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Gippsland PHN Submission - Parliament of Australia - Inquiry into Regional Inequality in Australia - November 2019

Introduction

Thank you for the opportunity to provide input to the Committee's inquiry into the indicators of, and impact of, regional inequality in Australia.

As per the Terms of Reference, this submission largely focuses on fiscal policies and improved coordination of policies that relate to funding and distribution models, with a focus on improved access to primary health care services in rural and regional areas.

There is an underlying emphasis on the role of health and wellbeing with a foundation of strong general practice services to complement and alleviate demand on publicly funded primary care and hospitals. Content also relates to infrastructure, decentralisation, workforce, education and employment.

Background

Primary Health Networks (PHNs) are a vital part of remote and rural communities and the primary health care sector. PHNs were established on 1 July 2015 with 31 PHNs across Australia.

The key PHN program objectives are to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and to improve coordination of care to ensure patients receive the right care in the right place at the right time.

Gippsland is a beautiful part of Australia and covers a vast area spanning from Bunyip River in the west, Omeo in the north, Mallacoota to the east, to Wilsons Promontory and Phillip Island in the south.

It includes six local government areas (Bass Coast, Baw Baw, East Gippsland, Latrobe, South Gippsland and Wellington) with a total population of over 270,000 people.

Gippsland PHN's vision is for a measurably healthier Gippsland, and we recognise that we must think beyond health to achieve this vision and have an impact at a population health level. We aim to achieve our vision through health planning, commissioning services, practice support and system integration.

Gippsland PHN relies on strong evidence and data together with crucial input from primary health professionals and the community to make decisions. We are in a unique and privileged position to work with community, general practice, allied health, hospitals and other primary and community health providers to drive, support and strengthen primary health in Gippsland to meet the needs of local communities.

A skilled, appropriately funded and available workforce underpins the effective delivery of primary health services. Key to our success is the composition and governance of our advisory structures, which include the Clinical Advisory Council, sub-regional Clinical Councils and the Community Advisory Committee.

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Terms of reference

a. fiscal policies at federal, state and local government levels
b. improved co-ordination of federal, state and local government policies
g. enhancing local workforce skills
i. decentralisation policies

Recommendation 1: Direct a larger proportion of overall health funding to primary health care and preventive health, especially in rural and regional areas.

A recent report by the Australia Institute of Health and Welfare on rural and remote health[1] concludes that:

"On average, Australians living in rural and remote areas have shorter lives, higher levels of disease and injury and poorer access to and use of health services, compared with people living in metropolitan areas. Poorer health outcomes in rural and remote areas may be due to multiple factors including lifestyle differences and a level of disadvantage related to education and employment opportunities, as well as access to health services."

This is especially true for people with social and/or economic worries, including people from Aboriginal or Torres Strait Islander backgrounds and people with low income and education levels. These inequalities in health outcomes must be addressed as part of addressing regional inequality more broadly. Without addressing health and wellbeing outcomes, it is not possible to address regional inequality.

A greater proportion of health funding should be directed to rural and remote communities to support primary health care with allocation based on population health needs.

The Medicare Benefits Schedule was designed when most medical care involved episodic interactions involved in the treatment of acute illness. With the growing burden of chronic and complex diseases, primary health care funding must recognise that there is a cost associated with health promotion, disease prevention, coordinated and comprehensive care and early intervention.

Recommendation 2: Recognise that government must invest more funding, separate to the Medicare Benefits Schedule to support the expansion of General Practice Teams to deliver sustainable, equitable and high-value healthcare.

[1] Australian Institute of Health and Welfare; https://www.aihw.gov.au/reports/rural-health/rural-remote-health/contents/rural-health

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The social determinants of health are many and varied. They include: income and income distribution, education, unemployment and job security, employment and working conditions, early childhood development, food security, housing, social exclusion/inclusion, health service access and affordability, gender, race and disability.

The challenges facing health care are well known. They include an ageing population, increasing chronic and complex diseases, mental health, increasing expectations and shrinking budgets.

General practitioners (GPs) and their teams provide care to over 90% of people in Gippsland,[2] making them a cornerstone of the Australian primary healthcare sector. They can be especially important in regional areas, placing patients at the centre of their care and supporting them in their health journey.

However, the extended team members of the general practice team are largely not funded by Medicare in its current construct, and it does not recognise the unique needs and circumstances of rural and remote areas in the traditional item number fee structure and arrangement.

Furthermore, any new funding from State and Federal governments is often directed to an already exhausted publicly funded sector. A significant proportion of care is undertaken by a “quasi-funded” sector called general practice.

The Medicare system is becoming increasingly inflexible and inadequate to fund an extended general practice team. The system fails to take into account the social determinant health needs of different communities and the additional costs associated with preventative health, early intervention, safe and quality care.

General practitioners remain key in the provision of primary care, but the system and how it is funded via Medicare relies fully on the GP. Funding to support the expansion of the general practice team will improve productivity through using the skills and knowledge of the GP to maximum effect while introducing a range of healthcare professionals to relieve the pressure of less complex care.

General practice team members could include allied health, nursing, pharmacy and related disciplines such as personal care attendants, science graduates or social welfare workers with the attitudes, skills and knowledge base to deliver holistic care and treatment within the general practice team under supervision of a clinician and designed to address local needs.

The future of primary care is likely to involve a different way of working with a different skill-mix in the general practice team. These positions could assist with early intervention, coaching, social prescribing, care coordination, health literacy, system navigation all underpinned by self-care strategies and an empowerment model.

Recommendation 3: Government accepts a special case exemption for areas not considered a Distribution Priority Area for GPs and Bonded Doctors.

[2] Australian Institute of Health and Welfare analysis of Medicare data; https://www.aihw.gov.au/reports-data

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The new health workforce Distribution Priority Areas (DPA's) classification system introduced on 1 July 2019 offered better placing of medical practitioners in communities of greatest need.

Instead of using a GP-to-population ratio, the DPA considers demographics (gender/age) and socio-economic status of patients living in a defined GP catchment area. Benchmarks are used to determine services required in GP catchment areas and will be fixed for three years to allow areas to stabilise the workforce.

There are examples in the Latrobe City (Morwell, Traralgon and Churchill) which are currently not classified as a Distribution Priority Areas yet have an obvious shortage of general practitioners and lack of bulk billing options. The sector has advised us, through our Clinical Council that there are up to 15FTE less GPs in the Latrobe Valley compared to this time last year.

Government should allow a special case exemption prepared by PHNs for areas where they can independently demonstrate GP workforce shortage combined with poor outcomes against broader social determinants of health wellbeing.

Recommendation 4: Federal, State and Local Government utilise the PHN needs assessments and population health planning resources to inform funding decisions and allocations.

PHN's have a strong focus on using available population health data, including service utilisation data and information from community and other local stakeholders to inform their needs assessment. With the establishment of a National Data Storage and Analysis Solution, PHNs are well positioned to develop robust population health needs assessments that inform Federal, State and Local Government primary health care funding allocations.

One trusted source will reduce duplication of effort and improve transparency of funding allocations.

Recommendation 5: Review the Bulk Billing Incentive Initiative and include the social determinants of health data in addition to the Modified Monash Model (MMM) to inform the incentive paid to a population.

The Bulk Billing Incentive[3] encourages medical practitioners to provide bulk billed services to vulnerable patient groups, such as people with concession cards and children under 16 years of age in rural and remote areas.

The rural Bulk Billing Incentive is the same across all MM 2 – 7 locations. This incentive program could go one step further by adjusting the amount paid based on the health needs of populations and specific population groups such as Aboriginal and Torres Strait Islander people.

The PHN is well positioned to inform this piece of work on an annual basis.

[3] Australian Government Department of Health; https://www.health.gov.au/resources/publications/bulk-billing-incentives-fact-sheet

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Terms of reference

d. infrastructure

Recommendation 6: Dedicate funding to connect affordable and reliable public transport options for regional and rural areas, including but not exclusive to trains. Specific, locally driven solutions to enable access to health and medical services is required.

Community input sought as part of the Gippsland PHN needs assessment[4] shows that access to health services is most difficult for people with social or financial worries, parents and people with a disability. A barrier to accessing health services is transport where the Gippsland community rated it as the third most significant barrier.

- *"Transport was the 3rd most commonly reported health issue in community interviews; in many cases directly mentioned as a barrier to accessing health care, especially for people with low SES."*

It is evident that a lack of transport options impacts heavily on life in regional and rural areas. The impact is not only on accessing health services but also affects work and education opportunities.

It must be recognised that access to affordable and reliable public transport is often not an option for regional and rural residents as it is for their urban counterparts. This includes less reliable train services, but many areas rely on a bus service as the only public transport option. The result is a significant contribution to inequality for regional residents.

Recommendation 7: Re-introduce and expand the Rural General Practice Infrastructure Grants to accommodate contemporary and expanded general practice services.

Australian people report that they see their GP more than any other health professional. The Rural General Practice Infrastructure Grants Program was last offered in 2016; it was designed to help deliver improved rural health services through additional infrastructure and increased levels of teaching and training for health practitioners.

Terms of reference

e. education
h. employment arrangements

[4] Gippsland PHN; https://www.gphn.org.au/populationhealthplanning/assessment/

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Recommendation 8: Increase medical, nursing and allied health training places for those from rural and regional areas.

The health care and social assistance sector is the main employer in Gippsland.[5] Workforce shortages, skills deficits and the impact of critical mass and consumer demand means there is a need for staff to multi task and assume broader responsibilities. Support for this industry through expanded local education and training is essential.

Community and stakeholder consultations included in the Gippsland PHN Needs Assessment[6] identified numerous service gaps for specific population groups, geographical areas and health conditions that were affected by workforce issues.

Community input has highlighted concerns about to access to GP services, encompassing a range of issues including long waiting times, compromised continuity of care due to lack of GPs and lack of bulk billing GPs, especially after-hours.

Workforce analysis shows:

- *Gippsland had an estimated 144 FTE registered medical professionals (other than GPs) per 100,000 people compared to 292 in Victoria as a whole.[i] All LGAs except Latrobe has an even lower rate (Latrobe 264)*
- *There are 1,177 FTE nurses (enrolled and registered) in Gippsland compared to the Victorian average of 1,273*
- *Allied health professional FTE in Gippsland (compared to Victoria):*
    - *Psychologists – 50 (Vic 102)*
    - *Occupational therapists – 48 (Vic 62)*
    - *Pharmacists – 84 (Vic 100)*
    - *Physiotherapists – 60 (Vic 99)*
    - *Podiatrists – 17 (Vic 23)*

Attracting and retaining skilled professionals is an ongoing challenge, especially difficult for rural and regional areas. Opportunities to upskill the local workforce via traineeships, scholarships, on-the job training and mentoring are encouraged and welcomed.

Recommendation 9: Support general practice nurses to become nurse practitioners through scholarships and increase the MBS rebates for a nurse practitioner in recognition of their scope of practice and specialist skills.

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[5] Gippsland PHN Community Snapshot; https://www.gphn.org.au/populationhealthplanning/resources-2/
[6] Gippsland PHN Needs Assessment; https://www.gphn.org.au/populationhealthplanning/assessment/

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A Nurse Practitioner is a Registered Nurse with the experience and expertise to diagnose and treat people of all ages with a variety of acute or chronic health conditions. They are the most senior clinical nurses in our health care system.[7]

The Victorian Department of Health and Human Services support Nurse Practitioner model development activities through the Victorian Nurse Practitioner Program. This program is limited to nurses employed by a public health service, and not available to general practices.

A nurse practitioner specialising in primary health care can enable more patient-centred, coordinated and integrated care with potential improvements in chronic disease management and the diversion of urgent care patients from the health service. It is a potential solution for rural areas that have minimal GP availability.

Scholarships to assist general practice nurses to undertake further education to become a Nurse Practitioner will enable them to increase their scope of practice.

Government should make a conscious decision to increase the number of Nurse Practitioners working in general practice. Not only do they need financial assistance to gain this qualification, but the Medicare rebates need to be reviewed and adjusted to better reflect their experience, expertise and role.

Conclusion

Poor access to primary health care is a key contributing factor to regional inequality. Sustainable primary health care requires Federal, State and Local Government commitment and investment.

Finding new ways to support and adequately fund general practice and primary health care to manage workload and demand is crucial to improve access, influence health outcomes and ensure sustainability now and in the future.

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[7] Australian College of Nurse Practitioners, Primary Health Care fact sheet: file:///C:/Users/liz.craig/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/459ROJ8C/Nurse%20Practitioner%20Fact%20Sheet%20-%20Primary%20Health%20Care.pdf