Dr MD MONIRUL HAQUE

RACGP 2024 Presidential Candidate's Statement

MBBS; FRACGP; Masters in Family Medicine (University of Cape Town); FACRRM (Honorary)

Director Sanctuary Lake Medical Practice Point Cook Victoria-3030

GP supervisor for the 3rd and 4th year (Final year of MD program) Medical Student from Deakin Uni.

Past Fellow of the Department of General Practice, University of Melbourne.

GP Supervisor for FSP (Fellow Ship Support Program)

Past Examiner and QA examiner for RACGP and Past Director of Geelong GP Division (PHN)

Present Councillor of the RACGP Victoria Faculty

Affiliate Senior Lecturer Geelong Clinical School Deakin University.

GPs are the “First and Foremost” - So Respect, Recognise and Remunerate.

2024 Campaign Highlights by Dr Monirul Haque

1. Continuous funding of general practice by present and prospective governments

2. Reframing and rebranding of general practice for more respect, recognition and remuneration

3. Advocate for 50,000 general practitioners (GP) - Value for fee and more service

4. Engaging and connecting - be part of better and greater general practice through more community engagement

5. Strengthening rural and remote GP workforce by supporting urban work forces and continuing support to the rural and remote workforce

6. Improving the GP work force by strengthening IMG intake, training and supporting local medical graduate’s

7. Embracing innovation - Artificial Intelligence involvement in General Practice which will strengthen the quality of care to patients by doctors.

GP’s are the first and foremost in Australian health care. If you vote for me and ask your colleagues to vote for me, I am committed to representing your voice effectively to advocate for better General Practice at RACGP, Medicare, and beyond. I am a grass roots GP with my own GP clinic and have worked in Australia as a GP for more than 20 years. My work has involved positions at Nambour Hospital in the Sunshine Coast QLD, rural Katherine NT, rural Mt Isa QLD and regional Gisborne VIC. Before moving to Australia, I have worked in Asia, Europe and Africa. I also sit within the GP clinic owners committee and support community events for health and wellbeing. I am a motivator and innovative person and would greatly appreciate your vote for me to be your voice for the continuum of better General Practice.

1. **Continuous funding of General Practice by present and prospective government:**

Often, government and non-GP specialists swiftly remove Medicare item numbers, like those for ECGs and wound care nursing support. I'll persist in lobbying parliamentary groups against reducing these numbers and their reimbursements. Additionally, I'll push to create new Medicare item numbers and raise reimbursements for existing ones that are currently undervalued, such as for Iron Infusions, follow-up hospital discharge summaries, and initial visits for interstate patients. Many women's health item number rebate needs to increase: such Mirena Insertion and or removal, Implanon XT insertion and or removal.

2. **Reframing and rebranding of General Practice for respect, recognition and remuneration**:

To achieve this, I will endeavour to do the following:

i. Reinstate the AFP (Australian Family Physician's) journal.

ii. I will aim to rename the Royal Australian College of General Practitioners to "Royal Australian College of General Practitioners and Family Medicine" so it includes Family Medicine. Younger GPs seek recognition as certified Family Physicians by RACGP, so this renaming would provide satisfaction and promote professional growth.

iii. Expand the scope of general practice and family medicine with extended skills on mental health, women's health, paediatrics, dermatology, endocrinology, neurology, geriatrics and surgery by offering structured training for Specialist in General Practice and family Medicine. This would include for example point of care ultrasound, allergy, Infection and immunology and research methodology with their choice of extended skill, keeping the advanced generalist method to treat common, complex and challenging medical conditions, like acne, ADHD, Autism, Type 1 Diabetes, perimenopausal and menopausal heath issue,

common addiction and pain, dementia, musculoskeletal condition treated by steroid injection etc.
Post fellow Family Medicine can be extended as an Advanced Fellow in Family Medicine with extended Skill. This advanced Family Medicine will give a growth path to young specialist in General Practice and Family Medicine.

3. **Be advocate for 50,000 general practitioners- Value for fee and more service**

i. RACGP membership fees and CPD costs are rising with limited RACGP-run courses for GPs. Many find measuring outcomes expensive. Private medical education companies are charging high fees to profit from CPD business. Non-fellow and hospital trainee GPs face increased membership costs, hindering MO (measuring outcomes). RACGP should offer more affordable CPD programs on EA, RP, and MO.

ii. Increasing resources support like for example the Therapeutic Guidelines Subsidies which now the independent GP must purchase for $400. This should be subsidised through RACGP as a training and academic institution.

4. **Engaging and connecting - be part of better and greater general practice through more community engagement**

I will advocate for 50,000 GPs. RACGP is one of Australia's largest doctors' organization with nearly 50,000 members, it should enhance its bargaining power with the government to meet GPs' needs and demands effectively.

The following are important issues that need to be addressed in order to get more support from grass root GP’s and needs to take appropriate action for the following issues:

i. **Better complaints management by AHPRA:**
General practitioners lack adequate protection from false patient claims, often unable to meet patient demands due to government regulations or community welfare priorities. Consequently, patients resort to complaints with AHPRA, which notifies doctors promptly, regardless of claim validity. AHPRA's complaint management system requires

enhancement. GPs endure prolonged stress and financial strain disproving claims. AHPRA should adopt systems from other nations, introducing a pre-investigation process to assess claim validity before involving GPs and their indemnity insurance. Despite charging steep annual registration fees, AHPRA fails to offer GP support against such claims, necessitating a faster triage and improved support system.

ii. **Fix mandatory reporting**: GPs hesitate to seek medical care due to strict AHPRA reporting laws, prompting calls for urgent reform. Current rules deter doctors, particularly concerning mental health, as seeking treatment risks immediate AHPRA notification without safeguards for the treating physician to delay reporting. A revised system should permit doctors to seek treatment without instant AHPRA notification, with a reasonable reporting timeframe. Given the GP shortage, prioritizing prompt care for GPs in centers and rural hospitals through special incentives could streamline services, easing emergency department congestion and improving overall patient care.

iii. **Protect the Dr Title**: Many non -medical graduates have started falsely using the 'Dr" title and purporting to be doctors. GP's should be able to collaborate with other medical organisations, lawmakers and law enforcers to develop mandatory restrictions preventing non -MBBS or MD holders from using Dr Title.

iv. **GP input matters**: There is lack of national authority to check the medical news in the national media. GP's need to be part of the authority to restrict the promotion of non -approved medical products in the national media. Media coverage on these products make it very challenging to explain these products lack scientific validation to patients.

v. **Reduce medical indemnity cost**: Professional medical insurance costs are rising and there is no mechanism to prevent these increases. Although we have a universal medicare levy to support medicare, it does not have a national medical insurance program to indemnify doctors. GP's should also be provided with government run medical indemnity insurance and or subsidies for the rising insurance cost as higher

premiums are leaving GPs with no choice but to force these increases to be passed on to patients through the consultation fees charged.

vi. **Raise community awareness about doctor-patient partnerships**: Often, patients fail to attend follow-ups and fault doctors. Legal pressures heighten doctor vulnerability. RACGP should promote patient responsibility for attending appointments, following up on results, and referrals. Increase advertisements in GP practices and social settings emphasizing the importance of patients promptly attending appointments and following medical instructions.

vii. **Prevention of fragmentation of GP care:** Many nurse-led or corporate clinics prioritize quick management, resembling third-world medicine, with frequent specialist referrals that increase costs for patients and the government. Every GP center should adhere to General Practice and Family Medicine principles. Without collaboration with GPs, nurses and pharmacists risk compromising continuity of care, leading to delayed diagnoses and missed serious disorders, as well as lost opportunities for health promotion and prevention. Specialists in General Practice training ensure comprehensive assessments from initial visits for acute or chronic issues to follow-ups, addressing ongoing health needs. Each visit to a GP is an investment in overall health, as medical issues are often interconnected. Fragmenting care with separate after-hours services diminishes care quality.

5. Improving GP work force by strengthening IMG intake and training

i. **IMG intake needs to be smoother**: After IMGs pass their AMC exam and PESCI, they often encounter issues with non-accredited supervisors and face challenges with limited registration approvals. It's challenging for IMGs to identify AHPRA-accredited supervisors. RACGP should coordinate the application process to verify supervisor accreditation status with AHPRA before submission.

ii. Act on "**Missed opportunities to train Australian resident or citizen OTD/IMG in Metropolitan cities in Australia"** - There is shortage of supervisors in rural and remote Australia, so completing two years GP training in Cities /urban practices before IMG goes to Rural area for fellowship training.

iii. **Pre Fellowship Program (PFP)** – Need to move the Metropolitan area (MM-1),as there is shortage of supervisors in rural areas and at least 25% of pre fellowship program funding will help with this. PFP is for those who would like to get a taste of general practice

iv. **More funding for supervisors and educators** -Funding to having a Family Medicine Department at Medical Schools within Universities, will encourage doctors to join and to be supervisors. As the department of General Practice does not give a status to specialists like our hospital specialist department like respiratory medicine etc.

v. **Develop mechanisms to support repeated unsuccessful FRACGP candidates** - It is a great loss of the training and GP manpower if a repeated unsuccessful GP does not get the opportunity to have more training and additional chances by independent supervisor and educator.

vi. **Develop mechanisms to identify vulnerable GP registrar** in the training program and support the candidate before their sixth attempts happens.

vii. **Reduction of Co- Supervisors Eligibility Tme to two years from three years post fellow:** To increase the supervisor numbers by reducing post Fellow time and one days supervisors training.

viii. **Development of a central GP telephonic GP support hub:** Having a centre point of call for isolated GP's for new and emerging rules and regulation changes related to General Practice. Neither AMA, nor medical indemnity insurance is providing such service. Such as during COVID-19 period issuing COVID-19 vaccine exemption certificate and sudden item number change etc.

ix. **Disaster Support Team for GP's** : Having a disaster support team for GP's when there are any disasters like floods, fires, cyclones or vandalism.

x. **Increase the viability of general practice as a business: Assist the GP's who would like to privately bill for their work.**

What are the barriers on becoming RACGP to be GP voice:

I will address and overcome barriers to ensure RACGP effectively represents GPs' voices. Constitutional barriers hinder GPs from advocating on critical work and training issues; these must adapt to meet GP needs. I'll enhance grassroots GP engagement with the RACGP board and council.

Policy and legal barriers also exist, and I will collaborate with all board members to advocate for GPs' needs effectively. I'll seek advice from the RACGP presidential council, continuing initiatives like the parliamentary friend for GPs started by President Nicole Higgin. RACGP will help to empower local GP’s to engage with their MP’s, Mayor’s, local decision makers, hospitals, PHN on issues relevant to their GP business, local health supply and delivery issues.

Additionally, I propose making practice managers associate members of RACGP for better access to education and resources. A specific interest group for practice owners will focus on integrating general practice and family medicine into business practices.

You can read more on me and on my campaign at **www.drmonirulhaque.com.au**