Statement from cohealth

Subject	Hearing for: Senate Community Affairs References Committee inquiry into **Provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians**
Attendees	**cohealth**: Kim Webber, Caroline Radowski, Nicole Allard
Date, Time & Location	Monday 7th March 8.30 – 9.30am online

Statement provided due to audio failure during witness appearance

Dr Kim Webber, Executive, Strategy and Impact, cohealth

Thank you for the invitation to appear before the Committee today. I am accompanied by Caroline Radowski, our Director of Clinical and Practice Excellence and Public Health Lead Dr Nicole Allard.

cohealth is one of Australia's largest not-for-profit community health services working across the inner, northern and western suburbs of Melbourne, in both inner and outer metropolitan areas. We have been operating for more than 130 years.

I realise this inquiry is about geography of need but we want to talk about our work with people of need. cohealth prioritises people who experience social disadvantage and are consequently marginalised from mainstream health and other services - such as people who have multiple health conditions, have a disability or mental illness, experience homelessness and unstable housing, Aboriginal and Torres Strait Islanders, people from refugee and asylum seeker backgrounds, people who use alcohol and other drugs, recently released prisoners, LGBTIQ+ communities and children in out-of-home care.

cohealth provides integrated general practice and nursing services, along with dental, allied health, mental health and community support services. We focus on health outcomes.

As the Primary Health Reform draft 10 Year Plan recently identified, the funding model needs to **focus on outcomes.** This will have particular benefits for the health of the communities we work with, and that have the greatest health need. The Plan envisages a primary health care system that provides integrated, multi-disciplinary care – the very model of care that community health services already provide. cohealth was astounded that community health was not explicitly recognised in the Plan as an exemplar model of care already working to deliver impact.

Caroline Radowski, Director of Clinical and Practice Excellence, cohealth

cohealth has 1,200 staff, 40,000 clients and has 42 GPs on staff, mostly part time making a FTE of 18.2 **cohealth has seven GP clinics** (in addition to more than 25 other sites) inner metropolitan areas.

10% of our clients live in outer metropolitan areas. Clients will travel from these areas to our clinics to access care and receive the quality of care, and cultural safety, that meets their needs. We also provide a range of related mental health and social supports to people in outer metropolitan areas through colocation and outreach.

At cohealth **most of our GPs are employed on a salaried basis**, with a few employed under a split fee arrangement.[1] We are committed to ensuring general practice medicine remains a key component of our integrated multidisciplinary model of care, as our experience – and the evidence – shows that this provides the best outcomes for patients.

MBS revenue is insufficient to support the complex and diverse needs of our client group, and our GP services lose millions of dollars each year, a position that isn't sustainable in the long term. Indeed, a number of community health services have found GP services are not financially viable, and as a result **not all community health services provide GP services**.

This is because the **current fee-for-service funding model** fails to adequately compensate for providing care to those who face a range of barriers to care. The vast majority of our clients are on very low income. As such, they require bulk billing, and cannot afford gap fees and co-payments. Combined with this, the diverse nature of our client group means they often need longer appointments, the use of interpreters, extensive follow up and referral, and can have higher than usual rates of non-attendance.[2] This is in contrast with private clinics that often charge a co-payment, or, for purely bulk billing clinics, need to have a large number of short (10 minute or less) appointments.

Some of our clients, particularly those with drug addictions or who are experiencing homelessness do not have Medicare cards but still have a right to GP care which we provide at no cost to them.

cohealth's experiences with recruiting and retaining GPs and other primary health providers reflect the challenges described by the other witnesses here today, and in the previous hearings. We are currently struggling to recruit more GPs to meet demand and we are now looking to overseas recruitment, which we will have to fund ourselves, to source GPs to service our patients.

---

[1] cohealth pays the doctors 65% of their earnings and 35% goes to the organisation.
[2] Non attendance rates can be up to 12% in some cases. In comparison, private GP clinics have a tolerance of around 5% and also may charge fees to those who do not attend.

Other witnesses have described the difficulties faced as a result of geography, in providing and receiving health care outside the major cities, and these are **compounded for people who face other barriers**, such as language other than English, homelessness, alcohol and drug issues or complex chronic diseases.

The **current primary health care funding system was also designed to respond to one-off episodes of care, rather than ongoing care for chronic conditions**. The funding system also does not work well for people with complex health and social circumstances, nor does it promote a focus on population health and preventative care. These limitations need to be addressed.

We also need to recognise the **cumulative impact of the freeze on Medicare rebates**, while the cost of providing GP services continued to rise. Costs associated with clinic consumables, rent, utilities and EBA wage increases for GPs all rose while Medicare income remained stagnant.

Dr Nicole Allard, Public Health Lead, cohealth

I and my GP colleagues and I **make deliberate choices to work in the community health sector**, where we can provide high quality collaborative team-based care in a setting where they can make a tangible difference to the lives of people with significant needs.

Our service model supports me to provide the time I need with a patient, rather than focusing on patient throughput. Our salaries are lower than we'd otherwise earn in private practice. While the cohealth service model and collaborative environment provides some degree of satisfaction to me as a GP, I am ultimately disadvantaged financially for choosing to support Melbourne's highest need patients.

I want to give a example of a family who lives between out metro Melbourne and Mildura. While the father was away picking fruit, I continued to manage his two chronic conditions. I liaised with local health services in Mildura and arranged for him to access blood tests and scans. I also assisted his partner with her health care and care of her children including one who has a disability. This advocacy work and the time taken to ensure care is unpaid. The time I spend explaining with an interpreter decreases my throughput and reduces the hourly earnings back to the organisation.

Compounding the lower wages, the specialised skills I and my fellow GPs have developed through working in community health services do not receive sufficient recognition. cohealth would like to see a **specialised program for GPs in community health**, similar to the accredited rural generalist pathway.

I work with cohealth to ensure the health and wellbeing of the community. I am a vital part of the community health team at cohealth. I want to continue to support the community and I want a team of GPs working with me but we need a funding system that allows cohealth to employ us in recognition of our skill and impact.

End statement.