1. RACGP position on GP workforce

General practice is the backbone of the primary care system, with nine in 10 Australians visiting their GP each year.[1] Evidence shows that a well-supported general practice sector will result in efficiencies for primary and secondary care, and the broader healthcare system.[2] Failure to invest adequately in general practice will result in continued increases in overall healthcare costs.

The health system is under stress, dealing with the added demands of the COVID-19 pandemic and vaccination rollout, and reduced immigration and ability to recruit doctors internationally. In addition to placing practices under strain, there are several broader health system implications. Lack of resourcing in primary care (particularly after hours) results in poorer patient access to appropriate services, and increased Emergency Department pressures, with many regions reaching crisis point in the past few months.

1.1 Supply of GPs

With almost 40% of GPs aged over 55,[3] 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.[4]
- There is an increasing proportion of female GPs[5] – who are more likely to work part time, and who also on average spend more time with their patients.[6]
- The Australian population is seeing an increased prevalence of chronic disease and of co-morbidities, requiring more complex care at the primary care level[7]
- Due to these increases in complexity and comorbidity, the proportion of long consults is increasing,[8] meaning GPs are able to see fewer patients in a standard work day.

The combination of these factors means that a greater headcount of GPs will be required to provide the same full-time equivalent (FTE) workforce in future, and a larger FTE workforce will be needed in the future.

While the current GP workforce is sufficient to meet demand – albeit with a need to re-distribute to meet areas of need – the future workforce supply is in jeopardy. The number of medical graduates choosing to enter GP training each year has stagnated. 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.[9]

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.

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.[10]

1.2 Shifts in specialisation

As discussed in the National Medical Workforce Scoping Paper, there has been a significant shift toward specialisation of the medical workforce. For every new GP, there are 10 new non-GP specialists; this gap between the number of non-GP specialists and GP specialists widened from 119 in 2009, to 4271 in 2017.[4]

2. 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.

2.1. How this has affected patient access to general practice

Geographic reclassification affects an estimated 7,000 GPs.[11] In May 2020, 261 locations that were previously a DWS became fully or partially non-DPA.[12] 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.

Changing geographic classification has several flow-on effects for practices, including:

- Reduced access to increases in bulk billing incentives. The recent budget announcement of $65m in additional payments for specific patient groups in rural areas will not be available to non-DPA practices.
- Inability to recruit IMGs who specialise in general practice. These IMGs must work in a DPA to get a Medicare provider number.
- Inability to recruit doctors from the Bonded Medical Places and Medical Rural Bonded Scholarship Schemes.

While over-reliance on overseas trained doctors and bonded schemes is not recommended, these doctors are an important and agile solution to workforce issues in many areas.

2.2. Impact on Aboriginal Medical Services

Until 1 January 2020, Aboriginal Community Controlled Health Organisations (ACCHOs) were exempt from the DPA system. However, this exemption has been removed and therefore ACCHOs located in urban and inner regional areas (MMM 1) can no longer employ bonded GPs. As bonded GPs account for at least 25% of all Australian-trained medical graduates, this will have a severe impact on the ability to recruit GPs for these important services.

Removal of this exemption also creates inconsistency; IMGs can apply for an exemption under Section 19AB from their 10-year moratorium working in rural areas if they choose to work in an urban ACCHO.

2.3. Inner regional and outer metropolitan growth corridors

While many areas of Australia are under pressure from lack of adequate medical services, there are several high growth areas that have been particularly impacted by changes to the DPA system and resulting inability to recruit enough staff to meet patient demand during the pandemic.

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.[13] 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.

Establishing models that can proactively identify and address health service needs is important. However, the DPA system has demonstrated that generic algorithms cannot be relied on to determine areas of workforce need. There must also be opportunity for practices to appeal their workforce priority status and be assessed to receive additional supports.

We cannot rely on one model to provide the solution to regional and rural issues such as workforce shortage and differential health outcomes. Introducing multiple levers will help address these issues and ensure practices receive the support they need. A more innovative and flexible approach to distributing funding to areas of high patient demand must be introduced to ensure patients do not miss out on essential general practice services.

The limitations of the DPA model are well-recognised and the RACGP welcomes the federal government's review of the DPA to improve assessment of GP services and areas of workforce need. The announcement of a new Exceptional Circumstances Assessment process is also welcome.

Recommended solutions:

- Allow practices in all locations to apply to extend the provider numbers of their GPs already employed under the section 19AB of the Australian Health Insurance Act 1973 to ensure minimal disruption to patient access to general practice services during the pandemic
- Introduce new initiatives to provide workforce support for areas of need and rapid population growth

3. Issues affecting recruitment and retention of GP trainees

3.1 Lack of early exposure to general practice

Patients receive most of their healthcare in general practice as opposed to the hospital system. Yet, the medical intern program in Australia is almost exclusively hospital-based. This is concerning, as the proportion of final year medical students listing general practice as their first preference specialty for future practice has fallen to 15.2%, the lowest since 2012.[14]

Exposure to, and experience in, general practice early in medical training is key to a better performing health system and efficient use of health resources. General practice is the most accessed health service in Australia and therefore all medical professionals should have an understanding of the specialty.

This challenge is recognised by the National Medical Workforce Strategy Steering Committee's proposed solutions document, and is expected to be reflected in the National Medical Workforce Strategy when it is released. Ensuring early exposure to primary healthcare for medical students is also recognised by the Primary Health Reform Steering Group in the Draft Recommendations for the Primary Health Care 10 Year Plan.

The RACGP supports the Australian Medical Council's proposal to amend their accreditation criteria to ensure that medical schools consider the needs of their communities and health services by encouraging students to pursue careers aligned with population health needs. This includes in certain geographical areas and medical specialties with shortages, as well as an increased focus on primary and preventive healthcare.

Recommended solutions:

- Increase exposure to general practice during medical school and prevocational years. Reinstatement of a model such as the Prevocational General Practice Placements Program to create a pipeline into general practice would be supported.
- Medical schools should foster students to pursue interests in general practice, generalism, and rural placements by increasing exposure to leaders in these fields and focussing on generalist competencies as the core of medical training.
- Review the teaching Practice Incentive Payment to ensure it adequately supports practices to host medical student placements.

3.2 Prestige perceptions, academic pathways

The RACGP supports the National Medical Workforce Strategy Steering Committee's proposal to increase research opportunities in general practice as a lever to increase the profile and prestige of the specialty. General practice research is essential to ensuring all Australians can access a high quality, effective and evidence-based primary healthcare system. General practice research will also provide evidence to underpin the development and implementation of new and innovative models of service delivery.

A lack of research pathways, PhD opportunities and representation of GPs in senior academic positions has a deleterious effect on medical students' perceptions of the prestige of the specialty. The number of GPs in senior academic positions is in decline due to long-standing lack of funding to the university sector, exacerbated by the COVID-19 pandemic. Many universities are restructuring and in some cases (such as Newcastle University) the general practice department is being combined with nursing and allied health. Unlike other specialties that are subsidised by the State health departments, universities must fully fund GP academic places.

There is strong evidence that doctors are interested in and driven by opportunities to do research. This increases the profile and prestige of these specialties and can help doctors to better balance clinical and non-clinical work—another important driver of specialty selection.

It is essential that trainees are exposed to positive GP experiences and impressions throughout the undergraduate and postgraduate years. This can include positive GP placements, influential role models and mentors, information on GP pathways and career opportunities, increased research into challenges faced, and support from organisations including universities and the specialist medical colleges.

The RACGP Research strategy includes developing research opportunities and career development opportunities to enable GP researchers to see a sustainable career path and build future research leaders.

Recommended solutions:

- The RACGP's 2020-21 pre-budget submission outlines how to support and promote general practice research as a viable career option for GPs. This can be achieved through funding of scholarships, fellowships and grants to sustain general practice researchers throughout their careers, and build robust general practice research in Australia.

3.3 Disparity between GP and other specialty trainee pay and entitlements

GPs in training face a number of financial pressures when they transition from the hospital training environment to general practice in community settings. Inadequate remuneration, for both GP trainees and specialist GPs, is contributing to reduced interest in becoming a GP. Significant reform regarding general practice support and funding is required to ensure the sustainability of general practice and the GP workforce, both now and into the future. See section 4.1 – Underfunding of Medicare for further discussion.

The RACGP understands that salary support in Aboriginal Community Controlled Health Services resulted in improved GP registrar attraction. Further consideration and evaluation of this initiative is warranted to understand the impact and its applicability to increasing registrar attraction to mainstream general practice.

It is vital that the government ensure that GPs in training are not disadvantaged, in comparison to their peers, as a result of pursuing a career as a specialist GP.

Single employer model

The RACGP sees potential benefit for a single employer model, however there are broader implications to the workforce that must be carefully considered to avoid unintended consequences. The results of Australian and international trials should be thoroughly reviewed and their broader applicability evaluated before further single-employer-models are put in place.

The RACGP recommends that a national body be established, independent of State and Territory governments, to protect GP registrar entitlements, achieve salary parity with hospital-based registrars, and improve the attractiveness of a career in general practice.

The proposed solution that States and the Territories be the single employer undermines the flexibility of workforce, as GP registrars would be limited to a single state which may restrict opportunities for career progression.

The solution to employment models must be College led. It rests with the RACGP and ACRRM to design GP training programs and consider any changes to GP employment models, in collaboration with GP members and stakeholders.

Portability of employment benefits

GP registrars do not retain their employment benefits during training as they move to a new employer each rotation. Moreover, junior doctors lose accrued entitlements from their time in the hospital setting when transitioning to community based practice. Junior doctors make crucial decisions about their career based on a range of factors, including remuneration, available entitlements and their family and personal circumstances.

The RACGP supports allowing portability of employment benefits through a third-party portability fund for GP registrars. This is a solution which could provide the incentives of the single employer model while still allowing GP registrars the flexibility of moving employers and locations. Any introduced scheme should also ensure portability of benefits interstate.

The protection of entitlements and guaranteed salaries must be offered to all registrars in GP training. If protection of entitlements and guaranteed salaries are only offered to those training as rural generalists or rural GPs, a two-tiered system will be created, dividing the profession, exacerbating AGPT recruitment issues, and undermining patient care.

The RACGP continues to work with government to progress policy in this area.

Recommended solutions:

The RACGP's 2020-21 pre-budget submission outlines actions required to better support and remunerate GP registrars by:

1. Increasing the base salary for GP registrars to reduce disparity with hospital-based counterparts.
2. Matching and retaining the leave entitlements of hospital-based doctors.

To address these issues a "National Entitlements Fundholder" is needed, governed by the RACGP or another appropriate entity independent of the State and Territory governments, and guaranteed by the Federal Government. This body would be responsible for the maintenance and distribution of registrar entitlements while GP registrars undertake training.

The "National Entitlements Fundholder" would manage leave entitlements including annual leave, sick leave, extended leave, parental leave, and long service leave for GP registrars.

Consideration could be given to feasibility of registrar salary top-up funding to guarantee minimum salary, ensuring base salaries are not less than their hospital registrar counterparts.

3.4 National approach to recruiting trainees into areas of workforce need

The current regionally based training programs create barriers for recruiting registrars to areas of work force need by making cross-jurisdictional transfers difficult. The planned transition to college led training is being used to enhance registrar recruitment and transfers into areas of workforce need.

RACGP planned initiatives include cross jurisdictional promotion of training in areas of work force need and a case-management approach to recruiting and preparing registrars to work in areas of workforce need.

3.5 Rural Generalist Pathway

The RACGP supports the Collingrove Agreement definition of Rural Generalism and has been training and supporting rural GPs who provide hospital services since we started our first training program. The RACGP has signed an MOU with ACRRM and are working together with the Rural Health Commissioner on achieving AMC recognition of the extended skillset of a Rural Generalist.

Rural Generalists provide an important contribution to rural workforce but the workforce requirements for our regional, rural and remote communities extend far beyond the limits of hospital roles where the Rural Generalist trains and remains. Rural Generalists (RGs) provide crucial support to hospital and emergency services where there are roles and industrial agreements that support RG employment models but sadly many of the community general practices in the same towns, and certainly those towns without hospital services remain underserved by general practitioners.

The data from QLD shows that the number of applicants for the well designed and funded QLD Rural Generalist Pathway is far below the total number of applicants for General Practice alone with only 62 doctors enrolling in the QLD RG Pathway in 2021. These numbers fall well below the rural workforce requirements in rural community practice in QLD. The QLD experience also shows that many who train as a RG remain in hospital roles without providing community primary care services. 2021 data shows 87% of the PGY4+ doctors are working in hospital roles with only 31% working in both hospital and a community general practice role (meeting the Collingrove agreement).

It is crucial that workforce and training programs recognise the importance of the non-hospitalist rural GP. Many rural GPs work in towns without hospital services to be able to practice RG skills and many choose not to engage in the 24/7 work that working in hospital roles requires. Federal programs must continue to provide funding, training and support for a rural GPs crucial role in rural communities even when they are not providing hospital services or we risk alienating these GPs and causing them to disengage. The key will be to balance the funding and workforce programs to support both RG and non-RG rural Gps in providing rural services.

4. Issues affecting sustainability of general practice

4.1 Underfunding of Medicare

Patient rebates for general practice services were “frozen” (ie did not receive an annual indexation increase from the government) between 2013 and 2017. The costs to provide general practice care 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. The cumulative value of lost indexation for general practice MBS rebates is estimated to be over $1.5 billion and growing.

For practices to remain viable, out-of-pocket costs to patients will increase. In 2018–19, for the first time, the average patient out-of-pocket cost was higher than the Medicare rebate for the most commonly used general practice item (standard GP consultation less than 20 minutes – item 23). In 2019–20, this trend has continued, and the gap between the patient rebate for item 23 and the average out-of-pocket cost has more than doubled from $0.26 to $0.58.[15] Average out-of-pocket costs increased by 2.26% between 2018–19 and 2019–20, whereas the consumer price index (CPI) fell by 0.3% over the same period. [15]

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.[15]

Recommended solutions:

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 MBS rebates.

4.2 Increasing multi-morbidity, stress and burn-out

General practice is increasingly called upon to manage patients with two or more co-occurring chronic medical conditions, or 'multimorbidity'. Patients with multimorbidity and complex health issues need to access more health services more often, and want this care to be well coordinated across the system.[16] General practice is well placed to coordinate care across sectors, providing continuity of care as guided by an ongoing relationship with the patient. However, GPs are challenged by the limitations of funding models, inadequate guidelines and fragmented health care systems which are built around single disease states. It has been shown that for every $1 invested in prevention, $14 is saved in subsequent public health interventions[17].

The Medicare rebate that patients receive is far lower (per minute) if they spend more time with their GP – as would be needed to discuss complex health and social care needs.[15]GPs treating patients with more complex health and social problems also spend more unpaid time undertaking care coordination activities.[15] Considerable unfunded time may be spent seeking links with other local agencies, and information to assist social prescribing, to improve the social support for their patients.

Studies have shown a link between patient complexity and GP burnout and low morale. Rates of burnout can be almost twice as high among GPs caring for the highest number of patients with multimorbidity, compared with those caring for the lowest number.[18] Limited time and resources for dealing with increased patient complexity can contribute to low morale and burnout among GPs.[19]

The existing pressures on general practice have been exacerbated by the COVID-19 pandemic, including the increased number of mental health presentations. Frontline healthcare staff have faced uncertainty and change, all while continuing to provide high quality care to their patients. 52% of GPs surveyed for the RACGP's 2020 Health of Nation report recounted at least one negative impact to their wellbeing during the early stages of the pandemic, with one in four reporting a deterioration in their mental health.[15] As the COVID-19 pandemic has drawn out over the months, the impacts on mental health and wellbeing have often been amplified.[20]

To support GPs in coming forward to discuss any mental health concerns they might experience, the RACGP is calling for changes to Ahpra's mandatory reporting laws that act as a deterrent to doctors from seeking appropriate care.

Recommended solutions:

- Introduce exemptions under the Health Practitioner Regulation National Law for health practitioners from reporting doctors under their care, in line with the model used in Western Australia.
- Invest in funding reform to support coordinated care, including investigating the viability of a Voluntary Patient Enrolment model that supports improved continuity of care

4.3 Medicare compliance burden, regulatory pressures

A proportion of the risk that generalists face arises from the medical complaints process as administered by Ahpra. As small businesses, general practices rely on the goodwill and word of mouth of their patients to run their business. A published tribunal decision can have the same effect on a general practice as a negative online review for any other business.

An additional barrier to practice is the complexity of Medicare item descriptors, and the stress caused by compliance processes as administered by the Department of Health. The current MBS is unnecessarily complicated and GPs spend too much time trying to understand its intricacies and keep up to date with regular amendments. Medicare compliance activities and Professional Services Reviews have also increased in frequency, with recoveries doubling in the past financial year.

Recommended solutions:

- The RACGP advocates for a shift from punitive compliance processes toward a greater focus on provider education, guidance on how to interpret the MBS, and simplification of the MBS to reduce the risk of error.

References

1 Department of Health. Annual Medicare statistics 2019–20. Canberra: DoH, 2020.

2 Baird B, Reeve H, Ross S, et al. Innovative models of general practice. London: The King's Fund, 2018.

3 Productivity Commission, Report on Government Services 2021, Canberra: Productivity Commission, 2021.

4 Scott A. The future of the medical workforce. ANZ–Melbourne Institute health sector report. Melbourne: Melbourne Institute of Applied Economic and Social Research, University of Melbourne, 2019.

5 Department of Health. GP workforce statistics: 2001–02 to 2018–19. Canberra: DoH, 2020.

6 University of Melbourne, Monash University. Medicine in Australia: Balancing Employment and Life (MABEL). MABEL Wave 10 survey. Melbourne: MABEL, 2019.

7 Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW

8 Medicare Australia. Medicare Item Reports. Canberra: DoH, 2020.

9 RACGP & Department of Health. Unpublished GP registrar intake data, 2018 to 2020. January 2020.

[10] Leiyu, S. The Impact of Primary Care: A focused review. Cairo: Scientifica 2012. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3820521/

11 Hunter New England and Central Coast Primary Health Network Health Workforce Distribution Priority Area Recommendation Paper December 2020

12 Senate Committee: Community Affairs, Additional Estimates 2019 – 2020, Questions on notice Portfolio Question Number SQ20-000183 www.aph.gov.au/api/qon/downloadestimatesquestions/EstimatesQuestion-CommitteeId2-EstimatesRoundId8-PortfolioId12-QuestionNumber171

13 Deloitte, General practitioner workforce report 2019, Cornerstone Health Pty Ltd

14 Medical Deans Australia and New Zealand, Medical Schools Outcomes Database National Data Report August 2020

15 RACGP General Practice: Health of the Nation 2020, Melbourne: 2020.

16 Productivity Commission, Innovations in Care for Chronic Health Conditions, Productivity Reform Case Study. 2021, Productivity Commission: Canberra.

[17] Masters R, Anwar E, Collins B, Cookson R. Return on investment of public health interventions: a systematic review. Journal of Epidemiology and Community Health 2017;71:827-834 https://pubmed.ncbi.nlm.nih.gov/28356325/

18 Pedersen A, Nørøxe KB, Vedsted P. Influence of patient multimorbidity on GP burnout: A survey and register-based study in Danish general practice. Br J Gen Pract 2020;70(691):e95-e101. DOI: https://doi.org/10.3399/bjgp20X707837

19 Owen K, H.T., Shortland T, Dale J. , *GP retention in the UK: a worsening crisis. Findings from a cross-sectional survey.* BMJ Open, 2019. 9(2):e026048.

20 Australian Institute of Health and Welfare, Mental Health Ramifications of COVID-19: The Australian context. 2020.