SUBMISSION TO THE SENATE ENQUIRY INTO GP SHORTAGES

From Wollongong Medical Service Co-Operative Ltd

An accredited after hours medical deputising service in the Illawarra region of NSW

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MEDICAL WORKFORCE SHORTAGES IN THE AFTER HOURS SECTOR

BACKGROUND

Wollongong Medical Service Co operative Ltd (WMSC) has been operating since 1974. It is one of the last remaining not for profit, Co operative structured, medical deputising services in Australia. It was established as a Co operative on the basis that members share the responsibilities of after hours care of their patients. Since that time many changes have occurred in General Practice including:

- Introduction of Medicare
- Corporatization of General Practice
- Changes in workforce structure eg. part time, more female GP's, training requirements
- Growth in extended hour practices
- Massive changes in technology (online or tele medicine)
- Changes in consumer expectations about medical services etc.
- Practice Accreditation

We operate in the Wollongong and Shellharbour local government areas. All visits are bulk billed for Medicare card holders. We operate exclusively in the after hours period, providing home visit medical care for, and on behalf, of our subscribing members. A record of each visit is transmitted to the patient's regular GP. Nationally, in 2015 16 approximately 2.8 million after hours home or aged care facility items were billed (ref Deloitte Access Economics 'Analysis of after hours primary care pathways' Nov 2016) and the after hours period represents more service hours per week than standard hours. After hours services are essential for high priority groups such as the elderly, those with disabilities and those with serious illness who require in home urgent medical care.

In the after hours sector there have been some major changes which have severely affected access to medical workforce including:

1. Reduction of MBS rebate for after hours visits for non Vocationally Registered doctors who comprise over 85% of the workforce
2. Reduced access to medical practitioners caused by greater competition for after hours doctors and tighter restrictions and oversight of non specialist and overseas trained doctors
3. Changes in consumer (patient) demands and expectations

OVERVIEW OF THE SITUATION

The Federal government sought to rein in growth in after hours MDS service provision and in particular what they perceived as overuse of urgent, after hours item numbers. Growth in billing of urgent items numbers grew nationally by 150% between 2010 11 and 2015 16 due in large part to the entry of a number of large, private companies which increased competition in urban areas but also expanded services into new areas providing improved access.

Following an MBS Review in 2018, the government implemented a number of changes (see table 1) which has jeopardised the viability of medical deputising services, particularly those in regional areas where access to medical workforce is a constant challenge.

TABLE 1 – SUMMARY OF CHANGES IMPACTING MEDICAL DEPUTISING SERVICES

Cut to the Urgent item number rebate from $130 to $90 for most AH doctors (depending on qualification) on 1/1/19
Cut to the item number rebate when doctor sees multiple patients at one location.
No Urgent Bookings until 6pm.
Increased red tape and compliance for overseas trained or junior doctors.
No advertising direct to the public (except website)
Financial Incentives for GP's to see their own patients after hours (after hours PIP).
Higher triage requirements at the Call Centre level to encourage more patients to see own GP the next day
Increased compliance monitoring from Medicare

Recruiting and maintaining a quality medical workforce presents the most significant challenge for regional after hours medical services. Working after hours, weekends and on public holidays is extremely unpopular and the change to after hours rebates has cut the earnings of most doctors working after hours by more than 30%.

The Department of Health which administers the Approved Medical Deputising Service (AMDS) program, which allows junior or International Medical graduates (IMG) to obtain a Medicare provider number for after hours work, has heightened its enforcement of program requirements in such areas as clinical supervision, advanced life support, membership of the RACGP, undertaking Fellowship exams, professional development. It is expected that after two years on the program the doctor must enrol in a college led GP specialist program eg. RACGP or ACCRM. This requirement restricts access to a range of highly suitable doctors who may be pursuing other specialisations eg. Geriatrics, Paediatrics, Emergency Medicine but are

then excluded from working for an after hours medical services. Additionally, the RACGP cut the value of hours worked towards professional experience by 50% meaning that for every 2 hours worked after hours it only counts as 1 for GP training purposes.

Medicare has also been actively reviewing and auditing the use of AH item numbers in an effort to curb, what they perceive as, unnecessary billing of urgent item numbers. While there remains definitional uncertainty about an urgent billing, the audits have terrified many doctors who have chosen to leave or resulted in the remaining doctors changing their billing so significantly that their hourly rate is now much less than that charged by a plumber called out on a weekend to unblock a toilet. While toilet unblocking is important, it does not carry the burden of responsibility of a medical practitioner making diagnostic and treatment decisions in often less than ideal circumstances.

In 2017 18, in the lead up to the government's medicare rebate review, the RACGP also ran a damaging campaign directed primarily against corporate AH MDS but ultimately affecting all after hours services. Their accusations involved such things as poor quality medicine, using inexperienced doctor, doctors rorting Medicare and the sector having no impact on ED presentations etc. Most of these accusations were not supported by any factual evidence but did upset many highly qualified and committed doctors who were working after hours and it certainly influenced the government's hard line policy decisions about the sector.

The net effect of these actions has been that many good, dedicated doctors have left the sector feeling insulted and dis heartened. This has meant that many after hours services are struggling to maintain adequate workforce, particularly in regional areas where doctor numbers are proportionally lower. Many suitable doctors are instead choosing to work in hospitals which often provide better remuneration and conditions and less legal and personal risk.

The government has also been actively trying to encourage GP's to provide their own patient care after hours. This has been through various funding mechanisms such as the AH Practice Incentive Payment (AHPIP) and grants schemes via Medicare Locals (now PHN's) aimed at supporting GP practices to form their own after hours co operatives, often in competition to established MDS.

While recruiting Doctors in our region has always been challenging the cuts and changes over the past three years have decimated the after hours doctor workforce. The first to abandon after hours work have been our most experienced, Australian trained doctors who can easily find alternative options and have opted out as it has just become "too difficult". The cut in earnings combined with concerns about medical liability and increased personal risk (working at night alone in private homes) have proven strong dis incentives for doctors. Given current regional demand for doctors in hospitals and general practice many are choosing the certainty and relative comfort of other workplaces.

COVID PANDEMIC IMPACTS

After hours home visit services have been severely impacted by the Covid pandemic. Patient consultations have declined some 30 50% (depending on the month) since April 2020. This has been caused by:

Reductions in usual seasonal illnesses eg. influenza, gastro

Restrictions on home visits due to transmission risk

Use of telehealth by regular GP's reducing the need for after hours home visits

Patient hesitancy in using home visit doctors

Low patient numbers have put further pressure on an already diminished workforce with doctors remuneration not able to compete with potential earnings in other locations eg. vaccination clinics or hospitals. Opportunities to engage with the sector to utilise the after hours medical workforce as part of the pandemic response eg. home vaccination have been completely overlooked by the government.

SUMMARY

The after hours sector provides more hours of medical care per week than daytime general practice. Its workforce has been intentionally undermined through a series of policy decisions which has reduced the quantity and quality of doctors willing to provide essential, episodic medical care outside normal hours. The result is that the public has reduced access to domicillary, after hours care and are instead using hospital emergency departments as first port of call for low acuity (Tier 4 and 5) presentations. In short, training demands, administrative red tape, legal concerns, financial costs of training/exams etc and personal demands are now so onerous that most doctors are unwilling to do this important work.

There should be significantly less barriers for doctors willing and interested in doing after hours work. In fact, junior doctors would benefit greatly from the unique challenges presented by home visit, after hours work. Consideration should be given by medical education organisations to mandatory work experience in the after hours, home visit environment.