Queensland Health

Reform Planning Group

Stakeholder Consultation: Written Submission

The Reform Planning Group ('Group') was established for a limited time period to prepare advice to the Director-General of Queensland Health and the Deputy Premier and Minister for Health and Minister for Ambulance Services on system-wide reform activities for Queensland's health system arising from the COVID-19 pandemic. Reform activities will focus on preventing ill health and delivering better value for our patients, our workforce and our public health system.

As part of the Group's engagement and consultation across the Queensland health system, short written submissions are being sought in the form of **two (2) key questions**.

*Please provide your responses to the questions in the space provided (a **500 character limit** applies to each question).*

Question One: In response to the COVID-19 pandemic, a number of changes were implemented with how many health services are delivered. Of these changes, which do you think should be adopted on an ongoing basis, and why?
AMA Queensland recommends the following changes to be adopted on an ongoing basis: • Telehealth should be continued beyond 30 September 2020 as a permanent change • There should be equal rebates for telehealth and telephone rebates as not all GP clinics have access to high speed internet needed for all telehealth platforms; not all GP clinics have the funding to support the set-up costs of teleheath (including upgraded server, headset, camera, Telehealth software, cable, IT service to install all of this) and most non face to face consults during COVID 19 have been via the telephone. • Telehealth should be available for rural / remote outpatient appointments, (where local specialists are lacking) in addition to telehealth and or telephone rebates for consultations with primary care specialists and multidisciplinary teams. • The mandatory bulk bill requirement should be removed so GPs can follow their usual billing practices in recognition that Medicare rebates (even with the double bulk bill incentives) are not enough to cover costs required to provide comprehensive medical care - Non GP specialists and allied health professionals are able to charge a gap, GPs should be entitled to the same. • To keep public outpatient and surgery waiting lists manageable, ongoing support should be provided for public surgery in the private sector and consideration given to the introduction of weekend outpatient and surgery lists with public private collaboration. These measures would not only reduce waiting lists but increase patient safety and satisfaction. • The increased after-hours cover should remain to ensure adequate patient care. • Online teaching to better link rural centres with metropolitan specialists for education. • Emergency departments – need to continue to keep access block to a minimum to as overcrowding in a COVID environment will not be tolerated by the public (and staff) as well as escalation pathways so ED's are kept safe for patients and staff safety. • Hand hygiene compliance was one of the key steps in reducing transmission of COVID-19 infections. AMA Queensland recommends the Queensland Government support the adoption of the Australian Standard AS1071:2015 for hand-hygiene "Placement and presentation of hand hygiene materials in relation to the basin in healthcare settings", could

increase hand hygiene compliance rates by 5% or more, as this is a mechanical solution that reduces human errors and increases ongoing compliance[1 2].

- Enabling for a localized manufacturing and supply chain infrastructure for PPE and hand sanitizer.

Question Two: What new opportunities for change have arisen out of the COVID-19 pandemic that you/your organisation would like to see pursued as part of long-term health system reform, and why?

AMA Queensland recommends the following opportunities be included as part of long-term health system reform:

- Maintain all Telehealth/Telephone item numbers (including those for mental health).
- Review all Medicare rebates as the actual costs of providing comprehensive medical care are beyond the costs of the rebates including PiP e.g. during COVID-19, the cost of providing care in a safe environment (including PPE, cleaning equipment and screens) have not been covered by the current rebates, with some reporting the need to re-invest all their income and take out loans to keep providing care for their patients. This is untenable.
- There should be an increase in the Practice Incentive Payment (PiP) to subsidise the cost of PPE that Doctors have incurred by continuing to see patients face to face.
- Consistent, succinct and timely communication across all media from a single trusted source should be provided, with sufficient time for doctors to apply the changes.
- Increased involvement of AMA Queensland and colleges in the decisions regarding the cancellation of elective surgeries, changes to billing practices and any decision that affects our patients access to clinics.
- AMA Queensland members to have ongoing involvement in:
  i. disaster/pandemic planning including local community health needs
  ii. all levels of hospital governance (from HHS Boards through to executive level management - even in traditionally 'metro' areas.
- More support for GPs to provide antenatal and postnatal services as pregnant women and new mothers are needing extra support due to the isolation and lack of access to normal services.
- Metro North's Residential Aged Care District Assessment and Referral service for Aged Care saves unnecessary transfers from Aged Care to Hospital – this service should be replicated to all HHS's.
- GP Clinics should be given similar priority to hospitals when it comes to the distribution of flu vaccines, PPE and hand sanitiser as they are on the front line of care. During COVID-19 the Queensland Government emailed our members to inform us to contact the PHN's to access PPE only to be informed they were unable to supply it.
- Category 3 hospital referrals should be managed by public hospitals as they are better placed and funded to manage these on the waiting lists. During COVID 19 our members report a significant increase in the bounce back of these referrals, with the reason given that the "referral cannot be categorised". This is not safe medicine.
- Consideration should be given for HHSs to set up MBS compliant case conferences via Telehealth with the GP prior to the imminent discharge of patients with complex conditions (which is MBS compensable). This should be accompanied by Electronic hospital discharge summaries /Electronic hand over directly to GP and GP specialist portals to be able to continue comprehensive care

- Having a designated staff specialist rostered Daily at the local hospital to take direct calls from GPS should GPS want immediate advice about a patient with costs being covered by the MBS telephone rebate.
- Support the senior active doctor registration category so senior doctors can contribute their expertise in a wide range of areas including:
  i. Vaccination and health monitoring of Queenslanders (e.g., flu vaccination, diabetes management)
  ii. Screening and interviewing patients as part of health plans
  iii. Counsel/mentor junior and senior doctors
  iv. Teaching of medical students and teaching and supervision of junior MOs
  v. Discharge management
  vi. Assisting with managing quality of care programs, and
  vii. Managing research.

*Please email your completed submission by **Friday 26 June 2020** to: reformplanning@health.qld.gov.au*