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AMA submission to Inquiry into provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians

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Australia has a shortage of GPs outside of metropolitan areas. This is not an issue created by the COVID-19 pandemic, but it has contributed to it while also drawing attention to it. There is no single, simple solution; genuine reform is required which will take years if not decades to have an impact.

While outer metropolitan general practices are experiencing workforce shortages, it is important to acknowledge the differences between these practices and regional and rural general practices. We need specific solutions to the workforce shortages for each area. These problems cannot be solved through changing classifications of rurality or workforce priority – under our current settings Australia does not have sufficient willing workforce for all of these practice.

Despite this, there are immediate policies and supports that can be implemented.

Key recommendations

- The Modified Monash Model must remain as the tool to determine rurality as it is the best system. It should not be the only consideration in determining incentives and the Government should explore the impact of its use in jurisdictions such as Tasmania that face unique workforce pressures.
- Supports and incentives for outer metropolitan general practice should be different from rural incentives.
- The Distribution Priority Area/District of Workforce Shortage model of medical workforce management, including the Health Insurance Act (1973) Section 19AB, is a useful tool but has its limitations due to its blanket nature that does not always reflect local circumstances. Modifications should be made, specifically new categories for practices in areas where the classification has recently shifted, but the model itself should remain.
- Existing rural and remote general practices require support to remain viable. Any new policy or program must not undermine the practice and profitability of existing private practices.

- A single employer model for GP trainees should be introduced nationally, providing GP registrars with comparable remuneration and entitlements to their hospital-based colleagues, to help arrest the steady decline in junior doctors choosing general practice
- General practice requires significant investment and support. Many recommendations in in the AMA's 'Delivering Better Care for Patients: The AMA 10-Year Framework for Primary Care Reform' and the government's "10 year primary care plan" are required to meet this goal.
- Increases to commonwealth supported places (CSPs) for medical students and intake of international medical graduates (IMGs) will not solve workforce maldistribution and should not be pursued.
- Continue to implement reforms to the Bonded Medical Place Program, with a view to a further review of workforce programs including their impact and evidence base.

The Current state of General Practice in Australia

General practice in Australia is delivering high quality care for patients but is under significant pressure. Beyond workforce shortages in many parts of the country, interest in GP training is decreasing and training places have gone unfilled three years in a row. There is no easy solution to this issue; it is the result of years of underfunding including but not limited to the Medicare rebate freeze, the cessation of successful programs providing general practice exposure and experience and their replacement with smaller and inferior programs, and broader cultural shifts. This problem is felt in outer metropolitan areas and most acutely in rural Australia.

At the core is funding for general practice. The AMA is clear that the Medicare fee-for-service model must remain the central funding pillar for general practice. This funding mechanism ensures accountability directly between the patient and the GP especially for acute health care needs that require accurate diagnosis and early intervention. However, as Australia's health care needs shift to managing an ageing population with more complex chronic conditions largely as a result of inadequate prior investment by governments in primary prevention, supplementary funding models will be required to support GPs to provide the necessary care. The AMA's proposals are outlined in the AMA's Delivering Better Care for Patients: The AMA 10-Year Framework for Primary Care Reform. Key recommendations include:

- General practice is resourced to support integrated and well-coordinated patient care through GP-led multidisciplinary teams.
- Data-driven quality care initiatives will improve patient outcomes through evidence-based, targeted interventions.
- General practice will be seen as an essential, inspiring and rewarding medical specialist career to ensure a sustainable GP workforce into the future.
- The general practice workforce will be well-distributed and will utilise technology as a complement to ensure that every Australian has access to high-quality health care.

To achieve the goals outlined in this document, the AMA is calling for 16 per cent of the federal health budget to be directed to general practice. Given that primary healthcare professionals

control or influence approximately 80 per cent of healthcare costs, this is not an unreasonable ask, particularly as investments in primary care have been repeatedly demonstrated to save costs and provide better outcomes for patients.

These are high level policies that will improve the appeal of general practice and enable doctors to provide world-leading health care over years, but they will not address the immediate workforce shortages.

Issues in outer metropolitan, regional and rural general practice

While the causes and solutions to workforce challenge for outer metro, regional, rural and remote general practice are different, the challenge is the same: a lack of qualified workforce locating to these regions and staying for four years or more. Without creating a larger pool of GPs to work in these areas, any efforts to address this immediate issue will fail.

Some areas are benefiting from workforce and/or financial incentives while others are not. A major issue emerges when these incentives are removed because many practices are only able to recruit doctors through 19AB exemptions, and the incentive payments were keeping practices viable. It is a result of these practices losing these incentives that have led to this Inquiry.

It is unacceptable that government funding policies now mean that general practices in outer metro, regional, rural and remote locations are only viable through incentive payments. Incentive payment must be actual incentives on top of otherwise sustainable businesses. The solution to the significant impact to general practices that lost rural incentives in the shift to the Modified Monash Model (MMM) is not to reinstate incentives, but to increase meaningful funding again to general practice.

It is important to note that there is currently a limited workforce willing and/or able to work outside of metropolitan centres in general practice. Changes to 19AB exemptions alone will not address this issue. The recruitment of doctors into rural areas is more complex and measures adopted must ensure that we do not see any end shift between rural and outer metropolitan areas and that there is strong encouragement for more locally trained doctors to work in underserviced communities.

It is also important to note that focus on bulk billing rates is detrimental to the efforts to increase GP workforce. The costs of running a practice continue to outstrip the indexation of MBS rebates and GP earnings continue to significantly lag their non-GP specialist colleagues. This is detrimental to GP recruitment and, in the absence of further initiatives to improve GP remuneration will continue to impact negatively on recruitment in the sector.

The AMA Rural Workforce Initiatives position statement outlines many reasons why there are fewer GPs outside of metropolitan areas. These include, but are not limited to:

- Inadequate recognition of skills and responsibility in providing safe, high-quality general practice through government mechanisms of remuneration.

- Work intensity including long hours and demanding rosters.
- Lifestyle factors.
- Professional isolation compounded by circumstances that prevent CPD leave and lack of critical mass of similar doctors.
- Reduced access to professional development.
- Reduced access to locum support.
- Hospital closures and downgrading or withdrawal of other health services.
- Local hospitals not supportive of in-hospitals service provision by local GPs (e.g., payment models, on call hours, indemnity, involvement in clinical governance, supported professional development).
- Under-representation of students from a rural background.
- Poor employment opportunities for other family members, particularly partners.
- Limited educational opportunities for other family members.
- Withdrawal of community services from such areas.

While outer metropolitan general practice also experiences some of these challenges, it is a unique problem which requires its own solutions. The rapid growth in population in many of these areas is one of the main challenges, as many practices struggle to recruit enough doctors to manage the demand from their communities. However, proximity to city centres means that concerns about employment and education opportunities for family members has less of an impact. These areas also are more likely to have services increase as these areas grow.

Despite this, many outer metropolitan areas have insufficient primary care in place as a foundation for a cost-effective health system, struggling to recruit and retain enough GPs to meet equitable population ratios, and the rapid population growth means that workforce incentive calculations may be outdated quickly. However, simply providing these practices with rural incentives will only decrease the workforce pool for rural practices. Outer metropolitan general practice requires its own solution.

Addressing the market failure of small rural practices

With the current funding models, small rural general practices and specialist practices cannot generate the economies of scale of large metropolitan or regional practices. In small towns with practices of up to 4 doctors, practice costs are significant and the current mechanisms for fee for service funding combined with inadequate supplements do not deliver a professional income proportionate to scope of practice and responsibility. GPs in small country towns in small practices are losing money once practice costs are taken into account. Small practices provide a relatively poor return on investment and as a result many GPs relocate to city practices where the pay is equivalent without needing to manage a business.

Rural general practice is an essential service, not only for the community itself but for governments constantly challenged by ramping, high hospitalisation rates and cost inefficiencies in the secondary and tertiary health sectors. Where practices face closure due to financial pressure, there are a number of financial aids that could be introduced to support the practice

including: rental subsidies, provision of housing, transport, childcare, employment and educational support for partners. A rural Practice Manager support payment would deliver significant improvements, particularly if the practice manager is part of a rural practice network.

The AMA has promoted the Easy entry, gracious exit model for years. This model for providing medical services in rural and remote towns enables rural GPs and rural generalists to work as clinicians without having to become small business owners and managers. However, often the costs of this model fall to local councils. This is a cost that city councils should not have to bear. The AMA supports this model being funded by the Federal Government.

Government policies to support the general practice workforce

In general, the AMA has supported many of the recent policies to strengthen and promote rural medical practice. There are positive programs underway which are focused on the future of the workforce, such as the National Rural Generalist Pathway (NRGP) and reforms to the Rural Health Multidisciplinary Training Program (RHMTP). The AMA is supportive of both, however these programs may not deliver for years.

The AMA supported the reforms to the Bonded Medical Places (BMP) scheme and has been working closely with the Department of Health to resolve recent issues with the implementation of the reforms. There will be a need to properly evaluate the impact of these reforms once they have been bedded down, looking also at the full range of Commonwealth workforce program to determine their evidence base and the extent to which they are having a positive impact on rural workforce.

There are a number of rural incentive payments available for rural GPs. However, they do not compensate for the opportunity cost of pracitising medicine outside of a city. For example, house prices have increased over the last ten years in metro Australia (and particularly Sydney and Melbourne) by over 50%. The capital gain alone on property in the city far exceeds incentives for rural medicine. Likewise, it is often difficult for partners to find employment, meaning the family unit earns less. Incentive payments must be increased and publicised to all practitioners working in the country to address this.

There are more reform options the Government could pursue to promote both general practice and a rural medical career. Rural origin students and medical students with positive rural experiences during training are more likely to practise in rural areas. Increasing the intake of medical students from a rural background from 25 per cent of all new enrolments to one-third of all new enrolments and increasing the proportion of medical students required to undertake at least one year of clinical training in a rural area from 25 per cent to one-third is a simple yet meaningful policy adjustment. These rural placements must be adequately supported. The creation of ‘end to end’ rural medical school programs should be supported through the redistribution of existing CSPs with no offsetting increase in full fee-paying student numbers. There are a number of proposals the AMA is aware of that could be readily introduced in the coming years.

The abolition of the Prevocational General Practice Placements Program (PGPPP) at the end of 2014 left general practice in the position where it was the only major medical specialty unable to offer junior medical officers a structured prevocational training experience before they make a career choice. While the Rural Junior Doctor Training Innovation Fund (RJDTIF) was introduced as part of the Stronger Rural Health Strategy (now John Flynn Prevocational Doctor Program), the program will only provide up 800 rotations by 2025. Australia currently graduates around 4,000 medical students per year. If more Australian graduates are to pursue general practice as a career, there must be more positive, structured exposure to general practice before doctors in training make decisions about their specialty.

The AMA community residency program sets out the design and funding principles that would support opportunities for prevocational trainees to undertake rotations of up to 13 weeks into general practice - helping them to experience life as a GP and to enhance their clinical experience.

Stronger Rural Health Strategy

The AMA welcomed the announcement of the Stronger Rural Health Strategy and the significant investment in rural general practice. This accompanied the gradual transition to the MMM and DPA for general practice. A key component of the strategy has been encouraging doctors on 3GA workforce programs to join a pathway to general practice fellowship, which the AMA supports as a policy goal.

The More Doctors for Rural Australia Program (MDRAP) is a major part of this, with many existing programs like Rural Locum Relief Program (RLRP) ending in 2023 and its existing participants encouraged to join MDRAP instead. Unlike the RLRP where doctors are entitled to 100% of the MBS rebate, on MDRAP they are only entitled to 80% until they are on a pathway. The main issue with this is that many of the doctors on MDRAP require level one (the highest level) supervision. This takes considerable time and effort, meaning practices lose through the MDRAP doctor earning less, and the supervising GP earning less by taking more time to supervise.

Grants of $30,000 per participant have been available through rural workforce agencies since the middle of 2021. This should be closer to $50,000 to truly cover the cost of supporting a doctor through the program. The grants were also painfully slow to eventuate. When they were first raised with stakeholders in August 2019, they were supposedly close to implementation.

The AMA understood that there were close to 6,000 doctors working in rural general practice not on a pathway to fellowship when these changes were being introduced at the end of 2018. We understand that the number of participants on MDRAP is still below 500.

DPA and MMM

The AMA supports the Modified Monash Model as the best available tool for determining rurality. It is not the only tool available and should not be used alone to determine incentives or resource allocation. The current DPA/DWS system is not perfect, however there is no system of workforce

distribution that can ensure all towns have sufficient workforce supply if there are not enough doctors to go around.

The AMA would like to see a more flexible system with adjustments to support rural towns to retain workforce once certain benchmarks are met. Incentives are often what bring doctors to rural towns. Removing incentives removes the doctors. We have seen that when many rural towns lose their DPA classification, their workforce numbers rapidly decline. Despite this, they remain non-DPA until calculations are redone. This creates a situation where towns will yo-yo from DPA to non-DPA. A simple solution is to include another category for rural towns who have reached the non-DPA benchmark to lose some, but not all, incentives, and retain the right to replace Medicare provider numbers.

The AMA was impressed by demonstrations of the HeaDS-UPP tool which we understood would be used to provide more up-to-date data on workforce. We have not received any updates recently on its application.

International Medical Graduates

International Medical Graduates (IMGs) are an integral part of Australia's medical workforce, substantially enabling access to high-quality health care for all Australians, particularly in rural and remote areas of the country.

The decision by the Commonwealth Government in the mid-1990s to restrict medical student numbers led to a shortage of general practitioners and junior doctors, resulting in the need to recruit doctors from overseas to fill workforce gaps. Acknowledging this, in 2000, Australia embarked on a significant expansion of medical education with medical schools almost doubling and graduates almost tripling.[1] Australia now graduates medical students at above the OECD average[2] which contributes to increased competition for entry into vocational training and exit block for employment of new fellows. However, our reliance on IMGs continues, particularly in rural Australia, due to a maldistributed medical workforce.

The Australian Government continues to develop mechanisms to use IMGs as a 'temporary solution' to a permanent problem. Recent data indicate that this is exacerbating the issue of maldistribution, with 74% of IMGs currently working in metropolitan areas, and the rate of growth of the IMG workforce in major cities higher than the domestic medical workforce (4.5% per annum compared with 3.8%).[3]

Under Section 19AB of the *Health Insurance Act (1973)*, IMGs are subject to a ten-year moratorium on billing Medicare in locations other than designated Distribution Priority Areas (for GPs) or Districts of Workforce Shortage (non-GP specialists). While this has increased the size of

[1] Laurence Geffen. A brief history of medical education and training in Australia. *Med J Aust* 2014; 201 (1): S19-S22. doi: 10.5694/mja14.00118.
[2] OECD. Medical graduates (indicator). 2021. doi: 10.1787/ac5bd5d3-en (Accessed on 24 February 2021).
[3] The National Health Workforce Dataset, available at: https/hwd.health.gov.au.

the rural workforce, it does not lead to sustainable long-term improvements. We need policies that reduce our reliance on this.

It is important that we balance future workforce and skilled immigration requirements with domestic demand and supply. Robust medical workforce data and projections must guide decisions on future skilled migration settings for medicine, such as the work underway by the Medical Workforce Reform Advisory Committee and the Department of Health to develop a National Medical Workforce Strategy to provide information on workforce demand, supply and future projections. These needs to be a single instrument to determine defined areas of workforce shortage used at all levels. This should be based on valid, defined, transparent and robust criteria that the Medical Board and Ahpra base their assessment upon.

It is vital that Australia's skilled migration program ensures ethical recruitment of IMGs. Australia has obligations as an international citizen. The recruitment of doctors from developing countries must be based on the principles of justice and fairness, where the benefits of international recruitment, and exchange of medical professionals, significantly outweighs any associated burdens for developing countries. In the context of a pandemic this is even more important.

GP training

GP training in Australia is in an uncertain situation at present. GP training is transitioning back to the GP Colleges, but details are far from final. Applications to GP training have been steadily declining. No agreement on reform of GP registrar remuneration has occurred since 2018. Reform in employment of GP Registrars, notably in rural areas, is sorely needed.

The AMA released the updated Vision Statement for General Practice Training earlier this year which outlines the vision, core components, priorities and outcomes for GP training in Australia. Central to the AMA's position is the need to maintain profession led governance and training structures and supporting a strong vocational training experience. The structural requirements to achieve this are:

- Organisational and clinical governance structures are profession-led, consultative and transparent.
- Funding models support and resource general practice to train general practitioners.
- Accurate workforce planning must match workforce supply and skills with demand.
- Clinical placement and supervision capacity meet workforce supply and demand.
- Collaborative partnerships exist between general practice, education providers, the profession, health sector, governments, and the community to support and resource general practice training.
- An employment model that delivers equitable working conditions, such as (but not limited to) a single employer model for general practice registrars, to ensure trainees have access to equitable remuneration and parental, study and other leave entitlements as they complete their training across multiple workplaces.

COVID-19

Australia's GPs have been at the frontline of our response to COVID-19 since the beginning of the pandemic. With the vaccine rollout to soon transition to a likely booster program and Australia approaching a level of vaccination where we "live with the virus", GPs will continue in this role for the foreseeable future. It is also important to note that many GPs have not had a break since the 2019/20 Summer bushfires. Many are burnt out, and the border restrictions within Australia to control the spread of the virus have exacerbated this by limiting the movement of the locum workforce.

The AMA understands that the Department of Health has worked closely with Home Affairs to ensure that international medical graduates (IMGs) are granted visas to come to Australia. Doctors and other health care workers are already on the Priority Migration Skilled Occupation List. A major issue throughout the pandemic has not been the willingness of IMGs to travel to Australia, nor the application and visa process; the issue is and remains the availability of flights to Australia.

AMA proposals

There are a series of long-term reforms to general practice outlined in the AMA's Delivering Better Care for Patients: The AMA 10-Year Framework for Primary Care Reform. The AMA has also made numerous submissions and contributions to the development of the National Medical Workforce Strategy which is soon to be released. It is essential that this document is considered in any reports and recommendations eventuating from this Inquiry. These plans are generally longer term and will not address immediate issues.

While longer-term reforms begin to take effect, the AMA has a series of proposals for immediate consideration:

Support non-metropolitan general practices through networking

Virtual practice managers and back-office operations can be shared by networks. Small geographically close practices could be incentivised to jointly contribute to a shared practice manager and back-office operation. For example, accounting, patient recall and health promotion activities could all be performed remotely through networked practice software. This would generate efficiencies for the practices. This would require minimal support from the Government and could be managed through PHNs.

Networks could also be established between rural and city general practices through incentives. This incentive would ensure that the city general practice provides locum support to the country general practice for specific periods of time each year. This creates continuity, confidence in workforce support, and provides rural patients a medical centre to attend when they are in the city which is staffed by GPs who are familiar with their town and their circumstances. The arrangement would also allow the rural GP to work in the city when required. For example, for

parental leave, training and upskilling. It would also reduce the professional isolation of small rural practices.

Infrastructure Grants

Infrastructure grants for investment in new technologies will support general practice to build on the increased productivity in general practices as a result of the introduction of MBS funded telehealth. Large infrastructure grants as they are currently delivered create cash flow issues for recipient practices in the following year. These grants are taxed and therefore considered income in the majority of cases and in the following years the PAYG tax is calculated as higher for the individual practice. These grants should be tax free.

Collaboration with hospitals and health services

While general practice is funded primarily at Federal level, greater involvement and support from jurisdictional health services will increase retention of GPs while decreasing costs. The AMA's Local Hospital Networks and GP-led Primary Care Services Designed to Reduce Potentially Preventable Hospitalisations position statement details how Local Hospital Networks can collaborate with general practices to design GP-led primary care services that will reduce potentially preventable hospitalisations.

The AMA has also recently released the Integration of General Practitioners into rural hospitals position statement which outlines key industrial components to support the integration of rural GPs and rural generalists into their local hospitals. This increases the professional satisfaction of GPs, supports optimal care for the community and reduces costs to health services by reducing demand for locums. Ensuring that these doctors, whether employed by the State or working in private general practice, are working together in rural towns in integrated and mutually satisfying arrangements will lead to increased job satisfaction and contribute positively to retention of this workforce. These services should support their GP workforce by contributing to the upskilling and reskilling of the GPs.

Home Monitoring

The Australian health system made tremendous progress through the pandemic with the introduction of telehealth and e-prescribing. The next step would be the widespread adoption of home monitoring of blood pressure, weight, blood sugar levels etc. at home with devices that can wirelessly transmit data to software within the practice. Many practices have started to use this technology, however there are no rebates for this type of care and it requires investment by the practice. As we shift to preventative care, this type of care must become more prominent, particularly for patients far from tertiary care.

Retention payments

Meaningful incentives for sustained long service (at least five years) would encourage GPs to remain in their communities for longer. This should be tiered by rurality and could begin in outer

metropolitan areas. Incentives could also come in the form of support for upskilling, with reliable locum cover at no cost to the practice. Long-serving GPs should be supported to develop advanced skills in areas of community need, for example skin cancer surgery, ultrasound, or mental health. Supporting these kinds of incentives will improve the likelihood that a doctor will stay.

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