AUSTRALIA HEALTH ALLIANCE
238 Seaford Road, Seaford, Adelaide, SA, 5169

1st September 2021

The Terms of Reference AHA would like to address in this submission are as follows:

a) The current state of outer metropolitan, rural and regional GP and related services.

We agree all these essential services are under serious threat; we also believe for each category there are different reasons. The situation for these groups varies so significantly, that an individual assessment is needed for each, to do justice to their specific situations. This is the only hope this committee will achieve; some resolution that will have a lasting impact on the communities each group serves.

b) The current state and former Government reforms to outer metropolitan, rural and regional GP services and their impact on GPs.

The policies of Government past and present certainly need more than a review to ensure the long-term effectiveness of this Senate committees finding. This will be the only hope to create a pathway to long-term improved health outcomes Nationwide. The existing system is so complicated with too many different Government Departments all placing their own interpretation, on what is necessary to achieve compliance with the legislative intent. For General Practitioners and related primary health services to comply with requirements of DPA, Workforce Certificates, boundary interpretation by GPEx and finally MMM geographical classification do nothing to clarify the equitable pathway to resolving this major challenge.

In the last two years we in General Practice have witnessed just how fragile our health system is in reality. The numbers of mental health patients have exploded and the underlining fear, worry and concern of normal average Australian has been revealed. The communities we serve are not coping and our traditional service delivery has fallen short of satisfying the demands and expectations of our patient base.

The impact of this inability has been the massive reduction in the numbers of graduates who want to serve the community by being a local GP in metropolitan, outer metro, rural or regional areas. The specialist doctors who treat mental health issues have been inundated and a four to six months wait to have the first consultation with one of these doctors is normal.

The consequence of this delay is the numbers of long consult has dramatically increased, diminishing the number of vacant appointments for those who present with usual medical issues. Young doctors especially are experiencing the pressure and as a result, reduce the numbers of consults they conduct each week, just to manage their own mental health balance.

c) The impact of the covid-19 pandemic on doctor shortages in outer metropolitan, rural and regional Australia.

South Australia generally is short of doctors and the only proven way to recruit any doctors is to increase their remuneration packages.
From an outer metropolitan perspective, we cannot compete with the disposable income enjoyed by patients living in the more affluent socioeconomic suburbs closer to the CBD. As a co-payment practice we

bulk bill all concession cards holders and children under fifteen years old. All others are charged a co-payment of $20.00 during business hours and $25.00 for all after hour consultations. This accounts for 24.69% of the 200 patients we see every day. Our clinic in the recruitment of locally trained doctors cannot compete with inner metropolitan Adelaide clinics that are charging every patient up to a $60.00 gap payment. When one adds the greater travel distances to Seaford there is no chance to recruit local doctors. We lose out with both remuneration and travel time.

d) Any other related matters impacting outer metropolitan, rural and regional access to quality health services.

We believe there are three pillars to achieving a vibrant, thriving community. These are affordable housing, quality education and available/affordable medical care. If Australia cannot produce sufficient numbers of medical graduates, to meet the demand of the population growth areas of the country, then the only solution is to attract suitably qualified International Medical Graduates to address the shortfall

From our experience these doctors come to Australia for the long term, a better lifestyle for their families, multicultural acceptance and an abundance of opportunities for their children's future. Clinics like ours can do our portion of the heavy lifting to see Seaford SA a vibrant thriving community but in reality we are turning away up to a hundred patients per day. To see a doctor of their choice, they need to wait three weeks. This we appreciate this reality, is a long way short of delivering quality medicine.

In both of our clinics have vacant rooms all fitted out waiting for doctors to come, we have the patients we cannot give appointments, we have the trained staff and we have overseas doctors wanting to come and work in our clinics. The biggest impact on our clinics stopping us from providing quality medical services is a lack of doctors. We can provide doctors with patients at a rate of six FTE every year until we have 45 FTE doctors working in our clinics. Currently we have 17 doctors on our books but only 11 FTE.

Over recent years the trend has been for our doctors reduce to part time because with us they are fully booked out and their income is guaranteed. However, their earning capacity dramatically increases with larger gap payments being paid inner metropolitan clinics. What clinics like us need is predictability and less complicated method of screening IMG's for their suitability to work in Australia and place them where the greatest needs exist.

At this moment there is no long-term plan going forward the rules that are governing us just keep growing and changing. With the current system we cannot meet the growing demand of the thousands who have already moved into the area or will continue to do up to 2035, when the urban infill this area is scheduled to be completed. None of these citizens will have access to a clinician to call their family doctor. Isn't that a basic right of every Australian?

The consequence of this situation is hospital overcrowding, long delays in ED and longer ambulance ramping. The current health system depends on GP's early intervention to keep patients out of the hospitals for as long as possible.

What we are experiencing is every patient we cannot treat through a lack of doctors, just shifts the problem directly to the public health department. The big losers are the State Hospital system, our patient and their families.

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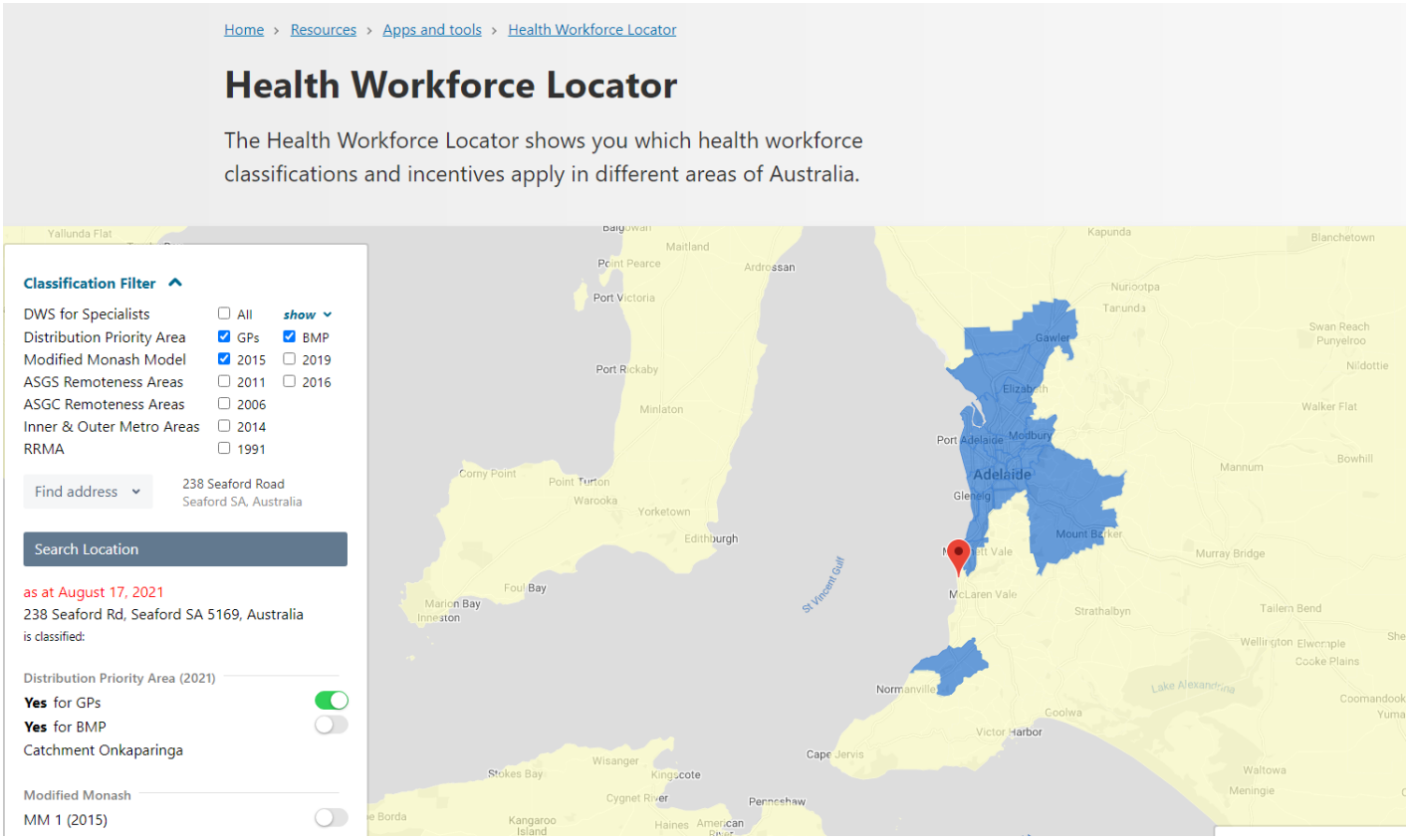
Inquiry into the provision of General Practice and related primary health services to outer metropolitan, rural and regional Australians – Submission

The Australia Health Alliance owns two General Practice clinics, one in Seaford and one in Seaford Meadows. Our clinical team currently consists of 17 GPs and 8 nurses. We consult an average of 1579 patients per week across the two clinics. In 2018/19 we consulted an average of 2095 patients per week. Without increases in our FTE Doctors this downward trend will continue. Our Seaford Meadows clinic was built following release of the Onkaparinga Council population projections for the coming years; evidencing exponential growth in population of 29,900 from 2011 to 2026, the area of this growth is largely Seaford. In the next decade their projection is an increase of 66,700. We currently welcome over 200/250+ new patients per month to our clinics, but without new doctors that number can only diminish.

As per the below image, both locations are noted as Distribution Priority Areas (DPA).
DPA identifies areas where people don't have enough access to doctors, based on the needs of the community. The DPA system takes into account gender and age demographics, and the socio-economic status of patients living in an area. Areas are classified as DPA when the level of health services for the population does not meet a service benchmark.



We are also considered an Area of Need (AoN), which is a special arrangement to assist employers in Australia who are experiencing difficulty recruiting medical practitioners. Area of Need allows the

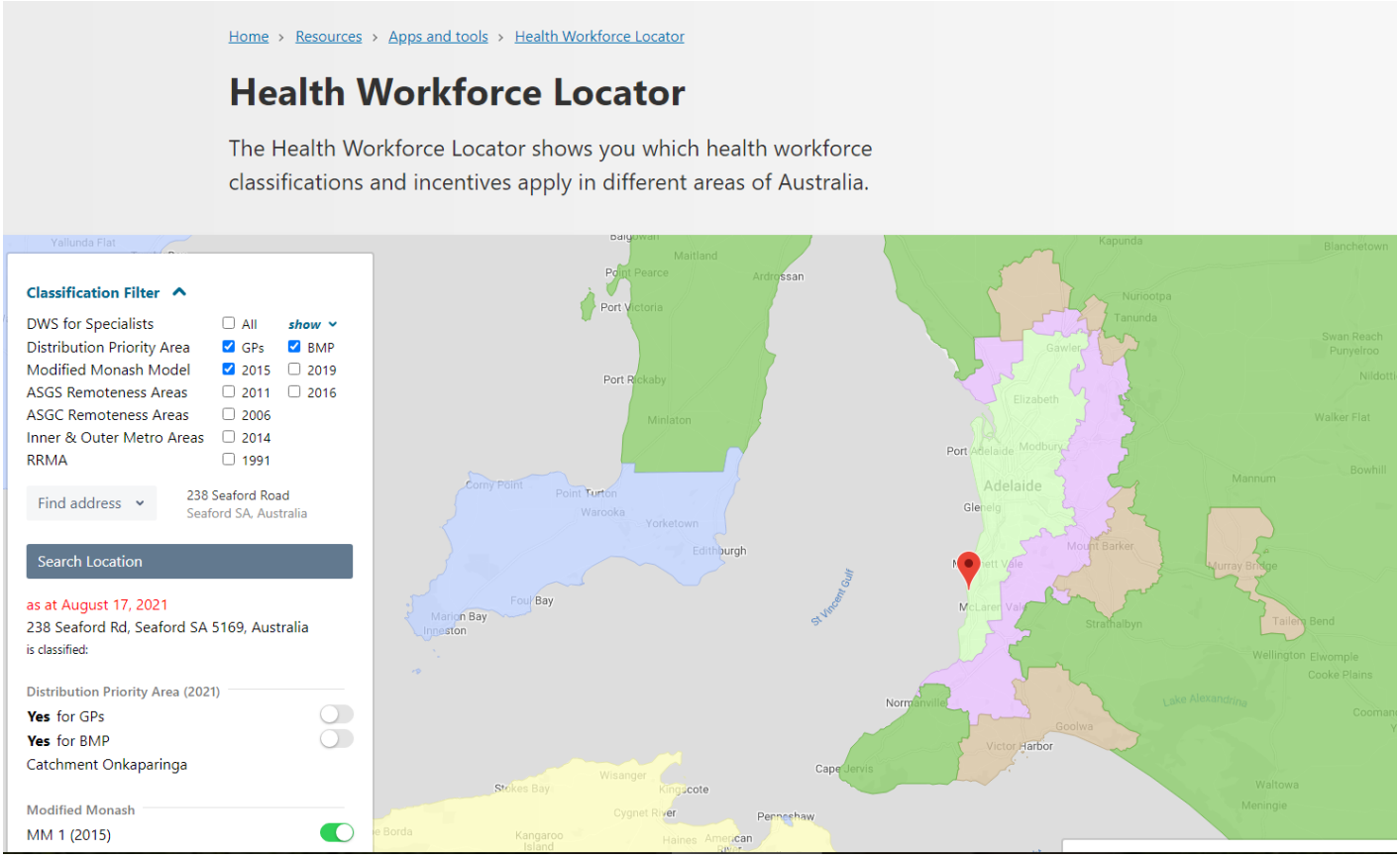
employers to recruit suitably qualified international medical graduates (IMGs) to vacant positions that have been approved as 'Area of Need'.

Our clinics are also able to obtain Health Workforce Certificates (HWC) and have had all applications approved.
Under this program, employers who are sponsoring a visa for an International Medical Graduate (IMG) must apply for a Health Workforce Certificate.
The Visas for GPs Program and the Better Distribution of Medical Practitioners initiative:

- ensure IMGs work in communities needing more primary health care services, such as regional, rural and remote areas
- make it easier for people in regional, rural and remote areas to access doctors
- create more training and employment opportunities for Australian medical graduates

<u>Here lies our problem…</u>

The image below shows the location of our clinics is considered to be in a Modified Monash (MM) 1 location. The Modified Monash Model (MMM) is how the Department of Health defines whether a location is a city, rural, remote or very remote. The model measures remoteness and population size on a scale of Modified Monash (MM) category MM 1 to MM 7. MM 1 is a major city and MM 7 is very remote.



Essentially AoN relates to obtaining AHPRA registration and DPA is related to eligibility of an overseas trained GP to get a Medicare provider number. HWC is obtained using tools provided by the Dept of Health, as is the decision on MM1-7 locations and GPEx the training provider is also funded by Dept of Health and consider 'outer metropolitan'.
Despite Seaford/Seaford Meadows being considered a DPA, AoN and our ability to be granted a Health Workforce Certificate, therefore obtaining a working visa for IMGs, we are unable to proceed with recruiting non vocationally registered GPs (requiring limited or provisional registration) because the requirement from the Royal College of General Practitioners (RACGP) is that from 1st January 2022 all IMGs

must be on a General Practice Experience (GPE) pathway. These pathways are only available to GPs who are employed to work at clinics in MM2-7 locations.
Not only does this mean we are unable to recruit IMGs on limited or provisional registration, it also means the GPs we currently have working for AHA and have supported on their journey so far in obtaining fellowship, will need to relocate to a clinic in an MM2-7 location by New Year, leaving us further short of GPs to service the community and unsettling those we have worked hard to integrate into our community.

To contribute to the conversation we wish to put forward some constructive suggestions:

1. Moratoriums for overseas medical graduates be revised MMM7 reduced to two years.
2. MMM5-6 be reduced to three years.
3. MMM 3-4 be reduced to five years.
4. MMM 2 remain at ten year.
5. Area of Need MM1 remain at ten years.
6. By reducing the moratorium timetables, places a real incentive for younger doctors to go to the more remote areas. This way once achieving fellowship they can easily go to their city of choice. Can we also suggest a fly in fly out service be provided to doctors working in remote areas? This has worked very well in the mining industry. With some financial incentives this may be an attractive proposition for more experienced doctors. The big benefit is, it assimilates new migrant doctors into both rural and city Australia at the same time. Affordability of houses in capital cities has escalated beyond saving capacity for many people trying to save a deposit while meeting daily life cost. Doctors working in the country face this issue all the time. Although our proposal shortens the time for the doctor it makes it possible to serve remote locations with medical services. A college education is very important for the children of doctors; with our suggestion it becomes possible.
7. The greater the distance one lives and works from major cities the more difficult it becomes to receive quality medical attention when needed. Technology is most likely to provide solutions going forward. With broadband services expanding in remote areas Zoom Health may be the next step. If each state was able to place an IT unit on each states largest hospital site, where doctor and specialist were available for zoom health consultations 24/7, top quality medical services could be delivered with the assistance of a local nurse at location. This solution is functioning with work from home principals along with telehealth. Medication could be delivered via drones with a 500k range at a much lower cost than traditional methods, drones are not limited by ground conditions e.g. fire and floods.
8. If the numbers of graduates going through the registrar program is continuing to diminish the funds allocated to doctor training needs to be diverted to the IMG program. Rural and outer metropolitan situation is only going to worsen. Urban sprawl has been relentless since post World War II. Fortunes have been spent on transport corridors for rail and road and yet the health care needs of all of those who dared to dream of owning their own home in areas like Seaford, is left unattended. What surprises us why is there not a huge outcry. In our case we are reaching the third point in the journey of residential expansion for Seaford and there is an acute shortage of doctors and no planning strategies to meet their accommodation needs. Due to the fact we work under the department of health requirements our problems will be replicated in every state. This is a major health issue confronting Australia and Covid-19 is bringing the flaws in our system to the surface rapidly.

   In conclusion, our current system is floored! The DPA, AoN, HWC and RACGP requirements are not in sync and our community needs are suffering as a result. This is a major concern and is hugely impacting our clinic and community and we are desperately seeking your assistance in rectifying this problem.

Written by John McMahon, Chairman, AHA and Gemma Gough, Senior Operation Manager, AHA