Hunter Urban Division
of General Practice
ACN 061 783 015 ABN 27 061 783 015

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SENATE SELECT COMMITTEE ON MEDICARE
NEWCASTLE HEARING 23/7/03
Prepared By Hunter Urban Division of General Practice
Dr. Arn Sprogis, CEO
21/7/2003

SUMMARY

1. The application of Medicare has in the past and continues to disadvantage rural and regional areas in relative resource terms. The proposed reforms by both political parties will make the relative disadvantage even greater.
2. The major issue for regional areas is not whether patients are bulkbilled but is whether they can be seen at all by GPs due to insufficient GP workforce.
3. The solutions proposed are based on the successes achieved in the Hunter with its after hours program (GPAAH) and focus on the provision of Medicare top up funding which will enable increased infrastructure, technology and nurse support as the short term solution to an under supply of GP workforce

OVERVIEW

Medicare and any reform proposals need to be seen in the context of their impact in a major regional area. This submission is related to the area bounded by the Hunter Urban Division Of General Practice which covers Lake Macquarie, Newcastle, Maitland and a section of Port Stephens, NSW. The HUDGP covers a population of approximately 450,000 and includes 397 GPs in 166 practices.

It should be noted that 32 of the poorest 50 electorates in Australia are in rural areas which are also the areas hardest hit by any adverse policy changes related to commonwealth funding for GP services. The Hunter region has large segments of its population in lower socio-economic categories and issues related to equity of health care provision are of primary importance to our community and our GPs.

The HUDGP has a strong track record of delivering GP care on an equitable basis as evidenced by the GP After Hours Service (GPAAH, see attachment for summary) with clinical care being delivered on a health needs, free at point of care basis. GPAAH is integrated into the public hospital sector, covers the whole population, provides home visits, free transport to and from the service if required and a nurse staffed call centre for advice and appointments. GPAAH will be used as an example of an optimal approach to the provision of high quality GP care based on health needs and not cost, to all sections of the population.

MEDICARE UNDERFUNDING FOR REGIONAL AND RURAL AREAS

- Medibank and now Medicare if viewed in funding equity terms has been a disaster for regional and rural areas since its inception as funding at the population level is

PO Box 572 ■ 3rd Floor Piccardi Bldg ■ 123 King St ■ Newcastle 2300 ■ Telephone: 02 4925 2259 ■ Facsimile: 02 4925 2268
Website: http://www.hudgp.org.au • Email: hudgp@hudgp.org.au

dependent on GP supply and the number of services which are provided per head of population per year.

- The HUDGP estimate is that since the inception of Medibank/Medicare the HUDGP regions population has had a total shortfall of $1billion of commonwealth funds for GP services (2003 dollars) when compared to funding for similar populations in capital cities.
- An example of the net effect of GP workforce under supply in our region is that there can be a 2x greater amount received in Medicare benefits per head of population per year in parts of Sydney compared to the Hunter which is entirely related to the number of services provided per person (Western Sydney 8 GP visits/year per person compared to Hunter 4/year or $200 per person subsidy in Sydney compared to $100 per person in the Hunter).
- This equates to a relative shortfall in our region of $30-40 million per year for GP services every year and translates into inadequate infrastructure, inadequate technology and an overworked GP workforce.
- The net effect has been a collapse in bulkbilling in our region over the past 2-3 years with the majority of the population contributing a co-payment of $10-30 per service.
- The patient problem in our region isn't the availability of bulkbilling, it's whether a patient can be seen at all when needed.
- The government's Medicare rebate reform proposals will make this situation worse by relatively rewarding capital city GPs significantly more than in a regional or rural area and reducing even further the ability to recruit new GPs.
- The only thing less likely than the government's proposal to improve the regions workforce and care provision capacity are the proposals put forward by the Labor party which make the rewards for city based GPs even greater.

GP WORKFORCE

- The shortfalls described above are directly related to relative GP workforce under supply in regional and rural areas including the Hunter.
- The relative GP under supply with the resulting reduction in patient consultation rates leads to a vicious cycle of less commonwealth Medicare resources for the region in turn leading to an even greater under supply of GPs.
- GP:Patient ratios of 1:2-3000 are not uncommon in our region and should be compared to some parts of Sydney with ratios of less than 1:1000.
- Our GP's are facing increasing exhaustion, burn out and premature retirement which is now reaching critical levels.
- The major issue for regional and rural areas is for the commonwealth to provide resources which make up for what is, and will continue to be a chronic relative under supply of GPs.

THE SOLUTIONS

- The solution needs to be regional and the committee need look no further than the example provided in the Hunter region by GPAAH (see attachment).
- First, adequate equity based regional funding (top up funding) should be provided in addition to Medicare rebates to make up for Medicare rebate shortfalls. This is comparable to funding allocations made by NSW Health.
- The regional top up funding would be used to provide equitable, accessible services based on health need and not capacity to pay.

- The additional resources would first be used to provide a short term solution by focussing on first preserving the existing GP workforce by innovative methods of managing patient care including:
  - The extensive use of technology (networked call centre, computerised records)
  - Ability to have universal GP access to additional nursing staff in a ratio of 1:1
  - Addition of adequate physical infrastructure
  - Providing management and human resources support so releasing GPs for clinical care
- Discussions are entered into with the HUDGP on how best to provide GP care for the poor and disadvantaged across the whole community using GPAAH as an example.
- The government's proposals for additional undergraduate and postgraduate training are enacted so that any GP workforce shortfalls can be replenished in the longer term and rural and regional areas are given priority for access to these programs.

Dr Arn Sprogis
CEO
Hunter Urban Division of General Practice

Attachment 1

BRIEFING PAPER: A REGIONAL SYSTEM OF AFTER HOURS CARE FOR THE HUNTER URBAN AREA

Prepared by Dr Mark Foster, Program Director
HUDGP 21/7/03

On July 1st 2003 the Hunter Urban Division of General Practice (HUDGP) commenced GP Access After Hours (GPAAH), and expansion of the highly successful service at Maitland. GPAAH is a comprehensive system of after hours services for the Hunter urban region, serving a population of 450,000. Five GP clinics situated adjacent to emergency departments, or in community health facilities will see 60,000 patients per year after hours. A telephone advice line, staffed by experienced nurses using sophisticated decision support software, arranges appointments in the clinics, home visits, funded taxi transport or advice that allows patients to stay at home as clinically indicated.

Workforce shortage is the major barrier to the provision of after hours medical services. Reversing national trends to reduced participation in after hours care, over 200 GPs have signed up to work in the service.

GPAAH's innovative funding model has resolved the key barrier to integrated service delivery, by dealing with the State-Commonwealth split at the regional level. The service is funded by contributions from:

- Medicare (a cost neutral offset corresponding to reduced billings associated with the service introduction)
- Hunter Area Health Service (cash and in-kind recognising reductions in emergency department workload)
- Department of Health and Ageing (for the additional costs of the telephone advice line)
- The HUDGP reflecting its commitment to improving patient services in this region.

This pooled funding arrangement allows the establishment of a rational system of services designed to attract a GP workforce and meet the needs of the community.

The service has already been very well received by the community. It demonstrates how devolving the funding and responsibility for service delivery to the regional level can lead to substantial improvements in services while minimising additional funding requirements.