RACGP | Aboriginal and Torres Strait Islander Health

RACGP Submission

Aboriginal and Torres Strait Islander Salary Support Program Review

2016-2017

July 2017

Healthy Profession.
Healthy Australia.

Introduction

The Royal Australian College of General Practitioners (RACGP) thanks the Department of Health for the opportunity to contribute to discussions regarding the Aboriginal and Torres Strait Islander Salary Support Program Review 2016-2017.

About the RACGP

The RACGP is Australia's largest professional general practice organisation, representing more than 35,000 members working in or towards a career in general practice in urban and rural areas.

The RACGP is responsible for:

- defining the nature and scope of the discipline
- setting the standards, curriculum and training
- maintaining the standards for high quality clinical practice
- supporting general practitioners (GPs) in their pursuit of excellence in patient care and community services.

About RACGP Aboriginal and Torres Strait Islander Health

Improving the health and wellbeing of Aboriginal and Torres Strait Islander people is one of Australia's highest health priorities. The RACGP is committed to raising awareness of Aboriginal and Torres Strait Islander health needs and as a result, RACGP Aboriginal and Torres Strait Islander Health ('the faculty') was formed to help 'close the gap'.

The faculty has approximately 8,000 members either working in the Aboriginal and Torres Strait Islander healthcare sector or who have a passion and interest in this area. The faculty undertakes a range of activities to help improve health outcomes for Aboriginal and Torres Strait Islander people. These include:

- developing guidelines and resources for GPs and health professionals
- delivering education and training
- advocating on issues relating to Aboriginal and Torres Strait Islander health
- celebrating Aboriginal and Torres Strait Islander culture and achievements by Aboriginal and Torres Strait Islander GPs, registrars and medical students.

Consultation process

A number of members, organisations and interested individuals provided detailed and considered feedback during the consultation process. The RACGP thanks all stakeholders who contributed to this important piece of work.

RACGP position

GPs are the cornerstone of Australia's primary healthcare sector.

General practices and Aboriginal Community Controlled Health Services (ACCHSs) are constantly evolving in response to patient needs, financial pressures and limited resources.

The review of the Australian General Practice Training (AGPT) Salary Support Program should equally consider educational opportunity, community support and financial imperatives. The RACGP has significant concerns regarding the inference that economic issues may be alleviated by registrars and services increasing their use of the fee for service model as a means to secure financial sustainability.

ACCHSs provide vital services to a complex and diverse range of patients and therefore adequate funding is required to ensure the quality and effectiveness of these services and in the training of doctors delivering those services. Appropriate funding that is distributed across the country equitably is needed to ensure that GP registrars receive quality training when working in Aboriginal and Torres Strait Islander health training posts.

For the Salary Support program to be effective in meeting its aims, it needs to be flexible enough so that it can accommodate the needs of ACCHSs, Regional Training Organisations (RTOs), registrars and local communities.

Any reduction in funding for this program directly conflicts with the Aboriginal and Torres Strait Islander Health Training Strategic Plans and bipartisan commitment towards 'closing the gap' in health inequities for Australia's First peoples.

The RACGP is resolute in its view that having an appropriately trained and skilled GP workforce, who are able to work effectively with Aboriginal and Torres Strait Islander patients in a range of settings, is key in eliminating health disparities between Aboriginal and Torres Strait Islander and non-Indigenous Australians.

RACGP submission

1. Salary Support Program Intent:

What should be the overall intent of the program?

A. Within a capped funding allocation, what outcomes and objectives should be prioritised?

The quality of training in Aboriginal and Torres Strait Islander health training posts must be the key priority of this program.

Training posts in ACCHSs provide registrars with valuable supervised training time to develop crucial skills in providing high quality primary healthcare to Aboriginal and Torres Strait Islander patients and communities.

These training positions are vital in ensuring that the future GP workforce have the appropriate skills and training to deliver quality and culturally appropriate and safe primary healthcare services to Aboriginal and Torres Strait Islander patients in both mainstream services and in Aboriginal Medical Services (AMSs).

Prioritisation of quality training in these training posts is a long-term solution for ensuring that Australia's medical workforce is culturally aware and responsive to the health needs of Aboriginal and Torres Strait Islander patients.

The program should also ensure that all registrar learning outcomes are achieved and that patients and communities have access to timely and quality general practice services. Additionally, through providing exposure to the sector, Aboriginal and Torres Strait Islander health training posts will help encourage the retention of the GP workforce within the sector.

We note that this question pre-supposes capping the funding. If this is non-negotiable, then the capped funding allocation should be set at a level designed to achieve the desired outcomes of the program as described above. Minimisation of spending should not be an aim of the program review.

B. What should be the focus of the program?

The focus of the program should be on training GPs who are effective in their care for Aboriginal and Torres Strait Islander people. This includes:

- understanding the social and cultural determinants of health
- understanding the cultural and historical perspective of the community they work in and not just a general national perspective
- being able to work with the complex mix of multiple chronic physical and mental health conditions
- understanding the geographic and socioeconomic barriers to timely and effective care.

Working effectively as a GP in an Aboriginal and Torres Strait Islander health setting is not restricted simply to the provision of medical care to people who happen to be Indigenous, or the management of a collection of common medical conditions.

An understanding of the contexts of Community Control and self-determination are crucial to be effective at working in this area, and the provision of salary support should both recognise and reflect these principles.

C. How can the program best contribute to the Government's commitment to Closing the Gap on health inequalities?

Growing Australia's culturally aware and responsive GP workforce

The Salary Support Program should not be seen as an isolated component of the Australian GP Training Program, but as an important part of the pipeline for doctors to become GPs who can work effectively with Aboriginal and Torres Strait Islander people and communities.

It is of paramount importance that Australia's current and future GP workforce is adequately trained and culturally responsive. This will go a long way in terms of reducing/eliminating health disparities between Aboriginal and Torres Strait Islander and non-Indigenous Australians.

Ensuring an adequate medical workforce in ACCHSs

As the work of people like Barbara Starfield shows, it is clear that accessible and timely primary healthcare is crucial for improving the health of Aboriginal and Torres Strait Islander people.

The Medical Workforce survey[1] shows that there were 723 doctors who described their main work setting as an Aboriginal Medical Service, 686 of these in clinical work. In October 2016, the Department of Health provided 2015 figures to Senate Estimates[2], highlighting that there were 397 GP registrars (157 FTE GP registrars) accessing the AGPT's Salary Support program via AMSs across the country.

Even allowing for these statistics, it is unknown how many GP registrars would have described their main workforce setting as being an AMS. Compare this to a total of about 27,000 doctors working as GPs, with another 4,228 on the training program and 2,585 described as "doctor-in-training" across the whole sector.

[1] http://www.aihw.gov.au/workforce/medical/additional/ Supplementary tables, Overview, Table 8

[2] http://www.aph.gov.au/~/media/Committees/fapa_ctte/estimates/sup_1617/pmc/health613.pdf

The above highlights that only a small proportion of the medical workforce (including GPs, registrars and 'doctors in training') are working in the sector. The sector needs to be adequately resourced to ensure that Aboriginal and Torres Strait Islander patients and communities can access appropriate primary healthcare services when they need to.

*Note - Department of Health does not have any data on the retention rates for registrars who have accessed the AGPT Salary Support Program.

Ensuring adequate funding for services and staff

Current funding mechanisms do not adequately support health care delivery for patients with chronic and complex disease. Chronic and complex management in an AMS requires significant time to coordinate patient care to engage members of the broader team such as Aboriginal Health Workers and Cultural Educators and Cultural Mentors. Importantly care plans must consider the socio economic and cultural context of each patient if medical services are to have a positive impact on patient outcomes. We contend that this is not adequately recognised by the current debate nor by Medicare remuneration.

Additionally, it should be recognised that remuneration for GPs working in ACCHSs is often significantly less than other settings, both for GP registrars and for experienced GPs. This creates a barrier for working in an ACCHS, especially for GP registrars who will often be re-paying education debts in addition to supporting families and establishing financial and personal independence (home ownership, schooling and the like). Salary support goes a little way towards ameliorating this for registrars and services.

Retention of workforce in the sector

The review of the monitoring and evaluation framework (Attachment B) showed the strong preference of registrars working in an AMS setting to continue in that setting after completing training. This shows the positive effect of the pipeline in action. Those registrars who stay on will contribute hugely to closing the gap in health outcomes between Aboriginal and Torres Strait Islander and non-Indigenous patients. Furthermore, they will also become the GP supervisors for future registrars entering the training program.

Changes to the Salary Support program must ensure that the pipeline of producing GPs able to work effectively in Aboriginal and Torres Strait Islander communities is not compromised. Registrars are more likely to stay on if there is a seamless process where they do not have to move away before returning to the service.

2. Salary Support Program Funding Eligibility

Breadth and/or depth? What are the considerations for having a smaller number of registrars who have spent a considerable amount of their training in an Aboriginal and Torres Strait Islander health setting versus a larger number of registrars who have less time in these settings?

A. How could Salary Support funding best support more AGPT registrars to identify a special interest in working in Aboriginal and Torres Strait Islander health settings and encourage them to continue their work post Fellowship?

In the past, there was a focus on increasing the capacity of ACCHSs to take on registrars for training and the Salary Support program was one component of this. The number of services and the number of posts in each service increased (though the number of overall training posts also increased, so the ratio remained the same). Without a focus on continuing to increase capacity of services, the Department is forced into a choice of a small number of long-term posts or a larger number of short-term posts.

There are a range of factors that need to be considered when looking at long-term versus short-term training posts:

Short-term attachments may not allow for the in-depth knowledge and decision-making skills essential for dealing in the complex mix of health and social needs encountered in Aboriginal and Torres Strait Islander patients and communities. Additionally, many Aboriginal and Torres Strait Islander communities have expressed frustration with the frequent turnover in doctors.

Multiple short term attachments risks worsening this, and actually reducing access to quality care.

Long-term attachments are undoubtedly more favourable for communities because of the continuity of care, and the better ability to develop trusting therapeutic relationships in that time. The ability to develop these relationships would be one of the key learnings from a registrar position, and not an optional extra.

Of course there is a need for more registrars to gain experience in Aboriginal and Torres Strait Islander health, but if this is gained at the expense of continuity of care and a deeper experience, then it is unlikely that they will develop skills that will actually make a difference in closing the gap.

Short-term attachments are frequently referred to as 'AMS tourism' by people on the ground.

It may be that the Salary Support program could be used to support registrars who have a special interest in working with Aboriginal and Torres Strait Islander patients and communities. However, many registrars identify this desire after starting work in an ACCHS, and Salary Support should be able to offer flexibility to enable those who want to experience working in an Aboriginal community, and those who see it as their desired career pathway.

Salary Support should be there to support these decisions, so that registrars and services aren't disadvantaged by decisions to train and offer training in Aboriginal and Torres Strait Islander health.

Could the Salary Support Program Policy put restrictions around the year of training for registrars (e.g. GPT2/PRRT2 and up) to train in Aboriginal and Torres Strait Islander health settings?

A. What do you consider would be the positive and/or negative impacts of limiting Salary Support to registrars, depending on their year of training?

Restricting salary support to GPT2, GPT3 and extended skills, with exceptions available for GPT1 where they have significant experience would seem to be a reasonable approach. Often the complexity of problems presented by Aboriginal and Torres Strait Islander patients mean it is useful for registrars to have a basic grounding in general practice before working in Aboriginal and Torres Strait Islander health training posts. It should be noted, however, that there are many excellent Aboriginal Health Training posts that would welcome GPT1 Registrars and provide an excellent training experience. Local circumstances may warrant flexibility with this.

The main problems with this restriction is that it means experienced GP registrars wanting to do the Fellowship in Advanced Rural General Practice (FARGP) concentrating in Aboriginal and Torres Strait Islander Health would be discouraged. There is a specific module for Indigenous Health in FARGP, but the removal of salary support for this would put either GP registrars or the community they want to work in at a financial disadvantage, where there could be considerable benefit from developing a highly skilled workforce willing to work long term in this setting.

Aboriginal and Torres Strait Islander health is an important component of rural skills. Anecdotally, most registrars wanting to participate in Advanced Rural Skills Training (ARST) in Aboriginal and Torres Strait Islander Health are in remote areas including Western Australia, Northern Territory and far north Queensland. While these areas tend to have smaller populations overall, they do have a higher proportion of Aboriginal and Torres Strait Islander patients in the general population that, in turn, have chronic disease and complex health needs.

Therefore, it is crucial that health services in these areas have an adequately trained and resourced medical workforce. Any restrictions to the program would see registrars wanting to develop higher skills in Aboriginal and Torres Strait Islander health being prevented from doing so.

The RACGP firmly believes that registrars, patients, rural and remote communities and ACCHSs should not be disadvantaged by restrictions placed on the Salary Support program.

What would be the impact of limiting Salary Support to registrars depending on their year of training? For example:

A. Have GPT1 registrars experienced enough training to provide services in Aboriginal and Torres Strait Islander health settings? Are the same or different issues relevant to PRRT 1 registrars?

Most GP registrars in GPT1 would need experience elsewhere in a community setting before working in an AMS. Training in hospital practice alone would be unlikely to be sufficient, as familiarity with the generalist approach, use of community resources and teams, chronic disease management, use of IT in primary care and Medicare billing are all unique parts of general practice work that should usually be in place before working in the more complex setting of an Aboriginal or Torres Strait Islander community.

However, there will certainly be registrars who have sufficient experience before GP training to work well in this area but this would need to be assessed on an individual basis, including by the community employing them.

B. What are the positive and/or negative impacts on supervisors and Aboriginal and Torres Strait Islander health settings and communities in placing a registrar early in their training?

For registrars early in their training, there is the opportunity to support the acquisition of appropriate skill and knowledge at the beginning of their general practice training. The skills required in Aboriginal and Torres Strait Islander health will serve a GP well wherever they work in the future. However, significant and protected time will be required for teaching, supervision, co-consulting and recording reviews in order to be confident that the registrar is practicing safely and feels supported to work in such a challenging environment.

For most GP supervisors, this work will be rewarding and be one of the positives that ensure long term career satisfaction. However, this time will reduce the service's capacity to see patients and generate Medicare revenue. This requires an in depth understanding of the benefits of having registrars, especially registrars early in their training, as there will be pressure felt to generate more Medicare revenue for the service.

Consider the option of capping the hourly rate and/or the use of a sliding scale of Salary Support Program funding.

A. Could funding be allocated based on the rurality of the training location? What stage of registrar training could this include?

It is worth noting that GP income in AMSs is often less than income in mainstream general practice in similar areas, for both GP registrars and for GP Supervisors. Salary Support allows AMSs to reduce this disparity for GP registrars (though not for supervisors) and the setting of a cap should take this in to account.

There is considerable anecdotal evidence for implementing a sliding scale based on the rurality of training location, as it is more difficult to recruit GPs to more remote areas. However, the evidence on financial incentives to work in rural areas suggests that such incentives need to be sizeable in encouraging GPs to move away from urban areas to rural areas, which may be higher than salary support could be set at.

Conversely, implementing a sliding scale may not result in improved long-term workforce in rural and remote areas. A sliding scale has the potential to adversely impact urban and regional areas, where most Aboriginal and Torres Strait Islander people reside.

One option might be to have a flat rate for each different stage of training, however this approach must be flexible to accommodate the local needs of the ACCHS, RTO and registrar and community.

The most appropriate stage of training for a sliding scale of salary support would be for registrars working towards their FARGP, as this has to be undertaken in rural and remote areas.

B. Could funding be allocated based on the rurality of the training location, or the demographic distribution of Aboriginal and Torres Strait Islander people?

See the previous answer regarding the rurality of training location.

It is not clear how salary support may operate on the demographic distribution of Aboriginal and Torres Strait Islander people. There are some ACCHs who see a large number of non-Indigenous patients, as they are the only bulk billing practice in town and are able to handle the complex mix of care required by those from low socio-economic backgrounds.

This should not result in penalising the service with reduced salary support, as the learning for the registrar is the same and is as much about working in the context of community control.

3. Period for payment of Salary Support funding to individual GP registrars

What would be the impact of limiting Salary Support Program funding to 12 months with a provision for a further 12-month extension at 50% funding (with a commitment to increase Medicare billings):

A. How would this impact positively and/or negatively, on retention of registrars and GPs and continuity of care?

The proposal to make the increasing of Medicare billings a component of salary support or registrar training in an AMS is fraught with danger and should be avoided. While GP registrars need to be taught about appropriate Medicare billing, the risk is that this can come at the expense of good clinical care. The support of Aboriginal and Torres Strait Islander patients must focus upon quality clinical healthcare and not be constrained by imposition of inadequate Medicare funding.

Increasing billings can often be seen as the doctors' responsibility as they are the respondents, however quality healthcare in ACCHs is dependent upon the capacity of the service and team members to provide systematic care, which may be beyond the control of the GP registrar or their supervisor. It is important that registrars are exempt from the pressure of generating revenue in order to ensure that they are receiving a positive learning experience and delivering good clinical care.

Often high quality care requires teamwork and practice systems looking at the arrangements of appointments and patient flow. It often requires planned care away from the acute needs of presenting patients and indeed from the immediate practice environment. The focus we submit should be on increasing the capacity of the service as a whole, and not merely on revenue raising using registrars as short term workforce solutions.

There is a strong evidence base for supporting the Patient Centred Medical Home (PCMH) model which is underpinned by a range of measures including patient enrolment and additional funding to support patients with complex and chronic disease. The increasing pressure to use the fee for service model, despite a move towards more innovative funding models (e.g. Health Care Home implementation), is not helpful. Arguably, these blended payment models are more important in ACCHSs because there are a higher proportion of patients with chronic and complex diseases.

Restricting the Salary Support to 12 months with subsequent reduction in funding for extensions would incentivise high registrar turnover, with the consequences described above for continuity of care and the development of skills that actually enhance health. In addition, longer attachments (over 12 months) were associated with retention of GPs in Aboriginal Medical Services post fellowship.

B. What activities can AGPT registrars undertake to increase Medicare billings in Aboriginal and Torres Strait Islander health settings?

The focus for GP registrars should be on quality training and the delivery of high quality general practice services in an Aboriginal and Torres Strait Islander health setting. While part of training is about understanding the appropriate use of Medicare, there is a real risk that Medicare billings, as something that is easy to measure, becomes the main focus of the registrar and the supervisor, especially if this is incentivised by the Department of Health.

There are activities that may result in increased billings – such as using the chronic disease item numbers or doing Aboriginal and Torres Strait Islander preventive health assessments. An attachment that just focused on the number of these would miss out on appropriate care for acute presentations, on child health surveillance, on development of rapport and on the use of appropriate community services.

It seems ironic that salary support is a capped program, and runs the risk of limiting the long-term medical workforce of AMSs, which makes it harder to bill (uncapped) Medicare in the long term.

C. Are there identifiable and quantifiable issues of time and resources involved in registrar involvement in increasing Medicare billings in Aboriginal and Torres Strait Islander health settings?

Given the low numbers of doctors working in Aboriginal Medical Service settings (see answers above) this limits the billing capacity of AMSs, as it is predominantly the doctors who bill Medicare. Having GP registrars increases the capacity for services to bill Medicare, but the requirements for training and supervision also act to reduce this capacity a little.

ACCHOs tend to generate less Medicare revenue than mainstream services because of the increased complexity, longer consultations and more (non-billing) health professionals seen in these services. Salary support was intended to reduce the financial impact on a service of taking a registrar.

It may be that mechanisms other than fee for service or salary support could be used, such as through the Practice Incentives Program or direct funding. Alternatives may also be considered in remote areas for expenses such as housing or transport, which may not be best funded through salary support. However, any change of this nature would have to be discussed thoroughly with the ACCHS sector and the GP training sector, to ensure it was acceptable without unintended adverse consequences.

D. What activities can Aboriginal Community Controlled Health Services or Aboriginal Medical Services undertake to increase Medicare billings within services?

The RACGP has serious concerns regarding the trend to encourage activities to simply increase Medicare billings within ACCHSs and AMSs.

The provision of quality primary healthcare services, not increased revenue, should always be the main driver for the delivery of health services. Encouraging increased billing patterns and activities risks high throughput GP services. It also risks GPs being relegated to care planner roles with ongoing care provided from specialist rooms. This is a considerably more expensive system of healthcare and one that creates further barriers for patients when trying to access affordable primary healthcare services. This model does not reflect the PCMH model, which has a considerable evidence base to support the provision of comprehensive, coordinated and holistic care. Such models are associated with improved health outcomes for patients including lower rates of hospital presentations and admissions.

While there are measures that could be taken to increase Medicare billings within services, a discussion paper on Salary Support in Aboriginal and Torres Strait Islander Health training within the AGPT program is not the appropriate discussion forum for proposals in this.

It is highly recommended that the Department seek specific advice from these sectors.

4. Strategic Plans and the Salary Support Program

Consider how the Strategic Plans Program impacts on the Salary Support Program

A. How could Strategic Plans better support the training of registrars in Aboriginal and Torres Strait Islander health settings?

Strategic plans should be written in partnership with their Aboriginal and Torres Strait Islander health training posts, and should include strategies to enhance the capacity and capabilities of ACCHSs in their provision of primary healthcare and in their educational activities. Salary Support is one of these measures, and ideally should be considered as part of a longer term workforce strategy.

Additionally, improved flexibility is also required to ensure that appropriate non-ACCHS practices (e.g. Inala Indigenous Health Service) and government health services who also provide good learning/training environments can be accredited to be an Aboriginal and Torres Strait Islander health training post.

Further flexibility is also required so that services are able to easily transition in and out of being an Aboriginal and Torres Strait Islander health training post to accommodate for whether they have a GP supervisor and the overall stability and capacity of the service at the time.

B. What are the roles and functions of Cultural Educators and Cultural Mentors in your region?

As a national organisation, the RACGP has both a local and national remit. We consider that the role of Cultural Educators and Mentors is absolutely crucial in the education of GP registrars in Aboriginal and Torres Strait Islander health. Such personnel have a recognised wide range of roles, including development, delivery and evaluation of GP training in Aboriginal and Torres Strait Islander health, cultural guidance and feedback to GP registrars at a programmatic and individual level.

For further information regarding the roles of and functions of Cultural Educators and Cultural Mentors, review *Building Aboriginal and Torres Strait Islander Cultural Education and Cultural Mentoring Capacity* which can be found here.

C. How could Cultural Educators and Cultural Mentors be more fully utilised and integrated into training and service delivery?

Cultural Educators and Mentors must be seen as full members of the Education team within the RTO. They need to be respected community members, with authority from the community to discuss cultural issues with GP registrars and with RTO staff. In order for their role to be more fully utilised and integrated, their role needs to be supported, funded and properly understood by all levels of the RTO, and be seen in the context of a partnership between the RTO and the community.

There should be opportunities for personal development and career advancement with appropriate remuneration for cultural educators and mentors. We would suggest implementing the recommendations in the report cited above.

This can also possibly be supported by the strategic plans and we would encourage RTOs to develop Reconciliation Action Plans

It is important to note that RTOs (as well as the RACGP and the Department of Health and Human Services) should not just teach registrars about effectively working with Aboriginal and Torres Strait Islander people; registrars need to demonstrate that they possess the necessary skills to consistently work in this manner.