Joint Submission:
WA Primary Health Alliance and Rural Health West

Inquiry into the provision of General Practitioner and related primary health services to outer metropolitan, rural, and regional Australians

Chris Kane, General Manager Strategy and Engagement
WA Primary Health Alliance

Tim Shackleton, Chief Executive Officer Rural Health West

30/09/2021

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1.0 Introduction

Western Australian Primary Health Alliance (WAPHA) and Rural Health West (RHW) are pleased to submit to the Inquiry into the provision of general practitioner (GP) and related primary health services to outer metropolitan, rural and regional Australians (the Inquiry).

Key Points:
Provision of high-quality primary health care is challenging across Australia. These challenges are acutely felt in many outer metropolitan, regional, rural and remote areas of Western Australia. Outside of inner metropolitan areas, many small scale private general practices are not sufficiently enabled to operate sustainably in ways that meet contemporary community needs unless they are supported by non-traditional funding sources. In many regional, rural and remote areas of the State, the following factors are driving primary health care workforce shortages:

- Uncompetitive remuneration;
- High workloads;
- Resources sector driven increases in housing prices and availability;
- Barriers to lifestyle and family support;
- Limited professional opportunities for education, networking and peer support;
- Limited opportunities for GPs to work to their full scope, and
- COVID-19 and border closures limiting the Fly in Fly Out and Drive in Drive Out Locum workforce

The most appropriate solutions to address challenges to the provision of primary health care vary in each local area. Local knowledge, strength-based partnerships and shared decision-making lead to the best health outcomes for the community, but can be difficult to implement within the current inflexible funding structure. New and reformed policies and funding models, such as those described in this submission, will allow primary health care to escape from the constraints of the existing policy and funding paradigm, and will enable the provision of truly patient centred, multi-disciplinary team care approaches to delivering primary health care.

WAPHA operates the three Western Australian Primary Health Networks - Perth North, Perth South and Country WA. WAPHA is responsible for planning, guiding and directing Australian Government investment towards important primary health care services. For many people, these services are the first contact they have with the WA health system and WAPHA works to keep Western Australians well and out of hospital when accessible, quality primary health care is more appropriate for them. WAPHA identifies priorities, links services, and funds primary health care services that are locally accessible, by working with GPs, health service providers, Australian, State and Local governments and their agencies, and with local communities. WAPHA partners with local organisations to further joint regional planning approaches and a shared opportunity for innovation in models of care and service delivery and joint funding arrangements.

Rural Health West exists to bridge the disparity between the health of Western Australians living in the country and those in the city, and the disproportionate health outcomes of Aboriginal and non-Aboriginal people. Rural Health West's purpose is to identify and deliver solutions to help close this gap in health disparity. The organisation delivers on this purpose by supporting rural health professionals, and those aspiring to work in regional, rural and remote settings, through a diverse range of programs and services including conferences, professional development workshops, scholarships and bursaries, rural immersions, personal and family support, outreach programs and business support and advice to regional, rural and remote general practices. With more than 30 years in the rural health

sector, Rural Health West has a long history of working collaboratively with government agencies, private organisations and other non-government organisations at local, state and national levels.

Rural Health West is funded through the Australian Government Department of Health and the WA Country Health Service, through the Better Medical Care for Country WA Initiative.

Please note:

- ***Throughout this submission, we will use rural in place of 'regional, rural and remote' for brevity. All references to 'rural' should be taken as the broader definition and relate to all locations classified as Modified Monash Model (MMM) 2 to 7.***
- ***Throughout the submission reference is made to MMM locations. The Modified Monash Model defines whether a location is a city, or is rural, remote or very remote. The model measures remoteness and population size on a scale of MMM1 to 7. MMM 1 is a major population centre and MMM 7 is a very remote location.***
- ***Throughout the submission reference is made to District Priority Area (DPA). DPA classification is an Australian Government policy that identifies locations in Australia with a shortage of medical practitioners. International Medical Graduates work in a DPA to be eligible for Medicare.***

This joint WAPHA and RHW submission is focused on the issues surrounding primary health care workforce and services in WA's outer metropolitan and rural areas. It is acknowledged that WA faces specific challenges in primary health care workforce capacity that are not always replicated in other Australian States and Territories. WAPHA and RHW assert that tailored solutions must be collaboratively designed and implemented in WA to meet the individual needs of rural areas of WA, with particular acknowledgement of the enduring and acute challenges experienced by WA's remote communities. The vast distance and isolation of much of WA results in significant and persistent challenges in attracting and retaining suitably qualified GPs and other primary health care professionals and contributes to the maldistribution of WA's primary health care workforce as will be outlined further in this submission.

There are significant issues of inequitable access to primary health care services within rural areas of WA. This, in large part, is caused by the maldistribution across the State of the primary health care workforce. People in rural areas generally have poorer overall health than metropolitan residents. Significant GP shortages also add to the pressures on the already stretched public hospital system. The metropolitan area, in the most part, is well serviced by primary health care professionals, but WA does experience workforce shortages in specific outer metropolitan areas.

A related area of concern is the funding models for general practice which are not well suited to the needs of key population groups most at risk of poor health outcomes, particularly Aboriginal people. Aboriginal people and communities in WA experience barriers to accessing culturally competent primary health care due to the difficulty in attracting GPs and other health professionals to outer metropolitan, regional, rural and remote areas of WA. Aboriginal Community Controlled Health Organisations (ACCHOs) are achieving positive outcomes for Aboriginal people in the areas they service as they improve access to culturally competent primary health care. However, ACCHOs require ongoing and targeted funding and support to meet the current and future health and social and emotional wellbeing needs of the communities they serve. In some areas, such as the Great Southern and Wheatbelt, there is no ACCHOs presence to provide a service. Both WAPHA and RHW have strong partnerships and relationships with the Aboriginal Health Council of WA and the ACCHOs across the State and we are willing and able to assist where we can, to support the delivery of, and access to, culturally appropriate primary health care to Aboriginal people and communities. We also

acknowledge the importance of leveraging, for mainstream general practice, the skill and capacity of ACCHO staff in providing culturally appropriate primary health care services to Aboriginal people.

GPs are spending more time treating an ageing population and increasingly complex patients presenting with multiple chronic conditions, including mental ill health. Mental health conditions, especially over the past couple of years, have been on the increase. It is acknowledged by GPs that patients presenting with mental health issues require considerable consultation time to ensure appropriate identification, early intervention and management. Models for funding more complex care in the primary care setting need to be considered with due recognition of the ageing population and the anticipated high rates of chronic disease and comorbidities into the future.

In most rural areas of WA, GPs operate their practices as small businesses - usually in an environment of higher costs for service delivery. Practice viability and sustainability is directly linked to improving the long-term health outcomes for people living in these areas. Low profitability of practices in communities with low populations has the potential to negatively impact communities as we see these areas experiencing a persistent lack of access to a GP or adequate primary health care.

Given the Australian Government's responsibility for primary health care funding and strategy, WAPHA and RHW consider this Inquiry to be a significant opportunity to improve access to primary health care services in WA. We consider the Inquiry to have the potential to implement long term reforms to service delivery and funding models that will assist in delivering more equitable and quality primary health care services across outer metropolitan and rural areas of WA. Any recommendations need to be supported by appropriate long-term funding models that ensure workforce suitability and sustainability. It is evident from current and past funding models that short term funding of programs does not provide security and commitment to the workforce to commit to rural areas.

Within this submission, WAPHA and RHW have endeavored to not only highlight the issues impacting primary health care workforce in outer metropolitan and rural WA, but to also make strategic recommendations for viable and sustainable solutions.

2.0 GP Shortages in WA outer metropolitan, regional, rural and remote areas

Western Australia has fewer GPs per capita than all other Australian States and Territories other than the Northern Territory[1].

Western Australia has a population of 2.6 million people, accounting for 10.4% of the Australian population. The State occupies one-third of the Australian continent, covering a vast and sparsely populated geographical area of 2.5 million square kilometers. Most of the population resides in the Perth metropolitan area, whilst approximately 500,000 people (19%) live in regional, rural and remote areas.

The provision of healthcare across WA represents significant challenges. Stakeholders have identified staff attraction, retention and the cost of travelling vast distances to provide clinical services as barriers to the provision of primary care in regional, rural and remote WA.

There is also a heavy reliance in WA on Fly in Fly Out (FIFO), Drive in Drive Out (DIDO) and Royal Flying Doctor primary health care services to fill workforce shortages in rural areas of WA. This is acutely prevalent and enduring as we consider the more remote areas of the State – where the services are critically needed.

The table below shows that in 2020, 15.22% of the GP workforce in rural WA was made up of FIFO / DIDO.

Table 1: Rural GP numbers by primary model of service provision 2019 v 2020[2]

Primary model of service provision	2019	2020	Difference		Proportion
Resident GP	486	478	-8	*-1.6%*	*54.3%*
Fly-in/fly-out and drive-in/drive-out*	135	134	-1	*-0.7%*	*15.2%*
Member of a primary health care team**	46	52	6	*13.0%*	*5.9%*
Hospital-based GP (DMO/SMO)	62	73	11	*17.7%*	*8.3%*
GP registrar	115	139	24	*20.9%*	*15.8%*
Other	3	4	1	*33.3%*	*0.5%*
Total	**847**	**880**	**33**	***3.9%***	***100%***

* *Includes fly-in/fly-out and drive-in/drive-out GPs working for RFDS Western Operations, WACHS (DMOs and SMOs), ACCHOs and private GPs*

** *Primarily ACCHO*

[1] *Government of Western Australia, Department of Health. (2018). General practice workforce supply and training in Western Australia.* https://ww2.health.wa.gov.au/~/media/Files/Corporate/Reports-and-publications/General-practice-workforce/13421-General-Practice-Workforce-Supply-and-Training.pdf

[2] *Rural Health West. (2020). Annual Workforce Update.* https://ruralhealthwest01.blob.core.windows.net/www-production/docs/default-source/marketing/publications/annual-workforce-update-november-30-2020_final-web.pdf?sfvrsn=2

An analysis of GP FTE alone points to an adequate supply of GPs in terms of GP to population ratio in rural WA. However, in isolation, this data does not appropriately identify the unique health service landscape or challenges experienced within the primary care sector.

GPs and primary health care services are maldistributed in rural WA. Services are located in the major townships and outreach to isolated towns and communities is impeded by travel and cost barriers. A higher rate of GPs in rural WA work in solo general practices, work longer hours and are older than GPs in the WA metropolitan area. This evidence points to the fragility of the current GP workforce in these areas when considering sustainability and viability into the future. RHW has undertaken considerable analysis of these factors when planning the GP workforce needs for these communities. The current arrangements with MMM and DPA impact primary care workforce in rural areas and further detail is contained within this submission.

Table 2: Rural GP numbers by region 2019 v 2020[2]

Region	2019	2020	Difference	
Goldfields	68	65	-3	*-4.4%*
Great Southern	102	101	-1	*-1.0%*
Indian Ocean Territories	4	4	0	*0.0%*
Kimberley	104	112	8	*7.7%*
Metropolitan (RFDS Western Operations)	13	13	0	*0.0%*
Midwest	88	87	-1	*-1.1%*
Outer Metropolitan	56	65	9	*16.1%*
Pilbara	60	68	8	*13.3%*
South West	271	280	9	*3.3%*
Wheatbelt	81	85	4	*4.9%*
Totals	**847**	**880**	**33**	***3.9%***

Table 3: Number of rural GPs by practice type and region[2]

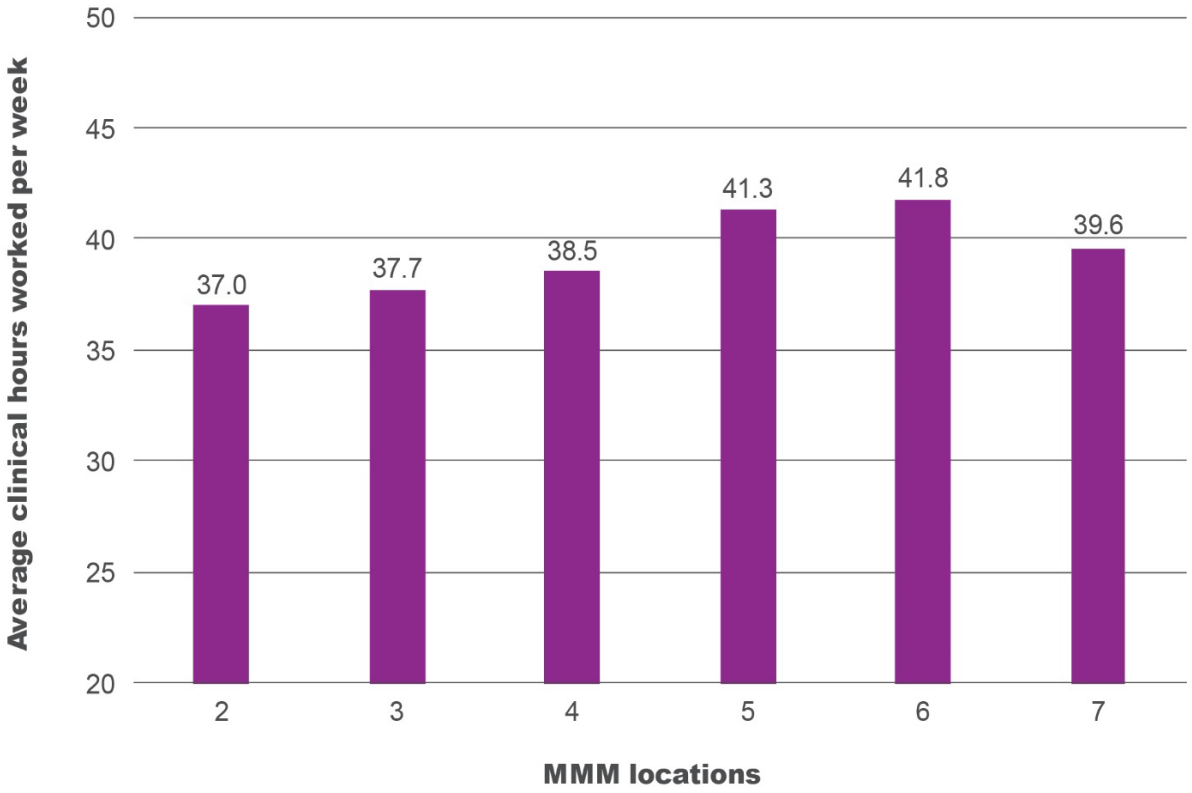
Region	Group	Solo	Total	% Solo
Goldfields	56	9	65	*13.8*
Great Southern	95	6	101	*5.9*
Indian Ocean Territories	3	1	4	*25.0*
Kimberley	108	4	112	*3.6*
Metropolitan (RFDS Western Operations)	13	0	13	*0.0*
Midwest	74	13	87	*14.9*
Outer Metropolitan	65	0	65	*0.0*
Pilbara	65	3	68	*4.4*
South West	270	10	280	*3.6*
Wheatbelt	68	17	85	*20.0*
Total	**817**	**63**	**880**	***7.2***

There is a correlation between increasing remoteness and clinical hours worked as is shown in Figure 1. The highest average clinical working hours were reported by GPs working in MMM[3] 5 and MMM 6 locations (41.3 hours and 41.8 hours respectively), with the lowest average clinical working hours reported by GPs working in MMM 2 and MMM 3 locations (37.0 hours and 37.7 hours respectively). It is important to note here that these reported hours do not take into consideration the time required for GP activities including finalising clinical notes and assessing patient results.

In developing primary care funding policy, due consideration must be given to the amount of time spent by health practitioners, particularly GPs, outside of face-to-face consultations. This time is not generally captured in data reports and, in the majority of cases, is not billable by the practitioners.

[3] *Modified Monash Model. Australian Government Department of Health.* https://www.health.gov.au/health-topics/health-workforce/health-workforce-classifications/modified-monash-model

Figure 1: Outer metropolitan, regional, rural and remote average clinical hours by MMM location[2]



A particular characteristic of the WA health environment is the use of General Practitioners to provide hospital services in rural areas. To address workforce needs in the country WA hospital system, General Practitioners are employed by the State hospitals as generalist resident medical specialists to provide acute care services to rural hospitals. As a consequence, when the acute care system is experiencing higher demand, it draws resources from primary care, thus further reducing access. Whilst RHW and WAPHA understand the rationale for this, the provision of hospital services by General Practitioners distorts GP FTE figures and inaccurately implies a higher supply of primary care services in rural WA.

Outer Metropolitan WA:

Outer metropolitan areas in WA often have a lower socio-economic status, have a high rate of chronic disease but have a lower supply of GPs per 10,000 residents. The key workforce challenge to the supply of both outer metropolitan and metropolitan GP FTE is an ageing workforce. In WA there are fewer GP FTE between the ages of 20 to 34 and more FTE in older age groups nearing retirement age. Again, the impact of this has been considered by RHW in its assessment of future workforce needs.

Outer metropolitan areas in WA often have a low socio-economic status and a high rate of chronic disease, but have a lower supply of GPs per 10,000 residents. Metropolitan areas, which include outer metropolitan, have substantial differences in access to primary health care services. Developing outer metropolitan areas, in general, have poorer health outcomes, lower socio-economic status and generally higher financial barriers to accessing non bulk billing GPs. Outer metropolitan areas have fewer GPs, resulting in patients having to wait longer for appointments and becoming sicker as they wait. GPs have little choice but to work longer hours and to see as many patients as possible, even though they are treating patients with complex needs who require more time and resources to manage. Practice viability is also reduced as the practices are often newly established practices trying to recruit workforce in order to service the growing outer metropolitan areas.

Recruiting GPs to these areas is particularly difficult given such high community need, structural limitations on remuneration and requirements for long working hours. For many doctors who have the option of practising in the inner metropolitan area, there needs to be an attraction to locate outside of inner city living. In most cases, the remuneration offered by government incentives, as well as the packages offered by practices, are the same as (or only slightly more attractive than) those offered by sought after inner metropolitan locations. This likely makes it more difficult to recruit GPs into outer metropolitan areas than into larger rural locations which have the advantage of additional incentives.

In addition, both inner and outer metropolitan areas are bluntly categorised together as 'major cities' (MM1) in the Modified Monash Model adopted by the Australian Government, and are excluded as a Distribution Priority Area for the recruitment of international medical graduates (IMGs). The impact of this change in policy from 2019 has had a significant compounding effect and is combined with existing pressures on the outer metropolitan workforce. To maintain a stable workforce, recruitment of IMGs has long filled some of the gaps in the provision of primary health care, and has helped mask the decline in GP Registrars. An added advantage is that in some cases, IMGs are from the same culture and language background as the predominant migrant communities living in these areas.

Another key workforce challenge to the supply of both outer metropolitan and metropolitan GP FTE is an ageing workforce. In WA there are fewer GP FTE between the ages of 20 to 34 and more FTE in older age groups nearing retirement age. Again, the impact of this has been considered by RHW in its assessment of future workforce needs.

Table 4: Outer metropolitan GP FTE per 10,000 residents by SA3 in WA (2019)[4]

SA3	FTE per 10k pop
Serpentine - Jarrahdale	5.5
Kwinana	7.0
Mundaring	7.2
Armadale	9.2
Wanneroo	9.4
Kalamunda	9.6
Swan	9.8
Rockingham	10.1
Mandurah	12.0
Western Australia	**11.6**

An immediate consideration to inform primary health care workforce planning in WA is to acknowledge that we have an ageing GP population in outer metropolitan and rural WA. This will continue to have a significant impact on the need for additional workforce in primary health care from current levels. WA will be required to replace what we know is an ageing GP and broader primary health care workforce.

[4] *Australian Institute of Health and Welfare. (2019). National Health Workforce Data Set.* https://hwd.health.gov.au/

In the next five to 10 years, as highlighted in the tables below, there is the potential to lose 1099.40 FTE in general practice across WA due to retirement. This workforce will need to be replaced over and above the additional immediate requirements. Of this, 259.9 (23.64%) GPs are in rural WA and 230.90 (21%) are in outer metropolitan WA.

Table 5: GP FTE by age and gender in WA (2019)[3]

	Age					
	20-34	**35-44**	**45-54**	**55-64**	**65-74**	**75-99**
Male	109.6	398.5	519.8	478.9	250.6	54.8
Female	144.8	408.0	349.9	242.7	66.4	6.0

Figure 2: Composition of the workforce by ten-year age group and gender[2]

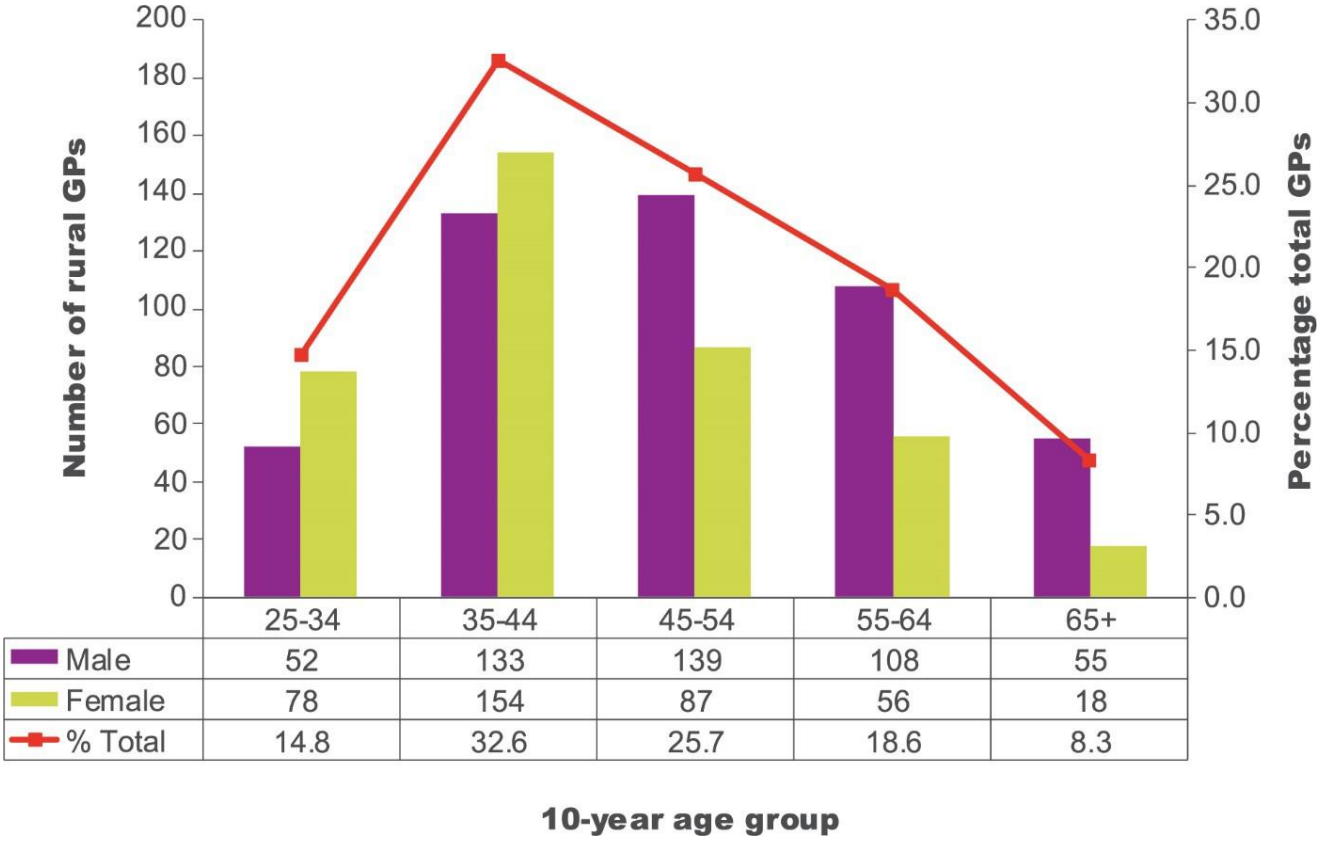


Table 6: GP FTE by age outer metropolitan WA (2019)[3]

SA3	Age					
	20-34	**35-44**	**45-54**	**55-64**	**65-74**	**75-99**
Armadale	7.0	19.4	31.2	15.9	8.5	0.0
Kalamunda	3.0	19.1	14.3	10.2	8.4	3.0
Kwinana	**3.0**	**9.3**	**11.9**	**5.6**	**0.0**	**0.0**
Mandurah	**13.6**	**36.1**	**36.6**	**28.4**	**8.9**	**0.0**
Mundaring	3.0	6.0	8.4	9.4	4.3	0.0
Rockingham	8.3	48.6	46.1	22.7	9.9	3.0
Serpentine - Jarrahdale	3.0	7.0	6.3	3.0	0.0	0.0
Swan	14.5	40.2	41.4	30.2	11.4	3.0
Wanneroo	15.3	79.2	56.0	30.3	11.8	3.0

A 2018 State Government report focused on general practice workforce supply and training in WA estimated that 21% of the GP workforce will retire by the end of 2021[1]. The report also noted that traditional work patterns were changing - with younger GPs preferencing part-time workloads and a greater focus on work/life balance. An ageing GP workforce, and a move by younger GPs toward part-time employment, will have significant impacts on access to primary health care across WA – and will be exacerbated in rural areas of the State.

Primary Health Networks (PHNs) have established agreements with general practices to extract de-identified patient data to assist general practices with quality improvement initiatives. An initial analysis of patient visits between June 2017 and June 2021 has indicated a decrease in patient visits to general practice in rural WA since 2019. This data must be further explored in order to identify impacts related to GP workforce and patient access.

PHN stakeholders have attributed this decrease to the continuing workforce shortages in rural WA and note that this has been exacerbated by the COVID-19 pandemic. Western Australian also experiences a shortage and maldistribution of Allied Health services. This impedes GPs in leading the delivery of comprehensive multidisciplinary primary care.

3.0 Consequences of poor access to GP services

Many people in rural WA experience persistent and substantial health inequities, including poorer health outcomes compared to metropolitan areas – and rural areas of other Australian States and Territories. Poor access to GPs can lead to delays in the diagnosis, early intervention and treatment of health conditions such as acute infections. This, in some cases, results in conditions that can be well managed in general practice developing into major health problems which severely impact people's health. In addition, the lack of access to transport, the costs of transport in these areas and the time required to travel can often further delay access to care. This may then require aggressive intervention including aeromedical retrieval and more complex care.

Serious and chronic health conditions, such as diabetes, are more prevalent in rural areas of WA than in the WA metropolitan area. GP shortages inhibit effective early intervention and ongoing management of these conditions in the community setting. This, in turn, adversely affects people's health outcomes and leads to greater demand on hospital services, increased costs to the health system and to patients, greater requirement for social welfare and negatively impacts community sustainability.

In the absence of adequate local GP services, the demand for GP-type services is shifted to public hospital emergency departments (EDs), despite these not being appropriate or efficient for the provision of GP services and comes with significant increased costs to the health system and to patients[5]. In this regard, it is noteworthy that in 2020-21, WA's country public hospitals accounted for 38.5% of ED presentations. However, only 20.2% of the State's population is in areas served by WA's country health service. More than half of the presentations were categorised as non-urgent, many of which could be appropriately addressed by a GP in the community setting.

The lack of GP services also has a flow on effect to other health services. Where there is a GP presence in an area, there is often the attraction of other health services in allied health, such as psychology, physiotherapy, pharmacy and nursing.

[5] *NewsGP (2019) GPs could save the health budget $1.5 billion by stopping lower urgency cases flooding emergency.* *https://www1.racgp.org.au/newsgp/professional/gps-could-save-the-health-budget-1-5-billion-by-st*

4.0 Impact of current and former Government reforms on services / Policy actions affecting access to GP services in outer metropolitan and country areas

4.1 Commonwealth policy actions affecting access to GPs

4.1.1 Stronger Rural Health Strategy

The Stronger Rural Health Strategy (announced in the 2018/19 Australian Government Budget) is a package of measures designed to encourage more doctors to practice in rural areas. The measures include bulk billing incentives for services delivered in rural areas, reforms to training and strengthened arrangements for bonded scholarships for medical students.

The most immediate measure needed is an increase in the MBS rebate for bulk-billed GP consultations. Prior to the measure, GPs in rural areas received a bulk billing incentive of $9.80 (and GPs in metropolitan areas received a bulk billing incentive of $6.50) for children under 16 years and concession card holders. Under the measure, GPs received an increased bulk billing incentive for bulk billed services delivered to the same population groups, with the extent of the increase varying with remoteness, and rising to $12.35 in very remote areas.

To date, analysis of GP recruitment and retention rates suggests that, in isolation, this does not provide sufficient incentive for GPs to relocate to rural areas. Incentives need to be packaged and structured in a way that attract GPs to a rural location – and keep them there for as long as possible. Incentives that require a GP to bulk bill do not appear to enable attraction and retention. Feedback from GP stakeholders highlights that this also continues to signal to patients that bulk billing is the standard in the industry. We are seeing that many general practices in WA are, in fact, endeavoring to communicate to patients that mixed or private billing is the norm. This is intended to achieve sustainability and longer-term viability of general practice.

Initiatives such as the 19AB exemption that place restrictions on GPs to force a move to rural areas are seen to have the opposite effect to the intention of increasing workforce attraction and retention rates. Imposing restrictions on a GP workforce that experiences low morale and extreme work-related pressures in these areas has a negative effect on attraction and recruitment. Governments should be looking to enable solutions that make general practice sufficiently attractive professionally, financially and personally, thus encouraging GPs to seek out these placements with enthusiasm rather than as a means to tick a box to facilitate a quick move to Metropolitan areas.

4.1.2 MBS Rebates for Telehealth Services

Primary health and acute care stakeholders in WA have long argued for the introduction of MBS items for telehealth, well prior to their introduction in alignment with the impacts of COVID-19. WA recognises that telehealth has the potential to significantly improve access to primary health care services for rural communities in the State and has made significant inroads into the application of telehealth for these communities. It is these communities that have the least access to reliable services and have the highest degree of need. WA has strongly advocated for removal of the uncertainty in the continuation of these items and for the specific and targeted use of telehealth for remote communities and for very small communities without a resident or visiting GP.

A barrier to achieving effective interface between hospitals and GP services is that, where GPs support a patient in a telehealth consultation with a public hospital specialist, they are only able to bill against the MBS if the specialist also bills against the MBS for the consultation. This effectively excludes the possibility of GPs participating in telehealth consultations with public hospital patients, such as for follow-up appointments after an inpatient admission. It limits the ability of GPs to ask questions and

otherwise access information that will assist them in managing their patient. These arrangements should be prioritised for review as they significantly impact on GP effectiveness within the ACCHO sector, particularly impeding integrated and coordinated care in the community. It is evident that revising these arrangements to enable coordinated, shared care between GPs and hospital specialists would achieve benefits for patients in rural areas.

WAPHA and RHW recommend that consideration be given to enabling MBS items specific to very remote locations (such as WA's Western Desert) which do not have the services of a resident GP or a regular visiting GP with understanding of the local context, referral pathways and local services. An organisation such as Rural Health West could then work with, and support practices in WA, to provide telehealth services to these areas with restrictions exempted from these regions until permanent in-situ workforce can be delivered. By default, if a GP establishes themselves in one of these remote locations in situ, the access to these items would cease.

WAPHA and RHW recommend specific restrictions on telehealth in areas where there are established resident GP services. In opening up telehealth with no restrictions, there is a risk that continuity of care between GPs and their patients is compromised. This has potential to occur when large corporate services commence delivery of telehealth from anywhere in the country, or potentially overseas, without a physical presence for face-to-face consultations. This would further undermine rural primary care workforce, as resident GPs may relocate to areas where access is less challenged (and thus, less viable from a business model perspective) if their patient numbers decrease.

Consideration should be given to allowing general practices with multiple sites to utilise telehealth for all patients within the practice group. This would allow group practices with multiple sites to provide enhanced services to patients within the group whilst still restricting the telehealth items to ensure services still need to have a face-to-face component from the practices. This maintains the intended protection, with services unable to be established solely for telehealth without the ability to deliver face-to-face consultations and supporting infrastructure within communities.

4.1.3 MMM (Modified Monash Model) and DPA (Distribution Priority Area)

22% of Western Australians reside outside of the Metropolitan area. There are inequities related to the application of the MMM. For example, Kalgoorlie, with its current MMM rating, is not recognised for its remoteness and is therefore unable to provide adequate incentives to attract and retain the required GP workforce to meet the primary health care needs of the regional population.

In July 2019, the Australian Government introduced the Distribution Priority Area (DPA) classification system, replacing the existing District of Workforce Shortage (DWS) Assessment Areas for General Practitioners (GPs) and Bonded Doctors. DPA is intended to improve the allocation of medical practitioners throughout Australia. The transition to the DPA system has significantly changed the status of general practices throughout WA. In the past two years, it is estimated by RHW that 25 practices have lost DWS/DPA status, representing approximately 9% of practices in Country WA. Most of these practices are in areas with high levels of healthcare demand, as measured by rates of lower urgency ED presentations, complex health needs and declining workforce levels. DWS/DPA status can significantly affect the viability of a practice, and the impacts of DWS/DPA changes have been felt in practices throughout Country WA.

Recruitment of GPs in rural areas is heavily reliant on DPA. The process of recruiting GPs is lengthy. It can take more than 12 months to recruit and commence practice for a GP coming to Australia from overseas. In most rural areas, the workforce is constantly changing, with GPs relocating for various reasons. An area that has sufficient GPs in a particular year, and is therefore not eligible for DPA, can quickly lose members of its GP workforce. Practices are constantly recruiting to ensure they are 12 months ahead of actual attrition to maintain GP numbers. Maintaining DPA status, even in years where workforce numbers for that area are higher, is vital to support ongoing recruitment to ensure a stable and sustainable workforce.

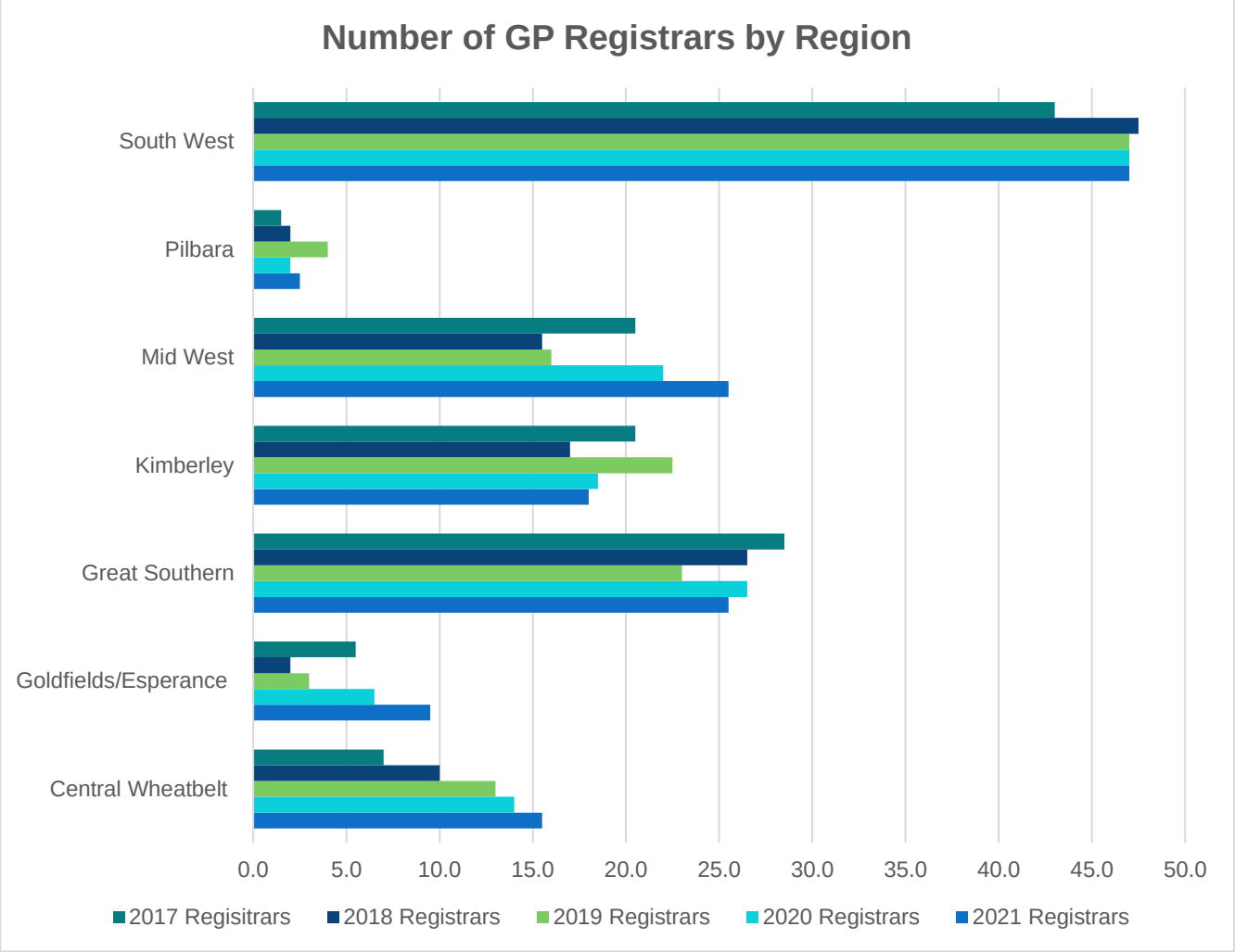
The introduction of MMM and DPA has seen improvements in classification of areas of medical workforce shortage. However, the application of these policies does not allow for individual circumstances and anomalies in locations and across regions of WA. Some rural areas face pressure in attracting and retaining medical workforce that are not reflected in existing DPA and MMM measures. The recent introduction of a mechanism to assess individual location factors when applying MMM and DPA, along with an appeals process to have classifications reconsidered, will help to reduce medical workforce shortage in these locations. The introduction of the new non-DPA appeals process is anticipated to assist in rectifying these workforce shortages. It is recommended that a similar process for reviewing individual community's MMM classification be introduced in the near future.

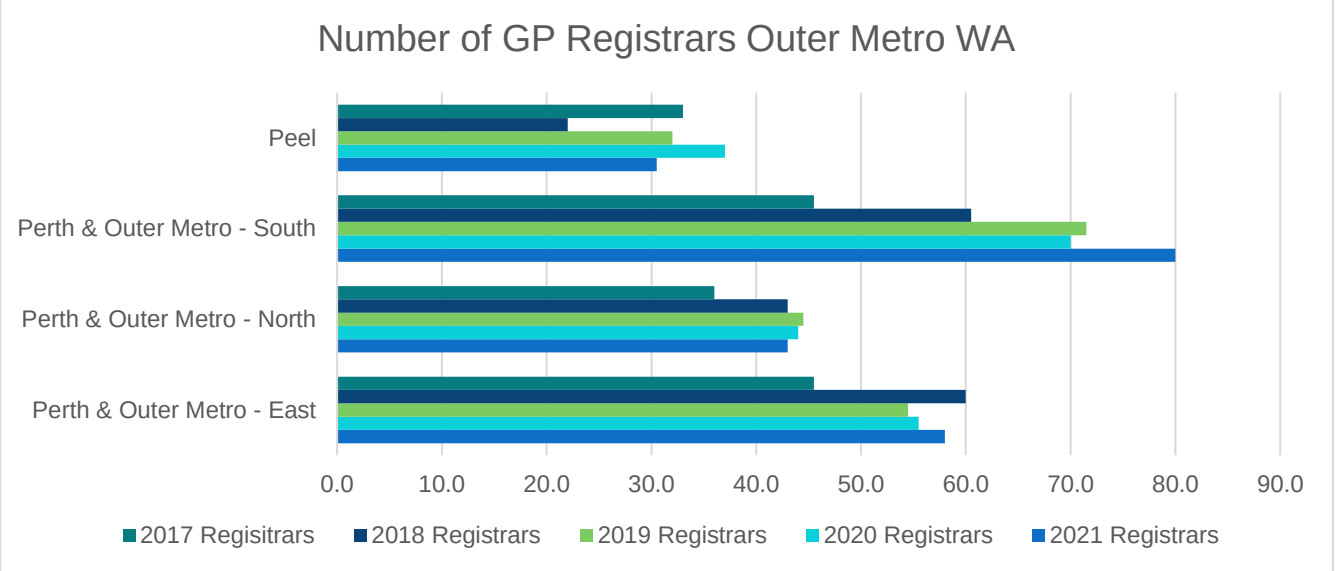
4.1.4 GP Training Reforms

The optimal time to encourage more doctors to embrace a career in rural primary health care is in their training years. For a GP to relocate from the city when they are already established in a practice, have family and a home and mortgage as well as children in school is not an easy decision or task to undertake. There is an opportune time to influence relocation to a rural area early in a doctor's career. This is potentially when there is a sense of adventure, willingness to explore new boundaries and locations and fewer obligations that impact the possibility of relocation. This is more likely to make rural general practice a more exciting prospect - rather than daunting and difficult.

A major initiative is in place through the WA GP Training provider (WAGPET) that is intended to support and prioritise GP training places into rural and outer metropolitan areas. This has been very successful with GP Registrars increasing in rural WA from 56 in 2002 to 153 in 2017. This was further supported with the introduction of WA's Rural Clinical School and efforts to provide additional advanced specialist training posts (zero in 2007 to 25 accredited posts in 2017). Furthermore, a GP procedural training program in WA provided support from major metropolitan services for rural proceduralists. Over a ten-year period, 96 graduates have commenced work with a 75% retention rate in rural areas[2]. However, as seen from the graph below, there is also a maldistribution of the GP Registrar workforce - with a majority being located in the more attractive coastal areas of the Southwest and Great Southern regions and more remote and inland areas having significantly lower GP Registrar numbers[6]. The Pilbara region, in particular, has traditionally had very low GP Registrar numbers. This is likely due to its remoteness and potentially the lack of available onsite GP training Supervisors throughout the region.

[6] *Western Australian General Practice Education and Training Limited. (2020). WAGPET placement data by town / MMM. *Data not publicly available.*





Reforms are needed within the National Terms and Conditions for the Employment of Registrars (NTCER) to recognise the additional value proceduralists bring to general practice when they commence work as a GP Registrar. Currently, all GP Registrars are remunerated equally. However, some come to practices already qualified in Anaesthetics or Obstetrics. This is of great benefit to rural

areas as these GP Registrars provide communities with an important additional skill that can be utilised in the hospital whilst they are completing their GP training program.

Some GP training programs are conducted within hospitals with little exposure to community based general practice until very late in the training program. Given that most rural and outer metropolitan based GPs routinely work across community and hospital settings it would be pragmatic to ensure this was a fundamental and integrated part of the GP training program, so that training occurs in the settings in which the GPs will ultimately practice.

Whilst WA has worked hard to increase the number of medical students to similar levels of other States and Territories, and has established a clear pathway for GP trainees into rural and outer metropolitan areas, there remains a major discrepancy between the attractiveness of general practice placements compared to other specialties. This is an issue only the Australian Government can effectively address, and there is an urgent need to do so. The current workforce and service delivery trends are increasingly focusing the Australian health system towards acute hospital-based services and away from preventing ill health and supporting community based primary care as the means of keeping Australians healthy and well, regardless of where they live. Although the data is not contemporary, this has been highlighted in a report by the WA Department of Health in 2018 focused on general practice workforce supply and training in Western Australia[1].

WAPHA and RHW believe there is a need to look at providing more availability for doctors to undertake their training in rural areas of WA. Optimally, this will include collaboration from multiple stakeholders such as WACHS, RHW, WAPHA, RCSWA and others to achieve this. This multi-agency collaboration recognises that doctors will pass through many stages and working environments as they progress towards a GP specialty. From a training perspective, this requires accessibility to all the stages as a doctor progresses through their training.

4.1.5 GP Workforce Incentive Program

The Workforce Incentive Program (WIP) was developed to improve access to quality medical, nursing and allied health services in rural areas. The two streams are the Doctors' stream which incentivises the GP and the Practice stream which incentivises the practice to engage nursing and allied health professionals.

The WIP is acknowledged to be a useful incentive to help practices engage nursing staff, especially as it assists to offset some of the higher costs of operating a general practice in rural areas. However, the WIP is not, in itself, considered to be pivotal in attracting and retaining GP workforce in rural areas. The WIP certainly assists practices to prepare an attractive package for GPs to incentivise them to relocate. However, in isolation of other incentives, it is not the driving factor in getting GPs to remain in rural areas.

4.1.6 GP Practice Incentive Program

The Practice Incentive Program (PIP) is used to encourage general practices to continue to provide quality care, enhance capacity and improve access and health outcomes for patients.

Traditionally, the PIP has been seen by general practice as an enabler for the Australian Government to link general practice incentive payments to key areas of health policy and reform. This often results in positive outcomes against the Quadruple Aim in Healthcare.

Some of the PIP incentives are vital to assist in the attraction of GPs to rural areas. Incentives such as the Rural Loading and the Procedural GP payment help practices to package incentives to increase the attraction to GPs to practice outside of the metropolitan areas.

It would be valuable to undertake a comprehensive evaluation of the PIP and WIP programs to assess whether they have made a significant difference in recruiting and retaining GPs into rural locations. This would assist in further development and quality improvement of these programs.

4.1.7 Voluntary Patient Registration

This Australian Government election commitment was due to commence on 1st July 2020. Voluntary Patient Registration (VPR) remains in development as part of the National 10 Year Primary Health Care Plan.

In principle, funding attached to VPR would appear to assist general practices across the board, and would be of significant benefit to rural general practices. Many remote practices and patients are negatively impacted by patients being seen elsewhere when visiting metropolitan areas or larger regional towns. There is evidence of other practices taking the opportunity to undertake a Care Plan or Health Assessment with no knowledge of the patient's medical history or personal circumstances. If a patient was able to enrol with their usual GP and practice this would likely ensure better health outcomes, enhanced continuity of care and would add a level of financial viability (and therefore sustainability) to smaller rural general practices.

The same issue may potentially exist with VPR as with the Health Care Home model in that it does not easily fit into the structure of most general practices. Where a quarterly payment for a patient is received by the nominated GP, this becomes problematic when that GP is on leave and another GP within the practice needs to provide care for the patient and may subsequently not receive any payment.

Any of these funding reforms and reviews need to work within the construct of general practice operations (both clinical and financial), otherwise they face significant implementation challenges from the outset. WAPHA and RHW strongly recommend that further development of models such as VPR is undertaken with rural primary health care stakeholders and that nuances across, and within, regions are taken into account.

4.1.8 Bonded Medical Program Reforms

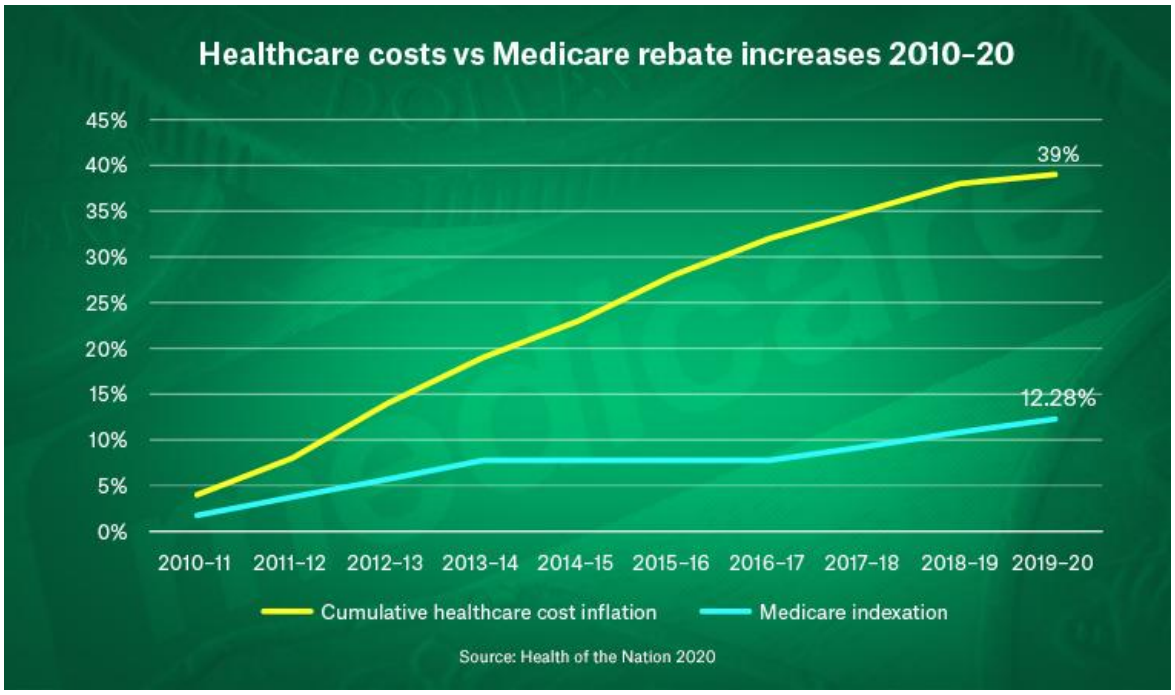
Bonded Medical Programs aim to provide more Australian trained doctors into areas of workforce shortage.

The recently reformed, and more flexible, Bonded Medical Program has added positive elements to assist program participants to complete their return of service in rural locations. These include the option to fulfil a return of service component prior to Fellowship, thus enabling rural exposure and experience during training, flexibility in how return of service can be completed and the ability to self-manage return of service obligations.

The reformed Bonded Medical Program is anticipated to result in an increase in completion of return of service obligations and aid in reducing workforce shortages in rural WA.

4.1.9 MBS Rebate Freeze

The ongoing MBS rebate freeze does have some impact on GP workforce recruitment and retention into rural areas. GPs consider this to be one of the fundamental issues impacting the viability of general practice. This is exacerbated by a narrative that reflects Australia's 80% plus bulk billing rates as being optimal in terms of access to primary health care. Whilst this is undeniably correct in respect to specific MBS items, it is not considered to be accurate for the core general practice consultation items. Most general practices are providing mixed billing options to patients and are moving more towards private billing in order to remain viable. This is especially the case in rural areas where there are smaller populations and limited opportunities for economies of scale.



With the Australian Government reducing access to the bulk billing incentive payment there will be further pressure on the viability of general practices. Commendably, this is intended to help shift GP workforce to rural areas. However, it is likely to reduce the ability of local GPs to bulk bill those people within our society who are at risk of poor health outcomes - including children and Aboriginal people. It will also negatively influence the viability and sustainability of country general practices. We have seen firsthand the implications of this with a large general practice co-operative in the ACT go into administration, in part due to the reduction of the bulk billing incentive in that area after a reclassification of the MMM[7].

Other models of financially supporting general practice should be considered outside the traditional MBS indexing. Ideally, we would consider the MBS as a rebate for patients, similar to private health insurance rather than as a payment model for general practice.

4.2 State Government Commitments affecting access to GPs

4.2.1 Southern Inland Health Initiative / Country Health Innovation Initiative

In 2011, the WA Government commenced an initiative known as the 'Southern Inland Health Initiative' (SIHI) which is now known as the 'Country Health Innovation' (CHI) initiative. This program has provided incentives for GPs to relocate to WA's southern inland regions.

A 2016 evaluation of the SIHI found that it had achieved a 50% increase in the number of GPs working in Southern Inland country towns. This has largely been maintained through 2021. As noted, CHI is a package of initiatives, and includes expansion of telehealth services, development of primary care facilities and upgrades to hospital infrastructure to improve clinical services provision and working environments.

At this point in time, this program has not been expanded into other regions of need in WA. Whilst it has achieved some positive results in the Southern Inland regions, we note that there are still significant shortages within that region. Also, other changes to models of care within country hospitals in regard

[7] *ABC News. (2019). Medicare bulk billing changes will lead to reduced services, doctors warn.* *https://www.abc.net.au/news/2019-05-22/medicare-changes-see-doctors-pulling-out-of-outer-metro-areas/11134250*

to proceduralist GPs have impacted on the retention rate that this program achieved. One of the KPIs of the initiative was to ensure that country hospital EDs had GP coverage, and there were adequate GP Anaesthetists and GP Obstetricians accessible to country communities. We are now seeing a significant shift in the models in State run country hospitals away from the GP Proceduralist model which is a perverse outcome against the initial goals of the SIHI program and is having the effect of GPs relocating away from the rural areas where they can no longer practice their procedural skills.

This has the dual impact on local communities of losing highly skilled procedural doctors within the hospital system and losing a GP from the region.

4.3 Areas of Commonwealth / State Cooperation

4.3.1 Places in University Medical Schools

In 2017, a third medical school was established in WA with the intent to grow a GP and primary care workforce, to reduce our reliance on recruitment of doctors from overseas and to address the growing maldistribution of medical practitioners in the State. A workforce assessment at the time recognised that WA had the lowest number of medical graduates per capita than any Australian State and it was posited that a third medical school was needed with a specific commitment to supporting graduates into general practice in rural and outer metropolitan areas, and the areas of Aboriginal health, aged care and mental health care. Essentially, supporting doctors to ultimately work in areas where the WA community needs them most. The first cohort of graduates will begin Internships in 2022. WAPHA and RHW are hopeful the intended outcomes of the new medical school are realised.

A dedicated effort needs to be made to structure training and incentives attracting these graduates to work in the specialty of general practice. Having an additional medical school is helping to increase the number of doctors, but if these graduates choose to remain in the hospital system, or move into other medical specialties, this will not increase the primary care workforce in the areas where workforce shortages are most acutely felt. Over the last five years there has been a decline in the number of graduates considering general practice as their specialty. Research published in the Medical Journal of Australia found that as of 2019, of the doctors who graduated from the University of Western Australia from 1985 to 2007, the number working as GPs has more than halved - reducing from about 40% to 15%[8].

4.3.2 Recruitment of Overseas Trained Doctors

Another important area of Commonwealth/State cooperation has been the introduction of arrangements allowing the recruitment of overseas trained doctors to work in rural areas. Under these arrangements, the WA Minister for Health can declare an area to be an “Area of Need” if sociodemographic data for the area demonstrates there is unmet need. In addition, the employer seeking to hire a medical practitioner must demonstrate that it has been unsuccessful in recruiting an Australian-trained practitioner. Following this declaration, it is then possible to recruit an overseas trained doctor to practise, under supervision, in the declared area. However, many fail the pre-employment structured clinical interview (PESCI) and limitations in access to sit the exam is a barrier to timely recruitment.

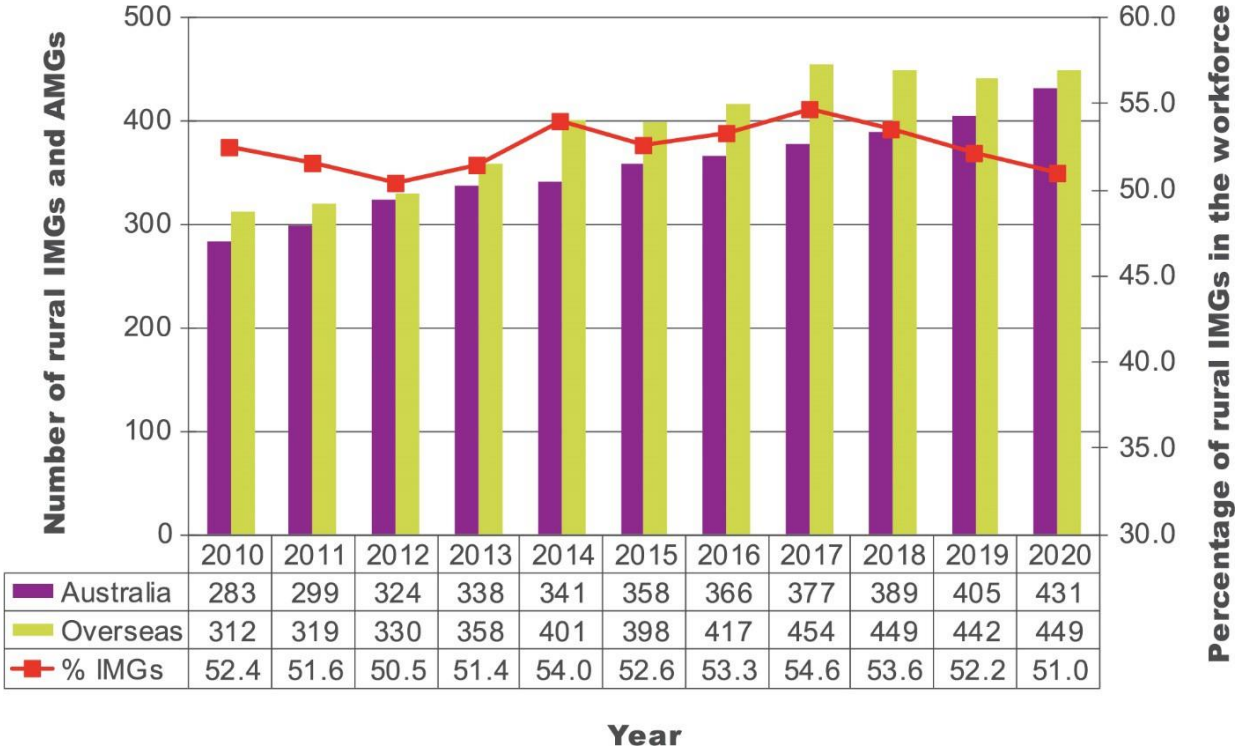
Overseas trained doctors have long been an essential component in maintaining workforce capacity in WA. As can be seen from the figure below, since 2010, over 50% of GPs working in WA alone had

[8] *Denese Playford, Jennifer May, Hanh Ngo & Ian Puddey. The Medical Journal of Australia. (2020; 212 (9)). Decline in new medical graduates registered as general practitioners.* https://www.mja.com.au/journal/2020/212/9/decline-new-medical-graduates-registered-general-practitioners

initially obtained their basic medical qualifications overseas. This demonstrates there is an enduring reliance on overseas trained doctors to provide primary care in rural WA.

Until such time that evidence can be shown that there is, and will continue to be, an adequate supply of Australian trained GPs to meet the needs of the workforce in rural WA, the continued supply of international medical graduate (IMG) GPs will be required to fill the need. There is an urgent need for the Australian Government to re-establish the intake of the IMG workforce to ensure access to primary care services in the short to medium term. More time is needed to collect evidence demonstrating that the required numbers of Australian trained GPs are coming to Western Australia and working in rural areas.

Figure 3: Number and percentage of rural IMGs 2010 to 2020



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Australia	283	299	324	338	341	358	366	377	389	405	431
Overseas	312	319	330	358	401	398	417	454	449	442	449
% IMGs	52.4	51.6	50.5	51.4	54.0	52.6	53.3	54.6	53.6	52.2	51.0

4.3.3 19(2) Grant Funding

Section 19(2) of the Health Insurance Act 1973, precludes state-remunerated health services claiming Medicare Benefits for non-admitted, non-referred professional services. In 2006–2007 the Council of Australian Governments (COAG) introduced the Section 19(2) Exemptions Initiative – Improving Access to Primary Care in Rural and Remote Areas Initiative (the Section 19(2) Initiative), with the objectives of:

- improving access to primary care for people living in rural and remote areas;
- supporting participating sites to attract and retain a relevant primary healthcare workforce; and
- assisting with the sustainability of the rural hospitals.

The Section 19(2) Initiative recognises that many people living in rural and remote areas throughout Australia face difficulties in gaining access to primary health care professionals and services in their community. The Australian Government Department of Health has engaged consultants from Healthcare Management Advisors (HMA) to 'undertake a robust review of the COAG Section 19(2) Exemptions Initiative – Improving Access to Primary Care in Rural and Remote Areas – to determine how the Initiative achieves its objectives.

In some areas, the allocation of 19(2) funding is making it more difficult for private general practice to recruit workforce or to establish private services outside of the hospital provided primary health care

which is available in some regions. The WA operated tertiary health system has regional areas where it provides GP primary care services from the hospitals. The State Department of Health provides significant packages to GPs to attract them to these regional areas at a more attractive remuneration than local private services could support whilst remaining viable under current remuneration models.

Under Commonwealth/State arrangements, and after due application, doctors employed at hospitals in small communities (of less than 7,000 people) can bill against Medicare for services provided to patients presenting to hospital Emergency Departments with low acuity health issues. This has an impact on the viability of private general practice to establish itself in areas where this is available through the hospital ED. There have been occasions in regional WA where private general practice has attempted to establish services but has exited due to an inability to operate a viable service whilst there are GP services available from the local hospital.

It would be beneficial for this funding to be focused on building GP workforce capacity and establishing private primary health care services that are not linked to the hospital. This funding can have a negative impact on the viability and sustainability of establishing and embedding general practice in a region. Ideally 19(2) funding should be utilised to assist in the establishment of viable general practice and other primary health care services and re-educating the community about GP services and the likelihood of gap payments and fees. The funding could be used in its current form where there is no interest to establish private GP services in a particular region. However, WAPHA and RHW advocate that this needs to be a flexible policy with funding being redirected once there is a commitment by private practice to establish services in the region. WAPHA and RHW look forward to considering the outcomes of the Australian Government Review into 19(2) funding and to working with WA's State hospitals to optimise this initiative in the long term interests of people living in rural WA.

5.0 Further Actions Required

In the focus areas below, WAPHA and RHW have highlighted priority actions which are required to improve the current primary care workforce issues. Consideration has been given to core issues impacting on attracting GPs to rural areas, and retaining them in the longer-term.

5.1 Factors Impacting GPs relocating and remaining in country areas

The provision of financial incentives for doctors has, over many years, proved to be a component of successful models in encouraging GPs to relocate to rural areas. Over recent years there have been contributing factors impacting on attracting GPs to relocate to rural areas and the ability to retain them. WAPHA and RHW have identified the current incentives available as well as other factors impacting relocation and sustainability thereof. WAPHA and RHW have put forward some long-term solutions for the Inquiry to consider.

- **WIP – Doctor and Practice streams.** This assists the practice in meeting recruitment costs and the high costs of operations in rural areas. The WIP – Doctor stream is a useful tool as a component of an overall package to attract a GP. However, in isolation, the WIP does not provide sufficient financial incentive to entice a GP to relocate.
- **Stronger Rural Health Strategy**. The initiative of an increase in the rebate for bulk billed consultations does not, of itself, influence GPs in their decision making to relocate to a rural area. More could be done with this initiative (that is not linked to a requirement to bulk bill) to make it financially more attractive for GPs to work in rural areas. An element currently in evidence is that GPs find it more sustainable to bill patients a private fee, with a gap over the rebate amount, and forgoing the bulk billing incentive. GPs consider this to be financially more beneficial when coupled with educating their patients around the value of their health care.
- **SIHI / CHI.** Has assisted in increasing GP recruitment in the Southern Inland areas of WA. Similar incentives in other areas have not been as extensive or effective. It would be beneficial to introduce an incentive covering the entire State, with tiered payments aligned to the location and the remoteness of the area or the duration the area has been without GP services.
- **Local Government (Shire) subsidies.** Many smaller regional WA local governments are providing packages to GPs or general practices to operate local practices. This model has several impediments to a sustainable GP workforce. Firstly, it is a sizable drain on the local government's financial resources as it usually involves a significant cash component, rental of the practice at peppercorn rates, a house and vehicle for the GP and the majority of practice equipment. Secondly, at some point, the community will question paying for a GP service not only through standard taxes for the Medicare rebate, but also via their local government Rates. Both funding sources are applied to subsidising the practice, and patients will potentially be paying a private fee for the service where the smaller practices, relying solely on a bulk billing model, are not viable. Even with these sizable subsidies, some local government areas in WA have still struggled to fill GP vacancies.

  Other subsidies being offered by local governments are for housing. Many will pay an allowance to GPs for the provision of housing. The amount is dependent on the area and varies considerably. The City of Karratha, for example, currently will subsidise $300 per week towards rental housing for GPs.
- **Housing affordability and availability.** This has become a significant issue impacting rural WA. Many rural areas are experiencing a severe housing shortage, with rental availability rates being at all-time lows. In part, this has been fueled by the resources sector boom in the northern regions of the State, but is also due to a rebounding housing market with investors taking the opportunity to sell residential properties. This draws availability away from the rental market.

COVID-19 has also been a factor, with access to building materials and trades becoming limited, and timelines for building being extended significantly. This further adds to WA's lack of housing availability.

Housing affordability has also become a major concern given its negative impact on enticing GPs and other health workers to rural areas. As an example, areas in the Pilbara region of WA are experiencing average rental prices of $1500 per week and there are significant numbers of people vying for the same properties. Rental prices have skyrocketed due to lack of availability and the booming resources sector.

The cost of housing is a significant factor influencing a GP looking at placement options and practices are resorting to considering subsidising this or providing GPs housing for a period of time to attract them to these regions. This puts significant pressure on the financial viability of practices in rural areas. Some local governments are providing assistance in this area as mentioned above, but many of these options are unsustainable in the longer term with the current resources available to local governments and general practices.

- **Costs of living.** Rural areas of WA experience an increase in the costs of living over and above housing costs. Most basic costs such as food, fuel, transport, travel and utilities, are more expensive in rural WA. Depending on the location, some basic utility costs increase significantly. For example, the cost of power in the Pilbara and Kimberley, is significantly higher due to increased usage of air conditioners which are required to operate 24/7 in the summer months. The State provides some areas with an air-conditioning allowance but this is not consistent.

- **Access to schooling and childcare placements.** Many GPs considering relocation to rural areas of WA have young families. Many of these family members are well established and settled in the metropolitan areas of WA. To address this, and attract GPs to relocate, there needs to be access to high quality schooling (primary and secondary) and childcare placements.

  Currently, there is a significant lack of childcare availability in rural areas. This has an impact on the decision of GPs and primary health care professionals to relocate and can also affect the hours worked by GPs and allied health professionals in rural areas. Many look to decrease daily working hours whilst waiting for childcare placement.

  To ensure sustainability of the GP and primary allied health workforce in rural areas, recognition is required of the needs of the broader family. The needs of family members is one of the key considerations for GPs when considering relocating to rural areas.

- **Ability to expand scope of practice or existing procedural skills to ensure variety of practice.** Providing GPs with choice in terms of expanding their scope of practice adds variety which is often sought after in general practice. Providing options within the hospital system for GP Proceduralists to regularly use, and enhance, their skills and allowing appropriately upskilled GPs to work shifts in EDs further enhances health care access for the community. It also contributes significantly to GP retention as GPs have access to work variety and complexity which many newly Fellowed GPs are seeking.

- **Professional development opportunities.** It is important to provide health professionals with professional development opportunities. This can be more difficult in rural areas due to time constraints and the additional costs of travel. This has eased somewhat since the peak of COVID-19 in WA, and the large scale move of many training platforms to a virtual environment.

  More could be done to assist in providing professional development and peer support for GPs in rural areas. Remoteness and disconnection from peers and support is a significant contributor to GPs ruling out rural practice in the long term.

RHW provides a comprehensive education and skills development program for rural health professionals that includes workshops, conferences and forums and the Health Workforce Scholarship Program. RHW's program provides scholarships and bursaries to assist health professionals in rural areas to retain and enhance their skills, capacity and scope of practice.

The regional Health Professionals Networks (HPNs) for which RHW, WAPHA and RCS are the statewide partners, were recommended in the *Towards a Medical Workforce Strategy for Rural WA* report to support a healthy and effective medical workforce for communities in rural WA[9]. WAPHA and RHW, together with partner agencies, have established HPNs in each region of WA to provide rural health professionals with opportunities to network, upskill, share information and collaborate in a supportive, professional environment.

- **Added pressures on viability of practices in regional areas.** Rural general practices face more significant financial pressures than most metropolitan practices. Costs, and the length of time associated with recruitment of GPs, are usually higher, costs of operation and staffing are more expensive and in most cases more incentives and reduced service fees need to be offered to the GPs to attract them to practise in rural areas.

  Another barrier for private general practices to compete and establish GPs within smaller communities is the quantum of the incentives and payments provided to GPs working in the State health system operated GP clinics. These incentives are very lucrative, and private general practices are unable to compete. For example, where the State is paying a GP over and above $500,000 per annum in salary plus incentives. However, of more concern is the remuneration expectation this sets for GPs which is not reflective across the broader profession.

  The State Government also provides tax concessions above WA's 26th Parallel to assist people working north of that point. However, there are many similarly isolated and remote areas within WA that are not advantaged by the same concessions.

- **Shortening of Moratorium periods.** Many GPs relocating to rural areas are overseas trained and on a moratorium, which excludes them from employment in a metropolitan setting. These GPs practise in more remote areas for the short term as these placements can significantly shorten their moratorium periods and expedite their practise in a metropolitan setting.

  In some ways this policy is counterproductive to establishing long term, consistent GP services to rural areas. Many of these GPs intend to complete two years' rural practice to achieve a moratorium period with their longer-term plan being a permanent move to the metropolitan area. However, in the absence of a shortened moratorium it is unlikely that practices would be able to attract these GPs at all.

All of the above have direct implications on attracting GPs to relocate to rural areas. They need to be considered in combination and a cohesive strategy must be considered in collaboration with general practice and relevant State and Commonwealth agencies as to how to best package up incentives to attract GPs to rural areas. Practices are having to reduce service fee percentages and privately fund benefits such as flights, housing and leave coverage to make it attractive for GPs to relocate. This adds pressure on the sustainability of the general practice businesses.

Australian and State Governments, working collaboratively with key primary health bodies such as PHNs, rural workforce agencies and general practices to package up incentives across the board, would provide more surety to practices regarding incentives and remuneration. This would enable a clear and consistent rural relocation offering for GPs when considering rural general practice.

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[9] *Healthfix Consulting. (2019). Towards a medical workforce strategy for rural WA. *Data not publicly available.*

5.2 Training in outer metropolitan, regional and remote areas

Rural practice experience is an important predictor of future rural practice. Therefore, attracting and supporting junior health professionals to train in rural areas is critical. The State public health system relies heavily on international medical graduates, which leads to a shortage of experienced GP Supervisors in rural areas. Rural GP training pathways can be strengthened by incentivising GP Supervisors to become more involved in rural GP training either in person, online or by telemedicine.

Experience can be further supported by rewarding or incentivising not only rural practice (such as through the WIP), but also incentivising completion of rural training during Fellowship. Junior doctors completing their compulsory hospital year (RACGP), or core clinical training year (ACRRM), are unable to access workforce incentives during training. Therefore, providing this additional training support could encourage greater participation and exposure.

When a junior doctor transitions from Internship and hospital training to a general practice employment arrangement within a small business setting funded largely by MBS, the doctor's public sector salary and entitlements are relinquished. Some Australian jurisdictions support GP training by maintaining publicly funded employee benefits throughout Registrar training periods until the achievement of GP Fellowship. If applied in WA, this would incentivise and support junior doctors to enter GP training.

Supporting rural secondary students to pursue a career in medicine would assist in addressing rural workforce shortages. Whilst this is a longer-term strategy, it is proven that students who have grown up in rural areas will be more likely to return once qualified - if the opportunity to do so is there.

There is significant merit in early identification, within the community, of Aboriginal students who have the interest to pursue a career in medicine. These students could be supported and incentivised to progress a career specialising in general practice. Potentially, there may be obligations tied to the incentives that encourage a return to their communities to practice for a set period of time. However, it is expected that many would have this intention if given the opportunities and education and training support. It is more likely that an increased Aboriginal primary health workforce would result in higher retention rates in rural communities.

More needs to be done to extend GP specialist training to rural areas. Placing young doctors in rural areas makes it more likely they will remain there longer term as they build networks and friendships.

To do this, additional funding is required to be dedicated to supporting and developing GP Supervisors in rural areas. GP Supervisors are integral to training and currently many of them take on this role with very little remuneration or support. This has become more important now with programs being offered such as the Practice Experience Program and More Doctors for Rural Australia Program (MDRAP) which require large amounts of GP Supervisor time. Expanding the options for remote supervision would also be beneficial. However, clear guidelines need to be placed around this to ensure compliance and clinical safety.

The introduction of the MDRAP 3GA program enables non-vocationally registered doctors to work in rural areas and access the MBS Schedule. This is an important program to improve workforce distribution by providing exposure to rural general practice for junior doctors and doctors without general practice experience, who would otherwise be unable to experience rural community general practice. The incorporation of training and supervision elements contributes to a quality experience for participating doctors. To some degree, the MDRAP has filled the gap resulting from the termination of the Prevocational General Practice Placements Program and John Flynn fellowships. However, the cessation of these programs interrupted the pipeline of students benefiting from exposure to general practice.

5.3 Benefits of Procedural GPs

A survey focused on rural health issues conducted by the AMA in 2019 highlighted that a key element GPs find most rewarding about working in rural medical practice is the variety of work available. This includes the ability to apply skills as a procedural GP[10]. For many GPs who have upskilled into procedural specialties, this is one of the highlights, and a key attractant, for them to practice in rural areas.

Many general practices in rural areas have relied on the availability of procedural work to attract GPs to the regions. These GPs are often unable to utilise their procedural skills in Obstetrics or Anaesthetics within the metropolitan area due to high numbers of specialists and hospitals having staff Consultants and Specialists. They will therefore look to rural areas in order to fully apply their training and work to top of their scope.

Of current concern in WA is the trend for some regional hospitals to move away from the GP Proceduralist model which has been highly successful in providing skilled workforce to the hospital system and to community general practices. The risk with this trend is that the current GP Proceduralist workforce will potentially be deskilled as a result of lower, or non-existent, caseloads and difficulties in keeping up with the latest clinical techniques.

The more significant impact of removing access to procedural work in rural areas is that GP Proceduralists will locate to areas where they can apply their full scope of practice. The result will be that rural communities will lose a GP from the region. We have seen evidence of this over the past two years in rural WA where the GP workforce has been depleted due to barriers to delivering procedural services to the hospital.

In larger regional areas in WA, having access to providing GP procedural services within the region significantly enhances success rates of GP recruitment. More GPs are looking to upskill in procedural specialties due to the variety of practice they are exposed to but they need the ability to apply these skills.

Ensuring the ongoing availability of access to GP procedural work in rural WA is essential to increasing workforce capacity and retention of GPs. GP Proceduralists comprise 22% of the GP workforce in rural WA, a very significant number.

[10] *Australian Medical Association. (2019). Rural Health Issues Survey.* *https://www.ama.com.au/sites/default/files/documents/AMA_2019_Rural_Health_Issues_Survey_Report.pdf*

Figure 4: Number and proportion of rural GP proceduralists 2010 to 2020

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
N proceduralists	188	172	189	177	174	173	177	182	188	193	194
% GP workforce	31.6	27.8	28.9	25.4	23.5	22.9	22.6	21.9	22.4	22.8	22.0

5.4 Alternative models for funding services

The effectiveness of primary care and successful general practice relies on a multi-disciplinary approach and GPs having access to allied health and nursing services to ensure their patients have access to timely and comprehensive primary health services. The MBS fee-for-service model is the norm, and is working. However, GPs are increasingly moving towards a mixed / private fee in preference to bulk billing. This is mainly due to maintaining the viability of general practices but is also because patients are presenting with more complex issues. With an ageing population, and with rural patients presenting with higher levels of chronic disease, GPs require longer consultation time to adequately manage and support these patients.

Alternatives to reliance on fee-for-service funding of GP services should be explored. However, the models considered need to reflect the business models of the majority of general practices in Australia. In practice, blended funding models can be difficult given the challenges for practices to distribute the income to the practice GPs and allied health professionals working under similar contracting arrangements with practices. This was a significant issue with the Health Care Home model where there was difficulty in making payment to the individual GP and major disruption occurred to the operating systems and processes of general practices.

Incentives to rural general practice in the form of infrastructure grants and annual operating incentives could be considered to ease the burden on local governments supporting their community general practice. This could also entice established general practice services to assume the operations of smaller country clinics.

Alternative models/solutions need to be developed by the local region to acknowledge the specific community context. Consideration could be given to the development of primary health care collectives, or integrated health groups, where multiple private small practices would share services and infrastructure.

5.5 Strengthening the Rural Generalist Pathway

The Rural Generalist program will partially address the deficit of Proceduralists and hospital-based clinicians in larger regional centres, but recognition is required of the importance of strong relationships between community GPs and hospital-based doctors. There should be sufficient incentive for GPs and rural generalists to provide community based primary care services, to prevent doctors moving exclusively into the hospital system. This could involve:

- allocating sustainable medium/long term funding for Rural Generalist support units;
- supporting a continuous training program funding model throughout the training cycle;
- supporting supervisors and mentors;
- supporting rural doctors to attain and maintain procedural skills in larger centres through funded attachments, and
- providing training completion incentives for doctors who have trained in excess of 50% of time in rural areas.

5.6 Primary care funded services in lieu of low MBS expenditure

There are a number of rural and remote WA communities with no GP and no satisfactory visiting GP arrangements. Efforts to attract GPs to deliver services to some communities are likely to remain ineffective until alternate models of engagement or funding can be implemented to make these areas attractive for a GP to practise longer term. Many of these areas are serviced by intermittent GP Locum services or GPs taking short term placements. This is not ideal for the communities and has an impact on continuity of care, particularly as these rural and remote communities generally have high numbers of patients with chronic disease and comorbidities.

Where there are low GP numbers there is low per capita expenditure via the MBS and therefore lower Commonwealth investment in primary health care. Additionally, as it proves difficult to attract and retain GPs in these areas, there is also minimal access to other funding initiatives such as the PIP and WIP. Making these funds available in lieu of the MBS expenditure provides the opportunity to address this access issue and potentially enables the establishment of more permanent GP services. The amount available for these services is the difference between actual MBS expenditure and the expenditure where a service has been provided at the national average per capita rate. Should this model be effective, a clear strategy must be in place to vary the model once consistent GP services are established, accessing MBS and other funding at rates consistent with the national average.

It is noteworthy that the Australian Government previously trialed this policy in 2004/05, in the form of the Primary Health Care Access Program. It was discontinued without explanation and retrospective assessment of the policy could result in some key learnings being applied to future policy development.

5.7 Assistance to GP practices to conduct business

One of the major factors preventing GPs locating to small towns or solo general practices is the workload, especially in those areas with an expectation that the GP will also service the local hospital on call. This is not sustainable long term and burnout of GPs is common, resulting in the GPs moving away.

In a small town, permanent local residents have ready access to the GP. Therefore, there is generally very little respite and downtime for GPs in a remote rural location.

Provision for incentives or contracts between established general practice groups to operate smaller, or solo, general practices would reduce the operational costs as a result of more centralised systems, policies, training and infrastructure.

The most difficult element of this model is in attracting and retaining GPs to staff the rural sites. This would require an attractive working package to be provided to the GPs.

Such initiatives would reduce pressure on local governments which, in the long term, cannot continue to fund community GP services. This may also enable the attraction of more doctors into the specialty of general practice in rural areas where GPs consider there to be a stable environment and a lifestyle / workload balance.

WAPHA and RHW have developed the Practice Assist service, which aims to deliver high quality, seamless and customer-focused practice support to general practices across WA. Practice Assist provides advice and support to general practices to help enhance their sustainability, viability and to improve patient outcomes by freeing up practice owners, principals and managers to care for and support the practice patients. This service is provided free-of-charge to all general practices across WA.

5.8 MBS rebates for services delivering telehealth

Telehealth must be developed to play a larger part in delivery of GP services, in particular to remote regions. WAPHA and RHW fully support the continued implementation of MBS items for telehealth, and a collaborative approach with general practice and primary health care stakeholders to further development and implementation.

Consideration may need to be given to specific MBS items for very remote locations without the services of a resident GP or a regular visiting GP. If restrictions are removed from these items, an open market for practices nationwide would be enabled to potentially deliver services into these areas. By default, when a GP is established in one of these remote locations in situ, the access to these items would cease.

Some restrictions on telehealth are required in areas with established resident GP services. Without this, the market is open to the encroachment of corporate entities and continuity of care between GPs and patients is compromised - further undermining viable and sustainable primary care workforce as resident GPs may relocate if patient numbers are diluted.

Something to be considered is allowing GP practices with multiple sites to utilise telehealth across all patients within a group.

To facilitate the continued use of telehealth, particularly via video or telephone consultation, there needs to be some significant investment in rural WA telecommunications networks. Successful use of telehealth requires clinician and patient literacy and engagement. This is enabled by a stable and fast internet connection. WA currently experiences significant network and accessibility issues in delivering virtual services into remote areas.

A specific case study highlighting the impact of telehealth on transforming primary health care service delivery is within a practice 650km north east of Kalgoorlie in the Great Western Desert - one of the most remote locations in Australia. This practice has, in the past, relied on GPs and allied health professionals flying in from South Australia to service the community. When COVID-19 hit, and borders closed, the community lost all access to their clinical services. The community implemented digital health services through telehealth and has been able to deliver similar, if not improved, services to the community[11].

[11] *Australian Digital Health Agency. (2021). Technology brings better health care to one of the most remote communities in the world.* https://www.digitalhealth.gov.au/newsroom/media-releases/recent-media-releases/technology-brings-better-health-care-to-one-of-the-most-remote-communities-in-the-world

5.9 Immigration constraints as a result of 457 visa changes

Every year there is a large turnover within the regional medical workforce. Where and when positions become vacant is unpredictable. Attempts to fill vacancies with Australian medical graduates are often unsuccessful, resulting in the need to recruit overseas trained doctors. Registration for many overseas trained doctors requires completion of a satisfactory PESCI exam. Application processes for 482 visas are more complex and costlier than for the 457 Visas. Continuing reductions in GP Visas are further reducing the capacity to fill GP vacancies. These issues require Australian Government attention.

5.10 Registration timeframes for GPs

The length of the Australian Health Practitioner Regulation Agency registration process for overseas trained doctors has increased considerably in recent years, and presently averages seven to eight months (compared to six to eight weeks in 2018). This has exacerbated challenges in recruiting GPs to work in rural areas and has resulted in significant interruptions to service continuity. Further, there are often delays in obtaining provider and prescriber numbers for GP Registrars at the start of each clinical year, and this is an impediment to these doctors being able to undertake their role.

Linking this to Visa issuing timeframes and constraints makes the process for getting a GP established and practising very time consuming and often costly as the GP is unable to practice whilst waiting for key requirements from regulators.

6.0 Impact of COVID-19

WA has long experienced ongoing challenges related to medical recruitment into rural areas, and this has been exacerbated by the COVID-19 pandemic. WA not only relies heavily on international medical graduates to immigrate to WA, but also on visiting practitioners and Locum doctors and allied health professionals from interstate. COVID-19 has resulted in reluctance of medical professionals to travel, and the controlled interstate border conditions have limited WA's access to interstate doctors. GPs and allied health professionals are now remaining in their home countries and Australian States as they are unwilling to accept the risks of remaining in two weeks' isolation as they enter and exit WA. Furthermore, the major attraction of providing locum services within WA was for GPs and other medical and health professionals to experience a working holiday. This is now much more difficult given the COVID-19 related complexities and constraints.

COVID-19 fast-tracked the introduction of new telehealth items, initially for GPs and then for non-GP specialists, to help with protection from infection and to support practices and patients. GPs are unable to access telehealth payments for specialist services such as Aboriginal health, women's health, chronic pain and addiction. These important services should have access to specialist telehealth item numbers to enable important care to be provided to rural regions.

7.0 Recommendations

7.1 Review alternative models of General Practice funding that complements the current 'fee for service' model

- Consolidate rural incentive / retention payments to streamline rural general practice / rural generalist remuneration packages. This would enable general practices to offer a holistic package of incentives and payments to increase attraction and retention of GPs in rural areas, and
- Any funding model needs to accommodate the current business and clinical models of general practice.

7.2 Solutions to remove excessive barriers to entry

- Install highspeed broadband for rural medical practices;
- Enable GPs with recognised procedural skills to access appropriate hospital credentialling and facilities;
- Provide spousal / family support that includes opportunities for housing, employment and education;
- Continue the infrastructure investment grants to attract general practices to invest sustainably in rural locations;
- Design and implement a funded program to support and incentivise Aboriginal students to progress a career in medicine, specifically GP training pathways, and
- Implement an appeals process for MMM classifications for individual areas. This would be similar to the recent non DPA status appeals process.

7.3 Review and provide solutions to address the issue of maldistribution of the GP workforce in rural WA

- Continue to encourage students from rural areas to enrol in medical school and provide students with opportunities for continued exposure to rural medical training, and
- The Australian Government to re-establish the intake of the IMG workforce to ensure access to primary care services in the short to medium term. Until such time there is evidence of sufficient Australian trained GPs being Fellowed, and prepared to work in rural WA, recruitment of the IMG workforce is essential.

7.4 Delivery models that are sustainable and accessible

- Embed the MBS telehealth Item numbers permanently. Further work is required to refine the delivery of telehealth and any restrictions imposed or relaxed from the current model. However, this can be done once certainty has been given that the Item numbers will remain accessible and general practice can feel confident in resourcing and enhancing this mode of delivery;
- Implement telehealth MBS numbers that allow for GPs to claim a rebate for attending consultations with public sector hospital patients without the need for the specialist to have been in attendance or to have billed the Item, and
- Further development of models such as Voluntary Patient Registration are undertaken in co-design with with rural primary health care stakeholders, recognising nuances across, and within, regions.

8.0 Implementation

WAPHA and RHW look forward to the findings and recommendations of the Inquiry and hope that our joint submission has assisted the Inquiry in its considerations.

Western Australia has some specific primary care workforce challenges which are not always experienced or understood by our interstate colleagues. Undoubtedly, the biggest challenge for WA is the distances and remoteness of many towns and communities within the State.

As has been highlighted in this submission, some positive work has been done by many agencies and organisations in an attempt to ease the primary health care workforce issues in WA. WAPHA and RHW see this as an opportunity to leverage the work done to date and to consolidate into a streamlined, simplified system that results in improved outcomes for workforce attraction, engagement and retention in outer metropolitan and rural WA. Ultimately, improving access to quality primary health care will see benefits against the Quadruple Aim of Healthcare, bridging the health equity gaps experienced by people in some outer metropolitan and rural areas and reductions in potentially preventable hospitalisations.

WAPHA and RHW have a proven working relationship, and together with our WA partner organisations, we are well positioned to assist in collaborating in the implementation of any recommendations made by the Inquiry. We look forward to the opportunity to undertake this task.