25 March 2022

Committee Secretary
Senate Standing Committees on Community Affairs
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Dear Chair

RE: Inquiry into the provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians

My name is Dr John Saul.

I presented to the Inquiry at its recent hearings in …… and undertook to write further to the Committee.

I have been a general practitioner for over half my life for a total of 35 years.

I hold a few titles, and I am on a few committees, but basically, I am a long-term GP.

However, unfortunately, I have never seen the profession in such troubled times.

Having read several submissions to the Senate Inquiry, you have at your disposal some of the best thinking of the nation concerning outer metropolitan and rural and remote medicine.

You have excellent facts and figures from the AMA, RDAA, Ochre Medical and the Tasmanian state government, to name a few. I see no reason to repeat any of this information but prefer to preface a personal view.

My late father was a successful builder. He called me his **$60000** investment as I received no government support to attend university. He calculated I would be 35 before catching up with one of his carpenters. If the carpenter built his own house in his spare time, I would need to work till 45 to reach financial equality. These are 1990 figures, and with the relative value drop in the Medicare rebate by approximately 40 per cent since then, no doubt we need to add another seven years to each of these stages.

I make this point as many people have a view that being a GP is a lucrative business, when the reality is that GP practices are closing or merging with corporate entities as it is no longer possible to simply hang up your shingle and hope to survive.

For 32 years, I have owned and managed the business side of general practice. Services from two to 10 doctors are no different to any other small business. There are economies of scale; one or two doctor practices are no longer viable whether in a city or rural location.

The funding I have seen over the years has comprised.

- Medicare federal income
- State and federal government support programs
- Local council funding
- Chook raffles and fundraisers.

For someone trained as a doctor, not as a businessman, this is becoming more and more problematic.

The Medicare rebate was once 85% of the recommended AMA fee. Medicare funding is now totally unviable. A mixture of freezes and indexed rises on such a low base have contributed to this. Income from private or workers' compensation payments is now three times that of palliative care and almost twice that of bulk billing patients in my practice.

Let's say I take thirty minutes to perform a CHAT score for a child with potential autism and bulk bill that activity; by the time I pay staff, insurances and building costs, the business side of the general practice suffers a financial loss.

Payment for a palliative care home visit does not cover the cost of my time, therefore, I can only do so many of them after hours using my own goodwill. The younger generation of GPs with young families are not willing or unable to provide such a service after hours. Thus, reducing the value of the Medicare rebate against the cost of providing the service, results in a reduction in the commitment of our great young doctors to this challenging medicine.

Over the years, state and federal support has produced some excellent headlines with various programs. Unfortunately, some are very complicated for small practices with limited administration support or expertise to be able to apply for. There are many pitfalls, for example, the Rudd government infrastructure grants cost us **$10,000** of time and consultant advice to apply for because of its complexity. Added to this, as we were a small business the grant was deemed as income by the tax department. The grant was very welcome but what came in one year also required a substantial amount going out the following year. The average practice is not set up for this style of funding.

Local councils and local community groups continue to have my admiration for their attempts to assist. We have recruited two good doctors at one of our surgeries but have also had to house four dogs and find a partner a meaningful job in the local community in order to attract them. As we borrow a house from one of the councils, as mentioned earlier, with a no dogs policy, please let's keep this quiet.

COVID impact is simply the equivalent of a flood or bush fire for our profession. We are constantly juggling lost staff and risk. Our poor health literacy patients present some of our most significant stress with limited understanding of their infection risk and the need to contact test and assess, to protect ourselves and our other patients. Older GPs with their

health at risk are retiring, and rightly so; some are well over 70. Overall, our work is slower and more challenging.

Delays in public hospital access pressure GPs again, especially in rural areas. The effects of late diagnosis of Cancer with simple delays in colonoscopies will be felt in our communities long after I have retired.

Our young medical students and graduates are voting with their feet and moving into other specialties with far better pay and conditions. In addition, managing complex multimorbid aged patients is now paradoxically paying the least remuneration and taking the most time. Less than 15% of current medical students in Australia have indicated general practice as their preferred career – when clearly the demographic need is at least 40%. Without the workforce coming on and older GPs retiring, General Practice as we know it, will die.

With the stress of the workload and the pressure to see patients every ten minutes, GPs are self-preserving by increasingly moving into part-time work or not working to their full scope of practice, but instead specialising in skin, diabetes or women's health only as examples.

We are seeing the perfect storm brewing in general practice in Tasmania with rising costs, more complex cases, a sicker older population, attraction, and recruitment at an all-time low, and lack of pay parity with colleagues in the public system and other specialities.

Very few GPs can afford to offer bulk billing, and many practices have closed their books. General practice vacancies across the state are rising exponentially, combined with a falling number of young doctors applying for the general practice training, so patients are left behind. As a result, Tasmanians are getting sicker and delaying care until they require an urgent visit to the emergency department for assessment.

Government investment in this area has not matched the increase in costs and demand, with rebate freezes and inadequate indexing contributing to the lack of financial support in providing high-quality care. And, the application of the Modified Monash Model has been most unkind to many areas, especially Tasmania. Some areas have missed out on significant funding by less than two kilometres, and overall, it is nothing short of shambolic for other regions.

Greater flexibility is needed in the current models, with many programs and incentives not likely to impact for years.

General practice needs the support and mechanisms to evolve as the community needs change. But at the same time, there is a desperate need to make changes now.

Unless significant amendments are made, the future of general practice in Tasmania is not sustainable. The already overburdened public hospital sector will be overwhelmed, and the community's health will deteriorate even further.

We know the COVID-19 pandemic has shone a light on the importance of general practice being at the centre of a patient’s care, however is has also shown the inadequacies of the public hospital system and the long-term under-resourcing of general practice.

Our general practitioners are at the front line of healthcare with many risking burnout. They are the people we turn to first when we are sick. They are also a workforce in crisis and need support to manage the increasing demand for their services on less and less returns.

The Medicare fee-for-service model must remain the central funding pillar for general practice, primary prevention and managing more complex chronic conditions require supplementary funding. But it is imperative the Federal government increase the Medicare rebate to keep healthcare affordable for Australians, while also ensuring that doctors are commensurably paid to their hospital counterparts to keep this pathway attractive for new medical entrants. We risk losing our critical GP workforce if we do not do this.

To help attract and grow the GPs of the future, the AMA has lobbied for the federal government to agree with the Tasmanian government to fund a 'single' employer model for GP registrars in Tasmania, designed in consultation with the profession, to deliver improved remuneration and employment conditions for GP registrars that achieve pay parity with their public hospital-based colleagues. It is increasingly difficult for general practice to shoulder the cost of these trainee doctors, who don't have the same earning power as fully trained GPs.

Increasingly, the AMA is hearing of GPs electing to retire earlier than initially planned despite shouldering the guilt of knowing there may not be a replacement for them. The culminating pressures of longer hours, difficulty in recruitment, increasing costs, pay parity, and more complex patient demands push them out the door earlier.

Aside from the pay parity issue and the stalled Medicare rebate, the Modified Monash Model is an area as mentioned above, particularly in Tasmania, which would benefit from an overhaul, alongside the implementation of other measures such as real-time ICT connection across the entire system, GPs role in maternity care, and establishment across all regions of Tasmania of the successful Urgent Care Centre New Zealand model that provides low-level GP emergency care after hours and for a short stay if required run under a cooperative model of GPs in the local community.

General practice is the humble foundation of a world-leading health care system providing exceptional care and coordinating access to the rest of the health system.

General practice desperately needs help now to avoid patient care across Tasmania suffering.

Finally, I would like to acknowledge our original landowners, the Palawa People of our great island. I must note I wish they would present themselves earlier to this older GP so we could work more on their chronic health issues, but that, of course, is another funding issue.

Thank you for the opportunity to give an older GPs perspective.

Dr John Saul