RACGP submission: National Strategy to Achieve Gender Equality

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Table of contents

Table of contents 2
1. About the RACGP 3
2. Introduction 3
3. Summary of recommendations 4
4. Improve women's access to health care 4
4.1 The funding of general practice and Medicare. 4
4.1.1 Women are more likely to delay or avoid healthcare due to cost. 4
4.1.2 Complex women's health issues impact quality of life and earning capacity 5
4.1.3 Female GPs tend to earn less than male GPs 6
4.1.4 Antenatal and reproductive healthcare requires further funding and support for women to get the care they need, when they need it. 6
4.2 Additional access barriers perpetuate the cycle of disadvantage 8
4.2.1 Additional access barriers create poorer health outcomes and perpetuate the cycle of disadvantage for many sub-groups of women 8
4.2.2 Support GPs to reach people experiencing abuse and violence 8
4.3 Research to support further improvements in primary care and women's health 9
4.3.1 Health research has historically focused on male participants and subsequently, the male experience of health and illness 9
5. Conclusion 9
References 10

1. About the RACGP

The Royal Australian College of General Practitioners (RACGP) is the voice of general practitioners (GPs) in our growing cities and throughout rural and remote Australia. For more than 60 years, we have supported the backbone of Australia's health system by setting the standards for education and practice and advocating for better health and wellbeing for all Australians.

As a national peak body representing over 46,000 members working in or towards a career in general practice, our core commitment is to support GPs from across the entirety of general practice address the primary healthcare needs of the Australian population.

We cultivate a stronger profession by helping the GPs of today and tomorrow continue their professional development throughout their careers, from medical students and GPs in training to experienced GPs. We develop resources and guidelines to support GPs in providing their patients with world-class healthcare and help with the unique issues that affect their practices. We are a point of connection for GPs serving communities in every corner of the country. Patient-centred care is at the heart of every Australian general practice, and at the heart of everything we do.

2. Introduction

The RACGP thanks the Australian Government for the opportunity to provide this submission. There are many complex and interacting issues that act as barriers to gender equality in healthcare. As the consultation discussion paper focusses on women and disadvantaged groups, as the group that suffer disproportionately from gender inequality, the RACGP's comments primarily focusses on these groups with a priority of improving access to ensure good healthcare.

General practitioners (GPs) are trained to deliver high quality, comprehensive, whole-person, patient-centred primary medical care. GPs contribute significantly to the healthcare of their female, trans and gender diverse patients. Almost 90% of the Australian population have seen their GP in the past year, with nine out of ten women have visited their GP in the previous 12 months[1,2], with women's health-related matters the fifth most reported reason for presentation overall in general practice[2,3.] GPs are also far better distributed throughout rural and remote areas than other medical specialists and many other health professionals[3].

It is important to note that women are expected to make up a significantly larger proportion of the general practice workforce in the future[3]. While males currently do make up a significantly larger proportion of GPs in terms of total headcount and in full-time equivalent (FTE), this gender disparity is narrowing[3].

Women's health has a wide scope in general practice, particularly for those practicing in rural and remote areas. GPs provide screening, testing, treatment, care coordination and management of women's health conditions including, but not limited to:

- Cancer prevention, screening and care.
- LGBTIQA+ health
- Sexual and Reproductive health
- Support and care for people who have experienced different forms of violence.

The RACGP has developed resources, guidelines and education relating to many aspects of women's health, including:

- Guidelines for preventive activities in general practice (the Red book)
- National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people (the National guide)
- Abuse and violence: working with our patients in general practice (the White book)
- Female genital cosmetic surgery: a resource for general practitioners and other health professionals
- Intrauterine devices / systems – resources for general practice
- 2022 RACGP curriculum and syllabus for Australian general practice – Women's health

Additionally, the RACGP has endorsed guidelines and accepted clinical resources from other organisations. These resources are available at the Women's health topic page.

3. Summary of recommendations

The RACGP's recommendations aim to address the health barriers faced by women broadly. However, these changes would particularly help to address the additional health barriers faced by women in rural and remote areas, and Aboriginal and Torres Strait islander women. These additional health barriers include geography, infrastructure, trauma, poverty, impacts of racism and discrimination.

In summary, the RACGP recommends:

Recommendation 1: Increase Medicare patient rebates to make healthcare more affordable for women who are disproportionately avoiding healthcare due to cost.

Recommendation 2: Improve availability and out-of-pocket costs of necessary investigations and specialist care.

Recommendation 3: Allow pregnant patients access to a higher rebate for complex antenatal consultations, by allowing GPs to bill Level C and D items for antenatal attendances.

Recommendation 4: Provide government funding and support for GP education to further extend skills in reproductive health and gender-diverse care (please refer to RACGP's submission to the Senate Inquiry into universal access to reproductive healthcare for further details).

Recommendation 5: Extend the temporary telehealth items for blood borne viruses, sexual or reproductive health consultations (video and telephone) and for non-directive pregnancy support counselling (items 92136 and 92138) beyond 30 June 2023.

Recommendation 6: Provide funding for an extensive awareness and education campaign about recent cervical self-collection changes

Recommendation 7: Include additional contraceptive options and menopause treatment to the Pharmaceutical Benefits Scheme (PBS).

Recommendation 8: Address the significant additional access barriers to healthcare, particularly in rural and remote Australia, to improve the health of disadvantaged women.

Recommendation 9: Increased support for general practice for patients experiencing domestic violence, through longer consultations, ongoing education and peer support groups.

Recommendation 10: Increase research funding into women's health conditions and women's, trans and gender-diverse experience of conditions.

4. Improve women's access to health care

We provide the following recommendations to make healthcare, and therefore women's health outcomes, more equitable.

4.1 The funding of general practice and Medicare.

4.1.1 Women are more likely to delay or avoid healthcare due to cost.

The Australian Institute of Health and Welfare (AIHW) *The health of Australia's females* report[4] found that at least once in the previous 12 months 1 in 25 females delayed seeing, or did not see, a GP when needed, because of cost reasons, in comparison to 1 in 40 males. This majorly disadvantages women who may consequently miss out on:

- opportunities for early intervention for chronic conditions,
- evidence-based screening and other preventive healthcare

- treatment for conditions that subsequently get worse and require hospital care.

The AIHW also found that[4]:
- women were more likely than men to have multiple chronic conditions, and
- the proportion of the female population in older age groups has been increasing.

This suggests that demand will continue to increase from women for increasingly complex consultations.

While systemic reforms will take time to develop and implement, the RACGP pre-budget submission 2023-24 outlines a range of measures which could be implemented quickly and bring significant relief to people struggling to access general practice care due to affordability.

The RACGP reiterates its call from the RACGP's 2023-24 pre-budget submission[5] for:
- a 20% increase to Medicare patient rebates for Level C (20-40 minutes) and Level D (40 minute plus) GP consultations
- the re-introduction of Medicare patient rebates for phone consultations for consultations lasting longer than 20 minutes, mental health and GP management plans as part of the permanent Telehealth model.

While our recommendation applies to all patients, increasing Medicare patient rebates for GP consultations will make healthcare more affordable and accessible for the women who are disproportionately avoiding healthcare due to cost. Importantly, longer consultations provide an opportunity to address major risk factors by allowing more time for preventive care and early intervention for chronic conditions[6].

The re-introduction of patient rebates for longer telephone consultations will also enable access to care for women with complex health needs and for women in rural and remote areas.

The cost barrier extends beyond general practice care and includes the out-of-pocket costs of investigations and specialist care. Cost and access to specialists such as gynaecologists can be prohibitive or may have long wait periods. Necessary investigations such as ultrasounds and laparoscopies can be expensive. Rural and remote areas have less availability of specialist services which requires patients to travel long distances for care.

GPs can undertake additional training in a range of gynaecological procedures (for example, ultrasound), which can be part of the solution in rural and remote areas with a lack of, or shortage of, specialist and investigative services. An increase in available training will go help address this.

4.1.2 Complex women's health issues impact quality of life and earning capacity

4.1.2.1 Menstrual health

Menstrual health conditions can affect productivity, sick days, need to reduce permanently hours or in severe circumstances, quit working altogether. This can encompass a number of conditions, including:
- period & pelvic pain
- menstrual migraine
- endometriosis
- heavy menstrual bleeding
- premenstrual dysphoric disorder, and
- menopause.

Endometriosis alone was estimated in 2017 to cost Australia $9.3 billion annually through reduced quality of life and productivity losses[13,14].

Secondary conditions such as anaemia, depression and anxiety can also affect the overall health and wellbeing of women and ultimately their productivity and earning capacity.

4.1.2.2 Mental health

In 2020–21, 15% of Australians aged 16–85 years experienced high or very high levels of psychological distress[3,15]. Women are more likely than men to report experiencing high or very high levels of psychological distress (19% compared with 12%)[3,15] with the number of young females experiencing psychological distress has been increasing at a greater rate than for other age groups[3,15].

In particular, a greater proportion of women (3.5%) than men (1.4%) reported problem eating behaviours, with 95% of Australian hospitalisations due to an eating disorder were women[16].

4.1.2.2 Carers

The health and care of family members also primarily falls on to women. The social roles and responsibilities expected of women, particularly regarding women being care providers to children and possibly ageing parents, has an associated physical and mental load[2].
Women disproportionately take time off work (or leaving their job) to care for the health of family, including children and elderly parents. The majority of informal carers (72%) are female, with 70% of people receiving the carers payment being female[17].
Over 60% of single mothers (who make up 80% of single parent households) nominate managing their health or mental health as a key challenge[9].

Funding for longer general practice consultations, improving the availability and out-of-pocket costs of investigations and necessary specialist care will allow women (and all people) with complex conditions to get affordable healthcare.

4.1.3 Female GPs tend to earn less than male GPs

Female GPs spend longer (average 19 minutes) with their patients compared with male GPs (average 16 minutes)[3]. This might be explained by the types of consultations conducted by female GPs. For example, female GPs report a significantly higher proportion of consultations with a mental health component, which are typically complex consultations, requiring more time. This means that they tend to see less patients, therefore earning less money. The remuneration for these consultations disadvantages those who undertake complex work such as mental health and women's health, which tends to be conducted by female GPs.

4.1.4 Antenatal and reproductive healthcare requires further funding and support for women to get the care they need, when they need it.

Antenatal and reproductive care has evolved significantly in recent decades, with advances in research, science and technology. This has resulted in longer time required for consultations to ensure comprehensive assessment is completed. however, Medicare and Pharmaceutical Benefits Scheme (PBS) funding has not changed alongside these advances.

4.1.4.1 Antenatal care

The current funded consultation length for general practice antenatal appointments is 20 minutes. However, to provide the complex and individualised care required as recommended by the evidence-base, antenatal consultations often extend beyond this time. This is especially the case for women in vulnerable and disadvantaged patient groups.

General practice antenatal consultations involve, but are not limited to:

- monitoring of existing or pregnancy-related health problems and potential complications - such as diabetes, anaemia and pre-eclampsia.
- appropriate testing and screening – which involves discussing the results with the patient and referral if required.
- advice on nutrition and physical activity – which is tailored to the individual patient's needs and abilities.
- mental health counselling - particularly for those with existing mental health conditions and/or at risk of postnatal depression.
- screening for intimate partner violence – which includes providing support, advice and referral if required.
- preparing for childbirth and breastfeeding – according to the patient's individual needs and wishes.

GPs are currently restricted to billing MBS items 16500, 91853 and 91858 for antenatal attendances, regardless of the length of appointment. The RACGP recommends that rules be amended to allow GPs to bill MBS Level C and D time-based attendance items (36, 44, 91801, 91802, 91894) for antenatal attendances that extend beyond 20 minutes.
This is a simple and positive step that can be taken to support pregnant patients, children, and families. Regular antenatal care, particularly in the first trimester, is associated with better material and child health in pregnancy, fewer interventions in late pregnancy, and positive child health outcomes[2]. Patients should be able to access a higher rebate if a consultation is longer or more complex, just as they can for other consultations or conditions.

4.1.4.2 Reproductive, sexual and gender-diverse care

Incentives and funding for general practice training

Government incentives will go a long way to support GP access to more affordable training opportunities across all areas of reproductive, sexual and gender-diverse health, particularly in areas of demonstrated workforce shortage. Training opportunities should include, but not be limited to:

- gender-diverse care, particularly on how to support their patients, provide appropriate information and prescribe gender-affirming therapy,
- surgical abortion, which is the only option to terminate a pregnancy after nine weeks,
- long-acting reversable contraception (LARC) insertion and removal.

The RACGP's recent submission on Senate inquiry into universal access to reproductive healthcare provides further detail on these points.

Extension of telehealth items
Enabling access to sexual and reproductive health services via telehealth provides flexibility and choice for patients to consult with their GP (or an alternative GP to their usual GP if they do not provide medical termination of pregnancy or is a conscientious objector) on sensitive health matters. On 1 July 2021, eight new MBS GP telehealth items were introduced for blood borne viruses, sexual or reproductive health consultations (video and telephone). These items are time-based and can be used for services related to blood borne viruses, sexual or reproductive health, excluding assisted reproductive technology and antenatal care. The RACGP recommends these items be continued beyond 30 June 2023 when they are scheduled to expire.
Similarly, we recommend the temporary telehealth items for non-directive pregnancy support counselling (items 92136 and 92138) be extended beyond 30 June 2023.

Funding for patient education and awareness campaigns
Funding for further awareness and education to eligible women (and people assigned female at birth with a cervix) that self-collection for cervical screening is now available. It will be important to target promotion to traditionally under-screened populations that will benefit most from self-collection including:

- People who have experienced sexual violence and trauma
- LGBTIQA+ people
- Aboriginal and Torres Strait Islander people
- People from culturally and linguistically diverse (CALD) communities
- People living with disability
- People who have had negative experience with screening in the past.

GPs play an important role in self-collection, supporting the patient by providing necessary advice, instruction and assistance if required.

Additions to the Pharmaceutical Benefits Scheme (PBS)
The RACGP recommends that the following additions should be made to the PBS:

- Copper IUDs – these are an effective long-acting contraception option for people who are unable to use hormonal contraceptives. Medicare rebates for the insertion of an IUD should be increased alongside in order to reduce or eliminate gap fees.
- Newer and emergency contraceptives – to improve affordability and accessibility to patients, particularly those with limited disposable incomes.
- Menopause treatments - patients should be able to access all efficacious menopause treatments on the PBS and not be inhibited by price increases for some treatments.

Recommendations

Recommendation 1: Increase Medicare patient rebates to make healthcare more affordable for women who are disproportionately avoiding healthcare due to cost.

Recommendation 2: Improve availability and out-of-pocket costs of necessary investigations and specialist care.

Recommendation 3: Allow pregnant patients access to a higher rebate for complex antenatal consultations, by allowing GPs to bill Level C and D items for antenatal attendances

Recommendation 4: Provide government funding and support for GP education to further extend skills in reproductive health and gender-diverse care (please refer to RACGP's submission to the Senate Inquiry into universal access to reproductive healthcare for further details).

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Recommendation 7: Include additional contraceptive options and menopause treatment to the Pharmaceutical Benefits Scheme (PBS).

4.2 Additional access barriers perpetuate the cycle of disadvantage

4.2.1 Additional access barriers create poorer health outcomes and perpetuate the cycle of disadvantage for many sub-groups of women

Groups of women and gender-diverse people who experience poorer health outcomes at higher rates should be prioritised for funding and assistance. These additional access barriers includes geography, infrastructure, language, trauma, poverty, impacts of racism and discrimination, impacting[7-9]:

- women who live in rural and remote areas
- Aboriginal and Torres Strait Islander women
- LGBTIQA+ people
- Women with disability
- Women in prison
- Culturally and linguistically diverse (CALD) women, particularly those with a refugee background
- Women living in poverty and/or experiencing homelessness.

Existing barriers for Australian women, in general, is exacerbated for these groups, not only impacting on their health outcomes, but the health outcomes of their children and their families.

GPs see the whole person. They are the usual first contact point for patients in the Australian health system, especially for women living in rural and remote areas. More regional and rural placements for medical school students should be facilitated in order to encourage future doctors to live and work outside of the major cities, with increase of funding in rural and remote areas for sexual and reproductive health services, including pregnancy termination.

Additionally, the RACGP clinical guidelines, such as the Red book and the National guide are important resources to assist GPs to improve preventive health of their patients, including those who are facing disadvantage.

4.2.2 Support GPs to reach people experiencing abuse and violence

While harassment, abuse and violence affects people, regardless of gender, women and gender diverse people are more likely to be the victim. This is particularly the case for[2,18]:

- LGBTIQA+ people (especially trans and gender diverse people),
- pregnant women,
- women with disabilities,
- women who live in rural and remote areas, and
- Aboriginal and Torres Strait Islander women.

Intimate partner violence is one of the leading contributors to death and disability for women of childbearing age, and has major effects on the health of children exposed to it[18].

Current survivors disclose to GPs more than to any other professional group, even more than to the police[19]. Without a key focus on GPs, many families will not be reached at an early intervention stage. GPs are key in this process as they

play a central role in the healthcare system and are often the only health professional seeing both the victim-survivor, the perpetrator, and their children. Increased support for general practice, through ongoing education and peer support groups, will greatly assist GPs to identify and safely work with victims, children, and perpetrators as well as work with other domestic violence services.

The RACGP's Abuse and violence - Working with our patients in general practice (White book) guideline for GPs offers a set of accessible, evidence-based recommendations and strategies ranging from how to respond to patients presenting with signs of abuse or violence, through to legal options to consider with their patients and guidance on working with perpetrators. This guideline also includes a specific chapter on education and training for healthcare professionals. The RACGP is working in collaboration with the Safer Families Centre to roll out training nationally.

The National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people also includes a chapter on Family abuse and violence that provides guidance on the identification and culturally sensitive interventions for Aboriginal and Torres Strait Islander people experiencing violence.

Recommendation:

Recommendation 8: Address the significant additional access barriers to healthcare, particularly in rural and remote Australia, to improve the health of disadvantaged women.

Recommendation 9: Increased support for general practice for patients experiencing domestic violence, through longer consultations, ongoing education and peer support groups.

4.3 Research to support further improvements in primary care and women's health

4.3.1 Health research has historically focused on male participants and subsequently, the male experience of health and illness

Historically, medical research has been primarily undertaken on male participants, with research data extrapolated and applied to females[10]. This is not ideal and can result in adverse health impacts on women, including delay in treatment; applying inappropriate, ineffective, or harmful treatments; or the withholding of effective treatments[10].
For example, a recent study from the Australian National University (ANU)[11] found that women are 75% more likely to experience adverse reactions to prescription drugs compared to men, due to a range of differences in traits between the sexes. Another example is the lack of research to understand the impacts of the menstrual cycle, pregnancy, birth, breastfeeding and menopause on girls and women with ADHD[12].
It is important that research is funded into women's health conditions and women's experience of conditions to ensure they have equal access to diagnosis and treatment.

The gender differences in presentation of conditions needs further research. Women experience health differently to men, and so research based on the male experience impacts on women's experience in the health system and their health outcomes. Increasing or incentivising research into women's health conditions and their experiences of conditions will ensure that recommendations for diagnosis, treatment and management improved for women. This research should also encompass the experience of Aboriginal and Torres Strait Islander women, trans and gender-diverse people.
There is little reliable data, particularly for trans, gender-diverse, and intersex people. The next Australian census should include questions about LGBTIQA+ people in order to ensure that appropriate levels of health services are available to meet the needs of this community.

Recommendation

Recommendation 10: Increase research funding into women's health conditions and women's, trans and gender-diverse experience of conditions

5. Conclusion

The RACGP looks forward to crucial and much-needed systemic short and long-term changes to improve the health and wellbeing of all women in Australia. The RACGP again thanks the Australian Government for the opportunity to provide this submission.
For any enquiries regarding this submission, please contact Stephan Groombridge, National Manager, Practice Management, Standards & Quality Care on 03 8699 0544 or stephan.groombridge@racgp.org.au.

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