 75, p 22.

<sup>666</sup> Submission 75, p 22.

key considerations for the Strategy and the Medical Workforce Reform Advisory Committee, in both the short and long term.

The committee notes that state and territory Health Ministers are currently considering the draft Strategy for approval.<sup>667</sup>

Committee comment

The committee considers that the development of the *National Medical Workforce Strategy* is a welcome step. However, from the evidence received by the committee during this Inquiry, it is evident that a broader health workforce strategy that encompasses all primary and allied health professionals is required to address the current health workforce shortages and to reduce the burden on the public health system. Such an approach will also recognise the importance of the provision of care by multidisciplinary teams and the complementary roles played by primary and allied health care professionals.

The committee recommends that the Australian and Queensland Governments commit to collaborating to produce a National Health Workforce Strategy to review the suite of Commonwealth and State Health Workforce programs as they apply to primary care and allied health care providers, including General Practice, and the rural and remote health workforce.

The committee considers that this strategy must address the entire training continuum from undergraduate through to ongoing professional development once health practitioners are fully qualified, and the incentives and supports needed to produce a sustainable health workforce, particularly in rural and remote areas.

**Recommendation 22 – Establishment of National Health Workforce Strategy**

The committee recommends that the Australian and Queensland Governments commit to collaborating to produce a National Health Workforce Strategy to review the suite of Commonwealth and State Health Workforce programs as they apply to primary and allied health providers, including general practice, and the rural and remote health workforce.

The strategy should address the entire training continuum from undergraduate through to ongoing professional development once health practitioners are fully qualified and the incentives and supports needed to produce a sustainable health workforce, particularly in rural and remote areas.

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<sup>667</sup> Australian Government, Submission 75, p 22.

## 5.12 Role and effectiveness of Primary Health Networks

### 5.12.1 Introduction

In 2015, the Australian Government established 31 Primary Health Networks (PHNs) nationally with the aim of strengthening primary care and improved patient centric service integration.<sup>668</sup> There are currently seven PHNs in Queensland:

- Brisbane North
- Brisbane South
- Central Queensland, Wide Bay, Sunshine Coast
- Darling Downs and West Moreton
- Gold Coast
- Northern Queensland
- Western Queensland.<sup>669</sup>

PHNs are primarily funded by the Department of Health.<sup>670</sup> The stated aim of PHNs is to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improve coordination of care to ensure patients receive the right care in the right place at the right time.

QPHN advised that PHNs work to:

- increase understanding of local health needs
- develop effective partnerships fostering integration (particularly with HHSs)
- develop innovative ways of commissioning services.<sup>671</sup>

PHNs are also funded for specific services or projects by various Queensland Government departments (eg Child Safety) or individual HHSs.<sup>672</sup>

QPHN stated that the PHNs' focus is:

... on primary care through the support of General Practitioners (GPs) and working with a range of government and community organisations, service providers and the community to develop and better integrate health and community care services and improve access to services with an emphasis on those most vulnerable people at risk of poor health outcomes.<sup>673</sup>

QPHN advised that PHNs are the experts on the primary health needs of their region and the central drivers for planning, reform, integration and equitable access across its health and social care system.

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<sup>668</sup> Queensland Primary Health Networks, submission 65, p 1.

<sup>669</sup> Australian Government, Department of Health, 'Queensland Primary Health Networks', <https://www.health.gov.au/initiatives-and-programs/phn/your-local-phn/qld-phn>.

<sup>670</sup> Australian Government, submission 75, p 6.

<sup>671</sup> Submission 65, p 1.

<sup>672</sup> Submission 65, p 1.

<sup>673</sup> Submission 65, p 1.

QPHN stated that, as regional commissioners, they aim to reduce fragmentation and address unmet needs working with HHSs and other partners through innovative and consistent service delivery.

The PHNs also aim to support the health care workforce to build capacity and capability and are positioned to support coordinated primary health care responses to emergency and natural disasters.<sup>674</sup>

The Australian Government advised that it is providing over \$1 billion to Queensland PHNs, 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
- alcohol and other drugs.<sup>675</sup>

PHNs are required to work with their corresponding HHS to plan and deliver efficient and effective health services for the relative region.

The Australian Government stated that innovative collaborations between several Queensland PHNs and HHSs demonstrates the opportunities to support joint planning, collaborative commissioning and health service integration between Australian and Queensland Government funded health services.

The Australian Government stated:

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.<sup>676</sup>

### 5.12.2 Effectiveness of Primary Health Networks

During the Inquiry, a number of submitters and witnesses questioned PHNs' effectiveness in discharging their functions and responsibilities.<sup>677</sup>

For example, OTA stated that PHNs needed to be properly resourced to fulfil their role of improving the efficiency and effectiveness of medical services for patients and improving coordination of care.<sup>678</sup>

IUIH raised concerns about PHNs' ability to commission Indigenous mental health, substance abuse and suicide prevention services given the variable levels of sophistication across PHNs and the procurement strategies adopted. IUIH considered that the strategies fail to recognise the *Close the*

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<sup>674</sup> QPHN, submission 65, p 1.

<sup>675</sup> Submission 75, p 4.

<sup>676</sup> Submission 75, p 3.

<sup>677</sup> Submissions 17, 21 and 23.

<sup>678</sup> Submission 17, p 5.

*Gap Agreement 2020 and National Aboriginal and Torres Strait Islander Health Plan 2013-2023* commitments to use Aboriginal and Torres Strait Islander community-controlled services.<sup>679</sup>

Queensland Health stated that 'PHNs have very limited budgets with which to commission services, and their ability to influence GP services is indirect rather than direct'.<sup>680</sup>

During the committee's public hearings, concerns were also raised about PHNs' performance, particularly in North Queensland, during the recent COVID-19 pandemic in relation to delays in establishing fever clinics and supplying necessary personal protective equipment (PPE) to GPs and aged care services.<sup>681</sup>

Concerns were also raised about whether PHNs are adequately funded to perform their functions. Brisbane North PHN advised that PHNs get a level of core funding, which supports the core operations of the organisations. Brisbane North PHN stated:

That has been pretty stagnant over the time you are talking about. We then get different buckets of money for different purposes. Given the types of figures that you are talking about, no, PHN funding has not increased at similar proportions, albeit that one of the clear purposes from a primary healthcare network's perspective is to try to keep people out of hospital and healthy in the community. It is better outcomes for the consumer. It would be nice if it was funded.<sup>682</sup>

IWC stated that:

The problem is that the PHN has little to no traction with general practice. It is supposed to be out there representing primary health care. The cornerstone of primary health care is general practice. They refer to everyone else and work in conjunction with everyone else, whether they be specialists or allied health. The PHN saga has failed dismally. That is where a lot of the problems lie. There are so many general practices out there that could be doing so much more and working so much better. There is a whole range of problems. That is one of them.<sup>683</sup>

#### Committee comment

The committee notes the concerns raised by submitters and witnesses about the ability of PHNs to perform their core functions and responsibilities to increase the efficiency and effectiveness of medical services for patients and improve coordination of care to ensure patients receive the right care in the right place at the right time.

The committee considers that, despite the best endeavours of staff and some examples of successful programs to improve patient outcomes, the PHN model suffers from a lack of clarity of purpose and funding certainty from the Australian Government.

The committee, therefore, recommends that the Australian Government commissions an independent review of the effectiveness of the PHNs in discharging their key functions and responsibilities, including how the recent allocation of \$1 billion to PHNs in Queensland will be spent and the expected outcomes.

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<sup>679</sup> Submission 21, pp 9-10.

<sup>680</sup> Submission 39, p 7.

<sup>681</sup> Public hearing transcript, Brisbane, 8 December 2021, p 20.

<sup>682</sup> Public hearing transcript, Brisbane, 8 December 2021, p 22.

<sup>683</sup> Public hearing transcript, Bundaberg, 2 March 2022, p 8.

**Recommendation 23 – Review of effectiveness of the Primary Health Networks model**

The committee recommends that the Australian Government commissions an independent review of the effectiveness of the Primary Health Networks in discharging their key functions and responsibilities, including how the recent allocation of \$1 billion to Primary Health Networks in Queensland will be spent and the expected outcomes.

**5.12.3 Opportunities for greater joint co-ordination, commissioning and planning**

Submitters, such as the Queensland Mental Health Commissioner, identified positive examples of partnerships, joint planning and co-commissioning by HHSs and PHNs, eg *The Way Back Support Service*.<sup>684</sup> Queensland Health also acknowledged that HHSs in Queensland work closely with PHNs to integrate services.<sup>685</sup>

However, a number of PHNs and HHSs acknowledged that more could be done to ensure greater joint co-ordination and planning.

The Metro North HHS stated that:

... we have identified that if we do not work in partnership with our primary healthcare network, the PHN, we will continue to face overwhelming demand on the system and, more importantly, our community will continue to encounter healthcare delivery that is not timely or delivered in the most appropriate setting. This healthcare alliance with the Brisbane Metro PHN has effectively facilitated and enabled local collaborative action. Its work is focused on improving health outcomes, progressing health system reform and integrating tertiary, primary and community care.<sup>686</sup>

Submitters, including Brisbane South PHN, raised concerns about the duplication of commissioning, service delivery, reporting efforts and competing outcomes from PHN and state government funders for the same area and population.<sup>687</sup> Brisbane South PHN noted that:

Eight per cent of Queensland Health's budget is allocated to population-based community services to address similar community needs to those identified by services commissioned by Queensland's PHNs.<sup>688</sup>

Brisbane South PHN, JCU and other submitters, called for greater information sharing, joint planning and greater use of innovative funding arrangements, such as co-commissioning and joint commissioning.<sup>689</sup>

Brisbane South PHN stated that while the '... level of collaboration and partnership works well at a regional level, the federal-state funding divide within the health system sometimes prevents effective cooperation at a state/departmental level'.<sup>690</sup>

Metro South HHS noted the importance of working in partnership with PHNs, stating:

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<sup>684</sup> Queensland Mental Health Commission, submission 44, p 6; the Way Back Support Service provides practical, non-clinical support following a suicide attempt, linking individuals and their families to appropriate services.

<sup>685</sup> Submission 39, pp 7-8.

<sup>686</sup> Public hearing transcript, Bribie Island, 9 December 2021, p 3.

<sup>687</sup> Submissions 30 and 68.

<sup>688</sup> Submission 30, p 1.

<sup>689</sup> Submissions 30 and 68.

<sup>690</sup> Submission 30, p 1.

... it is really important for us to be able to work in partnership with our other health services including the PHN, private hospitals and other agencies that provide different types of services to people who might come to our services. It is really important that we recognise that it is not easy to navigate health—even if you are a health worker, which I have found personally—and that we need to work towards making it as easy and timely for people when they need us most.<sup>691</sup>

QRRPHN noted that the NHRA outlines the need for Local Hospital Networks (HHSs in Queensland) and state-funded health and community services to work collaboratively with PHNs to integrate services, however, there are no clear guidelines defining this integration. QRRPHN stated that:

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.<sup>692</sup>

The committee notes that both PHNs and HHSs are required to undertake local needs assessments, Health Needs Assessment (HNAs) and Local Area Needs Assessments (LANA), respectively. In effect these assessments are considering the same issues. The Northern Queensland PHN stated:

That means you have two peak bodies running around the district asking for information from communities. It should be one, and we should do it really well. It is vital to us commissioning services and meeting those gaps. I think it would be vital if we could bring that together.<sup>693</sup>

QPHN recommend that the Queensland Government consider working collaboratively with the QPHN to:

- use the existing network and capability of PHNs as commissioning organisations that can codesign and support targeted interventions that meet local needs throughout Queensland
- build responses that are informed by national and statewide data as well as drawing from QPHN local need assessments
- use QPHNs ingrained knowledge and understanding of their communities and vulnerable groups within them
- tap into QPHNs ability to plan, respond and scenario test program responses in clinical and community settings.<sup>694</sup>

QRRPHN stated that:

To make best use of limited financial and physical resources and people resources, we would recommend that there be a co-commissioning approach between state, federal and even local government funding sources that is wrapped around local communities and that is worked through between the HHSs, the PHNs and the AMSs. That means that we can make best use of a pooled funding approach and we can co-design targeted support that is directed at the most vulnerable and the highest priority needs according to the local communities. That will reduce inefficiencies and duplication of services. A connected approach is essential if we are going to tackle the maldistribution of the health workforce.<sup>695</sup>

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<sup>691</sup> Public hearing transcript, Logan, 10 February 2022, p 2.

<sup>692</sup> Submission 70, p 2.

<sup>693</sup> Public hearing transcript, Brisbane, 8 December 2021, p 19.

<sup>694</sup> Submission 65, p 10.

<sup>695</sup> Public hearing transcript, Cairns, 7 February 2022, p 11.

QRRPHN recommended 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
- formally commits to joint planning, including the development of a single local area needs assessment, rather than the separate PHN local needs assessment and HHS Local Area Needs Assessment that reflects the requirements of both PHNs and HHSs
- 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.<sup>696</sup>

QPHN also recommended that the Queensland Government consider how their planning and resource allocation can be better shared with the primary healthcare sector including, but not limited to, housing, public transport, education, early childhood development, employment, and community and disabilities services.<sup>697</sup>

IUIH called for a new regional funding and governance model with CCHSs taking on the role of regional Indigenous Commissioners to lead and drive collaboration with PHNs and HHSs, stating:

This would require the current investment, across both Indigenous-specific and mainstream program areas, to be channelled through these Regional Indigenous Commissioners. This approach would see the 'Indigenous share' of the whole of population health services investment across primary health, transition care, mental health, aged and disability care (which is currently administered through various mainstream commissioners such as PHNs, Outreach Fund Holders, NDIS and Aged Care) apportioned and redirected to Regional Indigenous Commissioners.<sup>698</sup>

IUIH considered that this approach would 'facilitate integrated and holistic models of care delivered by local CCHSs, and mainstream partners where appropriate, under a single integrated and culturally safe regional model of care'.<sup>699</sup>

QRRPHN stated that 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.<sup>700</sup> QRRPHN called for both the State Government and PHNs to commit to joint planning and shared resources that leverage those resources that are locally available.<sup>701</sup>

#### Committee comment

The committee recognises the importance of greater partnerships between PHNs and HHSs, particularly in relation to HNAs and LANAs, which in effect are assessing the same issue.

The committee encourages PHNs and HHS to work collaboratively on these assessments to avoid duplication and reduce the impact on service providers in needing to provide the same information to each body.

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<sup>696</sup> Submission 70, p 3.

<sup>697</sup> Submission 65, p 11.

<sup>698</sup> Submission 21, p 10.

<sup>699</sup> Submission 21, p 10.

<sup>700</sup> Submission 70, p 5.

<sup>701</sup> Submission 70, p 5.

The committee also encourages HHSs and PHNs to work closely on workforce planning and recruitment in their respective regions.

#### 5.12.4 Short-term and narrowly defined funding streams

During the Inquiry, the committee heard that the Australian Government's primary care funding to PHNs is often restricted by narrowly defined funding streams and is provided on a short-term basis. A number of submitters highlighted the adverse impact that the short-term funding of programs and services has on communities' access to quality primary health care.<sup>702</sup>

Brisbane South PHN referred to the short-term funding of an after-hours program, which had been operating for approximately 8 to 9 years, stating:

That is scheduled for discontinuance by the end of this financial year, despite the fact that we as a PHN use it to fund our multicultural health team—and we are the only PHN that has a dedicated multicultural health team—as well as to fund our homeless program and to fund some of our domestic and family violence response. Every couple of years we see that the program is scheduled for discontinuance. In most cases it either continues for a further two years or morphs into something else. As with anything, our schedules at the moment will generally go two to three years in advance of what we are doing at the moment but, in all honesty, this time I am looking at potentially three programs that are due to cease from 30 June. We are obviously advocating for those to continue. They are the kinds of parameters we operate under and our providers do as well.<sup>703</sup>

Western Queensland PHN shared a similar experience, stating:

All of our projects are commissioned out for one year, just because of the way the funding has rolled. We have one lot of money, which is the alcohol and other drugs national ice strategy money, and 65 per cent of that AOD budget is actually ceasing at 30 June 2022. We are currently working with the federal government to check whether there is going to be anything going forward because we have done a lot of work in that space and we do not want that to fall over.<sup>704</sup>

IWC referred to the short-term funding for the provision of psychological services in Bundaberg for patients who cannot afford the gap. IWC advised that:

Artius was a group that had the funding for some time. It did not last. I had patients who were suicidal and were never seen, were phoned and told ridiculous stories about having to pay.

...

I have recently received a letter [from the PHN] to say that the funding has been cut. I have patients who finally found a psychologist and now they are being told, 'You have two visits left. Funding has been cut. You are going to have to pay \$150.'<sup>705</sup>

HWQ stated that the short-term funding cycles and program uncertainty for organisations that support general practice and primary health care does not ensure a foundation for a long-term comprehensive vision for general practice.<sup>706</sup>

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<sup>702</sup> Submissions 25, 30, 46, 50 and 65.

<sup>703</sup> Public hearing transcript, Logan, 10 February 2022, p 9.

<sup>704</sup> Public hearing transcript, Longreach, 4 March 2022, p 12.

<sup>705</sup> Public hearing transcript, Bundaberg, 2 March 2022, pp 7-8.

<sup>706</sup> Submission 25, p 6.

QNMU stated that short funding cycles, at times contracting services for only one year, results in organisations facing deep uncertainty over the sustainability of their service. QNMU considered that this is compounded by short notice periods regarding whether funding will be renewed, at times only weeks prior to the contracted term. QNMU stated that ‘Insecure funding causes disruption, anxiety, and distress among participants and staff’.<sup>707</sup>

Brisbane South PHN stated that ‘PHNs are separately advocating to the Commonwealth to increase the flexibility of funding arrangements to allow PHNs to better deliver place-based, local responses’.<sup>708</sup>

#### Committee comment

The committee notes the comments of submitters and witnesses about the adverse impact of short-term funding of programs and projects by the PHN, including experiences of funding for vital programs on which patients depend, being cut at short notice and the uncertainty this creates.

The committee notes the Australian Government’s funding of over \$1 billion to Queensland PHNs, from 2019-20 and 2022-23, to deliver and commission services. However, the committee questions the efficacy of the short-term funding models adopted by PHNs and whether communities are getting value-for-money from the services commissioned and delivered by PHNs.

The committee recommends that the Australian Government assesses the efficacy of each service commissioned or delivered by PHNs, including the amount of funding provided and outcomes, and publishes this information.

#### **Recommendation 24 – Transparency and accountability for funding and services delivered by Primary Health Networks**

The committee recommends that the Australian Government:

- establishes measures to assess the efficacy of services commissioned, or delivered, by Primary Health Networks
- publishes information about the amount of funding provided by service and the outcomes achieved.

The committee recommends that the Australian Government undertakes a review of the short-term funding model for PHNs to ensure that they can delivery funding over a sustained period of time and maximise the capacity of programs to make a real, long-term difference to the lives of individuals.

#### **Recommendation 25 – Short-term funding of Primary Health Networks**

The committee recommends that the Australian Government reviews the current short-term funding model for Primary Health Networks to ensure programs can be delivered over a sustained period of time to maximise their capacity to make a real, long-term difference to the lives of individuals.

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<sup>707</sup> Submission 69, p 28.

<sup>708</sup> Submission 30, p 2.

## 6 Private health care system

As outlined in Chapter 2 of this report, Australia's health care system is a blend of private and public services which are delivered by a range of health practitioners.

### 6.1 MBS funding of private specialist care and diagnostic services

The Australian Government advised that it continues to make a significant contribution under the MBS to private specialist care and diagnostic services in Queensland. The Australian Government stated that, in 2020-21, there were:

- 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)
- 6.5 million diagnostic imaging services, for which almost \$1 billion in benefits were paid (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 (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).<sup>709</sup>

### 6.2 Private health insurance

The Australian Government also supports people to take out private health insurance through tax rebates, supporting access to private hospital services (hospital treatment policies) and subsidised access to private allied health and other preventive care service (general treatment policies).<sup>710</sup>

Private health insurance is intended to allow people to access health services quicker than if they were to use the public health system,<sup>711</sup> and to cover the cost of services that Medicare generally does not offer.<sup>712</sup>

Private health insurance includes one, or both, of the following types of insurance:

- hospital insurance – this covers the cost of in-hospital treatment and other hospital costs, such as accommodation and theatre fees, in either public or private facilities
- general treatment (or 'extras') cover – generally for non-hospital medical services that are not usually covered by Medicare, such as dental, optical and physiotherapy.<sup>713</sup>

As discussed in sections 2.3 and 2.4, the Australian Government incentivises private health insurance take-up through:

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<sup>709</sup> Submission 75, p 5.

<sup>710</sup> Submission 75, p 5.

<sup>711</sup> Australian Government, Healthdirect Australia, 'The public and private hospital systems', December 2017, <https://www.healthdirect.gov.au/understanding-the-public-and-private-hospital-systems>.

<sup>712</sup> Australian Government, Australian Competition & Consumer Commission, 'Private health insurance', <https://www.accc.gov.au/consumers/health-home-travel/private-health-insurance#private-health-insurance-for-consumers>.

<sup>713</sup> Australian Government, AIHW, 'Australia's health 2020: in brief', <https://www.aihw.gov.au/getmedia/2aa9f51b-dbd6-4d56-8dd4-06a10ba7cae8/aihw-aus-232.pdf.aspx?inline=true>, p 35.

- the MLS – paid if a person earns above a certain income and does not have the appropriate level of private hospital insurance<sup>714</sup>
- LHC – people who have not taken out and maintained private patient hospital cover from the year they turn 31 pay a 2 per cent LHC loading on top of their premium for every year they are aged over 30, if they decide to take out hospital cover later in life<sup>715</sup>
- contributing to people’s private health insurance premiums. This contribution is income tested, which means people on higher incomes may have a reduced rebate entitlement, or may not be entitled to a rebate.<sup>716</sup>

The *Private Health Insurance Act 2007* (Cth) sets out the requirements for private health insurance and health insurers. The Private Health Insurance Rules provide more detail about private health insurance.<sup>717</sup>

Increases to private health insurance premiums can occur once a year, typically from 1 April. The Australian Government must approve increases before they can take effect.<sup>718</sup>

### 6.2.1 Community support principle and risk equalisation

Private health insurance in Australia is governed by the principle of ‘community rating’. This is different to most other types of insurance, such as life insurance, which are ‘risk rated’.<sup>719</sup>

Community rating requires that health insurers cannot refuse to provide health insurance cover to any individual, and must charge the same premium to each consumer for the same product in the same state for the same category of membership,<sup>720</sup> with the exception of LHC and limited discount

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<sup>714</sup> Australian Government, Services Australia, ‘Medicare and tax’, December 2021, <https://www.servicesaustralia.gov.au/medicare-and-tax?context=60092>.

<sup>715</sup> Australian Government, Australian Tax Office, ‘Lifetime health cover’, July 2021, <https://www.ato.gov.au/Individuals/Medicare-and-private-health-insurance/Private-health-insurance-rebate/Lifetime-health-cover/>.

<sup>716</sup> Australian Government, Australian Tax Office, ‘Private health insurance rebate’, June 2021, <https://www.ato.gov.au/individuals/medicare-and-private-health-insurance/private-health-insurance-rebate/>.

<sup>717</sup> Australian Government, Department of Health, ‘Private health insurance laws’, October 2020, <https://www.health.gov.au/health-topics/private-health-insurance/about-private-health-insurance/private-health-insurance-laws>.

<sup>718</sup> Australian Government, Department of Health, ‘Apply to increase private health insurance premiums’, December 2021, <https://www.health.gov.au/health-topics/private-health-insurance/operating-rules-for-private-health-insurers-and-providers/apply-to-increase-private-health-insurance-premiums>.

<sup>719</sup> Australian Government, Department of Health, Risk Equalisation Working Group, ‘Risk Equalisation Working Group Report to the private health Ministerial advisory committee, p 3, <https://www.health.gov.au/sites/default/files/documents/2021/12/foi-request-2712-release-documents-agendas-and-attached-documents-meetings-of-phmac-subcommittees-and-working-groups-between-september-2016-december-2018-foi-2712-report-risk-equalisation-wg-report-to-the-phmac.pdf>.

<sup>720</sup> Such as single people, couples, single parents and families.

provisions. This means that health insurers cannot set premiums to discriminate on the basis of age,<sup>721</sup> gender, health status or other factors.<sup>722</sup>

The effect of this is that people who place a minimal burden on their private health fund place pay the same as people who place a relatively high burden on their private health fund. The former group 'cross subsidises' the latter group.<sup>723</sup>

The committee notes that this cross subsidy can have implications on the composition of the private health insurance industry's customer base. It may lead to customers who use their insurance infrequently, and are relatively cheap to serve, to conclude they are not getting adequate value from their cover. Such customers may then end their private health insurance cover, or choose a less comprehensive private health insurance policy.

If relatively cheap to serve customers choose to end their private health insurance, this will not materially impact the cost of insuring the customer base. However, it will mean there are fewer customers to share this cost, placing upward pressure on insurance premiums.<sup>724</sup>

Some commentators consider that such changes in the composition of the private health insurance customer base have occurred in recent years, with fewer younger people taking out private health insurance.<sup>725</sup>

### 6.2.2 Private health insurance tiers

In April 2020, the Australian Government made it mandatory for hospital insurance to be categorised into four tiers – gold, silver, bronze or basic – with gold offering the most comprehensive coverage and basic the least.<sup>726</sup> Consumers can also purchase basic plus, bronze plus and silver plus private health insurance, which offer coverage above the minimum required for the tier.<sup>727</sup>

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<sup>721</sup> Other than age of entry for LHC purposes.

<sup>722</sup> Australian Government, Department of Health, Risk Equalisation Working Group, 'Risk Equalisation Working Group Report to the private health Ministerial advisory committee, p 3, <https://www.health.gov.au/sites/default/files/documents/2021/12/foi-request-2712-release-documents-agendas-and-attached-documents-meetings-of-phmac-subcommittees-and-working-groups-between-september-2016-december-2018-foi-2712-report-risk-equalisation-wg-report-to-the-phmac.pdf>.

<sup>723</sup> Grattan Institute, 'Stopping the death spiral: Creating a future for private health', May 2021, p 8, <https://grattan.edu.au/wp-content/uploads/2021/05/Stopping-the-Death-Spiral-Grattan-Report-1.pdf>.

<sup>724</sup> J Reid et al, 'Risk Equalization, Time to think differently?', Actuaries Institute, 2017, p 7, <https://actuaries.asn.au/Library/Events/SUM/2017/SUM17ReidEtAlPaper.pdf>.

<sup>725</sup> See for example: Grattan Institute, 'Private health insurance death spiral continues', August 2021, p 8, <https://grattan.edu.au/news/private-health-insurance-death-spiral-continues/>.

<sup>726</sup> Australian Government, Commonwealth Ombudsman, Private Health Insurance, 'Product tiers', [https://www.privatehealth.gov.au/health\\_insurance/howitworks/producttiers.htm](https://www.privatehealth.gov.au/health_insurance/howitworks/producttiers.htm).

<sup>727</sup> Australian Government, Department of Health, 'Private health insurance reforms – Gold, Silver, Bronze, Basic product tiers – campaign fact sheet', February 2019, [https://www.health.gov.au/sites/default/files/private-health-insurance-reforms-gold-silver-bronze-basic-product-tiers-campaign-fact-sheet\\_1.pdf](https://www.health.gov.au/sites/default/files/private-health-insurance-reforms-gold-silver-bronze-basic-product-tiers-campaign-fact-sheet_1.pdf).

Basic private health insurance has more ‘exclusions’ – where customers agree not to be covered for certain services – than the higher tiers.<sup>728</sup>

As discussed in section 2.4, it has been stated that in recent years, some people with private health insurance have downgraded their level of insurance, which has an adverse impact on the public health system.

### 6.3 Accessibility and availability of private health insurance

A study by the Grattan Institute has found that Australians are dissatisfied with private health insurance.

The committee notes that premiums are rising and consumers are dropping their cover, especially younger people, who are less likely to need health services. The Grattan Institute study found that those who are left are more likely to use services, driving insurance costs up further. It also found that Government subsidies and financial penalties to encourage people to take out private insurance are becoming less effective.<sup>729</sup>

#### 6.3.1 Demand for private health insurance

At June 2019, 11.2 million Australians (44 per cent of the population) had some form of private patient hospital cover, and 13.6 million (53 per cent) had some form of general treatment cover.<sup>730</sup> The Australian Government advised that, as at 30 September 2021:

- 2.1 million people in Queensland were covered by hospital insurance policies, representing 41.0 per cent of the Queensland population, compared to 44.7 per cent of the total Australian population covered by hospital insurance policies
- 2.5 million people in Queensland were covered by general treatment policies, representing 47.9 per cent of the Queensland population, compared to 54.5 per cent of the total Australian population covered by general treatment policies.<sup>731</sup>

The Australian Government stated that:

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.<sup>732</sup>

Figure 10 illustrates the percentage of people living in Queensland with hospital insurance and general treatment insurance from the June 1989 quarter to the September 2021 quarter.

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<sup>728</sup> Australian Government, Commonwealth Ombudsman, ‘What are exclusions and restrictions?’, <https://www.ombudsman.gov.au/publications/brochures-and-fact-sheets/factsheets/all-fact-sheets/phio/policy-exclusions-and-restrictions>.

<sup>729</sup> The Grattan Institute, *The history and purposes of private health insurance*, July 2019, Stephen Duckett and Kristina Nemet <https://grattan.edu.au/wp-content/uploads/2019/07/190715-WP-The-history-and-purposes-of-private-health-insurance-ISBN-Updated.pdf>.

<sup>730</sup> Australian Government, AIHW, *Australia’s health in brief 2020*, p 37.

<sup>731</sup> Submission 75, p 22.

<sup>732</sup> Submission 75, p 22.

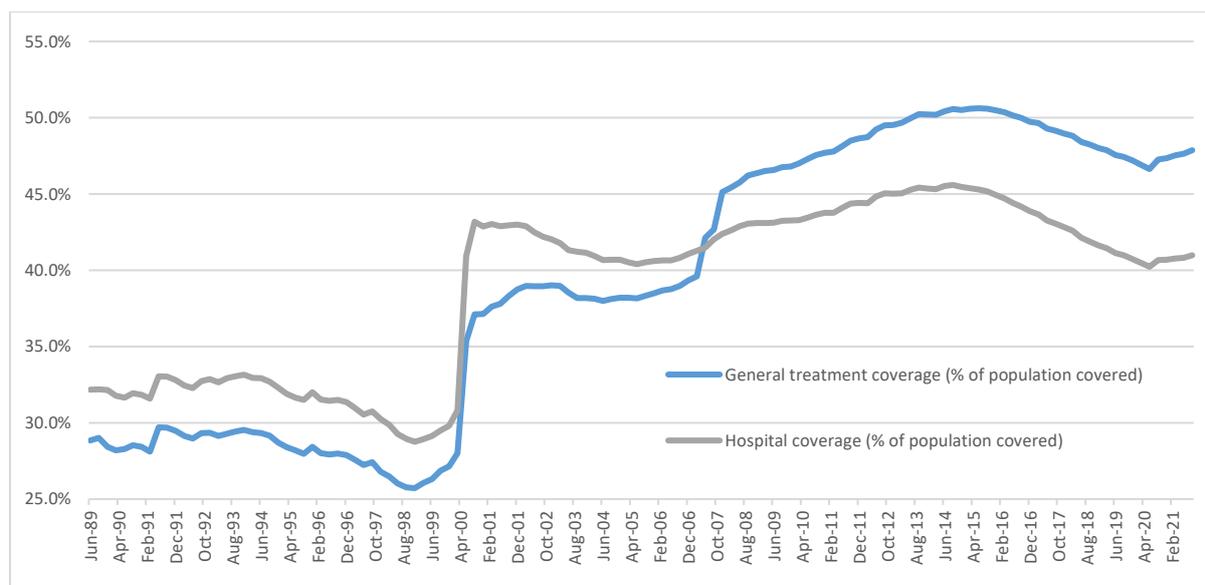


Figure 10 - proportion of people in Queensland with private health insurance, June quarter 1989 - September quarter 2021, source data from the Australian Regulation Authority<sup>733</sup>

Figure 10 shows sharp rises in the proportion of people in Queensland with general and hospital insurance around the April 2000 quarter.

The introduction of LHC on 1 July 2000 may have impacted the number of people taking out private health insurance. The Australian Prudential Regulation Authority notes that the introduction of the *Private Health Insurance Act 2007* (Cth) caused an artificial increase in the number of people purchasing general treatment insurance and a decrease in hospital insurance as a result of changes in definitions and reclassification of policies, although does not state which quarters' data would have been impacted as a result.<sup>734</sup>

Figure 11 shows the number of people in Queensland with general treatment insurance and hospital insurance from the September quarter 2002 to the September quarter 2021, broken down by age.

Figure 11 shows a clear increase in the uptake of health insurance among older Queenslanders. For the other age groups, take-up of general and hospital cover peaked in around 2015 and then steadily fell until around the June quarter 2020, after which take-up of both types of cover in people aged 30 and under and people aged 30 to 59 increased.

<sup>733</sup> Australian Prudential Regulation Authority, Quarterly private health insurance statistics, Statistical trends in membership and benefits, 'Quarterly Private Health Insurance Membership Trends September 2021' (downloadable Excel file), November 2021.

<sup>734</sup> Australian Prudential Regulation Authority, Quarterly private health insurance statistics, Statistical trends in membership and benefits, 'Quarterly Private Health Insurance Membership Trends September 2021' (downloadable Excel file), tab 'Notes on Statistics', November 2021.

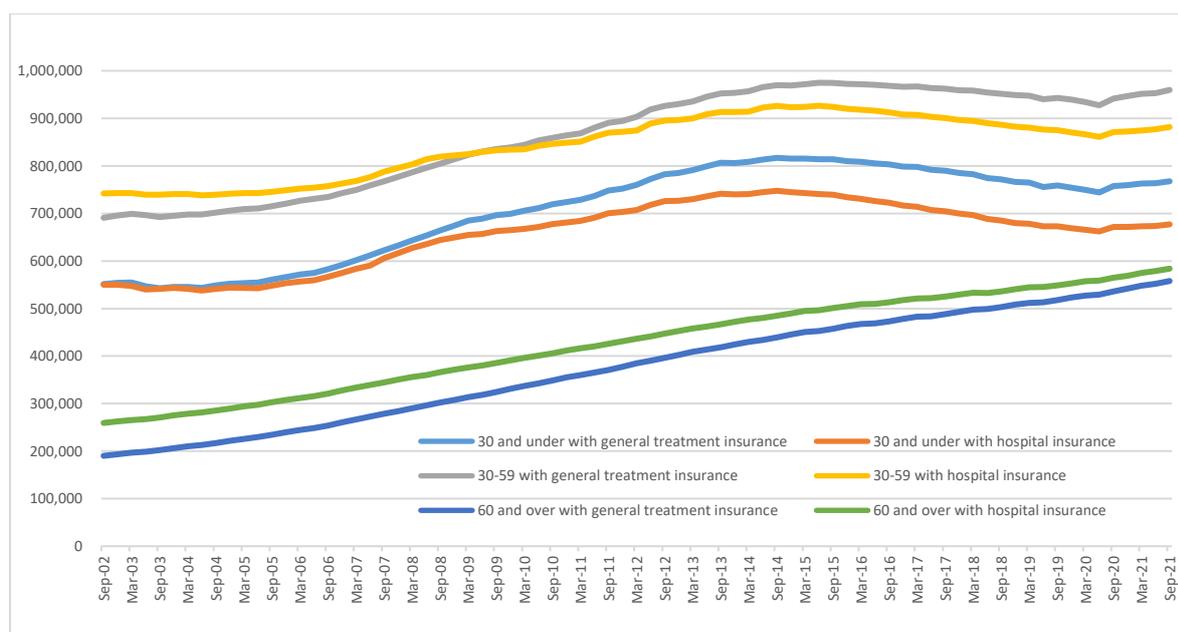


Figure 11 - People in Queensland with general treatment insurance and hospital insurance, September quarter 2002 - September quarter 2021, source data from the Australian Prudential Regulation Authority<sup>735</sup>

Queensland Health advised that across Queensland the level of private health insurance coverage is near the lowest levels seen in the past 20 years.

The committee were advised that there are now more Queenslanders without some form of hospital insurance than at any other period, with 3.1 million Queenslanders uninsured. Moreover, less than 40 per cent of all insured persons now have a policy which covers all hospital admissions and more than 85 per cent have a policy requiring co-payments – increasing reliance on the public system.<sup>736</sup>

### 6.3.2 Increase in ‘junk policies’

Some commentators questioned the usefulness of basic private health insurance. Before the introduction of the gold, silver, bronze and basic tiers of private health insurance, AMA called for an end to ‘junk’ policies, which it defined as ‘policies that are designed to avoid the Medicare surcharge, but which do not clearly explain that they are limited to low levels of coverage’.<sup>737</sup>

More recently, Catholic Health Australia (CHA) also stated some customers purchase basic, or junk, private health insurance to avoid paying the MLS, and that such customers are often treated in public hospitals because the number of services covered by junk policies is limited.<sup>738</sup> CHA stated that junk

<sup>735</sup> Australian Prudential Regulation Authority, Quarterly private health insurance statistics, ‘Statistical trends in membership and benefits’, ‘Quarterly Private Health Insurance Membership Trends September 2021’ (downloadable Excel file), November 2021.

<sup>736</sup> Queensland Health, submission 39, p 17.

<sup>737</sup> Australian Medical Association, ‘AMA Private Health Insurance Report Card 2018’, March 2018, p 1, [https://www.ama.com.au/sites/default/files/documents/AMA\\_Private\\_Health\\_Insurance\\_Report\\_Card\\_2018.pdf](https://www.ama.com.au/sites/default/files/documents/AMA_Private_Health_Insurance_Report_Card_2018.pdf).

<sup>738</sup> Catholic Health Australia, ‘Stop incentivising wasteful ‘junk’ health insurance policies’, 13 February 2022, <http://www.cha.org.au/home/cha-calls-on-the-government-to-stop-incentivising-wasteful-junk-health-insurance-policies/>.

policies represent more than one in 10 of all policies across Australia, and since 2015 the proportion of all private health insurance policies with exclusions in place has grown from one third to nearly two thirds.<sup>739</sup>

The Grattan Institute also highlighted the importance of considering the tier of private health insurance people take out, stating that most customers do not have gold tier, meaning people with lower tiers of insurance would need to use the public health system for medical services for services not covered by their private health insurance, such as maternity services and joint replacements.<sup>740</sup>

As outlined in Chapter 4 of this report, the decrease in private health insurance coverage has had a significant, adverse impact on the Queensland public health system.

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<sup>739</sup> Catholic Health Australia, 'Stop incentivising wasteful 'junk' health insurance policies', 13 February 2022, <http://www.cha.org.au/home/cha-calls-on-the-government-to-stop-incentivising-wasteful-junk-health-insurance-policies/>.

<sup>740</sup> Grattan Institute, 'Why young people dropping private health hurts insurers most, not public hospitals', February 2020, <https://grattan.edu.au/news/why-young-people-dropping-private-health-hurts-insurers-most-not-public-hospitals/>.

## 7 Aged care

As highlighted in section 3.2 of this report, Queenslanders are living longer than ever before, often with an increased burden of disease and complex healthcare needs.

The Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee (HCDSDFVP Committee), in its *Report No. 33, 56th Parliament - Aged care, End-of-life and Palliative Care*, recognised that this increase in the number of Queenslanders living to an older age will mean a significant increase in both demand for, and spending on, aged care and health care services.<sup>741</sup>

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

Aged care refers to services available to older people who are unable to live independently without assistance due to frailty, physical/mental disability or other age-related conditions and ranges from low-level support to more intensive services in their homes, community or residential aged care settings.<sup>742</sup> Aged care includes:

- assistance with everyday living activities, eg cleaning, laundry, shopping, meals and social participation
- respite
- equipment and home modifications
- personal care, eg help getting dressed and eating
- health care, including nursing and allied health care
- accommodation.<sup>743</sup>

Other aged care programs provide short-term or intermittent services (such as assistance in the transition from hospital to home); targeted care to people with specific needs (including dementia); and targeted care to particular population groups.<sup>744</sup>

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<sup>741</sup> Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, *Report No. 33, 56th Parliament – Aged care, end-of-life and palliative care*, March 2020, p 8.

<sup>742</sup> Productivity Commission, *Caring for Older Australians*, Report No. 53, 2011, Vol 1, p 4; Royal Commission into Aged Care Quality and Safety, *Navigating the maze: an overview of Australia's current aged care system*, Background Paper 1, February 2019, p 7; Royal Commission into Aged Care Quality and Safety, *A summary of the final report*, p 62: <https://agedcare.royalcommission.gov.au/sites/default/files/2021-03/final-report-executive-summary.pdf>.

<sup>743</sup> Royal Commission into Aged Care Quality and Safety, *A summary of the final report*, p 62: <https://agedcare.royalcommission.gov.au/sites/default/files/2021-03/final-report-executive-summary.pdf>.

<sup>744</sup> Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, *Report No. 33, 56th Parliament – Aged care, end-of-life and palliative care*, March 2020, p 15; Royal Commission into Aged Care Quality and Safety, *A summary of the final report*, p 62: <https://agedcare.royalcommission.gov.au/sites/default/files/2021-03/final-report-executive-summary.pdf>.

The Australian Government has three main levels of subsidised aged care services:

- home support – mainly through the Australian Government Home Support Program
- home care packages – designed for people with more complex care needs that go beyond what the Australian Government Home Support Program can provide
- residential aged care – for senior Australians who can no longer live independently at home.<sup>745</sup>

## 7.1 Royal Commission into Aged Care Quality and Safety

The Royal Commission into Aged Care Quality and Safety (Royal Commission) was highly critical of the aged care system throughout its inquiry, which concluded in March 2021 with the release of its final report: *Care, Dignity and Respect*.

### 7.1.1 Royal Commission – interim report *Neglect*

The Royal Commission, in its interim report, *Neglect*, identified areas requiring immediate action:

- to provide more home care packages to reduce the waiting list for higher level care at home
- to respond to the significant over-reliance on chemical restraint in aged care, including through the seventh Community Pharmacy Agreement
- to stop the flow of younger people with disability going into aged care, and expediting the process of getting those younger people who are already in aged care out.<sup>746</sup>

The Australian Government responded to the interim report, advising it would deliver a \$537 million funding package across the identified three priority areas, including:

- investing \$496.3 million for an additional 10,000 home care packages
- providing \$25.5 million to improve medication management programs to reduce the use of medication as a chemical restraint on aged care residents and at home, and new restrictions and education for prescribers on the use of medication as a chemical restraint
- delivering \$10.0 million for additional dementia training and support for aged care workers and providers, including to reduce the use of chemical restraint
- investing \$4.7 million to help meet new targets to remove younger people with disabilities from residential aged care.<sup>747</sup>

### 7.1.2 Royal Commission – final report *Care, Dignity and Respect*

The Royal Commission's final report, *Care, Dignity and Respect* revealed systemic failures in funding, regulation, workforce planning and risk management in the aged care sector. The Royal Commission summarised the systemic problems found in the aged care system as follows:

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<sup>745</sup> Australian Government, 'My aged care, types of care', <https://www.myagedcare.gov.au/types-care>.

<sup>746</sup> Royal Commission into Aged Care Quality and Safety, Interim Report: *Neglect*, Volume 1, p 10, 31 October 2019, <https://agedcare.royalcommission.gov.au/publications/Documents/interim-report/interim-reportvolume-1.pdf>.

<sup>747</sup> The Hon Scott Morrison MP, Prime Minister of Australia, 'Response to Aged Care Royal Commission Interim Report', media release, 25 November 2019, <https://www.pm.gov.au/media/response-aged-care-royalcommission-interim-report>.

Systemic problems are serious and recurrent issues that stem from problems inherent in the design and operation of the aged care system. They may be funding, policy, cultural or operational issues. These systemic problems are interconnected. None of them exist in isolation and they often have a compounding effect on the quality and accessibility of aged care.

The systemic problems we have identified include inadequate funding, variable provider governance and behaviour, absence of system leadership and governance, and poor access to health care.

The common characteristic of these problems is that, in our view, they are problems that significantly and repeatedly contribute to the aged care system not providing consistently high quality care to the people who need it. The purpose of identifying the systemic problems is to inform an understanding of how the aged care system should be redesigned to ensure it provides high quality care in the future.<sup>748</sup>

Some of the key findings of the Royal Commission in relation to systemic problems in the aged care sector include:

- the aged care system is difficult to access and navigate
- people find it difficult to make informed decisions about aged care services from the information available
- there are many problems with accessing aged care services, particularly home care, respite care and allied health care
- aged care services are not always meeting the needs of disadvantaged groups of people, as well as people living in remote, regional and rural Australia
- Aboriginal and Torres Strait Islander people do not access aged care at a rate commensurate with their level of need
- problems may also arise when a person's access to quality aged care is dependent on their access to another government-subsidised system, including the NDIS
- people receiving aged care, particularly those in residential aged care, do not consistently receive the health care they need
- many stories of substandard care being provided
- funding for aged care is insufficient, insecure, and subject to the fiscal priorities of the Australian Government of the day
- the Australian Government has undertaken little active management or shaping of the market for aged care services, which has impacted risk management and allowed the network of providers to become more concentrated over the last decade, with a significant expansion in very large providers and home care providers and limited scrutiny applied to their suitability
- many missed opportunities in research and innovation in the aged care sector.

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<sup>748</sup> Royal Commission into Aged Care Quality and Safety, *A summary of the final report*, p 73: <https://agedcare.royalcommission.gov.au/sites/default/files/2021-03/final-report-executive-summary.pdf>.

The Royal Commission's final report called for a significant and ongoing funding increase and transformational reform to improve Australia's aged care system, estimating that in 2018-19 the sector was underfunded by approximately \$10 billion.<sup>749</sup>

### 7.1.3 Australian Government's response

In response to the Royal Commission report, the Australian Government stated that it would invest \$17.7 billion over 5 years as part of the 2021-22 Budget. This includes \$7.8 billion for residential aged care services and sustainability reform.<sup>750</sup>

The Australian Government also allocated \$14.2 million over 4 years to support the review and enhancement of the Aged Care Quality Standards. The Australian 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
- transfer responsibility for setting the clinical components of the Quality Standards to the Australian Commission on Safety and Quality in Health and Aged Care from 1 July 2021.<sup>751</sup>

The Australian Government's response to the Royal Commission's final report also 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.<sup>752</sup>

The Australian Government will also invest \$630.2 million to make the aged care system more accessible for senior Australians with specific needs. This includes for 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.<sup>753</sup>

During this committee's Inquiry, Queensland Health raised concerns about the ability of the funding committed by the Australian Government to build a sustainable aged care sector or deliver the improvements that were envisaged by the Royal Commission and expected by stakeholders.<sup>754</sup>

The committee also heard that due to continuing issues in relation to accessing quality aged care, older people were instead turning to Queensland's public health system for care.

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<sup>749</sup> Royal Commission into Aged Care Quality and Safety, *A summary of the final report*: <https://agedcare.royalcommission.gov.au/sites/default/files/2021-03/final-report-executive-summary.pdf>.

<sup>750</sup> Submission 75, p 4.

<sup>751</sup> Submission 75, p 14.

<sup>752</sup> Submission 75, p 11.

<sup>753</sup> Submission 75, p 15.

<sup>754</sup> Submission 39, pp 18-19.

## **7.2 Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Report No. 33, 56th Parliament – Aged care, End-of-life and Palliative Care**

On 24 March 2020, the HCDSDFVP Committee tabled its Aged care, End-of-life and Palliative Care report, which included the findings of its extensive inquiry into aged care between 2018 and 2020.

A significant number of the HCDSDFVP Committee’s findings and recommendations related to the impact that failings and service gaps in the aged care sector had on the Queensland public health system and are, therefore, relevant to this Inquiry. In summary, the Aged care, End-of-life and Palliative Care report identified issues in the following areas:

- funding and interface between aged and health care services
- interface between the aged care system and public health systems
- interface between hospitals and RACFs
- barriers to accessing GPs, specialists and allied health professions in RACFs
- issues with accessing and navigating the aged care system
- the lack of home support and delays in receiving home care packages
- issues with RACFs, including inadequate staffing levels and the quality of personal care
- the aged care workforce.<sup>755</sup>

### Committee comment

The committee notes that the Aged care, End-of-life and Palliative Care report made 77 recommendations, a significant number of which were addressed to the Australian Government in relation to the aged care system.

The committee notes that, to date, the Australian Government has not formally responded to any of these important recommendations. These recommendations were based on over two years of work and the extensive testimony and personal stories of Queenslanders and expert evidence of professionals.

The committee considers that if these recommendations were acted upon, in a timely manner, a number of the recent tragic issues relating to aged care could have been avoided.

The committee has made a number of recommendations in this report (recommendations 27 to 30) calling on the Australian Government to act upon, and respond urgently, to the HCDSDFVP Committee’s recommendations, which if implemented would improve the aged care system, enhance the health and lifestyle of older people and reduce the burden on the public health system.

The committee also recommends that the Queensland Government provide a progress update on the implementation of recommendations contained in the HCDSDFVP Committee’s Aged care, End-of-life and Palliative Care report.

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<sup>755</sup> Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, *Report No. 33, 56<sup>th</sup> Parliament – Aged care, end-of-life and palliative care*, March 2020.

**Recommendation 26 – Queensland Government to provide a progress update on implementation of recommendations**

The committee recommends that the Queensland Government provides a progress update on the implementation of recommendations contained in the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Report No. 33, 56th Parliament – Aged care, End-of-life and Palliative Care report.

### **7.3 Accessibility and availability of aged care services**

In 2019-20, a total of 291,880 people in Queensland received aged care services, including home care or residential aged care. There are approximately 42,000 operational places in over 500 RACFs – public and private – in Queensland.<sup>756</sup>

The Australian Government advised that, 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.<sup>757</sup>

The committee notes that Queensland Health is an approved provider for delivering aged care and operates 16 RACFs across Queensland, mostly in larger population centres. It also operates a further 35 Multi-Purpose Health Services located in rural and remote areas. Queensland Health provides a total of 1,413 places, representing 3.3 per cent of the Queensland market. These facilities range from relatively recent purpose-built facilities to older facilities that have been converted from old hospitals.<sup>758</sup>

Queensland Health advised that an unsustainable, underfunded and fragile aged care sector reduces the health and wellbeing of older people and increases the risk of them moving into the acute hospital system. According to Queensland Health, it is being directly impacted by many of the issues highlighted in the Royal Commission’s final report, including:

- lack of primary and allied health services in RACFs
- significant workforce pressures and challenges, including recruitment, retention and skills shortages in aged care
- avoidable admissions due to delays in accessing Australian Government-funded home care packages
- long-stay older patients experiencing hospital discharge delays
- acting as the provider of last resort where there are business continuity failures.<sup>759</sup>

AMA’s *Putting health care back into aged care* report attributes the increased demand placed on hospitals on the failure to manage the health of residents in aged care facilities, including:

- a lack of access to GPs
- insufficient registered nurses employed in aged care facilities.

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<sup>756</sup> Queensland Health, submission 39, pp 18-19.

<sup>757</sup> Submission 75, p 11.

<sup>758</sup> Submission 39, pp 18-19.

<sup>759</sup> Submission 39, p 19.

AMA noted the resultant tendency of aged care providers to transfer to hospital many residents whose conditions could be treated by a nurse or GP onsite if one was available.<sup>760</sup>

Below are submitters' and witnesses' key issues in relation to aged care services, which reflect many of the key findings of the HCDSDFVP Committee in its Aged care, End-of-life and Palliative Care report.

### **7.3.1 Access to general practitioners in residential aged care facilities**

Several HHSs, as well as other submitters and witnesses, raised concerns about the lack of GPs who are willing to visit RACFs.<sup>761</sup>

The Council on the Ageing Queensland (COTA Queensland) stated that 'less than one in five GPs has worked in aged care facilities in the past month (approximately in the November 2021 period), and 56% of those GPs said they were unlikely to wish to work in this environment'.<sup>762</sup>

QRRPHN highlighted that RACFs in regional, rural and remote areas were often serviced by a sole GP, '... placing them at considerable risk if the GP's circumstances change and they are no longer able to provide those services'.<sup>763</sup> QRRPHN provided the example of the current situation in Townsville, where a sole GP servicing 650 RACFs patients ended those arrangements, leaving the patients without access to GP services.<sup>764</sup>

The committee notes that GPs visiting RACFs are eligible for a call-out fee of \$57.25 for the first patient seen on a RACF visit. Once a call-out item is billed, GPs may then bill an attendance item for each patient they see. These are \$17.90 for the most straightforward matters, \$39.10 for standard appointments lasting less than 20 minutes, \$75.75 for appointments lasting more than 20 minutes and \$111.50 for appointments lasting more than 40 minutes.<sup>765</sup>

RACGP has argued that these fees do not provide sufficient incentive for GPs to visit RACFs. This reflects factors such as:

- the time to travel to the facility and get patients into a private situation to undertake a consultation
- the fact that many patients have chronic conditions and co-morbidities and the additional time required to take a medical history and examine frail and elderly patients compared to seeing patients in the GP's consultation rooms.<sup>766</sup>

Queensland Health stated that these issues are evident in the difficulty that patients in many facilities have in accessing GP services. For instance, some RACFs in Brisbane, Sunshine Coast, Townsville and Cairns, as well as other locations, rely on telehealth to provide GP services to aged care facility

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<sup>760</sup> AMA, *Putting health care back into aged care*, 2021.

<sup>761</sup> Submissions 25, 36, 39, 48 and 65; public hearing transcripts: Logan, 10 February 2022, p 2; Brisbane, 11 February 2022, p 25; Bundaberg, 2 March 2022, p 22, Rockhampton, 23 March 2022, p 6.

<sup>762</sup> Submission 48, p 19; RACGP, *General Practice Health of the Nation 2021*.

<sup>763</sup> Submission 70, p 5.

<sup>764</sup> Submission 70, p 5.

<sup>765</sup> Queensland Health, submission 39, p 19.

<sup>766</sup> As referenced by Queensland Health, submission 39, p 19.

residents. Queensland Health considered that this is unlikely to deliver the standard of care required for older people.<sup>767</sup>

Dr Jackson, JCU, expressed similar views, stating:

GPs are leaving residential aged-care work in droves. The work is extraordinarily poorly remunerated and it is under-resourced. It is by its nature time consuming. Patients have complex multimorbidity, frequent communication difficulties, dementia—all occurring in an environment where basic clinical tools are frequently lacking. There is a lack of registered nurses in residential aged-care facilities. Clinical handover of any sort of patient concern is frequently from a non-clinically trained staff member. That makes remote assessment of the patient by the GP fraught with difficulty. However, trying to attend that person in person as a GP may take an hour or more of your time.<sup>768</sup>

COTA Queensland stated that GPs have indicated that they would require better remuneration via MBS item numbers for aged care, fewer administrative issues, more clinical staff in aged care settings, improved infrastructure with software, and better qualified staff to practice in aged care settings.<sup>769</sup>

Submitters noted that the lack of GP services in RACFs results in increased emergency department presentations with Queensland Health stating ‘... the lack of access to GP services reduces the scope to manage patients in facility, leading to avoidable hospital admissions’.<sup>770</sup> Dr Jackson, JCU, also commented:

GPs are not specifically funded to provide after-hours or on-call services to nursing homes. There is an ever-increasing paperwork burden associated with nursing home work which is unpaid time under the current fee-for-service structure. As a result of these issues, any non-routine problem in a nursing home frequently results in the resident being transferred to the local hospital for assessment. It is distressing to the resident and it is frequently clinically unnecessary.<sup>771</sup>

Dr Will Cairns agreed that GPs were disincentivised to work in residential aged care:

That is partly driven by the corporatisation of medicine where you are looking at hourly cash flow. You would take off and see a patient for an hour when the rebate was not really sufficient to cover the costs compared to, say, a specialist doing the same tasks for the same amount of time; they were remunerated at a much higher rate. There have been disincentives for GPs doing home care and I think the same applies to residential aged care.<sup>772</sup>

Dr Steve Salleras, JCU, spoke about both the benefits and challenges of working in RACFs as a GP:

I do not do aged care now, but I did until 2019 at the Port Douglas Ozcare aged-care facility and it was a very positive part of my world. To be honest, I think that the money it generated, with the visits themselves but also with some of the other work such as doing the annual health reviews and things, was okay. It is complicated and going into a different system with split medical records and complications with providing prescriptions and things was an additional challenge.<sup>773</sup>

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<sup>767</sup> Submission 39, p 20.

<sup>768</sup> Public hearing transcript, Bundaberg, 2 March 2022, p 22.

<sup>769</sup> Submission 48, p 19

<sup>770</sup> Submission 39, p 21.

<sup>771</sup> Public hearing transcript, Bundaberg, 2 March 2022, p 22.

<sup>772</sup> Public hearing transcript, Townsville, 9 February 2022, p 16.

<sup>773</sup> Public hearing transcript, Mossman, 8 February 2022, pp 8-9.

Mr Lentakis, UWU commented on the impact of inadequate access to GPs, not only on patients but also paramedics when complaints are made about emergency service response times:

Having adequate staffing and access to doctors is the other thing. A lot of the time they wait for the GP to turn up to decide what is going to happen with that patient, and in the meantime that patient has deteriorated to the point where the nurses cannot wait. They call us, we turn up and we transport them. Had access to medical staff been available earlier, it would have been a different story. That impacts on our staff. As clinical professionals, we turn up and we know that had we been there four or five hours earlier—in some cases, 18 hours earlier—and that is not necessarily the nursing home's fault. That is also a lack of resources that play a part in that. You can see the morale of our staff every time I have to interview somebody in relation to a complaint. They all think they are going to lose their registration or their job. The first thing they say is, 'We haven't actually done anything wrong. We got the call and we were gone within 10 minutes.' But they are not aware that call has been waiting for 18 hours.<sup>774</sup>

Queensland Health advised that HHSs have established RACF in-reach teams to partially fill the service gaps arising from the lack of GP services.<sup>775</sup> In this regard, Brisbane South PHN advised:

We initiated a pilot about three years ago that worked with Metro South to work with residential aged-care facilities to train the residential aged-care facility staff to be able to accept and work with not only people going through their last few days but also the families concerned. A third of our residential aged-care facilities participated in that pilot, and at the end of 18 months we saw a reduction from just over 40 per cent of residents in one-third of our residential aged-care facilities being admitted to hospital to just over 22 per cent. That is a significant drop. We also saw that the average length of stay in those last few days dropped from just over nine days to just under six days.<sup>776</sup>

The committee notes that a number of nurse practitioner-led models of care, eg Residential Aged Care District Assessment and Referral Service (RADAR) and the Geriatric Emergency Department Intervention (GEDI), have been established to provide outreach services to residential aged care services to reduce unnecessary hospital admissions for residents.<sup>777</sup>

In relation to GP access, AMA, in its *Putting health back into aged care report*, recommended the following steps be taken to save an estimated \$21.1 billion (between 2021 and 2025) from avoidable public and private hospital admissions, presentations and stays from older people in the community and in RACFs:<sup>778</sup>

- increase Medicare rebates for nursing home attendances by GPs by 50 per cent to compensate for the additional time and complexity involved in comparison to a GP consultation in their own rooms
- introduce MBS telehealth items for phone calls between a GP, aged care staff and relatives
- introduce a Medical Access Aged Care Quality Standard for nursing homes
- introduce Care Finders who work closely with GPs to coordinate both health and aged care services

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<sup>774</sup> Public hearing transcript, Brisbane, 21 February 2022, p 24.

<sup>775</sup> Submission 39, p 21.

<sup>776</sup> Public hearing transcript, Logan, 10 February 2022, p 7.

<sup>777</sup> Queensland Health, submission 39, p 24.

<sup>778</sup> AMA, *Putting health back into aged care*, p 9.

- introduce hospital aged care outreach teams in all HHSs, in coordination with a patient's usual GP
- ensure that Aged Care Assessment remains with State health services which involve medical specialists, coordinating and collecting information from the older person's usual GP
- ensure interoperability between GP clinical and aged care software systems, including My Aged Care and My Health Record.<sup>779</sup>

The Australian Government advised that the Practice Incentives Program (PIP) GP Aged Care Access Incentive aims to increase face-to-face GP services in RACFs and that it has committed \$42.8 million (2021-22 to 2022-23) to increase face-to-face servicing by GPs within RACFs.<sup>780</sup>

Committee comment

The committee notes the similarity of the concerns raised by submitters and witnesses regarding access to GPs for those living in RACFs to those of the HCDSDFVP Committee during its inquiry.<sup>781</sup>

This committee is of the view that older people in aged care should not lose their access to medical care when they reside in an aged care facility. The committee agrees with the HCDSDFVP Committee that the Australian Government needs to review the remuneration arrangements under the Medicare Benefits Scheme for GPs visiting residents in aged care facilities and in the community to ensure doctors are adequately compensated for their time.

In this regard, the committee also supports recommendation 3 of the HCDSDFVP Committee and calls for action in this regard:

Recommendation 3 Review of item numbers for visits by general practitioners to residential care - The committee recommends that the Australian Government review the schedule of item numbers that general practitioners, specialists and other allied health professionals can access to claim the costs of care they provide for patients, and their travel to and from residential aged care facilities or patients' homes and the formula used for calculating payment amounts. In reviewing the formula, the government should ensure the formula provides reasonable compensation for doctors and other health professionals for their time whilst removing incentives for practitioners to bulk visit facilities.<sup>782</sup>

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<sup>779</sup> AMA, *Putting health back into aged care*, p 5.

<sup>780</sup> Submission 75, p 13.

<sup>781</sup> Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, *Report No. 33, 56<sup>th</sup> Parliament – Aged care, end-of-life and palliative care*, March 2020, p 62.

<sup>782</sup> Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, *Report No. 33, 56<sup>th</sup> Parliament – Aged care, end-of-life and palliative care*, March 2020, p 62.

**Recommendation 27 – Australian Government respond to previous recommendations**

The committee recommends that the Australian Government responds to the following recommendations contained in the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Report No. 33, 56th Parliament – Aged care, End-of-life and Palliative Care:

***Recommendation 3 - Review of item numbers for visits by general practitioners to residential care***

*The committee recommends that the Australian Government review the schedule of item numbers that general practitioners, specialists and other allied health professionals can access to claim the costs of care they provide for patients, and their travel to and from residential aged care facilities or patients' homes and the formula used for calculating payment amounts. In reviewing the formula, the government should ensure the formula provides reasonable compensation for doctors and other health professionals for their time whilst removing incentives for practitioners to bulk visit facilities.*

**7.3.2 Availability of specialist medical staff and allied health professionals**

Similar to concerns regarding access to GPs, a number of submitters, including AHPA, BallyCara, AAC and ESSA, considered that access to allied health services is crucial to maintaining high quality of life and independence in aged care and reducing the incidences of hospitalisation.<sup>783</sup>

BallyCara was of the view that the ongoing feasibility of allied health services in aged care services (both RACFs and in-home) is in doubt under the Australian Government's current funding reforms.<sup>784</sup>

AAC stated that the provision of allied health services to residents in RACFs is limited to a few disciplines and for an inadequate range of services. For example, physiotherapy is only available for pain management and there is no funding available for exercise physiology.<sup>785</sup>

In expressing its concern about the lack of access to allied health care in RACFs, AAC stated that 'only 4% of residential aged care staff and contractors are allied health'.<sup>786</sup> AAC further stated that RACF residents without allied health '... have more pressure injuries, pain (and therefore pain medication and associated side effects)'. AAC continued:

This leads to more preventable hospital admissions and sadly, even deaths. Falls are the leading cause of death in older people. 37% of all deaths from injury occur from falls, with older people far more likely to die from falls, or have decreased quality of life after a fall, and an earlier death.<sup>787</sup>

AAC advised that falls cost Queensland taxpayers \$101 million a year, with around 50 per cent of the cost of falls arising from hip fractures. AAC stated that there are 10 falls a day of over 65-year olds in Queensland hospitals resulting in a fracture, which costs an average of \$15,000 per person or \$155,000 a day to treat. AAC also advised that 'physio alone has been shown to decrease falls 55% which could save up to \$55 million per year in preventable falls'.<sup>788</sup>

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<sup>783</sup> Submissions 12, 42, 52 and 61.

<sup>784</sup> Submission 12, p 3.

<sup>785</sup> Submission 12, p 3.

<sup>786</sup> Submission 52, p 8.

<sup>787</sup> Submission 52, p 3.

<sup>788</sup> Submission 52, p 3.

AAC, AHPA and ESSA considered that having allied health services in RACFs would lead to improvements in quality of life and reduce costly surgeries and hospital admissions.<sup>789</sup> AHPA contended that:

Everybody knows that the aged-care system has been a bit of a basket case for a while. One of the issues is that for many residents in aged care there is no, or very limited, access to allied health services who assist people with mobility to ensure reablement, to address falls prevention and pressure areas and malnutrition. All of those things lead to people winding up in hospital. If you fall in a residential aged-care facility and break your hip, you do not stay there; you end up in a hospital system.<sup>790</sup>

AHPA continued:

If allied health services were formally guaranteed in residential aged care, practitioners such as physiotherapists, exercise physiologists, occupational therapists, speech pathologists, podiatrists, osteopaths, social workers and music therapists could provide ageing Australians with the treatment they need. This would lead to improvements in quality of life and reduce the burden of disease, costly surgeries and hospital admissions, such as those associated with falls and musculoskeletal deterioration.<sup>791</sup>

AAC referred to the Royal Commission's findings that residents, including in Queensland, receive only 8 minutes of allied health care per resident per day.<sup>792</sup> AAC noted that 8 minutes per day per resident 'was considered inadequate by the royal commission into aged care' and that the Australian Government had agreed to significantly more allied health but did not fund it in the May 2021 budget. AAC continued:

At every point where I have raised these concerns I have been met by, 'Quality standards will look after it. Nursing homes are still accountable and need to provide physio and allied health.' I am sorry, but every nursing home I have spoken to cannot afford it, they cannot set their budgets and there is not the workforce for that. There is no point increasing compliance and penalties on nursing homes. These are some good people we work with and they want physio and allied health too. That is not under debate. What is under debate is how we are going to survive and look after our older people.<sup>793</sup>

APA stated:

With a better model where there would be more follow-up, there are also opportunities to do group classes. We would essentially bring people in who have the same injury and have a supervised group class and take a multidisciplinary approach. That would be where, as a physiotherapist, we would utilise exercise physiologists or exercise scientists to come through in a group class and then reassess. We do see that a little bit with the model that is available for veterans affairs, where a lot of the time a physiotherapist will assess the patient and prescribe an exercise program and then, in a group class setting that may be supervised by another allied health professional, they will work towards their common goals and then be reassessed with the physio.<sup>794</sup>

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<sup>789</sup> Submissions 42, 52 and 61.

<sup>790</sup> Public hearing transcript, Brisbane, 21 February 2022, p 5.

<sup>791</sup> Submission 42, p 1.

<sup>792</sup> Public hearing transcript, Bribie Island, 9 December 2021, p 19.

<sup>793</sup> Public hearing transcript, Bribie Island, 9 December 2021, p 19.

<sup>794</sup> Public hearing transcript, Brisbane, 21 February 2022, p 11.

AAC recommended that the Queensland Government lobby the Australian Government to ensure that physiotherapy and allied health is funded and mandated at 22 minutes per resident per day, as per international standards and the Royal Commission's recommendations.<sup>795</sup> AHPA stated that:

The royal commission stated in recommendation 38 that allied health should be funded as part of aged care—that it was integral to aged care and should be funded. Unfortunately, the Commonwealth government has only accepted it in principle and is looking for other ways to provide those services. MBS items are not fit for purpose for allied health services in aged care. Allied health chronic disease items are simply not fit for purpose and will not cut it. There are only five visits for all of allied health for the whole year, and that does not work in reablement. It also is reliant on GP referrals and we all know how difficult it is to get GPs into aged care, so it is a vicious cycle.<sup>796</sup>

AAC also sought separate funding from the Australian Government for physiotherapy and allied health for RACFs in the new aged care funding model (AN-ACC) from October 2022.<sup>797</sup> AAC stated:

My professional associations, OT Australia, physio associations, SARRAH and lots of groups have been saying—and I confirm this—that the federal government's decision not to separately fund physiotherapy and allied health in nursing homes will lead to the death of physiotherapy and allied health in nursing homes. I am not saying that for shock value; I am saying it because it is real. When we do not do physio on residents in nursing homes, they die. They have a fall and they come back from hospital. If they do not get moving in that first week particularly, after that unfortunately people do end up having morbidities et cetera.<sup>798</sup>

#### Committee comment

The committee notes that the Royal Commission found that levels of depression, anxiety, confusion, loneliness and suicide risk among aged care residents had increased since 2020 and called for urgent measures to prevent deterioration in their physical and mental health.

In this regard, the Royal Commission recommended the Australian Government urgently create MBS items to increase the provision of allied health services, including mental health services, to people in aged care during the pandemic.<sup>799</sup>

Similarly, the HCDSDFVP Committee in its report concluded that MBS item numbers should be available for a wide range of allied health services and specialist medical staff, including nurse practitioners and nurse navigators that are providing care of aged care recipients.

The HCDSDFVP Committee noted that better funding and incentives were required to deliver allied health services in RACFs, particularly physiotherapists.

This committee has heard similar evidence as detailed above and supports the conclusions of both the Royal Commission and the HCDSDFVP Committee during their inquiries into aged care. The HCDSDFVP Committee made a number of recommendations in this area, which this committee supports and calls on the Australian Government to respond.

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<sup>795</sup> Submission 52, pp 3-4.

<sup>796</sup> Public hearing transcript, Brisbane, 21 February 2022, pp 5-6.

<sup>797</sup> Submission 52, p 3.

<sup>798</sup> Public hearing transcript, Bribie Island, 9 December 2021, p 19.

<sup>799</sup> Royal Commission into Aged Care Quality and Safety, *A summary of the final report*, p 172: <https://agedcare.royalcommission.gov.au/sites/default/files/2021-03/final-report-executive-summary.pdf>.

**Recommendation 28 – Australian Government to respond to previous recommendations**

The committee recommends that the Australian Government responds to the following recommendations contained in the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Report No. 33, 56th Parliament – Aged care, End-of-life and Palliative Care:

***Recommendation 1 Trial of nurse practitioners***

*The committee recommends that the Australian Government allocate funding through the Primary Health Networks in Queensland to trial the use of nurse practitioners in residential aged care facilities. The trial could include expanding their scope of practice to prescribe certain medications and order certain pathology testing for residents in consultation with general practitioners.*

***Recommendation 2 Consistency of access to health services while in residential aged care***

*The committee recommends that the Australian Government in consultation with individual providers ensure that residents in residential aged care facilities enjoy the same level of access to health service providers as other elderly in their local community living outside of those facilities.*

***Recommendation 4 Care for frail elderly residents in aged care facilities***

*The committee recommends that Queensland Health examine opportunities to expand programs such as the Comprehensive Aged Residents Emergency and Partners in Assessment Care and Treatment program that focus on streamlining the care pathway for the frail elderly residents of aged care facilities.*

***Recommendation 5 Utilisation of nurse navigators in aged care to improve access to primary care***

*The committee recommends that the Queensland Government explore opportunities to better utilise nurse navigators in aged care to improve access to primary care for older people and supplement the care provided by general practitioners.*

**7.3.3 Staffing in aged care**

**7.3.3.1 Staffing levels and minimum care time**

Queensland Health advised that there are currently significant workforce pressures in the residential aged care sector.<sup>800</sup>

The committee notes that the 2016 Aged Care Census and Survey demonstrated that 63.2 per cent of RACFs reported a skill shortage in at least one direct care occupation. This varied between 55.9 per cent in major cities to 87.8 per cent in very remote areas.<sup>801</sup> Queensland Health advised that these shortages have been exacerbated by the impact of the COVID-19 pandemic, as typically 30 per cent of RACFs' workforce is sourced from the overseas migrant population.<sup>802</sup>

<sup>800</sup> Submission 39, p 21.

<sup>801</sup> Australian Government, AIHW, 'Aged Care Workforce 2016', <https://agedcare.royalcommission.gov.au/system/files/2020-06/CTH.1000.1038.0872.pdf>.

<sup>802</sup> Submission 39, p 21.

The 2020 Aged Care Workforce Census and Survey reported approximately 22,000 vacancies in direct care roles in aged care across Australia.<sup>803</sup> The 2020 survey also showed high turnover in the aged care sector, with approximately 30 to 35 per cent of workers leaving RACFs in the previous year.<sup>804</sup>

UWU noted that the Royal Commission found that 57.6 per cent of residents in RACFs have unacceptable staffing levels – defined as less than 215 minutes of total care and 30 minutes attention from a registered nurse, per resident per day.<sup>805</sup>

In response to the Royal Commission, the Australian Government is planning to introduce minimum care time requirements by October 2023. The minimum care time requirements will be an average of 200 minutes of care per resident per day, with at least 40 minutes of that care provided by a registered nurse.<sup>806</sup>

UWU considered that ‘this does not go as far as what the Royal Commission recommended, and it is too little, too late, to address the crisis of understaffing in aged care’.<sup>807</sup> UWU stated that all RACFs should be required to provide residents with enough care time to enable high quality care, suggesting that there should be an immediate increase to a minimum care time of 242 minutes per resident per day, with this increasing to at least 264 minutes by 2022.<sup>808</sup>

The committee notes that the Australian Government does not mandate staffing levels in RACFs. However, Queensland Government owned facilities do have to meet minimum standards:

Mandatory minimum Daily Resident Care Hours (DRCH) and minimum nurse and support worker skill mix ratios were introduced for public Residential Aged Care Facilities in Queensland Health in December 2019. This minimum nurse workforce legislation sets a minimum average DRCH of 3.65 hours per 24-hour period, and minimum nurse and support worker skill mix ratios of a minimum of 30% registered nurses and a maximum of 50% support workers of the total nurse workforce.<sup>809</sup>

Full compliance with the minimum nurse workforce legislation was required from February 2022.<sup>810</sup>

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<sup>803</sup> Australian Government, Department of Health, ‘2020 Aged Care Workforce Census Report’, <https://www.health.gov.au/sites/default/files/documents/2021/10/2020-aged-care-workforce-census.pdf>, p 9.

<sup>804</sup> Australian Government, Department of Health, ‘2020 Aged Care Workforce Census Report’, <https://www.health.gov.au/sites/default/files/documents/2021/10/2020-aged-care-workforce-census.pdf>, p 9.

<sup>805</sup> Submission 36, p 35.

<sup>806</sup> Australian Government, ‘Mandatory care time standards and reporting’, <https://www.health.gov.au/sites/default/files/documents/2021/05/residential-aged-care-services-and-sustainability-pillar-2-of-the-royal-commission-response-mandatory-care-time-standards-and-reporting.pdf>.

<sup>807</sup> Submission 36, p 6.

<sup>808</sup> Submission 36, p 6.

<sup>809</sup> Queensland Health, ‘HHS Statewide, Residential Aged care’, <http://www.performance.health.qld.gov.au/HospitalHealthService/AgedCareFacility/99998>.

<sup>810</sup> Queensland Health, ‘HHS Statewide, Residential Aged care’, <http://www.performance.health.qld.gov.au/HospitalHealthService/AgedCareFacility/99998>.

The committee notes that AMA supported the mandated minimum staff-to-resident ratios in nursing homes and a mandate for 24/7 on site registered nurse availability in nursing homes, and according to the level of residents' needs.<sup>811</sup>

Queensland Health noted that, despite additional funding from the Australian Government in response to the Royal Commission, the Australian Government did not mandate any increases to the salaries paid to aged care staff.<sup>812</sup>

UWU added that unattractive employment terms devalue home care work and are a disincentive to prospective employees.<sup>813</sup> Queensland Health stated that 'a lower skilled or overstretched workforce is also more likely to result in emergency department presentations as staff are unable to undertake some procedures in the facility'.<sup>814</sup>

Similarly, the Health Services Union (HSU) stated that 'when appropriate staffing levels are not maintained, public hospitals and ambulance resources must be relied on'.<sup>815</sup> HSU stated that in a survey of its members, 25 per cent reported that more than once a week they had to call ambulances or arrange for residents to be treated at hospital due to inadequate access to GPs or other health professionals.<sup>816</sup>

IMPACT Community Health Service spoke to the challenges they face relating to staffing levels:

We become frustrated by navigating the My Aged Care system, ACAT referrals in rural communities, ACAT referrals within hospitals and also the NDIS. It is our regular experience to also be unable to maintain recency of clinical practice for our staff. We have difficulty with recruitment and retention of health professionals. We become frustrated about referrals from hospital and failed discharges from hospital where there is early or inappropriate planning for discharge.<sup>817</sup>

UWU highlighted the impact on personal carers when adequate clinical support is lacking for their clients:

Our members are the personal carers who work in residential care and in-home care settings. While there might be more of them running around these facilities than there are registered and enrolled nurses, there are still not enough for them to make them feel like they are providing proper care for the people who live in those settings. The lack of clinical support that they have, when they know that people need it, is something that I am sure our colleagues from the QMNU will speak to as well. There are studies around what is safe, and half an hour of care a day for an elderly person in a care setting is not safe.<sup>818</sup>

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<sup>811</sup> AMA, *Putting health back into aged care*, p 5.

<sup>812</sup> Submission 39, p 22.

<sup>813</sup> Submission 36, p 6.

<sup>814</sup> Submission 39, p 22.

<sup>815</sup> Submission 26, p 3.

<sup>816</sup> Submission 26, p 3.

<sup>817</sup> Public hearing transcript, Bundaberg, 2 March 2022, p 17.

<sup>818</sup> Public hearing transcript, Brisbane, 21 February 2022, p 24.

QNMU maintained its concern for staffing levels, stating:

Unfortunately, we have seen in regards to improving staffing numbers in aged care that that has been kicked down the road until next year. There will be no improvement in staffing numbers until next year. There is not even going to be a commitment to one RN 24\7 until next year; it will be one RN for 16 hours a day. I do not know what is going to happen for the other eight hours a day.<sup>819</sup>

### 7.3.3.2 *Nurse-led care*

Queensland Health advised that nursing shortages are particularly acute in private RACFs. The committee notes that the private sector aged care nursing workforce is covered by the Commonwealth Aged Care Award – 2010 which does not provide the same level of salary and employment conditions as the Nurses and Midwives (Queensland Health) Award – State 2015.

Queensland Health advised that this has resulted in nursing staff seeking employment within the Queensland Health RACFs and acute care services, especially as vacancies have opened as additional nurses have been required for the COVID-19 pandemic response.<sup>820</sup>

Consequently, private RACFs are experiencing difficulties providing services due to nursing shortages, requiring Queensland Health to supplement nursing support from the HHS internal workforce and accept residents for care due to partial RACF closures.<sup>821</sup>

The Cancer Council Queensland also noted the large migration of nurses leaving community and residential aged care positions to deliver COVID-19 vaccinations for Queensland Health, stating that this ‘... is causing a considerable negative impact on the ability of some community services and Residential Aged Care Facilities to meet resident needs’.<sup>822</sup>

HWQ also noted that a ‘low perceived status of practice nursing among graduates’, together with higher pay opportunities with Queensland Health, can create disincentives to attracting and retaining primary care nursing staff.<sup>823</sup>

QNMU welcomed the Queensland Government’s commitment to minimum nurse to patient/resident staffing ratios in Queensland Government-run RACFs. QNMU considered that ‘this maintains minimum aged care staffing and skill mix and reduces unwarranted variation in service safety and quality in aged care’.<sup>824</sup> However, QNMU considered that privately owned RACFs not having mandated minimum ratios in place continues to diminish and deny the health care needs of those who live in those facilities. In this regard, QNMU advocated for nurse-to-patient ratios in all RACFs.<sup>825</sup>

ACN noted that personal care workers make up 70 per cent of the aged care workforce. ACN considered that this contributes to a poorer skill-mix, where fewer hours of care are provided by skilled

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<sup>819</sup> Public hearing transcript, Brisbane, 8 December 2021, p 8.

<sup>820</sup> Submission 39, p 34.

<sup>821</sup> Submission 39, p 34.

<sup>822</sup> Submission 40, p 3.

<sup>823</sup> Submission 25, p 1.

<sup>824</sup> Submission 69, p 17.

<sup>825</sup> Submission 69, p 17.

registered nurses.<sup>826</sup> ACN stated that this places residents at risk of 'sub-optimal care' and results in 'poor patient outcomes'.<sup>827</sup> QNMU agreed, stating:

... the current residential aged care workforce, comprised primarily of unregulated care workers, lacks the training and skills needed to adequately meet the care needs of this special needs group. The situation is compounded by the overall decreasing number of RNs and ENs employed in aged care which is resulting in the de-skilling of the workforce. Missed care due to inadequate staffing and skill mix means that residents are not receiving basic care needs in a timely manner putting them at greater risk of falls, pressure injuries and nutrition deficits.<sup>828</sup>

The committee notes AMA's recommendation for a mandated minimum qualification for personal care workers that includes basic health care, and continuous training of the aged care workforce with specific funding attached for training.<sup>829</sup>

UWU noted that it is not uncommon for there to be no nursing staff working overnight at private RACFs, which results in basic health care measures, such as changing a cannula, needing to be dealt with either by paramedics or transport to hospital.<sup>830</sup> Shan Cram, a QNMU member, advised that:

Residents are brought to the hospital at Mossman. It has happened for years. Even when I was an RN in the ED department, you would have people with dementia being transferred from Ozcare in Port Douglas because there was not a registered nurse on duty. That has a major impact on those residents. They become very distressed. As a nurse of 36 years, I get distressed because dementia and dementia care itself is a specialised area of nursing. People think dementia is dementia. It is not; it is very complicated. You need very experienced, qualified nurses to deal with patients with dementia.<sup>831</sup>

ACN continues to advocate for the implementation of the Royal Commission's recommendations that there be a focus on placing nurses back into aged care settings.<sup>832</sup>

JCU, Centre for Regional and Rural Health, commented on the importance of creating a career pipeline for the nursing workforce and the positive impact this would have on the aged care sector:

Certainly our aged-care workforce needs to be better paid, particularly the nursing workforce, in order to attract people into it. We also need to create a career pipeline. If we remunerated nurse practitioners in aged care sufficiently, there would be an aged-care nursing workforce pipeline because you cannot be a nurse practitioner unless you are an experienced aged-care nurse. That would drive a profession development pipeline into the future. I think that is one that should absolutely be explored. That could be supported by both the state and the Commonwealth.<sup>833</sup>

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<sup>826</sup> Submission 66, p 9.

<sup>827</sup> Submission 66, p 9.

<sup>828</sup> Submission 69, p 17.

<sup>829</sup> AMA, *Putting health back into aged care*, p 5.

<sup>830</sup> Submission 36, p 8.

<sup>831</sup> Public hearing transcript, Mossman, 8 February 2022, p 13.

<sup>832</sup> Submission 66, p 4.

<sup>833</sup> Public hearing transcript, Rockhampton, 3 March 2022, p 18.

QNMU stated that:

... hospital avoidance is best achieved by having the right staff with the right skills and the right support to ensure timely treatment can be provided in the residential aged care facility. This will then have the potential to reduce unnecessary harm and distress caused to residents by avoidable hospitalisations.<sup>834</sup>

To this end, QNMU recommended that the Australian Government mandate that a registered nurse must be available 24 hours a day, 7 days a week in RACFs to prevent adverse outcomes and costly hospital interventions.<sup>835</sup>

The committee notes that in its report, the HCDSDFVP Committee considered a number of workforce issues and challenges, many of which were also raised during this Inquiry, including:

- the quality of training for those entering the aged care workforce and a lack of ongoing training
- the importance of attitude as well as skills for workers
- the regulation of health care workers
- support for the Aboriginal and Torres Strait Islander workforce in aged care
- ability to attract and retain staff
- improving pay and conditions to address issues such as high staff turnover and low job satisfaction, and improve the standing of aged care as an employment option
- addressing the ageing workforce.<sup>836</sup>

#### Committee comment

The committee heard that the current workforce pressures in the residential aged care sector are impacting the level of care being provided and the welfare of staff, as well as increasing presentations to hospitals due to lack of skilled staff.

This workforce shortage is the result of several factors, including the COVID-19 pandemic due to the redeployment of nurses and the decreased intake of migrant workers; a significant portion of the workforce leaving RACFs to work in other areas; and unattractive employment terms, including pay and conditions, compared with similar roles in other areas of health care.

The committee notes that the Queensland Government has mandated staffing levels in its government-run RACFs but that privately-owned RACFs do not have to comply with this mandate. The committee acknowledges stakeholder concern about this and agrees that minimum nurse and support worker skill mix ratios and a minimum average Daily Resident Care Hours of 3.65 hours per 24-hour period are critical to providing quality care.

The committee supports the conclusions of the HCDSDFVP Committee during its inquiry into aged care that found 'there are insufficient staff and too few registered nurses in residential aged care facilities, and that this impacts on the time allocated to caring duties in residential aged care facilities'.<sup>837</sup>

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<sup>834</sup> Submission 69, p 18.

<sup>835</sup> Submission 69, p 19.

<sup>836</sup> Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, *Report No. 33, 56<sup>th</sup> Parliament – Aged care, end-of-life and palliative care*, March 2020, pp 233-246.

<sup>837</sup> Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, *Report No. 33, 56<sup>th</sup> Parliament – Aged care, end-of-life and palliative care*, March 2020, p 166.

The committee heard evidence that nursing shortages are of particular concern overnight, as well as for the care of frail residents and those with dementia. In this regard, the committee supports recommendations 20 and 21 of the HCDSDFVP Committee<sup>838</sup> and recommends that the Australian Government provide a response to these recommendations.

Similar to the HCDSDFVP Committee inquiry, the qualifications and experience of staff in residential aged care was also raised as an issue during this Inquiry.

The committee also notes stakeholder comments regarding the perceived status of nursing in the aged care sector, as well as the higher pay opportunities for nurses available in other areas of health. The committee supports the HCDSDFVP Committee's comment that 'minimum pay and conditions for workers in the industry should be raised to levels equivalent to workers in the health sector' in order to 'make the aged care industry a viable, attractive proposition to prospective employees and to aid employers to retain staff'.<sup>839</sup> In this regard, the committee supports recommendation 41 of the HCDSDFVP Committee<sup>840</sup>, and recommends that the Australian Government provides a response.

**Recommendation 29 – Australian Government to respond to previous recommendations**

The committee recommends that the Australian Government responds to the following recommendations contained in the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Report No. 33, 56th Parliament – Aged care, End-of-life and Palliative Care:

***Recommendation 20 Disclosure of staff to resident ratios at residential aged care facilities***

*The committee recommends that the Australian Government require providers to display in a public common area at each residential aged care facility the staff to resident ratios at that facility across each shift, for the information of residents, prospective residents and their representatives.*

***Recommendation 21 Publication of staff to resident ratios on the My Aged Care website***

*The committee recommends that the Australian Government require that information about residential aged care facilities that is published in the Schedule to the My Aged Care website includes staff to resident ratios at each of those facilities.*

***Recommendation 41 Better pay and conditions for aged care workers***

*The committee recommends that the Australian Government raise the minimum pay and conditions of employment for personal carers, nurses, administrators and other workers in the aged care industry to levels equivalent to their peers in the health sectors.*

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<sup>838</sup> Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, *Report No. 33, 56<sup>th</sup> Parliament – Aged care, end-of-life and palliative care*, March 2020, p 167.

<sup>839</sup> Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, *Report No. 33, 56<sup>th</sup> Parliament – Aged care, end-of-life and palliative care*, March 2020, p 245.

<sup>840</sup> Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, *Report No. 33, 56<sup>th</sup> Parliament – Aged care, end-of-life and palliative care*, March 2020, p 246.

### 7.3.4 Medication safety in aged care

PSA referred to evidence of significant medication safety issues within RACFs, with reports suggesting that almost all residents of RACFs have had one medication-related issue, while the average medication-related problem per person is three. The medication issues may relate to:

- incorrect dosages
- inappropriate medication being prescribed
- insufficient monitoring.<sup>841</sup>

PSA stated that these medication issues have been shown to lead to an increased rate of hospitalisations, with one study showing that 17 per cent of 'unplanned admissions' in high-care aged care residents were due to potentially inappropriate medication.<sup>842</sup>

PSA recommended that Queensland Health employ pharmacists in all state-operated RACFs at a minimum of 0.5 FTE per 100 beds. PSA also recommends that the Australian Government fund pharmacists to be embedded in all RACFs at a minimum of 0.5 FTE per 100 beds.<sup>843</sup>

### 7.3.5 Issues with home care packages

The committee notes that the increasing trend for older people to choose to age in their own home has led to a continuing growth in the demand for Home Care Packages. In Queensland, the number of people receiving a Home Care Package has increased by 35 per cent in the two-year period between 30 June 2019 (21,257) and 30 June 2021 (31,895).<sup>844</sup>

The Australian Government is responsible for funding and delivering Home Care Packages, and advised that it is committed to addressing the critical need for home-based care for senior Australians, stating:

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 an 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

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<sup>841</sup> Submission 47, p 7; PS Nishtala, AJ McLachlan, JS Bell, TF Chen, 'A retrospective study of drug-related problems in Australian aged care homes: medication reviews involving pharmacists and general practitioners', *Journal of evaluation in clinical practice*, 2011, 17(1), pp 97-103; P Gheewala, G Peterson, C Curtain, P Nishtala, P Hannan, R Castelino, 'Impact of the pharmacist medication review services on drug-related problems and potentially inappropriate prescribing of renally cleared medications in residents of aged care facilities', *Drugs and Aging*, 2014, 31, pp 825-835; S Price, C Holman, F Sanfilippo, J Emery, 'Are high-care nursing home residents at greater risk of unplanned hospital admission than other elderly patients when exposed to Beers potentially inappropriate medications?', *Geriatrics and Gerontology International*, 2014, 14, pp 934-941.

<sup>842</sup> Submission 47, p 7; S Price, C Holman, F Sanfilippo, J Emery, 'Are high-care nursing home residents at greater risk of unplanned hospital admission than other elderly patients when exposed to Beers potentially inappropriate medications?', *Geriatrics and Gerontology International*, 2014, 14, pp 934-941.

<sup>843</sup> Submission 47, p 7.

<sup>844</sup> Australian Government, submission 75, p 12.

## 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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rolling out in July 2021 will see further improvements to people receiving care in an HCP and the size of the NPS.<sup>845</sup>

Home Care Packages are funded at four levels depending on need:

- Level 1 – support for people with basic care needs at \$9,026.45 per year
- Level 2 – support for people with low level care needs at \$15,877.50 per year
- Level 3 – support for people with intermediate care needs at \$34,550.90 per year
- Level 4 – support for people with high care needs at \$52,377.50 per year.<sup>846</sup>

Depending on the level of Home Care Package 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 and allied health services
- services to keep people safe in their home – including cleaning, home maintenance and modifications and assistive technology
- services to keep people connected to their community – including transport and social support services.<sup>847</sup>

Home Care Packages are delivered by service providers who have been approved under the *Aged Care Act 1997* (Cth).

Submitters, including UWU and HWQ, highlighted delays in people receiving Home Care Packages.<sup>848</sup> As noted by the Royal Commission in its interim report, while waiting on the list for a home care package, ‘... there is a clear and present danger of declining function, inappropriate hospitalisation, carer burnout and premature institutionalisation because necessary services are not provided’.<sup>849</sup>

During its inquiry, the HCDSDFVP Committee also heard evidence regarding the long wait times for Home Care Packages, as well as stakeholder concerns about the administration and delivery of the packages and the adequacy of the packages to meet a person’s needs.<sup>850</sup>

While acknowledging that the Australian Government has increased the number of packages available, Queensland Health stated that:

- demand continues to outstrip supply
- the number of level 3 and level 4 packages provided by the Australian Government underestimates the level of need in the community

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<sup>845</sup> Submission 75, pp 11-12.

<sup>846</sup> Australian Government, ‘My Aged Care, Home Care Packages’, <https://www.myagedcare.gov.au/help-at-home/home-care-packages>.

<sup>847</sup> Australian Government, submission 75, p 12.

<sup>848</sup> Submissions 25 and 36.

<sup>849</sup> UWU, submission 36, p 5; Royal Commission into Aged Care Quality and Safety, 2019, Interim Report: *Neglect*, Volume 1, p 68.

<sup>850</sup> Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, *Report No. 33, 56<sup>th</sup> Parliament – Aged care, end-of-life and palliative care*, March 2020, pp 92-106.

- the supply of these higher-level packages is not keeping up with the approval rate or reflecting growing demand for community aged care.<sup>851</sup>

COTA Queensland agreed that ‘wait times for home care packages, suggested that demand was exceeding service availability’.<sup>852</sup>

The committee notes that, as at 30 September 2021, 21,566 Queenslanders were waiting for their approved level of Home Care Package. Of this figure, 8,842 Queenslanders were waiting for a Home Care Package and had not been offered an interim lower level package.<sup>853</sup>

As at 31 October 2021, people on a level 1 package could expect to wait 3 to 6 months and for people allocated levels 2, 3 and 4 packages, the wait time was 6 to 9 months.<sup>854</sup>

In contrast, the Australian Government advised that the number of senior Queenslanders waiting in the National Priority Scheme (NPS) for a Home Care Package 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, the Australian Government advised that 99 per cent had either been offered an interim level Home Care Package or been approved for Commonwealth Home Support Programme assistance.<sup>855</sup>

Queensland Health explained the impact of wait times:

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

As a result, Queensland Health incurs the cost of admissions from older people who would be able to remain in their own home if they received their home care package more quickly.<sup>856</sup>

Cairns and Hinterland HHS stated:

The sustained high demand for comprehensive assessment and support plans by our aged-care assessment teams in Cairns is compounded by the long wait times on the national prioritisation queue for the Home Care Package. Clients frequently require reassessment because they are waiting for access to services for more than 12 months and their care needs change during that time—sometimes even longer. Despite that long wait time, due to the lack of service availability in most rural communities in the Cairns and hinterland service area, an approval for the Commonwealth Home Support Program does not actually always translate to access to that service.

The overall impact of the system on clients and carers is that people do not have timely access to the services and supports they need to remain safely at home. This puts clients at risk of harm, hospitalisation and premature and early admission to residential care.<sup>857</sup>

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<sup>851</sup> Submission 39, p 22.

<sup>852</sup> Submission 48, p 8.

<sup>853</sup> Queensland Health, submission 39, pp 22-23.

<sup>854</sup> Queensland Health, submission 39, p 6.

<sup>855</sup> Submission 75, p 12.

<sup>856</sup> Submission 39, pp 22-23.

<sup>857</sup> Public hearing transcript, Cairns, 7 February 2022, p 3.

Metro North HHS considered that:

Commonwealth funding for ACAT does not reflect the growth in demand. We accept 19 per cent of the state's ACAT referrals here in Metro North. ACAT referrals have increased 20 per cent since financial year 2015-16 and, if you take into account the 2.5 per cent increase in staff wages, the Commonwealth funding has not increased since 2015-16. It is a significant issue. It is a significant issue for the families and loved ones who wait for those. Of course, it would be also remiss of me not to mention the lack of resources or even planning for aged care for our ageing and complex comorbid corrections population. That is a whole other conversation.<sup>858</sup>

Cairns and Hinterland HHS explained that the system was difficult to understand which impacts both their clients and carers:

Clients and carers struggle to understand the system and how to access their packages once offered. Clients living in remote Aboriginal communities in the cape struggle to access the My Aged Care system, access an offered Home Care Package and, indeed, access enough support to remain in their community. It places demand on the public health system to provide supports that should be readily available to clients of the aged-care system, not to mention the human cost of those changes.

We do know that that wait, especially for the level 3 or 4 packages, can be 12 months and beyond. There is a burden on the people themselves, on their families and on the health service. Again, it is around the right care for the right person at the right time in the right place. You can fail with all four of those.<sup>859</sup>

The committee notes the national Aged Care Navigator trials in relation to assisting people to understand and navigate the aged care system. Brisbane South PHN advised that it has been working with community organisations to deliver a range of services and activities to help older people learn more about government-supported aged care programs and how to access them.<sup>860</sup>

At the Bribie Island hearing, a representative from Home Instead Brisbane North and Caboolture explained the impact on an elderly couple when a Home Care Package was suspended while the husband underwent surgery:

We helped her balance her domestic assistance, gardening and transport. Her level 1 package allowed us to get her to her appointments only twice. If we could have had him closer, we may have got her there more. When he returned home last week he fell on Sunday. He has now been placed into residential care. I phoned up My Aged Care several times to get extra funding for this lady, and every time I phoned I was told that she has been put on a waitlist. Occupational therapists, physiotherapists, domestic assistance and gardening on the island are at capacity. This lady needs her federal package to come through. Those packages, when they do come through, help alleviate the stress on our public health system.<sup>861</sup>

AMA recommended that Home Care Packages be made available to all those who need them, at the level of their need and within a maximum of 3 months following the assessment.<sup>862</sup>

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<sup>858</sup> Public hearing transcript, Bribie Island, 9 December 2021, p 3.

<sup>859</sup> Public hearing transcript, Cairns, 7 February 2022, pp 3, 6.

<sup>860</sup> Submission 30, p 8.

<sup>861</sup> Public hearing transcript, Bribie Island, 9 December 2021, p 16.

<sup>862</sup> AMA, *Putting health back into aged care*, p 5.

During its inquiry, the committee also heard about the impact of high case management and administration costs in relation to Home Care Packages and NDIS care services.

A resident of Bribie Island, John Morris explained to the committee some of the costs incurred when trying to purchase a new cushion for his wheelchair through his aged care package:

My Aged Care said that anything I purchased had to be approved by an OT first, so they sent an OT around who said I might look at other cushions. I did not know what was on the market. I thought something new might be around. Basically I was quite happy with the one I had. They provided one. She slapped it on the chair while I stood up. I can stand for about a minute under certain circumstances. She put the cushion on and so on. The next time I came to get off I was just about at the point of pushing off to a standing position because I had to have my knees locked and the cushion took off. She had not battened it down. This is an OT. It was not attached. They then proceeded to drop off another four cushions, which were all different sizes and none of them were any good because I could not attach any of them. I could not use them. Anyway, after two or maybe three visits I had to ring up and say, 'Don't do any more to help.' That cost me \$770.<sup>863</sup>

Mr Morris added:

The one that really gets me is where the law apparently says that if I need to buy anything I have to get an OT to approve it. For things that break or crack that you have been using for years—like the seat on my commode needs changing; it has broken twice in I think 10 years—I still need an OT to come around and approve it. It is just crazy. They just fritter away my funds. I am only on \$52,000. I could tell you without even counting it that less than half of that actually goes to anything that I require. All of that is taken up by the provider and fringe dwellers—OTs, physios and so on. They are just doing the job that they are given to do, but it should not be needed. It is just crazy. I cannot believe it.<sup>864</sup>

Bribie Island resident, and disability advocate of Spinal Life Australia, Bill Peacock told the committee about increased costs especially for people with disabilities who are not eligible for the NDIS as they are over 65 years old and therefore rely on aged care packages:

The cost has just exploded since the NDIS, which has placed aged-care clients into an even more difficult position. A mobile chair has to be prescription designed. I noticed John Morris behind me here. His chair is probably even more expensive than mine because of the services. Four years ago my chair was \$12,500. This chair, purchased in March this year, was \$26,900. That sort of expense in your package is just unrealistic.<sup>865</sup>

In relation to the administration of the NDIS, Rachel Tosh from SARRAH told the committee:

The third element is that therapists and their clients—or providers and participants, to translate for those who are fluent in NDIS speak—are being strangled by red tape right now. For example, I have had to help local GPs in Toowoomba complete NDIS access request forms because they could not get any clarity from the NDIA directly. They were getting rejected for amputees or people with other obvious permanent disabilities simply because a poorly worded question meant they ticked one wrong check box on the form because nobody explained to them what that question actually meant.<sup>866</sup>

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<sup>863</sup> Public hearing transcript, Bribie Island, 9 December 2001, p 34.

<sup>864</sup> Public hearing transcript, Bribie Island, 9 December 2001, p 34.

<sup>865</sup> Public hearing transcript, Bribie Island, 9 December 2021, p 22.

<sup>866</sup> Public hearing transcript, Brisbane, 8 December 2021, p 3.

Committee comment

The committee acknowledges the concerns of stakeholders regarding the wait times for, adequacy of, and administration costs of Home Care Packages.

These concerns include that demand for Home Care Packages is exceeding service availability; long wait times are contributing to poor health outcomes for clients in their home and increased hospitalisations, increasing pressure on the hospital system and the need for residential aged care services sooner than would otherwise be required; and inequality of service delivery in regional, remote and rural Queensland as compared to higher population centres.

The committee supports the view of the HCDSDFVP Committee in its Aged care, End-of-life and Palliative Care report that 'such delays in providing care would not be permitted in a health service environment and are simply unacceptable in aged care'.<sup>867</sup> In this regard, the committee supports recommendations 10 to 14 of the HCDSDFVP Committee, and recommends that the Australian Government provides a response to these recommendations.

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<sup>867</sup> Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Report No. 33, 56th Parliament – Aged care, end-of-life and palliative care, March 2020, p 105.

**Recommendation 30 – Australian Government to respond to previous recommendations**

The committee recommends that the Australian Government responds to the following recommendations contained in the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Report No. 33, 56th Parliament – Aged care, End-of-life and Palliative Care:

***Recommendation 10 Increased funding for the Home Care Packages Program***

*The committee recommends that the Australian Government significantly increase the level of funding it provides to the Home Care Packages Program to ensure packages are sufficient to meet the costs of the required hours of care required for each level package, to clear the current backlog of packages that haven't been provided.*

***Recommendation 11 Removal of caps on Home Care Packages***

*The committee recommends that the Australian Government remove its cap on the number of packages available, at all levels, and provides as many packages as are needed.*

***Recommendation 12 Clearing of backlog in Home Care Packages that have not provided***

*The committee recommends that the Australian Government clear the current backlog of packages that haven't been provided.*

***Recommendation 13 Maximum waiting times for Home Care Packages***

*The committee recommends that the Australian Government ensure wait times for packages are reduced to a maximum of three months for delivery of all packages across all levels from the date of approval.*

***Recommendation 14 Access to interim care while waiting for Home Care Packages***

*The committee recommends that the Australian Government commit to provide interim care arrangements, close to the approved package level, for applicants for home care packages while waiting for their package to be provided.*

The committee notes submitters' and witnesses' concerns that service provider practices are resulting in Home Care Package and NDIS care funds being spent on case management and administration costs, rather than direct care through, for example, allied health services, in-home care and transport costs.

The committee recommends that the Australian Government reviews aged care and NDIS care service providers' practices to ensure that people's funds are being spent on direct care, rather than case management and administration costs.

In doing so, the committee recommends that the Australian Government considers the introduction of caps for case management and administration fees to ensure that funds are being spent on the care required to provide people with a better quality of life and health outcomes. The committee also recommends that the Australian Government review the adequacy of existing consumer protections for people receiving Home Care Packages and NDIS care services.

**Recommendation 31 – Australian Government reviews aged care and NDIS care service provider practices to ensure funds are spent on direct care, rather than case management and administration fees**

The committee recommends that the Australian Government reviews the practices of aged care and NDIS care service providers to ensure that Home Care Package and NDIS care funds are spent on direct care and not case management and administration fees.

As part of the review, the committee recommends that the Australian Government considers:

- the introduction of caps for case management and administration fees charged by service providers
- the adequacy of existing consumer protections for people receiving home care packages and NDIS care services.

### **7.3.6 Availability of aged care beds particularly those catering for people with complex needs**

The committee heard the following evidence in regards to the process for, and delays in, allocating aged care beds, the impact on people with complex needs including those with dementia, and concerns about what the future looks like. Metro South HHS stated:

As soon as someone is identified and the referral is made to the aged-care assessment team, there is usually an outcome within 24 to 48 hours within the Metro South region. The delay then ensues in terms of establishing those cares, so finding either a placement for the person or the in-home support. We find that the in-home support tends to take the longest, and that is a trend that has been observed over quite some time. The Department of Health has requested weekly reporting since about November on barriers to discharge that are identified by clinicians, and the greatest barrier is securing an aged-care service, whether it is a placement or it is home care.<sup>868</sup>

And:

We know from the aged-care royal commission that there is not enough of these specialist dementia type beds available nationally, and there have been plans underway to establish more specialist level services. I think the challenge around the provision of health care in aged-care facilities is a significant and troubling social problem from which then unfortunate and very distressing situations like this sometimes occur.<sup>869</sup>

Central Queensland HHS stated:

One of the critical challenges impacting this is the number of elderly patients waiting in our most acute beds awaiting aged-care or disability placement. Today there are 42 people across Central Queensland hospitals, but primarily here in Rockhampton, waiting for a residential aged-care facility bed and four people in acute beds here in Rockhampton Hospital awaiting the finalisation of their NDIS package. They are not medically or acutely unwell, they simply do not have anywhere else to go. The longer these people stay in hospital, the more likely it is that, despite the very best of care, they will fall, they will develop a pressure injury or they will simply pick up a nosocomial infection that can deteriorate both their cognitive and functional capability. For some people the lack of aged-care beds here in Central Queensland results in them living in Rockhampton Hospital for months. Two years ago I led a review on the growth requirements for aged-care beds in Central Queensland. The available evidence at the time described an immediate shortage of around 190 aged-care residential beds across Central Queensland and that will escalate if we do nothing to 2,000 beds short by 2036. Without any future investment it looks quite bleak.<sup>870</sup>

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<sup>868</sup> Public hearing transcript, Logan, 10 February 2022, p 3.

<sup>869</sup> Public hearing transcript, Logan, 10 February 2022, p 5.

<sup>870</sup> Public hearing transcript, Rockhampton, 3 March 2022, p 2.

These issues, and their impact on the public health system, is also discussed in Chapter 4 of this report.

### 7.3.7 Business and market failure and continuity of care

As demonstrated by the recent closure of the Earle Haven Retirement Village, where there is business failure, local hospitals are required to provide interim care for residents.<sup>871</sup>

Queensland Health stated that it is also at risk of becoming a de-facto provider of last resort when services decide to exit the market. Queensland Health advised that ‘market failure can arise where the market either does not exist, as in rural and remote locations, or for older people with very high needs that the private market may choose not to accept’.<sup>872</sup>

Queensland Health provided the committee with examples from rural and remote areas where private facilities had closed at short notice, including in Cunnamulla which required Queensland Health to convert the local hospital into a multipurpose health service to continue to provide appropriate aged care services to residents.<sup>873</sup>

RDAQ stated:

I can go onto aged care and the NDIS. We have good aged care in rural places where there is critical mass. For example, in the town here there is a good private aged-care provider. Where there is not the critical mass or where there is a market failure in that space, the HHS does provide, in conjunction with federal funding, aged-care places. That is done quite well in rural places. In aged care, one of the things that could be improved, though, is again looking at rebates. The Medicare rebate for an after-hours attendance at a nursing home by a GP is insanely small. It is often easier for patients to be transferred to a hospital for assessment rather than actually being seen by their GP.<sup>874</sup>

### 7.3.8 Dual regulatory regimes – NDIS and aged care

Since 1 December 2020, RACFs caring for participants under 65 years have been required to adhere to dual regulatory regimes (aged care and disability).

Queensland Health advised that this has reduced the number of RACF providers willing to accept NDIS participants over 65 years and that, in rural and remote areas, this often means that these participants must live in hospital.<sup>875</sup>

The committee notes that significant work has been undertaken under the Australian Government’s *Younger People in Residential Aged Care Strategy* to meet the goals of people:

- under the age of 65 entering residential aged care by 2022
- under the age of 65 living in residential aged care by 2025.<sup>876</sup>

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<sup>871</sup> Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, *Report No. 30, 56th Parliament, Investigation of the closure of the Earle Haven residential aged care facility at Nerang (Inquiry into aged care, end-of-life and palliative care and voluntary assisted dying)*, November 2019, <https://documents.parliament.qld.gov.au/tp/2019/5619T2173.pdf>.

<sup>872</sup> Submission 39, p 25.

<sup>873</sup> Submission 39, p 25.

<sup>874</sup> Public hearing transcript, Longreach, 4 March 2022, p 15.

<sup>875</sup> Submission 39, p 26.

<sup>876</sup> Australian Government, Department of Social Services, *Younger People in Residential Aged Care Strategy 2020-25*.

Queensland Health stated that if there are no alternative providers, these goals can result in NDIS participants living in hospital where a RACF is the only viable option for them to stay in their community.<sup>877</sup>

Bill Peacock explained the impacts of the system on people over the aged of 65 who are living with a disability:

One of our great problems has been the differentiation between aged care and disability. Disability does not discriminate; however, governments often do because, when we turn 65 and are disabled, the National Disability Insurance Scheme, NDIS, which was meant to be our safety net, did not cover us—whether we had a lifelong disability, we were born with disability or after the age of 65 we were given a disability. People over 65 living with a disability are funded through the My Aged Care scheme and not the NDIS. That means a person with a spinal cord injury receives \$52,000 a year maximum instead of \$165,000 a year, which is the average through the NDIS. We need to change that to ensure that all people, whether their diversity is in disability or aged care, are not being discriminated against.

At age 65, people with a disability are removed from the disability pension and put onto the aged-care pension unless we are smart enough to be able to say to the government, through Centrelink, ‘No, we don’t want aged care; we need to remain with our disability support pension so that we can have all of the cultural aspects of our lives met comfortably and reasonably.’<sup>878</sup>

### 7.3.9 Aged Care Assessment Team

The Public Advocate noted that older people are often admitted to hospital due to an infection (most commonly a urinary tract infection) or a fall in their home (eg potentially serious break to a bone) accompanied by, in some cases, concussion or a brain injury. The Public Advocate stated that:

When entering a hospital care setting with these types of conditions or injuries, older people, being particularly unwell, can be disorientated and not able to respond to simple questions on topics including where they are, what day it is, and the details surrounding their admission to hospital. Should, in these circumstances, an assessment of the person’s decision-making capacity be undertaken at this time, there is a strong possibility that they will fail this assessment.

This may then lead to either an attorney under an Enduring Power of Attorney assuming decision-making responsibility for the person or, if an enduring document is not in place, a guardianship order being made for a substitute decision-maker to make decisions related to the person’s discharge from hospital.<sup>879</sup>

The Public Advocate stated that once this process is complete and a person is deemed not to have decision-making capacity, their likelihood of returning home (which may be their wish) does appear to be curtailed by a number of issues, such as:

- the provision of transition, restorative, or rehabilitative care – if a person is deemed to lack decision-making capacity, they are also unlikely to meet the eligibility criteria for rehabilitation or transition care services, meaning that their ability to regain movement and function, particularly after injuries like a broken hip, are restricted
- the availability of options for aged care services – once a person is in hospital, they are unable to be assessed for aged care services to be provided at home. Aged care assessment teams,

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<sup>877</sup> Submission 39, p 26.

<sup>878</sup> Public hearing transcript, Bribie Island, 9 December 2021, p 18.

<sup>879</sup> Submission 16, p 2.

who determine eligibility for aged care packages, will not assess a person's service requirements for in-home care in an environment outside of their home.<sup>880</sup>

The Queensland Law Society (QLS) raised similar concerns, stating that the Aged Care Assessment Team (ACAT) will only assess a person for home supports if the assessment is conducted in the person's home. QLS stated that there is often limited flexibility for a person to be released from hospital to undergo an ACAT assessment in their own home, even when that is the person's preference.<sup>881</sup>

QLS sought further information as to whether a person's preference as to their living arrangements is recorded in the ACAT assessment and, if the person is assessed in a hospital setting but indicates that their preference is to receive home support.<sup>882</sup> The Public Advocate stated that:

The culmination of these factors means that an older person wishing to be discharged to their own home, even if they regain their decision-making capacity as part of their recovery, is not able to return home.<sup>883</sup>

The Public Advocate advised that a lack of rehabilitation services limits people's ability to regain the movement required to live independently and in-home aged care services are not available, as an assessment cannot be undertaken. Substitute decision makers may also decide that the person, although it is their wish to return home, should enter a RACF, often with the fear that they would be at risk if they returned home. Hence, these people become members of the queue, medically ready for discharge (within the restrictions noted above) but waiting for the availability of a place in a RACF.<sup>884</sup>

#### **7.4 Attempts to address the barriers to efficient discharging and unnecessary hospitalisations**

As outlined in Chapter 4 of this report, barriers to efficiently discharging older persons, who are medically ready for discharge, from hospital are having a significant impact on the public health system.

Queensland Health contended that many of the barriers to efficiently discharging older persons from hospitals are the responsibility of the Australian Government, but Queensland Health is also taking direct action in supporting older persons who require some level of care while advocating to the Australian Government for systemic change.<sup>885</sup>

##### **7.4.1 Hospital and Health Services investing in local aged care facilities and key initiatives**

The committee notes evidence from several HHSs regarding their investment in local aged care facilities, as well as other key initiatives. Townsville HHS advised:

In Townsville, our HHS invested almost \$900,000 last year for an additional 13 beds in a local aged-care facility to help cater for those awaiting placement so they did not need to wait in our hospital. In Townsville we have also funded a frailty intervention team operating out of our emergency department to provide 24/7 direct access for nursing homes in our region with immediate medical response for

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<sup>880</sup> Submission 16, p 2.

<sup>881</sup> Submission 24, p 1.

<sup>882</sup> Submission 24, p 1.

<sup>883</sup> Submission 16, p 2.

<sup>884</sup> Submission 16, p 2.

<sup>885</sup> Submission 39, p 24.

residents who become unwell but could be treated in their facility. Each month we have about 300 assessments and follow-ups that are provided in that service.<sup>886</sup>

Metro North HHS advised:

In an effort to avoid hospital presentations or admissions of residents of residential aged-care facilities in Metro North, we have two key initiatives amongst others: our geriatric emergency department intervention, GEDI, and the residential aged-care district assessment and referral service, RADAR. There are 90 residential aged-care facilities with approximately 10,000 residents in the Metro North catchment, and it is growing. In the past 12 months the Metro North GEDI and RADAR services made 4½ thousand visits to the residents of the aged-care facilities to support them at their care facility, in their home, to redirect presentations from our emergency departments. Just to give some local context, 11 per cent of those visits have been here in the Bribie area and the Ningi region.<sup>887</sup>

#### **7.4.2 Australian Government initiatives**

The Australian Government stated that the Department of Health assists with the discharge of older Australians from hospital and to avoid unnecessary hospitalisations.<sup>888</sup>

##### ***7.4.2.1 Older Persons Advocacy Network***

The Older Persons Advocacy Network (OPAN) delivers the National Aged Care Advocacy Program through its network of 9 service delivery organisations.

OPAN supports older Australians who are hospitalised by providing information about what aged care services are available, engagement with ACAT, involvement with discharge care planning, and facilitating access to services. This can involve connecting older people to transition care and accessing transitional care in the home following a hospital admission.<sup>889</sup>

##### ***7.4.2.2 Transition Care Program***

The Transition Care Program (TCP) is a flexible aged care program, jointly funded by the Australian and State and 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.<sup>890</sup>

TCP providers (including Queensland Health) seek to optimise the functioning and independence of older people post-hospitalisation, and where possible, delay a person's entry into residential aged care.<sup>891</sup>

Under the joint funding arrangements for the TCP, total funding is comprised of an Australian Government contribution of approximately 75 per cent and a state/territory contribution of 25 per cent.<sup>892</sup>

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<sup>886</sup> Public hearing transcript, Townsville, 9 February 2022, p 2.

<sup>887</sup> Public hearing transcript, Bribie Island, 9 December 2021, p 3.

<sup>888</sup> Submission 75, p 12.

<sup>889</sup> Australian Government, submission 75, p 12.

<sup>890</sup> Australian Government, submission 75, p 12.

<sup>891</sup> Australian Government, submission 75, p 12.

<sup>892</sup> Australian Government, submission 75, p 12.

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 was 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 increased numbers of 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.<sup>893</sup>

#### *7.4.2.3 Respite care*

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.<sup>894</sup>

#### *7.4.2.4 Dementia support*

The Australian Government advised that where placement in aged care homes may be affected by behavioural and psychological symptoms of dementia, health services are encouraged to talk with Dementia Support Australia (DSA) about how DSA can assist.

DSA deliver the Dementia Behaviour Management Advisory Services (DBMAS) and Severe Behaviour Response Teams (SBRT), 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 aged care homes with behaviour support planning and developing suitable activities through DBMAS, SBRTs and brokerage support. This can include increased funding initially to increase 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
- 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.<sup>895</sup>

#### *7.4.2.5 Initiatives to avoid unnecessary hospitalisations*

In addition, the Australian Government advised that support through PHNs will assist RACFs to avoid unnecessary hospitalisations through improved infrastructure to support on-site telehealth and establishment of comprehensive after-hours plans.

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<sup>893</sup> Submission 75, p 12.

<sup>894</sup> Submission 75, p 13.

<sup>895</sup> Australian Government, submission 75, p 13.

The Australian Government advised that nationally consistent dementia and aged care referral pathways will support better community-based management of complex care needs, preventing complications that lead to hospitalisation.

The Australian Government advised that commissioning of early intervention and monitoring activities to support better health and wellbeing would commence in early 2022 and 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.<sup>896</sup>

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<sup>896</sup> Submission 75, p 14.

## 8 National Disability Insurance Scheme

In August 2011, the Productivity Commission's *Inquiry Report into Disability Care and Support* recommended establishing a National Disability Insurance Scheme (NDIS). The NDIS was intended to deliver unified, national, long-term, high quality care and support to persons with a disability. The report was accepted by all Australian governments.<sup>897</sup>

The NDIS delivers care to ensure that Australians with a significant and permanent disability can socially, economically and independently participate in their communities. The NDIS funds disability support services that are found to be reasonable and necessary, unless:

- those supports are part of another service system's universal service obligation
- are covered by reasonable adjustment required under law dealing with discrimination on the basis of disability.<sup>898</sup>

The NDIS provides funds to participants with a 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.

These supports may include maintenance supports, given or supervised by qualified healthcare staff, and long term therapy or support. The participant's support is linked to the care and support they require to live in the community and participate in education and employment.<sup>899</sup>

The National Disability Insurance Agency (NDIA) is responsible for administering and operating the NDIS, and ensuring that participants are able to access support they need from service providers across Queensland.<sup>900</sup>

The Department of Social Services advised:

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.<sup>901</sup>

In 2015, all Australian governments agreed on the principles that determine the responsibilities of the NDIS and other service systems, including the Applied Principles and Tables of Support (APTOS). APTOS sets out the responsibilities of the Australian and State Governments to provide a range of support options to people with a disability, through the NDIS and other systems.<sup>902</sup>

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<sup>897</sup> Australian Government, Department of Social Services, correspondence, 14 December 2021, enclosure, p 1.

<sup>898</sup> Australian Government, Department of Social Services, correspondence, 14 December 2021, enclosure, p 1.

<sup>899</sup> Australian Government, submission 75, p 18.

<sup>900</sup> DSDSATSIP, correspondence, 17 December 2021, p 2.

<sup>901</sup> Australian Government, Department of Social Services, correspondence, 14 December 2021, enclosure, p 1.

<sup>902</sup> Australian Government, Department of Social Services, correspondence, 14 December 2021, enclosure, p 1.

The APTOS recognises the need for the NDIS, health, and mental health systems to work together at the local level to plan and co-ordinate streamlined care for individuals requiring both health and disability services and mental health and disability services.<sup>903</sup>

The *Bilateral Agreement between the Commonwealth of Australia and Queensland on the National Disability Insurance Scheme (Full Scheme Agreement)* outlines the roles and responsibilities of the Australian and Queensland Governments in relation to governance, policy, market development and oversight, and funding arrangements for the NDIS.<sup>904</sup>

Disability Ministers from participating jurisdictions have also agreed on market roles and responsibilities for the NDIS. These outline the role of governments in supporting and developing the NDIS market and building a responsive and capable NDIS workforce.<sup>905</sup>

The NDIS was introduced to Queensland in 2016 and, as of 31 December 2020, there were 5,474 active and registered NDIS providers in the state.<sup>906</sup> Nearly two-thirds of registered providers are organisations, largely not-for-profit, with the remainder being sole traders. There are around 77,600 people in the disability care workforce, and around half are casual workers.<sup>907</sup>

The Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships (DSDSATIP) advised that the NDIS is making a positive difference to the health and wellbeing of participants. The committee notes that, as at 30 September 2021, there were 97,475 active NDIS participants in Queensland, with NDIS plans valued at over \$7 billion per annum.<sup>908</sup>

## **8.1 NDIS expenditure and participant population in Queensland**

The Department of Social Services advised that ‘the NDIS is fully funded and demand driven’ and that states and territories make set contributions. These contributions are made under full scheme agreements to meet part of the cost of supports for NDIS participants.<sup>909</sup>

Queensland currently invests over \$2 billion per annum in the NDIS under the Full Scheme Agreement.<sup>910</sup> The Department of Social Services stated that the Australian Government meets the remaining costs through appropriations made by the Australian Parliament.<sup>911</sup> The Australian Government stated that it has invested an additional \$17 billion of funding in the last two budgets.<sup>912</sup>

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<sup>903</sup> DSDSATIP, correspondence, 17 December 2021, p 2.

<sup>904</sup> DSDSATIP, correspondence, 17 December 2021, p 2.

<sup>905</sup> DSDSATIP, correspondence, 17 December 2021, p 2.

<sup>906</sup> Queensland Productivity Commission, *The NDIS market in Queensland*, April 2021, pp viii, 120.

<sup>907</sup> Queensland Productivity Commission, *The NDIS market in Queensland*, April 2021, p 120.

<sup>908</sup> DSDSATIP, correspondence, 17 December 2021, p 2.

<sup>909</sup> Australian Government, Department of Social Services, correspondence, 14 December 2021, enclosure, p 1.

<sup>910</sup> DSDSATIP, correspondence, 17 December 2021, p 2.

<sup>911</sup> Australian Government, Department of Social Services, correspondence, 14 December 2021, enclosure, p 1.

<sup>912</sup> Submission 75, p 16.

The Australian Government also funds all of the operating costs of the NDIA and the costs of the Information Linkages and Capacity Building grants program.<sup>913</sup>

The December 2021 Mid-Year Economic and Fiscal Outlook estimates 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 Australian Government'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.<sup>914</sup>

In 2020-21, the Australian Government's 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.<sup>915</sup>

The 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, 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 being \$59,200.<sup>916</sup>

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 which represents about 20 per cent of active NDIS participants, noting the Queensland population is about 20 per cent of the national population.

Of the 97,000 participants in Queensland:

- 16 per cent were children aged under 7 years
- 9.6 per cent were Aboriginal and Torres Strait Islander peoples – this number is higher than the national proportion of Aboriginal and Torres Strait Islander peoples participating in the NDIS, which is 7 per cent
- 60 per cent of Queensland NDIS participants self-reported accessing mainstream health and wellbeing supports.<sup>917</sup>

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<sup>913</sup> Australian Government, Department of Social Services, correspondence, 14 December 2021, enclosure, p 1.

<sup>914</sup> Australian Government, submission 75, p 16.

<sup>915</sup> Submission 75, p 16.

<sup>916</sup> Submission 75, p 16.

<sup>917</sup> Submission 75, p 16.

## 8.2 Accessibility and availability of NDIS care services

In April 2021, the Queensland Productivity Commission (QPC) published its final report on its *Inquiry into the NDIS market in Queensland*. The QPC examined:

- structural, regulatory or other impediments to the efficient operation of the NDIS market
- factors affecting specific markets or market segments
- options for improved policies and measures to ensure the NDIS market meets participant needs.<sup>918</sup>

The report identified key issues regarding NDIS services that interface with, and potentially impact, Queensland's public health system. The QPC report highlighted systemic issues with the NDIS, including:

- potentially eligible Queenslanders not taking up the NDIS
- the size, complexity and inflexibility of the NDIS
- costly and inefficient compliance burdens
- creating high policy and regulatory risks for providers, and in doing so, deterring new entrants, investment, employment and innovation
- constrained market mechanisms and the effective functioning of the market.<sup>919</sup>

The QPC report made 56 recommendations to enhance the supply of disability supports and services and improve the efficiency and effectiveness of the Queensland NDIS market. The Queensland Government provided its response to these recommendations in October 2021.<sup>920</sup>

During the Inquiry, a number of issues were raised with the committee about the current operation of the NDIS and the impact they have on the public health system:

- **thin markets in Queensland** – gaps in the supply of NDIS support services that put pressure on the public health system
- **specialist disability accommodation (SDA)** – Queensland has the highest proportion of NDIS participants in Australia with specialist accommodation funding who are actively seeking a new specialist accommodation dwelling. This indicates the accommodation supply is not meeting the demand. The public health system must then accommodate people who cannot be discharged from hospital without appropriate accommodation in place, putting pressure on the public health system
- **service capacity for clients with complex needs** – Queensland Health reported concerns about discharging clients from hospital with complex support needs, due to a lack of suitable disability support providers or insufficient NDIS plan funding
- **insufficient outreach and assistance to access the NDIS** – referrals from Queensland Health, including mental health services, make up approximately half of the 1,711 referrals to the DSDSATSIP's Assessment and Referral Teams (operating with Commonwealth funding that

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<sup>918</sup> Queensland Productivity Commission, *Final Report -The NDIS market in Queensland*, April 2021, p x.

<sup>919</sup> Queensland Productivity Commission, *Final Report -The NDIS market in Queensland*, April 2021, p i.

<sup>920</sup> Queensland Government, *Queensland's strategic direction statement for the NDIS market*, October 2021.

expires in June 2022). This indicates a need for greater outreach and support for people intersecting with the public health system to access the NDIS

- **NDIS workforce** – the size of the disability workforce has increased with the introduction of the NDIS, however, labour supply shortages remain for several specialist occupations and some locations. This impacts the availability of specialist services and can place pressure on the public health system.<sup>921</sup>

### 8.2.1 Thin markets and access to NDIS services

Throughout the Inquiry, the committee heard about the adverse impact that ‘thin markets’ had on access to NDIS services.

The committee notes that for the NDIS to achieve its goals, there must be a provider in the area who is willing and able to provide the necessary supports. Thin markets occur when there is a lack of suitable service providers prepared to offer NDIS services at the price set by the NDIA.

Metro South HHS identified that ‘the funding model is very much provider led. Even though it is about reasonable and necessary supports, it is still dependent on those providers being available and being able to provide that response’.<sup>922</sup>

The committee notes that this creates a situation where a patient who has obtained an NDIS package cannot utilise it due to the lack of services, or ‘thin markets’, in their area. Simone Thomason told the committee that ‘We almost feel guilty when people get an NDIS package out here because we know we do not have support services’.<sup>923</sup>

Queensland Health advised that thin markets are more likely when the needs of participants are complex or in rural and regional areas.<sup>924</sup> The committee notes that access to NDIS services in rural and remote areas is impacted by the following factors:

- the lack of reliable demand for services, which makes it difficult for providers to establish themselves in an area or offer a full suite of services
- limited labour pools in rural and regional areas
- the high cost of providing services
- the risk for providers to meet required standards are incompatible with the price paid for the service – including the increase costs arising from the COVID-19 pandemic.<sup>925</sup>

RDAQ considered that the NDIS has had ‘mixed success’ in rural areas. It stated that rural participants were unable to use their approved packages because there were often no providers in their area. RDAQ also advised that some participants were unable to access state provided allied health once they became an NDIS client, and others were in a worse position once going on the NDIS:

An example of that might be clients who have disabilities where they qualify for supported accommodation, but most rural towns have no supported accommodation for them to go to. We have

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<sup>921</sup> DSDATSIP, correspondence, 17 December 2021, p 1.

<sup>922</sup> Public hearing transcript, Logan, 10 February 2022, p 5.

<sup>923</sup> Public hearing transcript, Longreach, 4 March 2022, p 23.

<sup>924</sup> Submission 39, p 25.

<sup>925</sup> Queensland Health, submission 39, p 25.

had situations where disabled people who are not aged are living in hospitals in rural Queensland because there is nowhere for them to go and their carer cannot care for them, which is not acceptable.<sup>926</sup>

Townsville HHS advised that access to the NDIS is also impacted by onerous administrative requirements and inflexibility when faced with changes to a participant's needs. Patients are forced to wait in public hospitals for NDIS plans or approval, or must return to the public system because their providers cannot support the participant's needs anymore.<sup>927</sup>

Metro South HHS identified the complexity of the NDIS as coming from its size and variety of services:

When you talk about a 'provider' that could be anything from the delivery of a specific intervention such as communication all the way to housing. That is incredibly confusing for people and they need a lot of support. I do think the model does make it difficult for the people who probably need it the most. They would have been participants of our state disability services, where they were the providers of last resort. That has shifted to Health in a lot of ways. I think it is a very complex scheme to navigate, both within and externally, but probably the most complex for people who need it the most.<sup>928</sup>

Health Consumers Queensland observed:

If we want to look to a system that really has not delivered what so many, particularly parents and carers, fought for, it is definitely the NDIS. The frequent requirement for people to have their plans revised, to pay an exorbitant amount of money for health professional reviews and to submit to those and the questioning of their conditions, which are permanent, is something that we see.<sup>929</sup>

An example of patients paying for tests and reviews to access NDIS services is the requirement for an occupational therapist's functional assessment. Ruth Marsh outlined her experience:

In terms of the cost of access and access to OTs [occupational therapists], with only five allied health appointments that we can access with a gap, it makes getting a functional assessment for access to the NDIS almost impossible. Often they are not allowed to do a functional assessment with those five allied health treatments.

The cost for me to get a functional assessment was extremely prohibitive. It was over \$800 and it had to be paid off before I could access the report and before I could try to apply for the NDIS. That is something that participants often have to come up with, particularly when they have something that is a little bit different. I have rheumatoid arthritis. I also have a connective tissue disorder. The NDIS need to see the function to decide whether you are severely impacted. That is why you require an OT functional assessment for a lot of things.<sup>930</sup>

Central West HHS advised that it had made the deliberate choice not to register as an NDIS provider, but still provides services to NDIS participants or those who will soon become NDIS participants while they wait for an NDIS package or provider. This puts further strain on the public health system. The dominant reason patients are waiting is functional assessments from occupational therapists:

Across the team we have about 25 people in that situation at the moment who are either applying to NDIS to be an NDIS participant or who have been accepted but do not have a current provider. That is mainly in OT and for those functional assessments that are such an important part of NDIS provision. That really puts a big strain on our three OTs, particularly currently because we have two vacancies in that area. Luckily, our

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<sup>926</sup> Public hearing transcript, Longreach, 4 March 2022, p 16.

<sup>927</sup> Public hearing transcript, Townsville, 9 February 2022, p 2.

<sup>928</sup> Public hearing transcript, Logan, 10 February 2022, p 5.

<sup>929</sup> Public hearing transcript, Brisbane, 8 December 2021, p 16.

<sup>930</sup> Public hearing transcript, Brisbane, 21 February 2022, p 18.

allied health team leader is also an OT and is able to step into that space. I know some of the NDIS providers in the HHS really do struggle with this, particularly that OT assessment, which is really a gateway into your plan. Barcaldine Regional Council, for example, are a provider but they struggle to get that OT assessment that can then lead their consumers into a plan.<sup>931</sup>

Submitters advised that the NDIS is ‘not working for us as First Nations people’. Witnesses claimed that referrals are not coming through to Aboriginal and Torres Strait Islander NDIS providers. First Nations people end up using mainstream services rather than Aboriginal and Torres Strait Islander owned or operated service providers.<sup>932</sup> Francis Tapim, a Torres Strait Islander community Elder commented:

In the NDIS there is a lack of cultural consideration in planning and development. They do not talk to us—again. We need more Indigenous Torres Strait Islander support and conversation about how to develop those programs. We are in this era now where we need to look forward at what we want to do to improve the health services of our people in the community, not only in this community but everywhere in Queensland.<sup>933</sup>

### 8.2.2 General practitioners and the NDIS

RACGP stated that the current level of Medicare cover does not incentivise GPs to take on and provide higher quality services to NDIS patients:

GPs do not participate in NDIS funding. We are often required to fill out forms that support NDIS, but NDIS very specifically will not cover services that Medicare would normally pay for. GPs would love to take on NDIS clients and receive some of the similar funding to, say, WorkCover or DVA rates even, but given that Medicare covers it that is the only funding and these people do not get great services from GPs.

We know that the funding per service, particularly in allied health in NDIS, is far above what is offered under Medicare rules or under those GP care plans so seemingly that should make for better access, but sadly many people do not have access due to rurality. We know that the access to NDIS allied health services gets lower the further out from Brisbane, Townsville, Cairns.<sup>934</sup>

Patients experience difficulties due to the lack of communication between GPs and the NDIS about the patient’s needs, the services they are accessing and who is providing the service under the NDIS. Dr Jackson, JCU, stated:

For many GPs the NDIS is a mystery. There appears to be no formal communication channel between the NDIS and a patient’s GP. I do not receive a copy of any assessment or plan for my NDIS patients. I am not informed as to which providers are involved in their care.

What I do hear repeatedly from my NDIS patients is that they cannot use their NDIS funding to access the services that they actually need. NDIS funding cannot be used for services that attract Medicare funding. However, there seems to be no requirement that those services are available in the local area.

As a result, I have patients who cannot use their NDIS funding to help pay the fees of a private local specialist and rather are required to travel to Brisbane in their wheelchairs, with their carers, to consult with a specialist in a Brisbane public hospital for a 20-minute appointment. This is grossly inefficient and it is an unacceptable burden for these patients.<sup>935</sup>

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<sup>931</sup> Public hearing transcript, Longreach, 4 March 2022, p 7.

<sup>932</sup> ABIS Housing, public hearing transcript, Townsville, 9 February 2022, p 45.

<sup>933</sup> Public hearing transcript, Townsville, 9 February 2022, p 50.

<sup>934</sup> Public hearing transcript, Townsville, 9 February 2022, p 8.

<sup>935</sup> Public hearing transcript, Bundaberg, 2 March 2022, p 22.

GPs are also impacted by the administrative burden of a person applying for NDIS services. One patient reported that multiple appointments with their GP were required to obtain NDIS approval:

In terms of the availability of GPs in Townsville, particularly ones who are willing and able to fill in NDIS paperwork, it takes many months and it certainly took me quite a few appointments to go through what needed to be put in the report. There were many turn-downs and we had to go back to the GP many times to get things reworded into the correct bureaucratic wording for the NDIS to get access. I do not know how much training they have had between now and when I was having trouble accessing, but it was certainly very difficult back then.<sup>936</sup>

### **8.2.3 Interface between NDIS and public health system**

The Public Advocate and OTA raised concerns about the lack of clarity at the interface between the NDIS and public health services.<sup>937</sup>

The Public Advocate stated that issues arising in the health sector, particularly for people with impaired decision-making ability, are primarily related to the current interfaces between the NDIS and state-based health services.<sup>938</sup> The Public Advocate advised:

Too often, a lack of co-operation and collaboration between Commonwealth and state services mean that people with impaired decision-making ability remain in acute, sub-acute and rehabilitation health care environments (including authorised mental health units) as they are unable to access funding for the supports they require to maintain their health and wellbeing (eg. NDIS and aged care), or access appropriate accommodation in the community, which could include residential aged care and social housing adapted to their needs.<sup>939</sup>

The Tablelands Community Association noted the existing confusion about what supports are funded by the NDIS, stating that:

... what is funded where is often a big issue. Health will say it is funded by NDIS and NDIS will say, 'That's not funded by us,' and the fact is that there are people in the middle there. They have a disability and they often have complex health issues alongside that and that needs to marry together for the best outcomes.<sup>940</sup>

Townsville HHS stated that the public health system must provide the evidence required for a person to access NDIS provider services, but evidence can be considered insufficient for NDIS support, forcing the patient to pay for extra tests and wait longer before accessing the support they need:

Our hospital system and staff are supporting the support coordinators to bring together the threads of accommodation, lifestyle support, assistive technology and equipment, and behavioural plans for very complex consumers. Our medical officers and experienced allied health professionals are providing health information and writing reports about a consumer's needs, but we are often finding that is not considered to be sufficient evidence for a higher level of support. Providers are then advised to obtain

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<sup>936</sup> Ruth Marsh, public hearing transcript, Brisbane, 21 February 2022, p 18.

<sup>937</sup> Submissions 16 and 17.

<sup>938</sup> Submission 16, p 1.

<sup>939</sup> Submission 16, p 1.

<sup>940</sup> Public hearing transcript, Cairns, 7 February 2022, p 24.

further functional assessments, which further delays the process as providers attempt to source the experts to complete the assessments and finalise the reports.<sup>941</sup>

The committee heard that the delays accessing NDIS services result in prolonged stays in hospital that could be avoided, with Townsville HHS advising:

[I]t is almost impossible to undertake a needs assessment about how someone functions in their environment in a hospital institutionalised setting that someone has lived in for the past 100 days. Unfortunately, we have had multiple cases in the past 12 months where this has resulted in avoidable stays in hospital of between 100 and 400 days.<sup>942</sup>

Spinal Life Australia considered that the public health system does not accommodate a disabled person's carer to join them for their hospital stay due to legislative restrictions:

When people with a disability arrive at a hospital, whether we are young or old, we are denied the right to have our carers with us because it becomes legislatively impossible for the staff in hospitals to maintain the care for our carers as well as ourselves. In the past five years I have waited up to five hours for an ambulance to arrive to take me to a hospital, only to find that even the very personal systems of care are denied me, and denied most people, because the carer cannot be with me at that time.<sup>943</sup>

The committee heard that this institutional lack of coordination and communication often results in state public health systems stepping in to fill the gap:

I want to say that the systemic issues within the NDIS caused issues with the Queensland Health system having to pick up the slack. The issues with communication between the systems can cause issues for all of us but particularly those of us living with disabilities who are already—I would not say that I am vulnerable, but inherently we need more assistance than other people.

Queensland Health could assist with some aspects for people with disability, especially to do with COVID and the COVID response. Disaster planning that includes cyclones, floods and COVID should also be completed in all aspects, including through the NDIS but also through Queensland Health, to lessen the impact on those of us with disability and obviously to lessen the impact on the Queensland health system.<sup>944</sup>

The Australian Government advised that the Disability Ministers agreed, on 28 June 2019, to NDIS funding for disability related health supports for NDIS participants. Disability related health supports are defined as 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.<sup>945</sup>

#### *8.2.3.1 Delays in discharge - people who acquire a disability who are admitted to hospital*

The Public Advocate stated that various interface issues exist for people who acquire a disability due to an accident or life changing health event, are hospitalised and are subsequently medical ready for discharge from hospital:

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<sup>941</sup> Public hearing transcript, Townsville, 9 February 2022, p 2.

<sup>942</sup> Public hearing transcript, Townsville, 9 February 2022, p 2.

<sup>943</sup> Public hearing transcript, Bribie Island, 9 December 2021, p 18.

<sup>944</sup> Ruth Marsh, public hearing transcript, Brisbane, 21 February 2022, p 19.

<sup>945</sup> Australian Government, submission 75, p 18.

- the person's sustainable discharge from hospital often relies upon a successful application to the NDIS for the development of a disability supports plan. Several interface issues make this process difficult, including knowing who to contact, determining eligibility for the NDIS and developing a plan (including the necessary supports). These issues are exacerbated if the person does not have a strong family or supporter-based network
- once initial eligibility has been determined, potential NDIS participants then need to undertake a series of functional assessments involving a range of medical professionals – facilitating these assessments from hospital can be difficult, in particular, if the professionals are not attached to the relevant HHS
- once an NDIS plan is developed and approved, additional issues can arise that delay discharge, including available suitable public housing, a requirement for a guardian and administrator to be appointed, home modifications or a need for new suitable rental accommodation.<sup>946</sup>

The Public Advocate stated that these issues can be exacerbated when a person has a psychosocial disability and is receiving treatment in an authorised mental health facility.<sup>947</sup>

#### *8.2.3.2 Delays in discharging – existing NDIS participants*

The Public Advocate also highlighted the difficulties experienced by existing NDIS participants in hospital who are medically ready for discharge. The Public Advocate stated that, in some circumstances, people with existing NDIS plans are admitted to hospital as a service provider of last resort. This occurs when the person:

- has a care relationship with a support provider that has broken down
- has a service provider that is not able to provide the level of supports required to maintain their health and wellbeing
- can no longer remain at their existing place of residence and no other suitable accommodation can be found.<sup>948</sup>

The Public Advocate stated that:

Often more intensive work is required with these participants, as they are more likely to have complex health and disability related needs. Again, the provision of collaborative and co-ordinated wraparound services, involving state and Commonwealth partners, is required in these circumstances. Work is also required with the NDIA to establish service providers and accommodation of last resort (so that people do not end up in hospital by default), particularly in thin NDIS markets in regional, rural, and remote areas of Queensland.<sup>949</sup>

The Public Advocate noted that a number of HHSs have employed NDIS and disability nurse navigators to assist patients with accessing the NDIS and other health services. The Public Advocate highlighted the Metropolitan South HHS as a good example of a disability/NDIS nurse navigation service.

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<sup>946</sup> Submission 16, p 3.

<sup>947</sup> Submission 16, p 3.

<sup>948</sup> Submission 16, p 4.

<sup>949</sup> Submission 16, p 4.

However, the Public Advocate noted that these services are not available in all hospitals, stating that 'the extent to which HHSs are committed to a wrap around process, including the engagement of state-based services to assist the person, varies'.<sup>950</sup>

Cairns and Hinterland HHS commented on the complexity of the NDIS system, stating:

In November last year, which was our last census count, there were 21 long-stay patients, of which six were aged care, with the vast majority of those exhibiting responsive behaviours, and 14 were NDIS participants. The NDIS has added another layer of complexity to our health and support system. It is already somewhat fragmented by the Commonwealth and state funding divide.

Our subacute services have experienced difficulties coordinating discharges due to delays in assessment and inflexible system requirements which have delayed access to community supports and services. These delays can be significant. One NDIS patient had an 11-month long-stay hospital admission. While 21 seems like a low number, 11 months in hospital is 22 rehab admissions, so 22 people could have been receiving rehab during that period.<sup>951</sup>

#### Committee comment

The committee notes submitters' and witnesses' concerns about issues with the interface between the NDIS and the public health system causing delays in the discharge of patients, including difficulties in undertaking assessments in a hospital setting, a lack of suitable accommodation, the lack of co-ordination, legislative restrictions and confusion about what services are funded under the NDIS.

The committee acknowledges that steps have been taken by both the Australian and Queensland Governments to resolve these issues, including the introduction of NDIS funding for disability related health supports and certain HHSs employing Nurse Navigators.

However, the committee considers that more can be done to improve discharge practices and ensure that appropriate NDIS supports are in place to ensure that discharges may occur in a timely manner.

The committee recommends that the Australian and Queensland Governments collaborate to improve discharge practices, including the appointment of additional NDIS Nurse Navigators, and other initiatives to improve the interface and communication between the NDIS and public health system.

**Recommendation 32 – Collaboration to improve interface between the National Disability Insurance Scheme and public health system**

The committee recommends that the Australian and Queensland Governments collaborate to improve discharge practices, including the appointment of additional NDIS Nurse Navigators, and other initiatives to improve the interface and communication between the National Disability Insurance Scheme and public health system.

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<sup>950</sup> Submission 16, p 4.

<sup>951</sup> Public hearing transcript, Cairns, 7 February 2022, pp 2-3.

#### 8.2.4 Supply of specialist disability accommodation

State and Territory Governments are primarily responsible for the provision of housing for people with disability, through public and community housing.

The Australian Government noted that safe, affordable and suitable housing is essential for the economic, social and cultural wellbeing of people with a disability. It stated that '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'.<sup>952</sup>

The NDIS also funds a range of home and living supports for eligible NDIS participants through their NDIS plans, including:

- Specialist Disability Accommodation
- Medium Term Accommodation (MTA)
- home modifications
- Independent Living Options.<sup>953</sup>

The Australian Government advised that 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 per cent of all NDIS participants nationally are expected to be assessed as eligible for SDA.

Queensland Health advised that Queensland has the highest proportion of NDIS participants in Australia with specialist disability accommodation funding who are seeking new specialist disability accommodation. This indicates that supply is not matching demand. Queensland Health advised that the public health system assumes responsibility to accommodate these people because they have nowhere else to go.<sup>954</sup>

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). As noted above, SDA is only for a small minority of NDIS participants. The NDIS is not responsible for meeting the accommodation needs of most NDIS participants.<sup>955</sup>

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.<sup>956</sup>

Queensland Health reported concerns about discharging clients with complex disability support needs from hospital. These concerns relate to insufficient NDIS funding or a lack of suitable disability support providers for the client:

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<sup>952</sup> Submission 75, p 19.

<sup>953</sup> Australian Government, submission 75, p 19.

<sup>954</sup> Public briefing transcript, Brisbane, 29 November 2021, p 6.

<sup>955</sup> Australian Government, submission 75, p 19.

<sup>956</sup> Australian Government, submission 75, p 19.

The NDIA is also ultimately responsible for implementing strategies to ensure critical functions are maintained for participants in the event of market failure, provider exits or sudden withdrawals of service; however, this role often falls to state health services as people present to emergency departments following the breakdown or unavailability of NDIS supports and services.<sup>957</sup>

Queensland Health advised that accommodation supports with the levels of care needed by NDIS participants with complex care needs may not be viable in rural and remote areas due to limited numbers of participants in the area, making service provision financially unsustainable.<sup>958</sup> Queensland Health stated that:

While the publication of SDA demand data has been improving, there is still insufficient visibility of unmet demand and no guarantee that participants will take up vacancies if a residence is built. Even where demand is visible and dependable, it is often difficult to attract construction workers who are often employed in well-remunerated roles within other sectors (including the mining sector). When this workforce needs to be sourced from cities or regional areas, the cost of labour increases. The combined effect is that SDA is in limited supply in remote and rural areas, often not in locations preferred by participants, and sometimes providers can carry SDA vacancies for long periods because participants cannot secure approval for SDA or sufficient plan funding.<sup>959</sup>

APR Disability Services advised that service providers aiming to build SDA facilities are faced with long wait times as they wait for the NDIS participant to be approved for SDA and onerous administrative requirements:

Other investors come to us and ask, 'What is it worth?' and 'Does it work?' Unfortunately, we have to say, 'Well, if you believe the advertisement that you will make money by having a house built for SDA, you have to consider that you will be waiting for a year before that client is approved for SDA. On top of that, you do not get payment. When the approval does go through, you are lucky to get the full amount of approval.'

We only opened in March 2020, because it took so long for our two premises to be registered. They are registered with council as residential care facilities. We have gone through the whole spectrum of getting those houses rebuilt and put together since 2016, so it was a three-year thing. With me being on the steering committee as well, it gave me insight into what was happening. Where we are today is where we are. We find that there is a lot of misconception about SDAs. People are going to get burnt. If the NDIA take what they are doing to us to other people, you will not have too many SDAs in Australia.<sup>960</sup>

SDA service providers also grapple with a lack of funds for an occupant's medical care, as SDA patients have high support needs:

The other situation is: with the profits that we have, if any, we hire nurses. The nurses are hired by us. We have two nurses working virtually full-time, which we believe is a necessity to look after extreme complex care. Of course, they are not funded, because they say that is the responsibility of Queensland Health. We just say, 'Okay, that is fine. We will just put it as an admin cost.'<sup>961</sup>

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<sup>957</sup> Public briefing transcript, Brisbane, 29 November 2021, p 6.

<sup>958</sup> Submission 39, p 25.

<sup>959</sup> Submission 39, p 25.

<sup>960</sup> Public hearing transcript, Townsville, 9 February 2022, p 32.

<sup>961</sup> Public hearing transcript, Townsville, 9 February 2022, p 31.

Committee comment

The committee notes that Queensland has the highest proportion of NDIS participants in Australia with SDA funding who are seeking new specialist disability accommodation. This demonstrates that supply is not matching demand and the public health system is often left to accommodate these people because they have nowhere else to go.

The committee recommends that the Australian Government increases investment in building SDA, particularly in rural and remote areas, to ensure that NDIS participants with complex needs have an appropriate place to live, where their needs can be met.

**Recommendation 33 – Increased investment in specialist disability accommodation**

The committee recommends that the Australian Government increases investment in building specialist disability accommodation, particularly in rural and remote areas, to ensure that National Disability Insurance Scheme participants with complex needs have an appropriate place to live, where their needs can be met.

**8.2.5 NDIS workforce**

During the 2019-20 financial year, there were approximately 52,300 NDIS workers in Queensland, consisting of approximately:

- 3,700 allied health professionals
- 14,000 community-based support workers
- 33,000 home-based support workers
- 1,600 in other occupations.<sup>962</sup>

The Department of Social Services advised that Queensland currently has the third largest number of NDIS workers nationally and accounts for approximately 18 per cent of the NDIS workforce.<sup>963</sup>

Modelling from the Department of Social Services forecasts the NDIS workforce in Queensland needs to keep growing due to continued growth in the number of NDIS participants. The Australian Government is 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
- promoting the benefits of working in the care and support sector to attract more workers
- training and supporting the workforce
- encouraging the effective operation of the market, including reducing red tape.<sup>964</sup>

The *NDIS National Workforce Plan: 2021-2025* (the Workforce Plan), launched on 10 June 2021 by the Minister for the NDIS, provides the framework for these activities.

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<sup>962</sup> Australian Government, Department of Social Services, correspondence, 14 December 2021, enclosure, p 1.

<sup>963</sup> Australian Government, Department of Social Services, correspondence, 14 December 2021, enclosure, p 1.

<sup>964</sup> Australian Government, Department of Social Services, correspondence, 14 December 2021, enclosure, p 1.

The committee notes that disability support, aged care and veterans' care programs are highly connected, with over a third of providers operating across all three areas. The Australian Government advised that 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.<sup>965</sup>

#### *8.2.5.1 Rural and remote areas*

HWQ advised that the *2021 Health Workforce Needs Assessment* reported a marked increase in the number of comments about the 'low availability of occupational therapists and speech pathologists, particularly for children'.<sup>966</sup>

HWQ stated that where the workforce exists, there is limited choice for patients to access support services and in many rural and remote communities it is not possible to access these services locally.<sup>967</sup> HWQ advised that the allied health workforce in rural and remote Queensland is generally limited, and disability services are competing for the same workforce pool as the mainstream health workforce.<sup>968</sup>

Queensland Health outlined multiple issues around the size and composition of the NDIS workforce. It noted that while the disability services workforce has grown with the introduction of the NDIS, there are supply shortages for key occupations and challenges when attracting and retaining health professionals in remote and rural areas.

Queensland Health highlighted that these shortfalls must be addressed by the public health system. It stated that more work was needed to monitor the progress and effectiveness of initiatives designed to attract and keep workers in the disability sector.<sup>969</sup>

QNMU considered that there was an urgent need for a specialist clinical workforce with the skills, training, and education to manage specific types of disability. QNMU stated that:

The absence of such a workforce may be a contributing factor to the supply gaps for supports and services for NDIS participants particularly those with complex needs which may be contributing to people with disability remaining in hospital for longer than is medically necessary.<sup>970</sup>

RACGP has observed that NDIS participants also have difficulty accessing GPs. RACGP proposed that if the NDIS matched the rates and benefits provided by the Department of Veterans' Affairs (DVA), more GPs would make themselves available to NDIS participants:

DVA pay much higher rebates than Medicare does and they pay for comprehensive wraparound care. If we had NDIS rates matching, for example, what DVA do, then you would find a lot more doctors deliberately targeting them.

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<sup>965</sup> Australian Government, Department of Social Services, correspondence, 14 December 2021, enclosure, p 1.

<sup>966</sup> Submission 25, p 4.

<sup>967</sup> Submission 25, p 4.

<sup>968</sup> Submission 25, p 4.

<sup>969</sup> Public briefing transcript, Brisbane, 29 November 2021, p 6.

<sup>970</sup> Submission 69, p 22.

DVA also pays for non face-to-face care and for coordinated team based care with allowances for the general practice. None of that is available to NDIS, so we certainly are aware that a lot of NDIS clients talk about difficulty in accessing general practice services.<sup>971</sup>

QNMU stated that its members raised concerns regarding delays in discharging patients to NDIS funded accommodation. Members cited the scarcity of facilities with a specialised clinical workforce capable of meeting the complex support needs of patients with specific disabilities.<sup>972</sup>

### Committee comment

As mentioned by a number of submitters, delays in discharging patients are sometimes the result of a scarcity of facilities with the specialised workforce to meet the complex needs of patients. Other submitters raised the issue of the lack of allied health workers in rural and remote areas. Queensland Health referred to shortages for key occupations in the NDIS workforce.

The committee recommends that the Australian Government considers the issues raised by submitters about key shortages in the NDIS workforce and the impact this has on hospital discharges, as part of the *NDIS National Workforce Plan: 2021-2025*.

#### **Recommendation 34 – NDIS National Workforce Plan**

The committee recommends that the Australian Government considers the issues raised by submitters about key shortages in the NDIS workforce and the impact this has on hospital discharges, as part of the *NDIS National Workforce Plan: 2021-2025*.

### **8.2.6 Medicine safety in disability care**

PSA stated that people with intellectual disability are more likely to experience potentially preventable hospital admissions with rates four times that of people without intellectual disability.<sup>973</sup>

PSA referred to evidence to suggest there may be a level of under-prescribing for chronic health issues in people with disability, with one study finding only 20 per cent of people with intellectual disability who were diagnosed with asthma used medication to manage their condition.

Somewhat paradoxically, PSA stated that there also appeared to be a degree of over-prescribing for people with disability, with one study finding 82 per cent of people with intellectual disability prescribed psychotropic medication were receiving this medication inappropriately.<sup>974</sup>

PSA stated that for people with disability, medicine safety is a significant issue which contributes to higher rates of hospitalisation. PSA stated that:

Increasing pharmacist involvement in both aged and disability care can make significant contributions to reducing hospitalisations related to medication use, at a cost of approximately \$5,700 per person. Currently the National Disability Insurance Scheme (NDIS) does not enable accredited pharmacists to be

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<sup>971</sup> Public hearing transcript, Townsville, 9 February 2022, p 8.

<sup>972</sup> Submission 69, p 22.

<sup>973</sup> Submission 47, p 7.

<sup>974</sup> Submission 47, p 7; E Cocks, A Thomson, S Thoresen, R Parsons, L Rosenwax, 'Health status and use of medications by adult with intellectual disability in Western Australia', *Journal of Intellectual and Developmental Disability*, 2016, 41(2), pp 87-96; M Song, R Ware, T Doan, L McPherson, J Trollor, D Harley, 'Appropriateness of psychotropic medication use in a cohort of adolescents with intellectual disability in Queensland', *Australia, BJPsych Open*. 2020, 6(6), e142.

registered providers under the NDIS and there are no services for the delivery of a tailored schedule of supports for a person with disability aimed at improving medicine safety.<sup>975</sup>

PSA recommended that Queensland Health facilitate embedded pharmacist roles in disability care facilities to ensure continuity of medication safety initiatives. PSA also recommended that the Australian Government enable pharmacists to be registered providers under the NDIS to allow for the delivery of a tailored schedule of supports for a person with disability aimed at improving medicine safety and their engagement with society.<sup>976</sup>

### **8.3 Attempts to address the impacts on the public health system in Queensland**

The committee notes that Queensland Health has committed significant workforce effort and investment to support long stay patients who no longer require medical care in a hospital to be discharged into an out-of-hospital setting more appropriate to their needs and wellbeing.<sup>977</sup>

This section of the report outlines some of these initiatives.

#### **8.3.1 Queensland Government initiatives**

##### *8.3.1.1 Long-Stay Rapid Response Initiative*

As part of its \$100 million Care4Qld Strategy, the Queensland Government has invested \$4 million into the Long-Stay Rapid Response (LSRR) initiative to support appropriate hospital discharge for patients awaiting access to disability and aged care supports.<sup>978</sup>

LSRR is an internal escalation pathway for HHSs and operates by funding solutions, including interim accommodation, home modifications or increased nursing supports. LSRR has also established six new clinical staff dedicated to facilitating hospital discharge for long-stay patients and those at risk of becoming long-stay.<sup>979</sup>

Queensland Health advised that, as at 22 November 2021, 154 patients involved in the program were discharged from hospital and a further 61 patients were in the process of being supported to be discharge.<sup>980</sup>

##### *8.3.1.2 Queensland Civil and Administrative Tribunal program*

In March 2020, Queensland Health collaborated with the Queensland Civil and Administrative Tribunal (QCAT) to fund a trial expansion of a program which accelerates the QCAT process for long-stay patients awaiting QCAT decisions to ensure they are discharged to appropriate accommodation in a timely manner.

The program is based in Metro North HHS and the expansion trial has successfully reduced average waiting times for QCAT hearings by approximately 61 days, from 98 days to 37 days as at November 2021.

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<sup>975</sup> Submissions 47, p 7.

<sup>976</sup> Submissions 47, p 8.

<sup>977</sup> Queensland Health, submission 39, p 29.

<sup>978</sup> Submission 39, p 29.

<sup>979</sup> Submission 39, p 29.

<sup>980</sup> Submission 39, p 29.

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

The committee notes that the COVID-19 funding concluded on 30 June 2021 and the initiative is now funded under the Care4Qld Strategy.<sup>981</sup>

#### 8.3.1.3 Summer Foundation Hospital Discharge and Housing Project

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

The project improved staff capability, supported discharge for complex long-stay patients, assisted to prevent unnecessary admissions and improved clinical governance structures. The project also contributed to the reduction of long stay younger patients seen in 2020.<sup>982</sup>

#### 8.3.1.4 Queensland Government's Assessment and Referral Team

DSDSATSIP is currently delivering an Australian Government-funded project to support access to the NDIS by disadvantaged or otherwise hard to reach clients.

The Assessment and Referral Team works closely with Queensland Health to provide support to health consumers requiring NDIS access, including to facilitate their discharge from hospital; and to people with psychosocial disability to gain access to the NDIS in particular circumstances.

Referrals from Queensland Health, including Mental Health services, make up 49.5 per cent of the 1,711 referrals to the Assessment and Referral Team from Queensland Government agencies since commencement in February 2020. The Assessment and Referral Team will continue to accept referrals for health consumers requiring support to access the NDIS until 30 June 2022, when Australian Government funding is due to cease.<sup>983</sup>

#### Committee comment

The committee notes the success of the Assessment and Referral Team program in supporting health consumers to access the NDIS. The committee is aware that the Australian Government funding for the program ends on 30 June 2022.

The committee recommends that the Australian Government commits continued funding to the Assessment and Referral Team program to assist health consumers to access NDIS care services.

#### **Recommendation 35 – Continued funding of Assessment and Referral Team program**

The committee recommends that the Australian Government commits continued funding to the Assessment and Referral Team program to assist health consumers to access National Disability Insurance Scheme care services.

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<sup>981</sup> Queensland Health, submission 39, p 29.

<sup>982</sup> Queensland Health, submission 39, p 30.

<sup>983</sup> DSDSATSIP, correspondence, 17 December 2021, p 3.

### **8.3.2 Australian Government initiatives**

The Australian Government advised that the NDIA is implementing a range of activities nationally to address the issues that contribute to discharge delays for NDIS participants, including:

- 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
- 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.<sup>984</sup>

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.

The Australian Government advised that, 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.<sup>985</sup>

### **8.4 Submitter suggestions to improve hospital discharging and reduce avoidable hospitalisations**

During the Inquiry, submitters and witnesses made a number of suggestions as to how to address some of the issues arising from the health and NDIS interface.

The Public Advocate highlighted the need to improve the interface between State and Commonwealth systems, with a collaborative approach and services to enable people with impaired decision-making ability to be sustainably discharged from hospital and other health and community settings.<sup>986</sup>

#### **8.4.1 Creation of short-term, transitional accommodation**

The Public Advocate suggested that an option for the Queensland Government, in the short term, was the development, or conversion of existing facilities, to provide transitional accommodation for people finalising their NDIS plan or waiting to enter residential aged care.<sup>987</sup>

The Public Advocate recommended the development or formalisation, if already in place, of discharge teams, consisting of representatives from health, housing and community services, as well as NDIS support coordinators, aged care finders and nurse navigators to address the interface issues and current barriers.<sup>988</sup>

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<sup>984</sup> Submission 75, p 19.

<sup>985</sup> Submission 75, p 19.

<sup>986</sup> Submission 16, p 4.

<sup>987</sup> Submission 16, p 4.

<sup>988</sup> Submission 16, p 5.

#### 8.4.2 Improving inpatient access to disability supports

To address the issue of long-stay hospital patients, Queensland Health recommended that the Australian Government and NDIS' processes should be streamlined and flexible to enable inpatients to more easily access disability supports. Queensland Health suggested that this could be achieved by:

- reinstating the policy directions adopted by the NDIS in response to COVID-19, such as allowing access to MTA for participants who are awaiting an NDIS funded home and living solution without a final discharge destination confirmed
- upskilling NDIS support coordinators to better understand and navigate the health system, including establishing local partnerships
- joint Commonwealth and State development of a new, national targeted Hospital Discharge Delay Action Plan that outlines interface points between hospital and community, including responsibilities and timeframes.<sup>989</sup>

Queensland Health also suggested that the level of local engagement by the NDIA to improve participants' access to supports should be increased and an individualised immediate response provided where required. This could be achieved by:

- establishing a network of dedicated NDIS planners with health expertise that are engaged in the health system and able to work proactively to resolve discharge barriers
- ensuring local staff have sufficient levels of planning delegations to affect safe and timely discharge.<sup>990</sup>

Queensland Health has already taken steps by creating internal pathways to help long-stay patients leave hospital:

Queensland Health established an internal escalation pathway for the long-stay rapid response funding, which has benefited six of our NDIS residents and patients. Without this funding, these residents and patients would still remain in hospital awaiting accommodation.<sup>991</sup>

Queensland Health stated that to encourage positive outcomes for NDIS participants and health systems, the NDIS should reimburse hospitals for excess length of stay caused by NDIS delays or market failures. Queensland Health advised that this will require the development of nationally consistent definitions for long-stay (eg may include a minimum time frame).<sup>992</sup>

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<sup>989</sup> Submission 39, p 30.

<sup>990</sup> Submission 39, p 30.

<sup>991</sup> Cairns and Hinterland HHS, public hearing transcript, Cairns, 7 February 2022, p 3.

<sup>992</sup> Submission 39, p 31.

### **8.4.3 Improving access to supports in community**

Queensland Health called for improved access to timely supports for NDIS participants to enable them to remain in the community and avoid hospitalisation. Queensland Health suggested that this could be achieved by:

- strengthening the Participant Service Guarantee to implement regular checks to monitor participants' needs and any changes in needs over time
- better identification of when participants are not receiving appropriate supports.<sup>993</sup>

Queensland Health also recommended a review and expansion of the crisis referral line functions of the Exceptionally Complex Needs programs, including:

- increasing funding for the crisis referral line to facilitate an expanded scope to enable referral of patients facing crisis within the community at risk of hospitalisation before they present to an emergency department
- access for providers who are intending to cease providing services that result in a hospital admission to support them to continue to deliver services while issues are resolved.<sup>994</sup>

### **8.4.4 Better management of escalating behaviours of concern**

Queensland Health stated that presentations and hospital admissions could be avoided if providers were supported to manage escalating behaviours in situ. The committee noted that this would require specific and high-level behaviour intervention expertise.

Queensland Health recommended the introduction of NDIA commissioned tertiary consultancy to support providers with NDIS participants who are showing behaviours of concern. Queensland Health considered that the consultancy could also provide wide-ranging policy and practice development and training for disability workers and professionals.<sup>995</sup>

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<sup>993</sup> Submission 39, p 30.

<sup>994</sup> Submission 39, p 30.

<sup>995</sup> Submission 39, p 30.

## 9 The future of health care in Queensland

Throughout the Inquiry, the committee heard from submitters and witnesses who referred to the complex and fragmented nature of the current health care system given its delivery via different levels of government, as well as the private sector.<sup>996</sup> For example, QNMU considered that:

... federal and state governments and private sector providers including primary health and aged and disability care providers all play different roles. Responsibility for health service planning and delivery is divided and collaboration is not incentivized. As a result, care is fragmented and costs are shifted, contributing further to system dysfunctionality. In addition to this fragmentation is the added complexity on how to navigate care, particularly for those with complex health care needs.<sup>997</sup>

Health and Wellbeing Queensland concluded:

Consumers want to see greater integration between healthcare services, similar to how services are linked in a hospital setting. This includes improving integration between different HHSs and between public, private and community healthcare providers.<sup>998</sup>

The *Commonwealth Scientific and Industrial Research Organisation Report 'A Health Horizon'* highlights that the future of healthcare in Queensland should transform towards a health-networked hub. Under this approach, the management of population health in Queensland would become a cross-sectoral and cross-government coordinated effort.<sup>999</sup>

In its submission to the Inquiry, the Australian Government confirmed that all governments have agreed to progress long-term system-wide health reforms under the NHRA. It further advised that reform work is examining how the different components of the health system and other care sectors interact to improve service integration and outcomes for people, stating:

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.<sup>1000</sup>

This final chapter of the report draws together suggestions to address the issues associated with the fragmented health system and strategies for easing pressure on the public health system, including:

- increasing the focus on prevention and early intervention
- addressing inequities in access to health care
- committing to an integrated person-centred approach to health care
- utilising innovative models of care – including the promotion of multidisciplinary teams and permitting health professionals to work to their full scope of practice.<sup>1001</sup>

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<sup>996</sup> Submissions 17, 46, 49 and 69; public hearing transcripts: Brisbane, 8 December 2021, pp 12, 21; Cairns, 7 February 2022, pp 3, 10, 11; Bundaberg, 2 March 2022, p 18.

<sup>997</sup> Submission 69, p 3.

<sup>998</sup> Submission 58, p 4.

<sup>999</sup> C Naughtin, E Schleiger, K Mann, SJ Le, N Good, D Hansen, H Pham, L Christian, S Iyer, D Tolcher, 2020, 'A healthy horizon: Megatrends and scenarios for the future of healthcare in Queensland out to 2040 – Summary report', Brisbane, Australia, *CSIRO Data 61*.

<sup>1000</sup> Submission 75, p 3.

<sup>1001</sup> Submissions 40 and 41.

## 9.1 A greater focus on promotion, prevention and early intervention

Chronic diseases are the leading cause of illness, disability and death, with respiratory disease, cancer, and cardiovascular disease responsible for some of the greatest death and disease burden in Australia.<sup>1002</sup>

The AIHW recently published a report that found more than 38 per cent of the disease burden was preventable due to modifiable risk factors, including: tobacco use; being overweight; all dietary risks; high blood pressure and alcohol use.<sup>1003</sup>

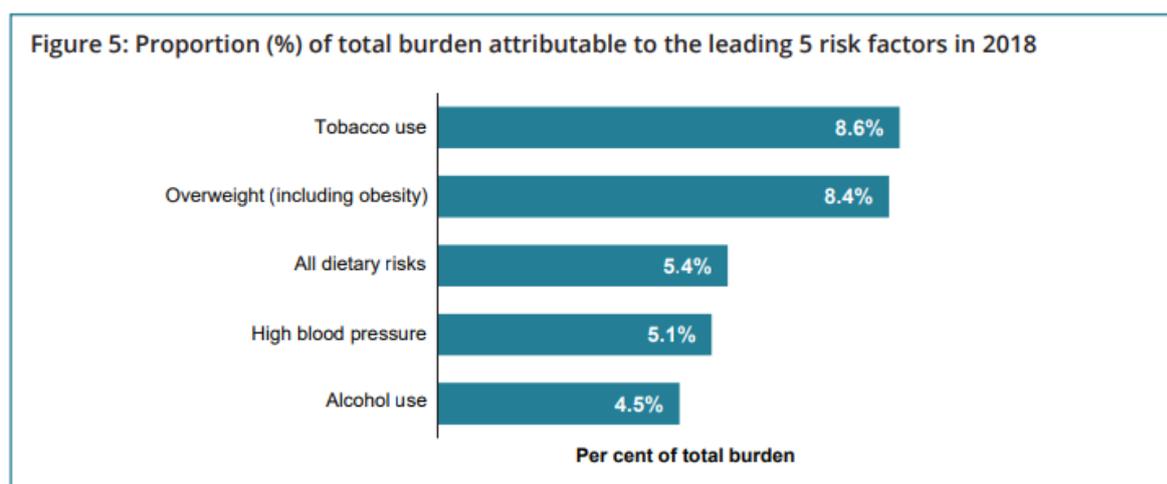


Figure 12 - Proportion (%) of total burden attributable to the leading 5 risk factors in 2018, source Australian Government, AIHW, Australian Burden of Disease Study 2018: key findings

Health and Wellbeing Queensland advised that, if Australians lived in a healthy weight range:

- diabetes would be reduced by 53 per cent
- coronary heart disease would be reduced by 25 per cent
- strokes would be reduced by 22 per cent.<sup>1004</sup>

It also stated that a total of 114,400 episodes of care and 305,000 patient days among Queensland hospitalisations were associated with overweight and obesity in 2015–16. Queensland's rate of potentially preventable hospitalisation is 22 per cent higher than the national average.<sup>1005</sup> QNMU referred to AIHW data which showed that chronic conditions made up approximately half of all potentially preventable hospitalisations (46 per cent), which in 2015-16, cost the Australian health care system over \$2.3 billion.<sup>1006</sup>

<sup>1002</sup> Submissions 41 and 58.

<sup>1003</sup> Australian Government, AIHW, 'Australian Burden of Disease Study 2018: key findings', <https://www.aihw.gov.au/getmedia/d2a1886d-c673-44aa-9eb6-857e9696fd83/aihw-bod-30.pdf.aspx?inline=true>.

<sup>1004</sup> Submission 58, p 1.

<sup>1005</sup> Submission 58, p 1.

<sup>1006</sup> Submission 69, p 8; Australian Government, AIHW, 'Australia's health 2020: Data insights', <https://www.aihw.gov.au/getmedia/be95235d-fd4d-4824-9ade-34b7491dd66f/aihwaus-231.pdf.aspx?inline=true>.

It is estimated that, in Queensland, obesity-related illness cost the Queensland healthcare system \$756 million in 2015. The total financial impact of overweight and obesity on the Queensland economy was estimated to be \$11.2 billion.

The Joint Submission noted that even before the COVID-19 pandemic, there was a \$1.137 billion increase in Queensland Health's operating budget. The Joint Submission stated that 'Without a commitment to increasing investment in long-term preventive health measures, this demand will continue to put Queensland's public health system under extreme pressure'.<sup>1007</sup>

### 9.1.1 Health and Wellbeing Queensland

The Joint Submission welcomed the Queensland Government's establishment of Health and Wellbeing Queensland, on 1 July 2019, and its focus on improving the health and wellbeing of Queenslanders, including reducing the burden of chronic diseases and health inequity.<sup>1008</sup>

The committee notes Health and Wellbeing Queensland's important work in preventive health, including:

- Deadly Choices – which aims to empower Aboriginal and Torres Strait Islander peoples to make healthy choices for themselves and their families – to stop smoking, to eat good food and exercise daily.
- the Gather + Grow program – focused on improving remote food insecurity for Aboriginal and Torres Strait Islander communities in the Torres Strait, Cape York and Lower Gulf regions of Queensland
- My Health For Life – a diabetes and chronic disease prevention program that targets Queensland adults at risk of developing conditions such as type 2 diabetes, heart disease and stroke
- Pick of the Crop – a whole-school healthy eating program to increase opportunities for Queensland primary school children to learn about and consume vegetables and fruit.<sup>1009</sup>

#### Committee comment

The committee intends to continue to engage with Health and Wellbeing Queensland to support its vital work aimed at reducing the burden of chronic diseases, through targeting risk factors, and reducing health inequity.

In order to promote awareness and encourage uptake of services, the committee encourages Health and Wellbeing Queensland to publish contact information on its website for health care providers, including non-government organisations, who provide services for diseases and conditions, such as kidney disease, Motor Neurone Disease, dementia and epilepsy.

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<sup>1007</sup> Submission 41, p 2.

<sup>1008</sup> Submissions 41 and 58.

<sup>1009</sup> Health and Wellbeing Queensland, 'Health and Wellbeing Initiatives', <https://hw.qld.gov.au/make-healthy-happen/health-wellbeing-initiatives/>.

### 9.1.2 Current funding of preventive health

Health and Wellbeing Queensland observed that ‘health expenditure is currently spent primarily on the treatment and disease’ and stated that ‘Investment in prevention needs to be enhanced to achieve a better balance between treatment and prevention in Queensland’.<sup>1010</sup>

Health and Wellbeing Queensland observed that ‘Queensland funding of preventive health initiatives has historically been inconsistent limiting long term, sustained population health impact strategies’. The latest AIHW Expenditure Australia 2016-2017 report showed that Queensland spent significantly less than nearly all other Australian jurisdictions on preventive health.<sup>1011</sup>

Queensland Health recognised the need for a greater focus on promotion, prevention and early intervention as being critical to preventing or slowing the deterioration of underlying health conditions or trajectories, stating:

An effective, sustainable and integrated health care system, underpinned by strong primary care, is key to managing the complex array of issues impacting on Queensland’s public health system.

Integrated healthcare is fundamental to improving the patient experience by achieving, connected accessible, and continuous care that feels seamless for patients.<sup>1012</sup>

The Joint Submission noted that the Australian Government has recently launched the National Preventive Health Strategy. The Joint Submission stated that ‘In the spirit of collaboration and working across all levels of government, we encourage the Queensland government to take an active role in implementing this strategy in Queensland’.<sup>1013</sup>

The Joint Submission recommended that all levels of government commit to:

- long-term and consistent funding for preventive health initiatives, with a minimum 10–15- year time horizon and review points every five years
- identifying and recognising the preventive health workforce as an integral part of the health system workforce with associated workforce planning strategies developed to support this.<sup>1014</sup>

### 9.1.3 Calls for increased investment in preventive health measures

Submissions, including QNMU, the Joint Submission and AHPA, considered that investment in preventive health measures was proven to be cost effective and advocated the benefits, including:

- reduced pressure on the public health system
- reduced burden on individuals and communities
- better use of health system resources
- healthier workforces
- increased health literacy

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<sup>1010</sup> Submission 58, p 1.

<sup>1011</sup> Joint Submission, submission 41, p 2.

<sup>1012</sup> Submission 39, p 4.

<sup>1013</sup> Submission 41, p 3.

<sup>1014</sup> Submission 41, p 4.

- improved economic performance and productivity.<sup>1015</sup>

Submitters called for an increase in the funding of prevention programs as the most effective way of reducing the pressure on Queensland's public health system in the long-term.<sup>1016</sup>

Health and Wellbeing Queensland stated that studies have shown that for every dollar invested in preventive health interventions, there is a median return on investment of \$14.<sup>1017</sup>

Health and Wellbeing Queensland, and the Joint Submission, recommended that investment in preventive health be increased to 5 per cent of the total health expenditure.<sup>1018</sup> Health and Wellbeing Queensland noted that this would be in line with the *National Preventive Health Strategy 2021-2030*.<sup>1019</sup>

QNMU explained that 'Prevention and intervention will not only reduce the pressure on the health budget, but it will also increase workforce participation and productivity and improve the health of future generations'.<sup>1020</sup>

#### Committee comment

The committee acknowledges the importance of government investment in early intervention and preventive health care. The committee also congratulates Health and Wellbeing Queensland on the important work they have undertaken since July 2019 in this regard.

The committee notes the AIHW report that 38 per cent of the disease burden in Australia is preventable due to modifiable risk factors, including: tobacco use; overweight; all dietary risks; high blood pressure and alcohol use. The committee also notes that preventive health measures have proven to be a cost effective way of reducing the pressure on the public health system and improving patient outcomes.

Accordingly, the committee recommends that the Australian and Queensland Governments increase investment in preventive health, education and support services, so that it accounts for five per cent of total health expenditure across Australian, state and territory governments by 2030, in accordance with the *National Preventive Health Strategy 2021-30*.

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<sup>1015</sup> Submissions 41, 42, and 69; Su Gruszin Diana Hetzel and John Glover, 'Advocacy and action in public health: lessons from Australia over the 20th century', Australian National Preventive Health Agency, December 2012; Australian Government, AIHW, 'Australia's health 2016', Australia's health series no. 15 Cat. No. AUS 199, 2016.

<sup>1016</sup> Submission 71.

<sup>1017</sup> R Masters, E Anwar, B Collins, R Cookson, S Capewell, 'Return on investment of public health interventions: a systematic review', *Journal of Epidemiology and Community Health*, 2017, 71(8), p 827.

<sup>1018</sup> Submissions 41 and 58.

<sup>1019</sup> Submission 58, p 1.

<sup>1020</sup> Submission 69, p 8.

**Recommendation 36 – Australian and Queensland Governments to increase investment in preventive health**

The committee recommends that the Australian and Queensland Governments increase investment in preventive health, education and support services, so that it accounts for five per cent of total health expenditure across Australian, state and territory governments by 2030, in accordance with the *National Preventive Health Strategy 2021-30*.

In addition, the committee recommends that the Queensland Government explores options to further invest in early intervention programs in primary care to prevent chronic conditions, such as heart disease and diabetes, and mental health conditions, to reduce the burden of these diseases and conditions and reduce the impact on the public health system.

**Recommendation 37 – Queensland Government investment in early intervention programs**

The committee recommends that the Queensland Government explores options to further invest in early intervention programs in primary care to prevent chronic conditions, such as heart disease and diabetes, and mental health conditions, to reduce the burden of these diseases and conditions and reduce the impact on the public health system.

## 9.2 Addressing health inequities

A key theme of submitter commentary was the need to address health inequity in Australia.

Health and Wellbeing Queensland stated that equity is about the absence of unjust and avoidable disparities in life outcomes within a population. They detailed a range of upstream causes of inequity, many of which fall outside of health, including income, education, employment and housing. Health and Wellbeing Queensland acknowledged that these drivers are complex, intertwined and beyond the remit of health actors to address.<sup>1021</sup>

The Joint Submission noted that despite changes to the way health care is accessed as a result of the COVID-19 pandemic, including embracing technology to connect people with vital health services, health inequity remains a challenge. Submitters highlighted that the following communities still experience health inequity:

- First Nations people
- people who live in regional and remote areas
- people from culturally and linguistically diverse backgrounds
- LGBTIQ+ communities
- adolescents and young adults
- older people
- people with a disability
- people who experience socio-economic disadvantage.<sup>1022</sup>

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<sup>1021</sup> Submission 58, p 2.

<sup>1022</sup> Submissions 21, 41, 48, 57, 58 and 66.

The Joint Submission called for efforts to ease pressure on the public health system to include targeted strategies to address health inequity and supported initiatives such as localised health strategies by HHSs to improve cultural awareness and accessibility to health care.<sup>1023</sup>

### **9.2.1 Queensland Equity Framework**

Health and Wellbeing Queensland is leading collaborative cross-government efforts to reduce inequitable life outcomes for those most in need, through the development of a *Queensland Equity Framework*.<sup>1024</sup>

The Framework will be designed to strengthen Queensland's recovery, growth, and resilience by guiding policy, practice and value-based investment that enhances equity and removes system barriers that contribute to disparities in life outcomes. Health and Wellbeing Queensland advised that this requires addressing the social determinants such as housing, transport options, access to education and job opportunities.<sup>1025</sup>

Health and Wellbeing Queensland stated that the application of the Queensland Equity Framework will provide identification of the right support, at the right time, to the right people and communities. Use of Queensland-specific data will be central to informing decisions and identifying equity-related indicators for tracking and impact measurement.<sup>1026</sup>

Health and Wellbeing Queensland noted that enhancing equity and removing system barriers can result in savings by reducing the economic costs associated with inequity in health and other quality of life outcomes. In health specifically, the aim is to reduce hospitalisations, minimise investment waste, improve the precision of interventions and ensure maximum engagement by consumers.<sup>1027</sup>

### **9.2.2 Making Tracks Together – Queensland's Aboriginal and Torres Strait Islander Health Equity Framework**

*Making Tracks Together*, Queensland's Aboriginal and Torres Strait Islander Health Equity Framework, co-designed in partnership with the Queensland Aboriginal and Islander Health Council, is the Queensland Government's commitment to addressing the health inequities apparent in the health system for First Nations peoples in Queensland.<sup>1028</sup>

The Framework seeks to drive health equity, eliminate institutional racism across the public health system and achieve life expectancy parity for First Nations peoples by 2031. In a national first, structural enablers for long term success in addressing this inequity have been established, through the passing of new public health system legislation. This new legislation requires HHSs to prioritise First Nations equity and mandates the participation of Aboriginal and Torres Strait Islander peoples in the design, delivery, monitoring and review of health care services.<sup>1029</sup>

Health and Wellbeing Queensland stated that it was proud to be part of this renewed and shared agenda for First Nations health equity reform and was a prescribed stakeholder in supporting HHSs in

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<sup>1023</sup> Submission 41, p 4.

<sup>1024</sup> Submission 58, p 2.

<sup>1025</sup> Submission 58, p 2.

<sup>1026</sup> Submission 58, p 2.

<sup>1027</sup> Submission 58, p 2.

<sup>1028</sup> Submission 58, p 3.

<sup>1029</sup> Submission 58, p 3.

the development and implementation of their Health Equity Strategies. These strategies aim to improve health outcomes, experiences, and access to care for First Nations Queenslanders across the health system, based on their needs and seek to achieve an equitable future and long and healthy lives for the generations of First Nations Queenslanders to come.<sup>1030</sup>

The committee notes that Health and Wellbeing Queensland will work closely in collaboration with the HHSs and First Nations communities and other prescribed stakeholders, on the priorities identified and help address those preventable conditions and hospitalisations, many of which are caused by social and economic drivers of inequity. The inaugural three-year (2022-2025) Health Equity Strategies will be released in April 2022.<sup>1031</sup>

### **9.3 A coordinated, integrated, person-centred health care system**

A number of submitters including Health and Wellbeing Queensland, HWQ, ACN, OTA, QPHN, JCU, QNMU and the Joint Submission emphasised the importance of establishing a co-ordinated, integrated and person-centred health care system.<sup>1032</sup> QNMU commented:

Unless we join what the federal government is responsible for—which is the funding of aged care, disability and primary health care—with what the state is responsible for, we are going to continue to get more of the same. In our view we need to have a fundamental look at the drivers, otherwise we will just keep putting band-aids on a haemorrhage.<sup>1033</sup>

Health and Wellbeing Queensland highlighted the ‘significant division between healthcare sectors limited by fractured funding arrangements, lack of integrative data systems and siloed approach to service planning’.<sup>1034</sup> However, Queensland Health commented that ‘an effective, sustainable and integrated health care system, underpinned by strong primary care, is key to managing the complex array of issues impacting on Queensland’s public health system’.<sup>1035</sup>

Palliative Care Queensland espoused the value of collaboration and innovative models, including a shift in focus to home-based models of care and transparent funding arrangements, which it argued, can reduce hospital and institution admission and care costs.<sup>1036</sup>

Cancer Council Queensland called for a reorientation of our health system towards integrated management of chronic conditions, stating that it ‘is essential to ease pressure on the public health system’ and that ‘strong primary healthcare that is proactive, rather than reactive, has been proven to provide better health outcomes at lower cost’.<sup>1037</sup>

Health and Wellbeing Queensland mounted a similar argument, stating:

A coordinated, integrated approach to health care is needed to deliver the right care, in the right setting at the right time; responsive to consumer needs informed by evidence. An approach which bridges the

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<sup>1030</sup> Health and Wellbeing Queensland, submission 58, p 2.

<sup>1031</sup> Submission 58, p 2.

<sup>1032</sup> Submissions 17, 25, 41, 58, 65, 66 and 68.

<sup>1033</sup> Public hearing transcript, Brisbane, 8 December 2021, p 8.

<sup>1034</sup> Submission 58, p 3.

<sup>1035</sup> Submission 39, p 4.

<sup>1036</sup> Submission 49, p 10.

<sup>1037</sup> Submission 40, p 2.

## 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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jurisdictional and healthcare sector divide to healthcare planning and delivery is required to leverage sector strengths and reduce service duplication.<sup>1038</sup>

The Joint Submission stated that a multidisciplinary approach involves patients being supported to build a team of health professionals who work collectively to support the patient's needs. This can include GPs, allied health professionals, pharmacists, nurses and medical specialists.<sup>1039</sup>

OTA considered that to adequately service communities, the health workforce must be supported beyond traditional primary health services such as general practice referrals. The OTA stated that:

This requires a primary health workforce that is fully informed of the role of allied health professionals, including occupational therapy, and can therefore ensure that people are able to access the right care, in the right setting. A coordinated system where GPs fully utilise the allied health workforce would help remove barriers for clients to access allied health services.<sup>1040</sup>

OTA contended that by inefficiently funnelling allied health through an already overstretched GP workforce, an unnecessary hurdle is added to accessing multidisciplinary care. In addition to referrals from GPs, access to allied health professionals should be available and encouraged through other primary health programs.<sup>1041</sup>

The Joint Submission advised that ensuring that people living with chronic conditions have access to multidisciplinary care results in better health outcomes for patients and reduced costs to the health system. The Joint Submission noted, however, that:

... current structural, funding and workforce issues do not support the delivery of multidisciplinary care in Queensland. Our health system is siloed and difficult to navigate for patients, particularly those with lower health literacy.<sup>1042</sup>

The Queensland Mental Health Commissioner noted positive examples of existing partnerships, joint planning and co-commissioning of mental health care, for example regional planning and commissioning by HHSs and PHNs, co-designed with community members. The Commissioner recommended that reforms should build on and strengthen programs such as The Way Back Support Service - co-designed and co-commissioning by local HHS and PHNs.<sup>1043</sup>

Queensland Health stated that 'It is critical that patients receive the right care at the right place at the right time'. To achieve this, Queensland Health acknowledged that the Australian Government funded health services and State health system need to 'work together seamlessly'.<sup>1044</sup>

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<sup>1038</sup> Submission 58, p 3.

<sup>1039</sup> Submission 41, p 11.

<sup>1040</sup> Submission 17, p 2.

<sup>1041</sup> Submission 17, p 2.

<sup>1042</sup> Submission 41, p 11.

<sup>1043</sup> Submission 44, p 6.

<sup>1044</sup> Submission 39, p 4.

The following sections focus on practical ways to provide a more coordinated, integrated, person-centred health care system:

- creation of Health Hubs
- satellite hospitals
- Care4Qld Strategy.

### 9.3.1 Creation of additional Health Hubs

Health and Wellbeing Queensland recommended the establishment of Health Hubs across Queensland to enable greater cross-sectoral integration between primary, community, hospital and social care, strengthening the prevention workforce capacity and capability, and partnering with the communities in addressing cultural, social and economic factors contributing to social and health inequalities.

Within a Health Hubs Model, cross-departmental partnerships are expected to empower communities to address the social determinants of health, reducing the burden of chronic illness and improving outcomes. In addition, enhanced integration between primary, secondary and tertiary care settings will create a seamless healthcare system supporting Queensland families to navigate with ease, reducing consumer burden and healthcare costs.<sup>1045</sup>

The committee notes that Health and Wellbeing Queensland has partnered with UQ Health Care to develop and trial a Health Hub model in Logan – Logan Health Living. Under the model, a comprehensive Lifestyle Management Program is delivered by a student-infused allied health workforce in an environment of teaching and research at the Logan Healthcare Centre.<sup>1046</sup>

Metro South HHS, Griffith University, UQ Health Care and Brisbane South PHN have also formed an alliance to develop a model of integrated chronic disease care, which leverages the expertise and resources of a range of partners while recognising that successful prevention and management of chronic disease requires a collaborative approach.<sup>1047</sup>

ACN was also supportive of the health hub model, advising that:

Providing the right care at the right time in the right place, closer to home through integrated care hubs acting as an interface between acute and primary health care offers a solution. Such nurse led models could link specialists and work within PHNs to avoid emergency department admission while working collaboratively with the local PHN.<sup>1048</sup>

QRRPHN confirmed that similar models have been proposed for disability and NDIS, elderly, and rehabilitation, stating:

... all providers are advocating for hubs or one-stop shops where you can co-locate a wide variety of services without the barriers of federal funding versus state funding—whether it is a local government service. We need to make the best use of the dollars that are being invested into local communities and clinicians actually need to be working alongside each other as well.<sup>1049</sup>

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<sup>1045</sup> Health and Wellbeing Queensland, submission 58, p 4.

<sup>1046</sup> Health and Wellbeing Queensland, submission 58, p 4.

<sup>1047</sup> Health and Wellbeing Queensland, submission 58, p 4.

<sup>1048</sup> Submission 66, p 7.

<sup>1049</sup> Public hearing transcript, Cairns, 7 February 2022, p 13.

Committee comment

The committee notes the potential of the health hub model to enable greater cross-sectoral integration between primary, community and hospital and social care to provide seamless care to patients. The committee recommends that the Australian and Queensland Governments explore partnership arrangements to increase capital investment in primary health clinics and health hubs to deal with low acuity presentations that are currently falling on emergency departments.

**Recommendation 38 – Increased investment in primary health clinics and health hubs**

The committee recommends that the Australian and Queensland Governments explore partnership arrangements to increase capital investment in primary health clinics and health hubs to deal with low acuity presentations that are currently falling on emergency departments.

### 9.3.2 Satellite hospitals

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

In addition, in 2020 the Queensland Government announced its Satellite Hospital Program, a \$265 million commitment to deliver seven new facilities to support public healthcare delivery in rapidly growing communities across South East Queensland.<sup>1050</sup>

The committee notes that each facility will provide healthcare services that are more appropriately delivered in community, closer to home and in a more convenient setting. Satellite hospitals aim to:

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

Queensland Health advised that it is expected that one benefit of the program will be to reduce potentially preventable hospitalisations.<sup>1051</sup>

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<sup>1050</sup> Queensland Health, submission 39, p 17.

<sup>1051</sup> Submission 39, p 17.

On 22 February 2022, the Honourable Anastacia Palaszczuk MP, Premier and Minister for the Olympics (the Premier) announced the sites of the seven satellite hospitals:

- Eight Mile Plains
- Ripley
- Tugun
- Caboolture
- Pine Rivers
- Bribie Island
- Redlands.<sup>1052</sup>

The Premier stated that ‘Our satellite hospitals are the first of their kind in Australia’.<sup>1053</sup>  
The Minister for Health elaborated on the plans:

Construction will start later in the year and we hope to have all of these operational in late 2023. This model of care is really important. We know that to continue to improve our health care in this state we need to keep looking at and investing in new innovative ways of delivering care which includes taking the care closer to the community. We know there are a lot of services that are run in our big tertiary hospitals that do not need to be located in those hospitals. This is expensive real estate that should be freed up for overnight beds and for elective and emergency surgery.

We know there are services that we can take out of those hospitals and put into local communities where we have the largest population growth. That would free up space to increase the ward capacity. That is what we are doing with these seven satellite hospitals, an investment of \$265 million by the Palaszczuk government, which is such an exciting initiative—it is a nation-leading initiative—that the Premier and this government has committed to.

This infrastructure, of course, will also support jobs during the construction phase. It will support around 773 local construction jobs, with Hutchinson Builders being appointed the managing contractor. The great and innovative way we have procured this contract is having a single contractor looking after all seven satellite hospitals, which means we can build them quicker and more affordably and ensure we are delivering health care where it is needed: closest to the community.<sup>1054</sup>

Queensland Health advised that satellite hospitals are:

... a major investment by the state government to essentially bridge that gap. They will provide a place which is not a very high cost acute hospital, but it is also not the traditional general practice. It is where services can be provided in that missing middle—be it closer to where people live; be it urgent care which is not in an emergency department but someone needs that care today; be it chemotherapy, renal dialysis and so on; or be it ambulatory care, outpatients or chronic disease care. It is the sort of place where that care can be provided. We would argue that is the Commonwealth’s responsibility but we are stepping in to do that.<sup>1055</sup>

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<sup>1052</sup> Queensland Parliament, Record of Proceedings, 2 February 2022, p 24.

<sup>1053</sup> Queensland Parliament, Record of Proceedings, 2 February 2022, p 24.

<sup>1054</sup> Queensland Parliament, Record of Proceedings, 2 February 2022, p 24.

<sup>1055</sup> Public briefing transcript, Brisbane, 29 November 2021, p 14.

### 9.3.3 Care4Qld Strategy

In response to very high demand for emergency and unplanned care, the Queensland Government has developed the Care4Qld Strategy to improve emergency access and patient flow through Queensland's public hospitals (launched 11 May 2021).

The package targets investment in aspects of the critical care pathway including targeted investment in additional hospital beds, improving models of care and management strategies, and providing alternatives to emergency and hospital admissions where clinically appropriate and aligned to patient outcomes.

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

In addition, Care4Qld makes significant investments to improve access for patients to receive care in community and home-based settings.

This includes permanently expanding Hospital in the Home initiatives which were temporarily established as part of the COVID-19 response, permanently increasing the funding for the Residential Aged Care Support Services (RaSS) for vulnerable elderly populations in communities across Queensland, and funding to pilot targeted expansions of post-acute care services (such as physiotherapists, occupational therapists to support faster and safer discharge from hospital).<sup>1056</sup>

Metro North HHS referred to the Aboriginal and Torres Strait Islander Hospital in the Home initiative, stating that:

It is an initiative with the Institute for Urban Indigenous Health. They will be providing primary health care after admission to hospital. We are piloting that at the moment with the intention that that might open up more broadly for other service providers. It will enable our Aboriginal and Torres Strait Islander community, which in this area we have an over-representation of, to have health care provided in a more appropriate setting. That will reduce some of the impact on our service provision as well as provide outcomes for them.<sup>1057</sup>

In relation to RaSS, Annaleese Ockhuysen, a QNMU member, advised:

Approximately seven years ago my service was a pilot site in Metro South and we developed a hospital and emergency substitutive care service for residential aged-care facilities. We currently service over 100 aged-care facilities in Metro South and it is looking at about 10,000 beds at this point in time.

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<sup>1056</sup> Queensland Health, submission 39, pp 15-16.

<sup>1057</sup> Public hearing transcript, Bribie Island, 9 December 2021, p 6.

People living in residential aged-care facilities present to emergency departments at a rate of 0.1 to 1.5 transfers per residential bed per year, and 40 to 60 per cent of these presentations are admitted to hospital. Prior to the initial COVID outbreak in 2020, smaller equivalent services called RaSS services were rolled out to each of the HHSs to assist with the redistribution of clinical care out of the public sector. We were able to provide aged-care residents with a choice of where they received their emergency care. During the Royal Commission into Aged Care Quality and Safety it was recommended that a service like ours or similar should be rolled out federally, but this is yet to occur. It is only in Queensland that this has happened.<sup>1058</sup>

Committee comment

The committee notes the important work undertaken under the Care4Qld Strategy, including RaSS, in providing acute care services to residents in RACFs. The committee recommends that the Australian Government and Queensland Health collaborate to explore partnership opportunities with aged care providers to expand RaSS, or other similar services, to all HHS regions and service areas across Queensland.

**Recommendation 39 – Australian Government and Queensland Health to collaborate to explore opportunities to expand Residential Aged Care Support Services, or similar type services**

The committee recommends that the Australian Government and Queensland Health collaborate to explore partnership opportunities with aged care providers to expand Residential Age Care Support Services, or other similar services, to all Hospital and Health Service regions and service areas across Queensland.

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<sup>1058</sup> Public hearing transcript, Gold Coast, 10 February 2022, p 10.

#### 9.4 Future role of telehealth

The Australian Government advised that the introduction of MBS telehealth items has had a significant effect on the way that patients access primary care.<sup>1059</sup>

In 2020-21, over 171.5 million non-referred GP consultations were provided through the MBS nationally – a 5.1 per cent increase over the previous 12 months. Over 38 million of these services were provided by telehealth.<sup>1060</sup>

The Australian Government noted that this increased access to care extends to the after-hours period, stating:

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.<sup>1061</sup>

The Australian Government contended that the introduction of telehealth has proved popular with patients, with the 2020-21 Australian Bureau of Statistics report on Patient Experiences in Australia showing that more than 83 per cent of respondents reported that they would use telehealth for a consultation again if it was offered.<sup>1062</sup>

The Australian Government stated that, in September 2020, it 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 PHN 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.<sup>1063</sup>

ACN, and other submitters, supported the retention of the MBS telehealth items, stating that ‘... it can help to address the urban/rural divide that exists in access and equity to healthcare services’.<sup>1064</sup> However, ACN noted that:

Telehealth is not a substitute for face-to-face visits to health care providers, but it can provide a flexible and convenient option to supplement traditional visits. Telehealth may also improve coordination of care by allowing for case conferencing between a patient and the various members of their care team, such as their nurse, GP, allied health providers and specialists. Virtual health care must be underpinned by a strong clinical governance framework that ensures high levels of safety, quality and effectiveness.<sup>1065</sup>

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<sup>1059</sup> Submission 75, p 8.

<sup>1060</sup> Submission 75, p 8.

<sup>1061</sup> Submission 75, p 8.

<sup>1062</sup> Submission 75, p 8.

<sup>1063</sup> Submission 75, p 8.

<sup>1064</sup> Submission 66, p 3.

<sup>1065</sup> Submission 66, p 8.

## 9.5 Innovative models of care

The committee notes that innovative models of care have been developed to counter the lack of flexibility and adaptability in the primary healthcare funding system.<sup>1066</sup> ACN, and other submitters, advocated for the establishment of innovative, multidisciplinary and integrated community and primary health care models of care in Queensland.<sup>1067</sup> For example, QPHN stated that:

Innovative models of care that build the capacity of the practice team through incorporating nurses and allied health specialties to broaden the expertise available, would enable person-centred, team-based care within a region or community.<sup>1068</sup>

QNMU noted that the COVID-19 pandemic forced government and health care providers to consider alternative ways to deliver health care and adapt and develop new strategies, including:

- virtual care which improves access and convenience for patients, eg virtual diabetes clinics
- Hospital in the Home – a hospital avoidance strategy implemented to treat and monitor patients in the home
- triaging models and assessment tools such as in-car triage/fever clinics and open-air consultations where patients arrive in their car, drive-through to where nurses take swabs, from which the sample is sent for COVID-19 testing
- telehealth
- 13Health – health advice provided by registered nurses over the phone
- testing and fever and vaccination pop-up clinics.<sup>1069</sup>

QNMU recommended that the Queensland Government evaluate the innovative models of care established in response to the COVID-19 pandemic with a view to those models being retained as regular practice.<sup>1070</sup>

### 9.5.1 Australian Capital Territory – walk-in-centres

In 2010, the Australian Capital Territory (ACT) established walk-in-centres, providing free primary health care services to the community across five locations without the need for an appointment.

The clinics are located at the Community Health Centres at five locations across the ACT and are open from 7:30am to 10:00pm daily, including public holidays.

The committee understands that these nurse-led clinics offer advanced practice nursing care, innovative and cost effective nurse-led models of care which aim to improve access to health care and give people choice while also enhancing the patient's experience.

ACN stated that these clinics are run by highly skilled nurse practitioners and advanced practice nurses who undertake comprehensive assessment, provide timely person-centred care, opportunistic

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<sup>1066</sup> See QRRPHN, submission 70, p 9.

<sup>1067</sup> Submissions 65 and 66.

<sup>1068</sup> Submission 65, p 3.

<sup>1069</sup> Submission 69, p 7.

<sup>1070</sup> Submission 69, p 7.

education and support, continuity of care and link patients to other health professionals and services and take pressure off emergency departments.<sup>1071</sup>

ACT Public Health Services reported that in quarter 3, 2021 Walk-in-Centres managed:

- 19,404 presentations
- 44,600 presentations at COVID-19 Testing Centres.<sup>1072</sup>

It also reported that 75.7 per cent of its presentations received treatment at the Walk-in-Centres, without the need for redirection to another service, such as an emergency department or GP.<sup>1073</sup>

### 9.5.2 Queensland Health's New Models of Care Projects

Queensland Health's *New Models of Care Projects* have established allied health practitioners, including physiotherapists, as the first practitioner point of contact in the hospital system for eligible patients. For example:

- physiotherapists delivering primary contact services in emergency departments – treating clients with a range of agreed musculoskeletal presentations. This first point of contact typically includes assessment, intervention, and referral on for further assessment, treatment and discharge as appropriate. This service has assisted HHSs to meet emergency length of stay targets
- physiotherapy-led primary contact model of care support female patients referred to gynaecological, colorectal and urological specialist outpatient department services. Physiotherapists provide early conservative management, thereby reducing unnecessary referrals and associated waiting times, and providing specialists with increased time and capacity to see patients that require medical intervention.<sup>1074</sup>

The Joint Submission stated that Innovative Models of Care, such as GPs with a special interest and outreach hub and spoke models are needed if we want to maximise the limited resources that we have available.<sup>1075</sup> The Joint Submission considered that this can only occur with collaboration and communication. It strongly supported the importance of Statewide Clinical Networks, which facilitate information sharing and build connections across the silos of the health system. The Joint Submission stated that the work of these networks was vital in reducing duplication and achieving systems-level thinking.

The Joint Submission welcomed the recent creation of the Queensland Aboriginal and Torres Strait Islanders Clinical Network and called for other gaps in the provision of these clinical networks to be addressed.<sup>1076</sup>

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<sup>1071</sup> Submission 66, p 6; R Fedele, 2020, 'How nurse-led models of care are reshaping healthcare – ACT's Walk in Centres', *Australian Nursing and Midwifery Journal*, <https://anmj.org.au/leading-the-wayhow-nurse-led-models-of-care-are-reshaping-healthcare-walk-in-centre-kirsten-madsen/>.

<sup>1072</sup> ACT Health Quarterly Performance Report - Quarter 3 - 2020-21, p 7. <https://health.act.gov.au/sites/default/files/2021-07/Quarter%203%2C%202020-21%20QPR.PDF>.

<sup>1073</sup> ACT Health Quarterly Performance Report - Quarter 3 - 2020-21, p 8. <https://health.act.gov.au/sites/default/files/2021-07/Quarter%203%2C%202020-21%20QPR.PDF>.

<sup>1074</sup> Submission 57, p 5.

<sup>1075</sup> Submission 41, p 13.

<sup>1076</sup> Submission 41, p 12.

### 9.5.3 Multidisciplinary models of care and health professionals working to full scope of practice

A number of submitters, including ACN, QNMU and Pharmacy Guild of Australia, considered that a solution to ease the current pressures on Queensland's public health system was to support the use of multidisciplinary teams and permit allied health practitioners, eg pharmacists, nurse practitioners, paramedics, to work to their full scope of practice.<sup>1077</sup>

In his submission, former paramedic, Associate Professor Ray Bange OAM stated:

Registered Nurses, Nurse Practitioners and Paramedics may be the most qualified local health professionals available in rural areas to cater for unscheduled and acute care events. They are also the professionals most likely to be able to complement and support a GP and maximise the patient care.<sup>1078</sup>

QNMU considered that an essential component in delivering primary health care is through multidisciplinary teams, working together to improve health outcomes for patients and reduce the strain on the wider health care system. QNMU stated that health practitioners from a range of health disciplines, and with varied skill mixes deliver comprehensive, coordinated primary health care with significant benefits that include:

- reduced emergency department visits
- reduced hospital admissions and readmissions
- reduced inappropriate healthcare interventions
- reduced duplication of services
- care that is better aligned to patient and family needs
- care that is collaborative
- decreased total health spending
- a healthier, more supported population.<sup>1079</sup>

At the public hearing in Longreach, the representative from JCU Murtupuni Centre for Rural and Remote Health provided the example of Gidgee Healing, an Aboriginal community controlled health service, which operates on a multidisciplinary model:

It has similar sorts of things like a GP, so people will see a doctor. In smaller communities you might have a nurse practitioner who does that. Ideally in the bigger centres they will have wraparound services such as all your allied health services. Because it is holistic, they might have child services or social services. Aged care is coming into the mix now for Gidgee. Care will be different in that you will see Aboriginal and Torres Strait Islander health practitioners or health workers at the coalface. It will be led by health workers. It is a multidisciplinary comprehensive team that deals with that. It is different in the sense that it is more holistic, I would say—it is that patient journey right through.<sup>1080</sup>

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<sup>1077</sup> Submissions 45, 66 and 69.

<sup>1078</sup> Submission 50, p 9.

<sup>1079</sup> Submission 69, p 8.

<sup>1080</sup> Public hearing transcript, Longreach, 4 March 2022, p 20.

### 9.5.3.1 *Nurse-led models of care*

QNMU recommended that the Queensland Government support the growth of innovative nursing and midwifery models of care, which it considered would enhance the ongoing sustainability and safety of the public health system.<sup>1081</sup> QNMU encouraged:

... the Queensland and federal governments to: invest in the health system by committing to working with us on joint immediate solutions, such as nurse and midwife-led models of care that are part of a multidisciplinary health care team in community settings; identify long-term solutions for a sustainable health system, given that the economy includes workforce planning, recruitment and retaining of not only nurses and midwives but all health practitioners.<sup>1082</sup>

ACN noted the fundamental role nurses can play in such models, referring to the substantial evidence that suggests that ‘... nurse-led models of care can not only improve patient outcomes ... but can also reduce costs and unnecessary hospitalisations’.<sup>1083</sup>

QNMU referred to research that demonstrates that ‘nurse-led and midwife-led models of care do not dilute access to or quality of primary health care services but strengthens the provision and access to primary health care’.<sup>1084</sup>

QNMU referred to research which shows that nurse-led models of care:

- improved access to healthcare services, particularly in rural and remote areas
- provided co-ordinated care across acute and community boundaries
- improved continuity of care by acting as a link between primary health care services and other health service providers
- increased early intervention of health issues through building a rapport with the patient and community
- reduced avoidable emergency department/hospital admissions and ambulance trips.<sup>1085</sup>

QNMU member, Kim Rayner explained the health benefits of nurse-led models of care:

In summary, the nurse/nurse practitioner-led primary healthcare models of care increase patient access to high-quality, cost-effective, person centred care in a timely manner. They reduce unnecessarily and costly hospital representations or presentations and inpatient stays, freeing up the public health system’s capacity. They provide timely assessment, diagnosis and improved management and monitoring of chronic and complex health conditions in the community, preventing those hospital presentations. They allow for enhanced access to health care and social support services. Early intervention can respond to complex community and individual healthcare needs and meet service system gaps effectively and efficiently. Given the nursing skill set and high level of training in collaborative skills, nurse-led models can provide direct clinical care while also providing effective, outcomes focused care coordination across

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<sup>1081</sup> Submission 69, p 5.

<sup>1082</sup> Public hearing transcript, Brisbane, 8 December 2021, pp 6-7.

<sup>1083</sup> Submission 66, pp 5-6.

<sup>1084</sup> Submission 69, p 9.

<sup>1085</sup> Submission 69, p 9; C Douglas, D Schmalkuche, D Nizette, P Yates and A Bonner, 2018, ‘Nurse-led services in Queensland: A scoping study’, *Collegian*, pp 363-370.

many domains in a person's life. One of our greatest strengths is to pull things together to resolve the fragmentation that is occurring.<sup>1086</sup>

Ms Rayner also explained that nurse-led models of care can address hospital avoidance and improve quality-of-life outcomes for vulnerable populations through targeted, accessible and flexible outreach services.<sup>1087</sup>

### 9.5.3.2 *Nurse navigators*

In 2016, Queensland Health introduced nurse navigators to address the fragmentation of health care being delivered; assist patients with co-ordinating their care; and keep patients well and out of hospital. QNMU referred to the successful introduction of nurse navigators, advanced practice registered nurses, in delivering nurse-led models of care.<sup>1088</sup> Nurse navigation models deliver person-centred care co-ordination, create partnerships with patients and between stakeholders in patient care, improving patient outcomes and facilitating system improvements.<sup>1089</sup>

QNMU advised that preliminary reports of the benefits of the introduction of nurse navigators in Queensland are 'extremely encouraging'. For example, the Torres and Cape HHS reported:

- a 61 per cent decrease in visits to emergency departments
- a 77 per cent decrease in unplanned re-admissions to emergency departments
- a 58 per cent decrease in hospital bed days per month
- a 61 per cent decrease in total hospital bed days.<sup>1090</sup>

QNMU also highlighted the important work undertaken by disability nurse navigators in providing person-centred care to people with a disability and interacting with the NDIA in an advocacy capacity.<sup>1091</sup>

### 9.5.3.3 *Nurse practitioners*

QNMU also highlighted the important role played by nurse practitioners in the delivery of primary health care.<sup>1092</sup>

Nurse practitioners are experienced registered nurses educated to master's degree level and competent to function autonomously and collaboratively in an expanded position. Nurse practitioners have access to the MBS and PBS and provide high levels of clinically focused autonomous nursing care.

QNMU stated that a recent cost-benefit analysis report produced for the Department of Health identified that for nurse practitioners to be effective they should not be regarded as a substitute for

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<sup>1086</sup> Public hearing transcript, Brisbane, 21 February 2022, p 30.

<sup>1087</sup> Public hearing transcript, Brisbane, 21 February 2022, p 29.

<sup>1088</sup> Submission 69, p 10.

<sup>1089</sup> C Hannan-Jones, G Mitchell and A Mutch, 2021, 'The nurse navigator: Broker, boundary spanner and problem solver', *Collegian*, pp 622-627.

<sup>1090</sup> Submission 69, pp 10 -11.

<sup>1091</sup> Submission 69, p 11.

<sup>1092</sup> Submission 69, p 11.

GPs, but rather as an opportunity for meeting unmet needs and were seen as valuable particularly in rural and remote areas and residential aged care facilities.<sup>1093</sup>

QNMU referred to successful nurse practitioner-led models of care which provide after-hours urgent care for rural communities. QNMU stated that after-hours nurse practitioner roles emerged as multi-faceted, able to use their advanced clinical skills and provide holistic care in rural communities. QNMU stated that 'Utilising NPs in primary health care in rural communities will alleviate the burden on GPs and hospital services and contribute to primary health care access for all'.<sup>1094</sup> They also referred to the ACT Walk-in clinics as an example of a successful nurse-led model of care.<sup>1095</sup>

#### *9.5.3.1 Utilising the full scope of practice – nurses and nurse practitioners*

ACN contended that a number of the issues impacting on Queensland's public health system could be mitigated by allowing nurses, in particular nurse practitioners and advanced practice nurses, to 'fill the gap that doctors are unable to bridge'.<sup>1096</sup>

QNMU agreed, stating that nurses and midwives working to their full scope of practice were able to improve the health of the community through preventive health and chronic and complex disease management, which keeps people well and out of hospital.<sup>1097</sup>

ACN stated that evidence suggests that when nurses can effectively utilise their skills, knowledge, and expertise in the provision of health care, patient outcomes improve dramatically, while job satisfaction and retention increase.<sup>1098</sup>

ACN recommended removing barriers to community and primary health care nurses working to their full scope of practice through targeted funding for research, legislative changes to improve incentives and employment conditions, enhanced and relevant professional development and mentoring, further funding for transition to practice programs and clearer pathways for advancement.<sup>1099</sup>

ACN recommended that the Australian Government focuses on the approximately 44,000 advanced practice nurses in Australia that are unable to work to their full scope of practice, but who are already deployed in their respective communities, along with investing in developing a stronger nurse practitioner workforce that numbers just over 2,000 after having been present in Australia for over twenty years.<sup>1100</sup>

Queensland Health recommended that the Australian Government increases the scope of practice for nurse practitioners in primary health care, aged care and mental health.<sup>1101</sup>

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<sup>1093</sup> Submission 69, p 11.

<sup>1094</sup> Submission 69, p 11.

<sup>1095</sup> Submission 69, p 11.

<sup>1096</sup> Submission 66, p 2.

<sup>1097</sup> Submission 69, p 31.

<sup>1098</sup> Submission 66, p 7.

<sup>1099</sup> Submission 66, p 3.

<sup>1100</sup> Submission 66, p 10.

<sup>1101</sup> Submission 39, p 34.

Committee comment

The committee notes the important role that nurse navigators and nurse practitioners can play in helping co-ordinate care for patients and the delivery of primary health care, ultimately leading to less hospitalisations and reducing the burden on the public health system.

The committee recommends that the Australian and Queensland Governments collaborate to explore opportunities to:

- increase the scope of practice of nurses and nurse practitioners in primary health care settings
- consider trialling nurse-led and nurse practitioner-led models of care and walk-in-clinics for low acuity episodes of care, similar to the model adopted in the Australian Capital Territory.

**Recommendation 40 – Scope of practice and nurse-led models of care**

The committee recommends that the Australian and Queensland Governments collaborate to explore opportunities to:

- increase the scope of practice of nurses and nurse practitioners in primary health care settings
- consider trialling nurse-led and nurse practitioner-led models of care and walk-in-clinics for low acuity episodes of care, similar to the model adopted in the Australian Capital Territory.

9.5.3.2 Pharmacists

PSA stated that pharmacists are generally considered the most accessible health care professionals, and as such are well placed to provide support to rural and remote communities as a way to avoid hospitalisation and relieve pressure on the Queensland public health system.<sup>1102</sup>

Submitters stated that pharmacists working to their full scope of practice possess the competencies to contribute to patient care in the following ways:

- non-medical prescribing – structure prescribing arrangements (protocols) and autonomous/independent prescribing
- dispensing – medicine supply and dispensing of a prescription
- review – medicine reconciliation and review of current therapy
- administration – administration of vaccines, other injectable medicines and other non-injectable medicines.<sup>1103</sup>

The Pharmacy Guild of Australia noted that ‘in many rural and remote areas, the local community pharmacy is often the only primary healthcare provider immediately accessible to meet the community’s urgent healthcare needs’.<sup>1104</sup> It stated that Queensland’s extensive network of approximately 1,200 pharmacies could be further leveraged to provide additional support to general practice and the public health system to achieve sustainable, accessible and high-quality healthcare.<sup>1105</sup>

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<sup>1102</sup> Submission 47, p 4.

<sup>1103</sup> Submissions 45 and 47.

<sup>1104</sup> Submission 45, p 2.

<sup>1105</sup> Submission 45, p 2.

The Pharmacy Guild of Australia stated ‘more than one third of Queensland’s emergency department presentations are ailments or injuries that could be treated by a pharmacist if authorised’.<sup>1106</sup>

PSA stated that an alternative care model, wherein pharmacists provide assessment, triage and management of cases deemed non-urgent would significantly reduce the burden on the Queensland public health system, as well as reducing state government expenditure. PSA stated that some estimates suggest between 2.9 and 11.5 per cent of all emergency department services in Australia could be managed solely by community pharmacists, meaning up to 179,610 emergency department presentations in Queensland could be safely transferred to this model of care.<sup>1107</sup>

Other stakeholders raised concerns about increasing the scope of practice of pharmacists citing safety concerns and concerns that the person prescribing medication should not also be selling it.<sup>1108</sup>

#### Committee comment

During its Inquiry, the committee noted the success of a number community pharmacist trials, which provide quality health care previously considered outside their scope of practice:

- *administering vaccinations* - prior to 2014, pharmacists in Australia were not authorised to vaccinate. With the support of Queensland Health, Queensland pharmacists were the first to be authorised to vaccinate in Australia as part of the Queensland Pharmacy Immunisation Pilot. Now over 740 pharmacies in Queensland are providing vaccination services and participating in the COVID-19 vaccine roll out
- *Urinary Tract Infection Pilot (UTIPPQ)* - over 6,000 women accessed UTI treatment through Queensland community pharmacies. The current UTIPP-Q pilot was due to compete on 15 December 2021 however, it has been extended until 30 June 2022 while the outcomes of the pilot evaluation, and the future mechanisms to support the service within Queensland, can be progressed within Queensland Health<sup>1109</sup>
- *Reducing Medical Admissions and Presentations into Hospital through Optimising Medicines (REMAIN Home)* - places non-dispensing pharmacists in 14 general practices with the explicit task of supporting the management of patients who had been hospitalised

The intervention provided comprehensive face-to-face medicine management consultation with an integrated practice pharmacist within seven days of discharge, followed by a consultation with their GP and further pharmacist consultations as needed.<sup>1110</sup>

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<sup>1106</sup> Submission 45, p 2.

<sup>1107</sup> Submission 47, p 5.

<sup>1108</sup> See RACGP, submission 73, p 5; Dr Heather McNamee, public hearing transcript, Mossman, 8 February 2022, p 1.

<sup>1109</sup> Submission 45, p 2.

<sup>1110</sup> Christopher R Freeman et al, ‘Reducing Medical Admissions and Presentations into Hospital through Optimising Medicines (REMAIN HOME): a stepped wedge, cluster randomised controlled trial’, *Medical Journal of Australia*, 214 (5), 15 March 2021, p 212.

The study found that combined re-admission and emergency department presentation incidence were significantly lower for intervention patients than for those in the control group. In addition, the estimated incremental net cost benefit of the intervention was \$5072 per patient, with a benefit–cost ratio of 31:1.<sup>1111</sup>

It concluded that a collaborative pharmacist–GP model of post-hospital discharge medicines management can reduce the incidence of post-hospital discharge and hospital re-admissions and emergency department presentations, achieving substantial cost savings to the health system.<sup>1112</sup>

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<sup>1111</sup> Christopher R Freeman et al, 'Reducing Medical Admissions and Presentations into Hospital through Optimising Medicines (REMAIN HOME): a stepped wedge, cluster randomised controlled trial', *Medical Journal of Australia*, 214 (5), 15 March 2021, p 212.

<sup>1112</sup> Christopher R Freeman et al, 'Reducing Medical Admissions and Presentations into Hospital through Optimising Medicines (REMAIN HOME): a stepped wedge, cluster randomised controlled trial', *Medical Journal of Australia*, 214 (5), 15 March 2021, p 212.

## Appendix A – Submitters

<b>Sub #</b>	<b>Submitter</b>
001	Number not used
002	Torres and Cape Hospital and Health Service
003	Number not used
004	Name Withheld
005	Name Withheld
006	Elizabeth Breene
007	Number not used
008	Parkinson's Queensland Incorporated
009	Theo and Elisabeth Moret
010	Number not used
011	Caryn Quinn
012	BallyCara
013	Australian College of Rural and Remote Medicine
014	The University of Queensland
015	Number not used
016	The Public Advocate
017	Occupational Therapy Australia
018	Number not used
019	William and Sandra Tento
020	Dr Maureen Mitchell with supplementary submission
021	Institute for Urban Indigenous Health
022	Professor Claire Jackson
023	Indigenous Wellbeing Centre
024	Queensland Law Society
025	Health Workforce Queensland
026	Health Services Union NSW, ACT, QLD
027	Hepatitis Queensland
028	Australian Medical Association Queensland

029	Gold Coast Retirees Inc.
030	Brisbane South Primary Health Network
031	Confidential
032	Logan City Council
033	Australian Psychological Society
034	Office of the Health Ombudsman
035	John Morris
036	United Workers Union
037	Queensland Network of Alcohol and Other Drug Agencies Ltd
038	Joe Kelly MP, Member for Greenslopes
039	Queensland Health
040	Cancer Council Queensland
041	Joint NGO submission
042	Allied Health Professions Australia
043	Confidential
044	Queensland Mental Health Commission
045	Pharmacy Guild of Australia
046	Together
047	Pharmaceutical Society of Australia - Queensland Branch
048	COTA Queensland
049	Palliative Care Queensland
050	Associate Professor Ray Bange OAM
051	Arthritis Queensland
052	Allied Aged Care
053	Loris Doessel plus supplementary submission
054	Aged and Disability Advocacy Australia
055	Nicole Wynn
056	Name Withheld
057	Australian Physiotherapy Association
058	Health and Wellbeing Queensland

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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- 059 Community Nurse Service PTY LTD
- 060 Lung Foundation Australia
- 061 Exercise and Sport Science Australia
- 062 Shane Knuth MP, Member for Hill
- 063 Ali King MP, Member for Pumicestone
- 064 Moura Community Advisory Group
- 065 Queensland Primary Health Network
- 066 Australian College of Nursing
- 067 Australian and New Zealand Society of Palliative Medicine
- 068 James Cook University
- 069 Queensland Nurses and Midwives' Union
- 070 Queensland Rural and Remote Primary Health Networks
- 071 Diabetes Queensland
- 072 Independent Advocacy North Queensland
- 073 The Royal Australian College of General Practitioners
- 074 Julie Glenn
- 075 Australian Government
- 076 Jason Harrison
- 077 Frank Perry
- 078 Dr Chris Jackson
- 079 Australian Society of Anaesthetists

## **Appendix B – Officials at public departmental briefing**

**29 November 2021**

### **Queensland Health**

- Dr John Wakefield PSM, former Director-General
- Associate Professor John Allan, Executive Director, Mental Health, Alcohol and Other Drugs Branch
- Mr David Harmer, Senior Director, Social Policy and Legislation Branch
- Professor Keith McNeil, Acting Deputy Director-General, Prevention Division and Chief Medical Officer
- Ms Deborah Miller, Acting Chief Nursing and Midwifery Officer

### **Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships**

- Ms Kathy Parton, Acting Director-General
- Mr Max Wise, Assistant Director-General, Disability and Seniors Connect

### **Department of Education**

- Ms Carmel Ybarlucea, Executive Director, State Schools – Disability and Inclusion
- Ms Hayley Stevenson, Executive Director, State Schools – Operations

## **Appendix C – Witnesses at public hearings**

### **8 December 2021 – Brisbane**

#### **Services for Australian Rural and Remote Allied Health**

- Mr Edward Johnson, President
- Ms Cath Maloney, Chief Executive Officer
- Mr Allan Groth, Director Policy and Strategy
- Ms Rachel Tosh, Speech Pathologist

#### **Queensland Nurses and Midwives' Union**

- Ms Beth Mohle, Secretary
- Ms Deborah Twigg, Senior Research and Policy Officer
- Mr Dan Prentice, Professional Research Officer

#### **Health Consumers Queensland**

- Ms Melissa Fox, Chief Executive Officer

#### **Primary Health Network (PHN) Cooperative – Queensland**

- Ms Libby Dunstan, Chief Executive Officer, Brisbane North PHN
- Ms Karin Barron, Executive Director, Health System Integration and Innovation, Northern Queensland PHN

#### **Griffith University**

- Professor David Ellwood, Head of School of Medicine and Dentistry, and Dean of Medicine

#### **Cancer Council Queensland**

- Ms Carly Hyde, Senior Policy Advisor

#### **Lung Foundation Australia**

- Ms Paige Preston, Advocacy and Policy Manager

#### **Arthritis Queensland**

- Ms Emma Thompson, Chief Executive Officer

#### **ForHealth Group**

- Ms Kim Pryce-Lunt, General Manager
- Dr Clive Tucker, Regional Clinical Director

#### **Australian College of Rural and Remote Medicine**

- Dr Daniel Halliday, Board Member

#### **Regional Australia Institute**

- Dr Kim Houghton, Acting Chief Executive Officer

#### **Queensland Ambulance Service**

- Dr Stephen Rashford, Medical Director

## **9 December 2021 – Bribie Island**

### **Metro North Hospital and Health Service**

- Ms Angie Dobbrick, Executive Director, Caboolture, Kilcoy & Woodford Clinical Directorate

### **Ningi Doctors**

- Dr Stephen Kearney, Practice Owner

### **Goodwin Drive Family Medical Centre**

- Ms Angela De-Gaetano, Practice Manager

### **Bribie-Moreton Hospice Health Services Incorporated**

- Ms Maree Cunningham, Honorary Secretary

### **Home Instead Brisbane North and Caboolture**

- Ms Annette Lourigan, Care Manager

### **Allied Aged Care**

- Mr Alwyn Blayse

### **Disability Advocate and Spinal Life Australia**

- Mr Bill Peacock

### **Pumicestone Indigenous Education and Employment Council Inc and First Nations Bribie Island Community Elders Group**

- Ms Michelle Watson

### **First Nations Bribie Island Community Elders Group**

- Ms Flo Watson

### **Individual speakers**

- Mr Theo Moret
- Mrs Elisabeth Moret
- Mr John Morris
- Ms Tania Walkerden
- Mr Ron Watson
- Mrs Janet Watson

## **7 February 2022 – Cairns**

### **Cairns and Hinterland Hospital and Health Service**

- Ms Tania Cavanagh, Acting Executive Director, Allied Health
- Dr Edward Strivens, Clinical Director, Older Persons Health Services

### **Northern Queensland Primary Health Network**

- Ms Robin Whyte, Chief Executive Officer

### **James Cook University**

- Professor Denise Doolan, Acting Director Research Portfolio, Australian Institute of Tropical Health and Medicine
- Dr Aileen Traves, Senior Lecturer – Medicine, College of Medicine and Dentistry, (General Practitioner - Thrive Medical Cairns)
- Professor Caryn West, Professor of Nursing, College of Healthcare Sciences
- Professor Peter Thomson, Head of Dentistry and Professor of Oral and Maxillofacial Sciences

### **Tableland Community Link Association Inc.**

- Ms Carrie de Brueys, Service Manager

### **Individual speakers**

- Dr Louise Burns

## **8 February 2022 – Mossman**

### **Cairns Sexual Health Service**

- Dr Heather McNamee, General Practitioner

### **James Cook University**

- Dr Steve Salleras, Medical Educator and General Practitioner, College of Medicine and Dentistry

### **Queensland Nurses and Midwives' Union**

- Mr Sam Mills, First Nations Branch Member
- Ms Yoko Nakata, Member
- Mr David Beckham, Organiser
- Mr Shaun Cram, Member

### **Individual speakers**

- Mr Bill Allison

## **9 February 2022 – Townsville**

### **Townsville Hospital and Health Service**

- Ms Danielle Hornsby, Executive Director, Allied Health

### **Royal Australian College of General Practitioners**

- Dr Michael Clements, Chair RACGP Rural

### **James Cook University**

- Professor Richard Murray, Deputy Vice-Chancellor, Division of Tropical Health and Medicine
- Professor Sarah Larkins, Dean, College of Medicine and Dentistry
- Associate Professor Anne Jones, Head of Physiotherapy

### **Healthlink Family Medical Centre**

- Mr Kevin Gillespie, Director

#### **APR Disability Services**

- Mr Peter Adami, Chief Executive Officer

#### **Townsville Multicultural Support Group**

- Ms Catherine O’Toole, President, Management Committee
- Ms Stephanie Naunton, General Manager
- Ms Rukiye Apaydin

#### **Wulli Wulli Indigenous Disability Services**

- Mr Graham Pattel, Director

#### **ABIS Housing**

- Mrs Angelina Akee, Chairperson
- Mr Francis Tapim, Community Elder, Torres Strait

#### **Individual speakers**

- Dr Will Cairns
- Ms Erin Robino

#### **10 February 2022 - Logan**

##### **Metro South Hospital and Health Service**

- Ms Rachel Phillips, Executive Director, Allied Health

##### **Brisbane South Primary Health Network**

- Mr Michael Bosel, Chief Executive Officer

##### **Inala Primary Care Ltd**

- Ms Tracey Johnson, Chief Executive Officer

##### **Salvation Army**

- Ms Robyn Masters, Child Health Pathways Program Lead

##### **Individual speakers**

- Mrs Lenore (Wendy) Beresford
- Ms Jocelyn (Jos) Hall
- Mrs Anne Turnbull

#### **10 February 2022 – Gold Coast**

##### **Gold Coast Hospital and Health Service**

- Ms Sara Burrett, Executive Director, Allied Health and Rehabilitation Services
- Ms Karen Spence, Acting Program Manager, Integrated Care Services

##### **Queensland Nurses and Midwives’ Union**

- Ms Annaleese Ockhuysen, Member
- Mr Scott Stringer, Member

- Ms Paula Rogers, Community Campaigns Coordinator

### **11 February 2022 - Brisbane**

#### **Australian Medical Association Queensland**

- Mr Jeffrey Allen, Policy Manager
- Dr Maria Boulton, Chair, Council of General Practice

#### **Pharmacy Guild of Australia - Queensland**

- Professor Trent Twomey, National President
- Mr Chris Owen, Branch President
- Mr Gerard Benedet, Branch Director

#### **University of Queensland Faculty of Medicine**

- Associate Professor Riitta Partanen, Director of Rural Clinical School

#### **Aged and Disability Advocacy Australia**

- Mr Geoff Rowe, Chief Executive Officer
- Ms Karen Williams, Principal Solicitor

#### **COTA Queensland**

- Mr Mark Tucker-Evans, Chief Executive Officer
- Ms Stephanie Power, Research Assistant
- Mr John Stalker, Policy Co-ordinator
- Mr Paul Gabbert, Project Officer, Community and Stakeholder Engagement

#### **Queensland Mental Health Commission**

- Mr Ivan Frkovic, Commissioner

#### **Logan City Council**

- Cr Darren Power, Mayor

#### **Australian College of Nursing**

- Professor Kylie Ward, Chief Executive Officer

#### **Australian Counselling Association**

- Mr Philip Armstrong, Chief Executive Officer
- Mr Isaac Ryan, Policy and Government Relations Officer

#### **Health Workforce Queensland**

- Dr Ross Maxwell, Chair
- Mr Chris Mitchell, Chief Executive Officer

#### **Health and Wellbeing Queensland**

- Dr Robyn Littlewood, Chief Executive Officer
- Ms Joanna Munro, Director, Health System Partnerships

### **Individual speakers**

- Associate Professor Ray Bange OAM
- Dr Maureen Mitchell

### **21 February 2022 – Brisbane**

#### **Torres and Cape Hospital and Health Service**

- Ms Vivienne Sandler, Executive Director, Allied Health

#### **Allied Health Professions Australia**

- Ms Claire Hewat, Chief Executive Officer

#### **Australian Physiotherapy Association**

- Mr Nick Marshall, Queensland Branch President

#### **Exercise and Sport Science Australia**

- Ms Anita Hobson-Powell, Chief Executive Officer
- Dr Camilla Williams, Accredited Exercise Physiologist

#### **United Workers Union**

- Ms Fiona Scalon, Ambulance Co-ordinator
- Mr Nicholas Lentakis, State Council Delegate
- Ms Amy Gomes, State Council Delegate
- Mr Jamie Rhodes-Bates, State Council Delegate

#### **Queensland Nurses and Midwives' Union**

- Ms Kim Rayner, Member
- Mr Sye Hodgman, First Nations Strategy, Policy and Research Officer
- Mr Sam Mills, First Nations Branch Member
- Ms Yoko Nakata, Member

#### **Individual Speaker**

- Ms Ruth Marsh

### **2 March 2022 – Bundaberg**

#### **Wide Bay Hospital and Health Service**

- Mr Stephen Bell, Executive Director, Allied Health

#### **Indigenous Wellbeing Centre**

- Mr Wayne Mulvany, Chief Executive Officer
- Dr Alicia Kohn, Medical Director

#### **Community Nurse Service**

- Ms Sandra Ilett, Director and Nurse Continence Specialist

#### **IMPACT Community Health Service**

- Ms Tanya O'Shea, Managing Director
- Ms Pamela Mackie, Practice Manager

#### **James Cook University**

- Dr Cynthia Jackson, Medical Educator - Wide Bay, Practice Principal - Childers Family Medicine

#### **Individual speakers**

- Ms Josie Meng
- Mr Patrick Tomkins
- Mr Martin Morison

### **3 March 2022 – Rockhampton**

#### **Central Queensland Hospital and Health Service**

- Ms Kerrie-Anne Frakes, Executive Director, Rockhampton Business Unit

#### **Rural Health Management Services, Central Queensland Rural Division of General Practice**

- Ms Sandra Corfield, Chief Executive Officer

#### **James Cook University**

- Professor Sabina Knight AM, Director of Murturpuni Centre for Rural and Remote Health (Mount Isa) Director of Central Queensland Centre for Rural and Remote Health

#### **Central Queensland Multicultural Association**

- Ms Dawn Hay, President

#### **Individual speakers**

- Ms Linda Kirby

### **4 March 2022 – Longreach**

#### **Central West Hospital and Health Service**

- Dr David Walker, Executive Director of Medical Services
- Ms Louise Poole, Assistant Director of Nursing, Primary Healthcare Team
- Ms Karen McLellan, Acting General Manager Acute Health Services
- Dr Anthony West, General Manager Primary Health Services (currently acting HSCE)

#### **Western Queensland Primary Health Network**

- Ms Leisa Fraser, Executive Manager Service Provider Commissioning

#### **Rural Doctors Association of Queensland**

- Dr Clare Walker, Secretary

#### **James Cook University Murtupuni Centre for Rural and Remote Health**

- Associate Prof Catrina Felton-Busch, Associate Professor Remote Indigenous Health and Workforce

**Individual speaker**

- Ms Simone Thomason, Nurse Navigator

## Statements of Reservation

## **QUEENSLAND HEALTH CRISIS**

At the outset, the Opposition would like to place on the record our serious reservations with respect to this inquiry.

The crisis which has beset Queensland Health is now well known. For more than five years, Queensland Health's ability to treat patients quickly and on time has significantly slipped. From how long it takes for an ambulance to arrive, through to waiting times to see a specialist, our public health system is buckling under extreme pressure. Yet, in the midst of this crisis for which it is ultimately responsible, the State Government chose to launch a Parliamentary inquiry into everything but Queensland Health. It beggars belief.

The State Government, in establishing this inquiry, was contemptuous in its treatment of the Queensland Parliament's Committee System. The Committee's time and resources have been used for the political advantage of the Labor State Government and their Labor Federal colleagues. From the moment the Health Minister read out the terms of reference of the inquiry, the motive behind it was clear. This inquiry has been used as a political weapon to blame the Commonwealth Government for the significant problems across Queensland's public health system in the shadows of a Federal election.

Despite the obvious political connotations, members of the Opposition tried in good faith to engage in this inquiry. Genuine efforts must be made to improve access and care across all these sectors, however the same must be said for Queensland's public health system.

The Opposition agrees that improvements must be made to how we care for the Queenslanders in aged care and people with a disability. Further, the Opposition acknowledge that work must be done to ensure that access to Primary and Allied Healthcare in Queensland is as seamless as possible. Though, to look at these things in isolation to try and solve Queensland Health's own problems is futile.

What this inquiry failed to look at, was Queensland Health's own backyard.

Of the Committee's 40 recommendations, 36 call for action by the Commonwealth Government. Only 14 recommendations even mention the Queensland Government and even then they're vague requests to follow things up. There is no more clear indication about the motives behind this inquiry than these very numbers.

Queensland has both a growing population and an ageing population. These two things are both well understood. Our state is also the most decentralised in the nation. The State Government's own failure to appropriately plan for and adapt to these things means that our public health system is bursting at the seams. It's resulted in what is now widely referred to in the public discourse as the 'Queensland Hospital Crisis'. It's a crisis which is real, yet the State Government has tried to absolve itself of all blame associated with it.

It has left our frontline health staff exhausted and our public health system resources stretched to a point they've never been before. Our frontline staff are desperate for help and for someone to listen. An almost uninterrupted thirty years of long-term Labor State Governments have failed to expand the capacity of our public hospital system. In doing so, access to public health services in Queensland has been detrimentally affected.

Queensland's elective surgery waiting list has nearly doubled since the beginning of 2015 – growing from 30,000 to nearly 60,000 people.<sup>1</sup>

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<sup>1</sup> Queensland Health Data, available at:  
<http://www.performance.health.qld.gov.au/Hospital/ElectiveSurgery/99999>

Likewise, at the beginning of 2015, 98% of elective surgery patients received their surgery on time. Now, one in ten Queenslanders who need elective surgery can expect to wait longer than what is clinically recommended.<sup>2</sup>

Many of those who made submission to the inquiry were acutely aware of the crisis Queensland Health finds itself in. Even the United Workers Union was able to identify the issue, summarising in their submission to the Committee that, “a sense of crisis surrounds the health system in Queensland, particularly in the areas of emergency hospital care and the ambulance service” (Submission 36 – United Workers Union).

Critically, Ambulance Ramping in Queensland has soared to alarming levels not ever seen before. At many hospitals across the state, more than half of all patients who arrive by ambulance are not offloaded within the clinically recommended timeframe and across the state, nearly 40% of all ambulance arrivals won't be offloaded in the clinically recommended time.<sup>3</sup>

We know that some patients are waiting up to eight hours on the ramp, in corridors or hallways before they are seen by a doctor or nurse. That is a startling number, and it is something we should never accept. Behind these numbers are Queenslanders, and that can't be forgotten.

Shockingly, a witness at the Bribie Island public hearing advised that they were aware of a death of a patient whilst ramped at the Caboolture Hospital (Page 12, Transcript of Proceedings, Bribie Island). And yet, Opposition members were not able to ask about the issues which matter most to Queenslanders.

The Queensland Audit Office (QAO) published a report in March last year (Planning for sustainable health services, Report 16: 2020-21) which detailed concerns about the state government's ability to plan appropriately for our future public health system.

The report identified serious short comings in how Queensland Health plans for future health services and its future workforce. These deficiencies were not explored as part of this inquiry.

Nor were the QAO findings from the Health 2021 report (Report 12: 2021-22). In this report, the Auditor-General quoted that, “the time it takes the ambulance crews to transfer patients into the care of emergency departments has increased significantly over the last five years”. That statement alone should be cause for serious concern in relation to the internal practices of the Queensland Ambulance Service and the state's Hospital and Health Services.

Queensland is heavily reliant on overseas trained doctors to meet demand, with the vast majority moving out of regional Australia into metropolitan areas once they've met their visa and migration obligations. Few students of medicine in Australia see general practice as an option. Regional, rural and remote communities across Queensland find it even more difficult to attract and retain doctors and specialists. Many HHS and GP practices are becoming increasingly dependent on expensive locums to cover shortages and gaps in services. There is broad support for greater recognition of the role of nurse practitioners and nurses generally with suggestion being made that they have much more to offer but are being restricted by out-dated risk adverse policies and practices.

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<sup>2</sup> Queensland Health Data, available at:  
<http://www.performance.health.qld.gov.au/Hospital/ElectiveSurgery/99999>

<sup>3</sup> Queensland Health Data, available at:  
<http://www.performance.health.qld.gov.au/Hospital/EmergencyDepartment/99999>

Given our heavy reliance on overseas trained health professionals there is an urgent need to provide more university places, training and work placement opportunities across all disciplines and vocations of health, aged care and disability services. There is also a need to review the requirements, exemptions, and processing times of skilled visa programs for Allied and Specialist health care workers and General and Medical Practitioners.

Furthermore, we need to embrace rural health programs like those offered by James Cook and Griffith Universities as the retention rates of trained rural health workers and specialists are higher among their graduates in regional, rural and remote Queensland. Priority should be given to more places and training places or schools of medicine in regional and remote towns and cities.

These programs should be prioritised over schemes like the Bonded Medical Places scheme, where a recent hearing of the Senate Community Affairs Committee was told that nearly half of the 13,521 participants had either withdrawn from the scheme or had not yet completed their obligations, which one witness said was due to those students not intending to work in rural areas, instead using the program for a free place in medical school.

A significant impediment to more rural health graduates and trainees is the lack of decent affordable accommodation in many smaller communities. Many HHS haven't maintained or upgraded old purpose-built accommodation on-site, many of which are no longer fit-for-purpose or have asbestos.

Witnesses spoke about silos and duplication that exist within and outside the health system in respect of information sharing. MyHealthRecord doesn't always provide timely information between public and private practitioners, discharge summaries from public hospitals are often weeks late or contain scant detail making it difficult for GPs to understand or properly plan and support the health needs of their patients. The referral system and information flow between GPs and public health specialists is inefficient and often leads to duplication of expensive tests and scans, and Queensland Health needs to acknowledge their flaws in this space and make improvements that lead to better holistic patient care.

While external factors do contribute to the pressures faced by Queensland's public health system, they don't happen in isolation. We know that a failure to deal with internal problems within Queensland Health has contributed to the 'Queensland Hospital Crisis', and yet this committee failed to examine those very issues.

The Opposition believe this inquiry was a missed opportunity to assess and understand Queensland Health's own problems. These include:

- A departure from the Metropolitan Emergency Department Access Initiative recommendations which have contributed to Ambulance Ramping at levels not ever seen before in Queensland.
- Rostering processes and practices inside the Queensland Ambulance Service which are unworkable and leaving densely populated areas with little ambulance coverage, particularly on nights and weekends.
- The impact of elective surgery and specialist outpatient 'long-wait' patients, who due to extensive waiting times and their deteriorating condition, present at emergency departments.
- Exploring governance reforms to devolve decision making authority to local clinicians and administrators so that they can tailor health services to the needs of the local population.
- Current attraction and retention practices for clinical staff employed by Queensland Health in regional and rural Queensland.

- Examining how Queensland Health plans to build the healthcare infrastructure and health workforce required for the future; and
- The rationale and selection process for current health infrastructure projects, and whether these projects will sufficiently meet community needs.

The Opposition would also like to place on the record its reservations in how complex aged care and disability patients were often blamed for causing bed block issues inside Queensland's public hospitals. While exceptional circumstances may exist, many of these people genuinely do require care in hospital settings - some for lengthy periods of time. Throughout this inquiry, there was an underlying rhetoric to characterise these residents as responsible for the lack of acute hospital beds across Queensland. Each representative from each HHS that presented to the inquiry read this key message out by rote during their opening statements. One could be forgiven from thinking that they had all been given the same script to read from. The inquiry found that the average length of stay for these patients was in fact 31 days, not the extreme examples referred to at some public hearings.

Under the National Health Reform Agreement, Queensland Health is the systems manager of public hospitals and health services across the state and is obliged to provide equitable and free access to public hospital services as to all Queenslanders as public patients when they need them regardless of geographic location. The Queensland Government and Minister for Health would do well to remember they are the lead agency for all things health in Queensland and should first consider what reforms can be undertaken within the existing health system to improve service delivery, reduce red tape and meet its obligations.

Greater access to funding for disability services and growing demand from our aging population have resulted in chronic shortages of nurses, carers, specialist and allied health services from Cooktown to Coolangatta. Simply put, demand is out-stripping supply. Many service providers claim they simply can't secure the services or personnel they need. One NDIS service provider from the Cairns Region said their service demand had increased from 40 to 160 clients in just two years, and while there was plenty of funding available to deliver services there just weren't the specialist practitioners available in the region to service the needs of the clients.

One could be forgiven for believing that the elderly and those with disability are no longer welcome at Queensland Hospitals, as this inquiry is focussed solely on laying blame at someone else's feet, instead of acknowledging their own shortcomings.

The Queensland Parliament owes it to the Queensland people to examine, review and scrutinise the problems facing our health system in a proper and fulsome way. That is rightly what the Queensland public should expect. However, this inquiry didn't deliver that.

Instead, the Labor State Government used this inquiry to score cheap political points.

Why was it that a Queensland Parliamentary Committee was tasked with looking into every part of the health system, except the very part which our elected representatives have responsibility for? It's an important question, and only the Premier and the Health Minister can answer it.

There is a confluence of factors feeding the Queensland health crisis and the pathway forward is going to require significant resources and the political will to breakdown the silos, build more infrastructure, drive innovation and most significantly find and train the doctors, nurses and allied health specialists needed to meet demand.

While not really contained with-in the terms of reference it would be remiss not to at least flag the growing Homelessness and Housing Crisis here in Queensland. Many submitters during

the inquiry highlighted concerns about pathways out of health care for aged and disadvantaged Queenslanders. Hospital to homelessness is simply not an acceptable option and so much more needs to be developed in terms of supported housing in every remote rural, regional and urban centre across the State.

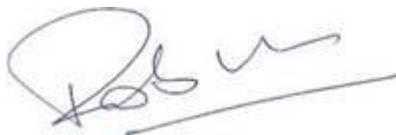
While better planning and resourcing is needed across the entire health system it should also be noted that more beds, more health employees and more money alone cannot address the deeper needs of those Queenslanders living alone and isolated. Last year the Community Support and Services Committee of the Queensland Parliament released its Report (no.14) into social isolation and loneliness in Queensland. Its many recommendations need further exploration and it's beholden on each and every one of us to be more aware, more caring and to look-out more broadly for each other. The Covid Care Army has been a great initiative during these challenging times, we need that spirit of volunteerism and care to continue into the future, we need to look out for each other.

Finally, the Opposition would like to thank those individual Queenslanders who took the time to attend public hearings or contribute by way of written submission to the Committee. Many stories which were shared were deeply personal. Likewise, the Opposition would like to thank those organisations who contributed to the inquiry constructively, and in good faith.

We also want to put on the public record our thanks to all those Queenslanders who work in both the public and private health sectors. Every paramedic, doctor, nurse, nurse practitioner, allied health worker, receptionist, hospital orderly, kitchen hand, laundry worker, department manager and administrator deserves our sincere thanks not just for their service but to them and their families for navigating and carrying Queensland and Queenslanders through these past two very challenging years. The pandemic with its ever-changing rules, lockdowns, controversy and health risks has made life difficult to navigate not just for those who work in our health systems but their families, neighbours and extended families. Thank you.

The Opposition want to see exceptional patient care delivered for Queenslanders across all settings and sectors in this state. Sadly, the findings of this inquiry won't deliver that. The State Government chose to look at everyone else's problems, just not their own. Health care in Queensland can only improve with a sharper focus on collaboration, sharing of information and resources, more beds, more hospitals and more infrastructure.

The Queensland Government are losing control, they are failing to listen and are clearly more concerned about how things look than rather than how things are.



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**Rob Molhoek MP**  
Deputy Chair  
Member for Southport



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**Sam O'Connor MP**  
Member for Bonney

# STATEMENT OF RESERVATION

STEPHEN ANDREW, MP

7 April 2022

I am concerned that there is some kind of deliberate crashing of our health and hospital systems going on and I feel that the report did not really look at the bigger picture of what is going on worldwide with plans to 'reset' the global health sector.

This is not restricted to Queensland but a global phenomenon.

I therefore have to believe that, at some level, there is a deliberate agenda to run down our hospital and health system so they can replace it with something else.

It's pretty widely understood that there is a determined move towards the roll-out of automation, robotics, artificial intelligence (AI), machine learning, synthetic biology, all of these things that they keep trying to sell people on as a way to transform the world.

Listening to Queensland Health and other submitters during the course of this inquiry, there is a running theme in everything they are saying which indicates a desire to continue this state of shutdown, lockdown, paralysis, and feeding us into this AI sort of data management system where they're harvesting our biometrics.

All public health bureaucrats, it seems, are obsessed with tagging us, harvesting our data, and genetically profiling everyone, as a means by which they can build up a new system based on DNA nudges, preventative medicine, predictive medicine to replace the current market-based system.

And it's not about individual people. It's about the system and it is clear from what Queensland Health and others are saying that they want to change it.

It's vital that we acknowledge this larger framing, because what we're seeing now is a framing for a much longer-range program.

Why else would the governments be rolling out all these wearable technologies including something called the DNA Nudge Band, which is a wearable wrist technology.

They introduce things like the DNA Nudge and make it all sound fun and like a novelty. But there will come a time when you can't opt out of it and you can't function unless you're hooked up to this system where you're constantly inputting your data into it.

Using terms like preventative healthcare, the plan is for micromanagement to be taken down to like the nano management. Let's manage humans at the genetic level.

The whole mindset is what is behind the new disability payment system - NDIS - which will be on blockchain.

It will be digitally programmed and the real reason they are reworking and revisiting many disabled people is to see whether they can be put to work or not.

In the field of health management, the language is being used to direct health care providers towards big-data, tech-centred solutions.

There's also a lot of talk around reducing healthcare expenditures on chronic illness, which it's claimed will reap hundreds of billions of dollars in "savings."

Given the amount of money on the table, it seems clear the plan is for health care to be outsourced, using outcomes-based contracts that will deploy emerging technologies like health care wearables.

It is incredibly dangerous thinking to push responsibility for chronic health conditions solely onto the individual, giving a free pass to social systems designed to harm large subsets of our communities.

By adopting a data-driven approach to health outcomes, government and health care systems appear to be setting health care consumers up to become vehicles for data generation via digital devices.

The incorporation of myHealth (mobile health) technologies is a key element of the healthcare disruption process.

Increasingly, wearable technologies will transmit real-time data, surveilling the bodies of the insured.

MyHealth solutions are being built into healthcare protocols, so private investors will be able to track which treatments offer “high-value care.”

The use of wearables and health apps also permits corporate health systems to insert digital “nudges” derived from calculated behavioural economic design, into the care provided, and monitor which patients comply, and which do not.

At the moment, the tech industry is working intently to integrate blockchain technology and Internet of Things sensors like fit bits and health apps on smartphones.

This kind of “innovative” healthcare delivery is all about people’s analytics, behaviour change via tech, and blockchain technologies.

Already, we are seeing innovative financial and technological infrastructures being rapidly put into place for those on social benefits.

As these surveillance technologies move full steam ahead, it would be wise for cautionary voices invested in the “healthcare for all” conversation to provide strategies to address the serious ethical concerns surrounding wearable technologies, tele-health / tele-therapy, and value-based patient healthcare contracting.

If safeguards are not put in place that guarantee humane delivery of care without data profiling, the medical establishment may very well be hijacked by global fin-tech interests.

The goal is to “steer medical decision making towards higher value and improved patient outcomes. Sample healthcare nudges include embedded prompts in digital platforms (for screenings), changing default settings (to generic prescriptions), framing information provided to clinicians (not sure what this means), and framing financial incentives as a loss.

We need to begin to understand the depth and breadth of this threat.

A handwritten signature in blue ink, appearing to read "S. Andrew".

Stephen Andrew, MP