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Submission from the Australian General Practice Alliance to the Senate Enquiry regarding:

The provision of general practitioner (GP) and related primary health services to outer metropolitan, rural, and regional Australians, with particular reference to:

a. the current state of outer metropolitan, rural, and regional GPs and related services;
b. current state and former Government reforms to outer metropolitan, rural and regional GP services and their impact on GPs, including policies such as:
    i. the stronger Rural Health Strategy,
    ii. Distribution Priority Area and the Modified Monash Model (MMM) geographical classification system,
    iii. GP training reforms, and
    iv. Medicare rebate freeze;
c. the impact of the COVID-19 pandemic on doctor shortages in outer metropolitan, rural, and regional Australia; and
d. any other related matters impacting outer metropolitan, rural, and regional access to quality health services.

About the Australian GP Alliance

Founded in 2016 the Australian GP Alliance (AGPA) exists to represent General Practice Principals – the General Practitioners who work in the General Practices in which they have some proportion of ownership.

The majority of General Practitioners (GPs) in Australia are self-employed contractors who work in Practices in which they have no ownership. In metropolitan areas it is not uncommon for GPs to work in multiple Practices.

A key issue for primary health care in Australia is that the General Practices that provide the facilities for GPs to provide their services are generally small business. The viability of the Practices as businesses is as critical to the delivery primary health care in Australia as is the supply of qualified and experienced GPs. ie without the facilities that the Practices provide most GPs would be unable to provide primary health care to their patients.

The AGPA notes that government primary health care policy frequently ignores the need for these business to be viable and as a consequence of this the viability of many General Practices is now questionable. This has implications for the ownership succession of these Practices and the development of new generations of Practice Principals.

Therefore the AGPA contends that the provision of primary health services in Australia needs to address not only the shortages of GPs but also the factors which impact on the viability of the General Practices from which they provide services.

GP Shortages

AGPA notes that while there has been an emphasis on improving the numbers of GPs in rural areas, there are now acute shortages of GPs in all MMM areas of Australia.

AGPA members report significant difficulties in sourcing GPs in most areas including outer metropolitan areas.

Anecdotally, a factor in GP shortages is the changing pattern of work (this is possibly a societal trend rather than specific to General Practice) with many GPs electing to work part time, so that it is necessary to think in terms of Full Time Equivalents (FTE) GPs rather than the total number of GPs available. AGPA members report situations where the number of GPs working from a Practice may be up to twice the GP FTE availability.

Another significant trend is the increasing demand for GP services, driven by both increasing population and an aging population requiring more GP services.

A Deloitte Access Economics General Practitioner Workforce Report 2019 produced for Cornerstone Health suggests that by 2030 the gap between the demand for GP services and the available supply of those services will in fact be most acute in outer urban areas rather than in regional and remote areas. The report suggests that by 2030 there will be:

- A 37.5% national increase in demand for GP services between 2019 and 2030
- A shortfall of 9298 full-time GPs or 24.7% of the GP workforce.
- Deficiency of GPs is expected to be most extreme in urban areas with a shortfall of 7,535 fulltime GPs or 31.7% by 2030.

While the demand for GP services is apparently increasing, interest from medical graduates in specialising as GPs appears to be declining.

RACGP Health of the Nation 2020 reports a fall in application rates for their Fellowship Program as declining from 2458 applicants in 2015 to 1555 applicants for the 2022 intake.

Some reasons for this decline have been suggested to include:

- Lack of emphasis of GP in medical training coupled with a late exposure to GP as a speciality caused by internal placements within the hospital system.
- Perceived salary differences between hospital based training and GP Fellowship training salaries. AGPA notes that some of this difference is due to a difference in payment method with GP registrars receiving a guaranteed minimum salary and a percentage of MBS billings while a first year hospital based intern receives a fixed salary, but the difference between these two base levels is significant.

Another factor in disinterest in GP as a specialisation is the remuneration dissatisfaction from those within the specialty. RACGP Health of the Nation 2020 reporting 25% of GPs are dissatisfied or very dissatisfied with their remuneration compared to 8% of other medical specialists.

Accordingly, with declining interest in General Practice from medical graduates increasing demand for GP services and widespread dissatisfaction with remuneration from current GPs recruitment and retention of GPS are major issues for Practices with significant implications for the quality of primary health services for Australia within the next decade.

Viability of General Practices

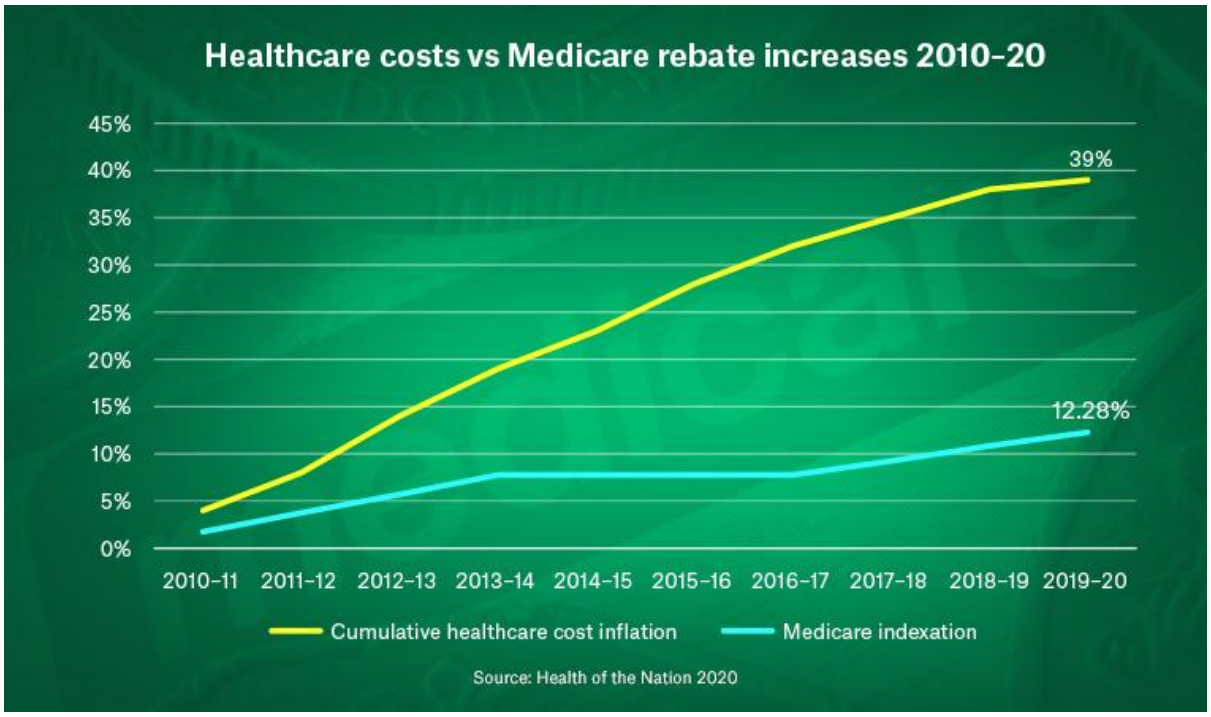
The small businesses that are General Practices are primarily funded via an earnings share arrangement with the GPs that the Practice supports. GPs are usually charged 30- 35% of revenue by the Practice for the services provided.

GP revenue is based on MBS payments for bulkbilled patients (some Practices are entirely bulkbilling Practices), additional charges to patients in excess of the MBS benefit rate for mixed billing Practices, and in some cases privately billed consultations which are not covered by the MBS scheme.

Practices also receive direct funding from government via programs such as PIP (Practice Incentive Program). These are based on the size of the Practice (number of patients seen). Practice size is determined by the Standardised Whole Patient Equivalent (SWPE).

Other revenue sources for Practices may include renting rooms for purposes such as pathology collection (ACC) and non-GP services such as physiotherapy etc.

Impacts of Medicare Freeze and Other reductions in General Practice Funding



The figure developed by RACGP shows the impact of the decision to freeze Medicare rebates, with a gap of 26% now existing between the cost of delivering primary health services and the indexed Medicare rebate. This difference is borne by GPs (via reduced income), patients (via additional charges) and Practices (via reduced income and additional costs).

Accordingly the viability of General Practices has declined significantly over the last 10 years making Practices more dependent on other revenue streams.

Those other revenue streams have also been under pressure particularly in the last 18 months when pathology companies sought to reduce rents and closed collection centres during the 2020 COVID lockdowns, and the Department of Health decision to not include telehealth consultations as part of the SWPE calculation, thereby reducing PIP payments to Practices.

Conclusion

There is an urgent need to:

- Address the attractiveness of General Practice as a specialisation to rapidly increase the numbers of medical graduates seeking to become GPs.
- Recognise that the shortages of GPs is not confined to rural regional areas and that it is a significant issue for all MMM zones, particularly 2-7.
- Recognise that viable General Practices are an essential part of the primary health system and that the primary health system needs them to be viable.

Many of these issues would be addressed significantly by restoring the “lost” Medicare indexation, and addressing the difference between the cost of primary health delivery and its funding by government.

Any solution must recognise the way in which the primary health system is structured with most GPs working as self-employed contractors in Practice structures organised and funded by Practice Principals and other Practice owners. Proposed solutions that are undermine or seek to overturn that structure by making GPs employees of the Practice (intentionally or accidentally) are unlikely to be successful and run the risk of taking Practices below the point of viability as they become liable for the oncosts associated with additional employees.

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References

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The Royal Australian College of General Practitioners. General Practice: Health of the Nation 2020. East Melbourne, Vic: RACGP, 2020.