Royal Australian College *of* General Practitioners

RACGP submission to the 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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Introduction

General practice is the backbone of the primary care system, with nine in 10 Australians visiting their GP each year[1]. With over 40,000 members, and representing four out of five rural GPs, the Royal Australian College of General Practitioners (RACGP) is the voice of GPs in Australia. The health system is under stress dealing with the added demands of the COVID-19 pandemic and vaccination rollout, rising rates of chronic disease, an ageing population, a looming mental health crisis and workforce issues. The issues putting pressure on our healthcare system are best addressed through greater investment in, and use of, general practice.

Our submission will take a rural focus, looking at the benefits of greater investment in primary care, recommendations to address GP workforce shortage in rural areas, and the impact of government policy decisions including Distribution Priority Areas and the Medicare freeze.

Poorer health outcomes in rural areas

The national picture is well known, with a wealth of research and data confirming that patients in rural, regional and remote communities have poorer health outcomes than those living in the major cities. Evidence has been gathered over several decades, describing the challenges facing these communities, and investigating some of the underlying reasons for the inequity in outcomes when compared to communities in urban areas.

The Australian Institute of Health and Welfare (AIHW) publishes regular reports on the health of the approximately 7 million Australians who live in rural and remote communities, providing up to date information on the national picture in Australia. These reports[2] [3] detail the poorer health outcomes found in these communities, including:

- Higher mortality rates and lower life expectancy
- Higher road injury and fatality rates
- Higher reported rates of high blood pressure, diabetes, and obesity
- Higher death rates from chronic disease
- Higher prevalence of mental health problems
- Higher rates of alcohol abuse and smoking
- Poorer dental health

These poorer health outcomes are a result of a variety of factors as outlined in the AIHW report including challenges accessing the appropriate health professional; social determinants such as income, education and employment opportunities; higher rates of risky behaviours, for example smoking and alcohol use; and higher rates of occupational and physical risk including farming or mining work.

A 2020 report from the Queensland Chief Health Officer[4] shows that the situation mirrors the national picture with Queenslanders living in remote and very remote areas carrying significantly higher burden of disease rates per 1000 of population compared to those in major cities and inner regional areas. This translates to Queenslanders outside of metropolitan areas having a one-to-three-year lower life expectancy.

The future of GP supply

With almost 40% of GPs aged over 55[5], the government must invest in our future GP workforce. A decline in specialist GP numbers will have a devastating impact on the health of the nation. 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.

The nature of the GP workforce and workload is changing:

- The average number of hours worked per week is declining[6]
- There is an increasing proportion of female GPs[7]– who are more likely to work part time, and who also on average spend more time with their patients[8]
- The Australian population is seeing increased prevalence of chronic disease and co-morbidities requiring more complex care at the primary care level[9] and this is reflected with increases in the proportion of long consults meaning GPs see fewer patients in a standard workday[10].

The 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.

The future workforce supply is in jeopardy. The number of medical graduates choosing to enter GP training each year has stagnated. Just 15.2% of final year students are listing general practice as their first preference specialty[11]. Eligible applications for GP training dropped by 22% between 2015 and 2020. Unfilled rural training places increased from 10% (65 places) in 2018 to 30% (201 places) in 2020[12]. New and significant investment in training GP registrars is needed. 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 specialty training programs.

Recommendations to address rural GP supply

Evidence shows that the two key drivers of GPs choosing to work in rural areas are: the quality and duration of the rural training experience; and having grown up in, or spent a considerable time living in, a rural community[13]. We recommend initiatives aimed at training rural GPs, attracting experienced GPs to rural areas, and supporting existing rural GPs, such as:

- Increasing the number of rural-origin students in medical school
- Increasing exposure to rural general practice in undergraduate and graduate medical courses
- Increased support for rural GP supervisors, including increased funding for compensation, and access to training and professional development.
- Increasing support for GPs training in rural communities eg bursaries to train in rural communities, travel expenses, accommodation provision etc
- Initiatives to support GPs to experience rural medicine and to move to rural communities
- Streamline credentialing processes so that it's easier for GPs from other areas to locum in rural communities to fill gaps
- Encouraging a whole-of-community approach to settle GPs into rural communities, for example supporting the GP to find accommodation, childcare or education options for their children, work for their partner etc.
- Provide greater incentives, rebates, and scholarships for rural GPs to gain and maintain additional skills to benefit their community. This should include both procedural (eg surgery, anaesthetics, obstetrics, emergency) and non-procedural (eg mental health, paediatrics, palliative care) skills
- Involve GPs in disaster management plans, and help them support their communities when disasters happen
- Supporting innovative models which are adapted to suit diverse communities

Distribution Priority Areas

On 1 July 2019, the Commonwealth Government introduced the Distribution Priority Area (DPA) classification system, replacing the Districts of Workforce Shortage (DWS) Assessment Areas for general practitioners and bonded doctors. The Department of Health uses the DPA classification system to distribute primary care doctors subject to location restrictions, such as international medical graduates and Australian doctors participating in the Bonded Medical Programs. The DPA system applies only to general practice; other specialties continue to be assessed under the DWS system, although this is under review in 2021.

It was intended that the benchmarks used to determine services required in GP catchment areas would be fixed for three years to allow stabilisation of the workforce. However, several adjustments were made during the timeframe, including an update to the Modified Monash Model (MMM) classification system effective 1 January 2020.

Geographic reclassification affected an estimated 7,000 GPs[14]. In May 2020, 261 locations that were previously a DWS became fully or partially non-DPA[15]. 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 those in Bonded Medical Programs which exacerbated doctor shortages for these communities. It also impacted practice viability with reduced access to bulkbilling incentives.

DPA also impacts large regional and outer metropolitan growth corridors. RACGP members have raised issues about recruitment challenges in high population areas such as the Sunshine and Gold Coast. Modelling in 2019 based on the Stronger Rural Health Strategy (which restricted overseas trained doctors from practising in urban areas) forecast a shortfall of 7,535 full-time GPs or 31.7% in urban areas by 2030. In 2019, 68.1% of GP services were demanded in urban areas however only 62.4% of GPs were in those areas[16]. This modelling did not consider the likely additional impact of changes to the DPA system, nor the added pressures created by the COVID-19 pandemic.

The Federal Government's review into DPA and the announcement that from 1 January 2022 those in MMM3-7 areas would be automatically classified as DPA was a welcomed step to address these issues. It's also important that the option to apply for an exemption remains, particularly for those facing GP shortages in outer metropolitan growth areas.

Underfunding of Medicare

Patient rebates for general practice services were “frozen” (did not receive an annual indexation increase from the government) between 2013 and 2017. The costs to provide general practice care, including practice and staffing costs, increase year on year, and successive governments have not matched these increases in the patient rebates provided by Medicare. 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. Full time GPs are estimated to have each lost $109,000 in total income from 2015-2020 as a result of the Medicare freeze.[17] The cumulative value of lost indexation for general practice MBS rebates is estimated to be over $1.5 billion and growing.

Without reasonable increases to MBS rebates, out-of-pocket costs to patients will increase so that practices can remain viable. 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.[18] The average patient out-of-pocket cost is higher than the Medicare rebate, has been since 2018 and will continue to grow.

Scheduled patient rebates for GP services are undervalued when compared to those for other medical specialist consultations, even after adjusting for years in training between specialisations. The RACGP estimates a loading of at least 18.5% must be applied to all GP consultation MBS rebates to bring them to the level of other specialist consultation items.

GPs consistently rank Medicare rebates and creating new funding models for primary care as the highest priority health policy issues for government action[19].

Recommendations

The Primary Health Care 10 Year Plan is a critical opportunity to improve the lives of all Australians through achievable and cost-effective reforms and investments in primary care. Many of the recommendations put forward by the Steering Group are a step in the right direction to achieve this. The RACGP’s submission responds to the Primary Health Reform Steering Group recommendations and promotes:

- the development of a sustainable model of high-quality, cost-effective and patient-centred primary care. Key funding priorities should be improving the accessibility and capacity of primary care to promote health and wellbeing across the lifespan in a cost-effective way; supporting the increased demands for chronic disease care to be provided in the community; and integrating services across the health system to ensure comprehensive and coordinated care.
- the need to modernise Medicare to reflect the cost of providing care with initial reforms including:
    - improved Medicare Benefits Schedule (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
- 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.

Adequate primary care funding improves patient outcomes and saves money

Evidence shows that a well-supported general practice sector will result in efficiencies for primary and secondary care, and the broader healthcare system[20]. Failure to invest adequately in general practice will result in continued increases in overall healthcare costs. It has been demonstrated that primary care improves patient outcomes, lowers mortality rates, lowers hospital admissions, reduces the burden on tertiary care, improves patient experience of health, lowers infant mortality rates, improves quality of life and decreases the use of more expensive health services.[21]

The *RACGP Vision for General Practice* is a framework for excellence in healthcare and demonstrates how a well-supported general practice team can deliver sustainable, equitable, high-value healthcare, benefitting patients, providers and funders. The Vision was assessed independently with economic benefits estimated at $5.6 billion plus 520,000 quality adjusted life years (QALYs) over five years.[22] In 2020-21 there were over 1.8 million presentations to emergency departments in Queensland, 10.3% of which were deemed non-urgent (category 5) and 32.1% deemed semi-urgent (category 4) presentations[23] which could have been handled by a general practitioner. The cost of a non-urgent emergency presentation is estimated at $540[24], compared to a 40-minute GP consultation which is $111.50. It makes sense to invest in general practice.

Pharmacists are not GPs

There has been a mounting push for pharmacists to increase their scope as a health workforce solution and there have been several pilot programs to assess the viability of such measures including the Queensland Urinary Tract Infection prescribing trial. Suggestions that pharmacists can manage non-urgent or low urgency conditions are unsafe. The RACGP has significant concerns with moves to expand the role of community pharmacies beyond their core role – these concerns are outlined in our position statement on retail pharmacy, but the primary issues relate to:

- fragmenting care and duplicating services while directing patients away from the coordinated medical care provided by their GP
- pharmacy health screening programs resulting in over-testing and over-treating patients
- incentivising business needs over patient care
- the sale of non-evidence-based products posing a risk to patient health

Pharmacists are a key part of the patient healthcare journey, but they're not a replacement for the high quality, patient-centred, whole-of-person, specialist care provided by GPs. Trials that expand the scope of pharmacy practice beyond current legislation such as the proposal for pharmacist to prescribe Schedule 4 drugs are unsafe.

Federal election campaign

The RACGP has been advocating for the following reforms ahead of the federal election to ensure every Australian is supported to take the time to prioritise their health with the support of their GP – there's a role for state government in supporting changes in primary care funding with the federal government.

- Support for regular, continuous, and preventive care for people over the age of 65, people with mental health conditions and people with a disability
- Investment in longer general practice consultations to support complex care
- Reinstate phone consultations for long consultations, mental health, and GP management plans as part of the permanent telehealth model
- Introduction of a GP follow-up consultation within seven days of an unplanned hospital admission to reduce unplanned hospital readmissions
- Strengthen rural healthcare by:
    - increasing Workforce Incentive Programs with additional payments for those doctors who use additional advanced skills in rural areas scaled to rurality
    - providing access to the relevant specialty MBS items when a GP holds advanced skills in Internal Medicine, Mental Health, Paediatrics, Palliative Care and/or Emergency, in a rural area

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