

The Senate

Community Affairs References Committee

Provision of general practitioner and
related primary health services to outer
metropolitan, rural, and regional
Australians - Interim Report

April 2022

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Terms of Reference

The provision of general practitioner (GP) and related primary health services to outer metropolitan, rural, and regional Australians, with particular reference to:

- (a) the current state of outer metropolitan, rural, and regional GPs and related services;
- (b) current state and former government reforms to outer metropolitan, rural, and regional GP services and their impact on GPs, including policies such as:
 - (i) the Stronger Rural Health Strategy,
 - (ii) Distribution Priority Area and the Modified Monash Model (MMM) geographical classification system,
 - (iii) GP training reforms, and
 - (iv) Medicare rebate freeze;
- (c) the impact of the COVID-19 pandemic on doctor shortages in the outer metropolitan, rural, and regional Australian; and
- (d) any other related matters impacting outer metropolitan, rural, and regional access to quality health services.

Abbreviations

ACCHO	Aboriginal Community Controlled Health Organisation
ACRRM	Australian College of Rural and Remote Medicine
AGPT	Australian General Practice Training program
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
ASGS-RA	Australian Statistical Geography Standard – Remoteness Area
CSP	Commonwealth Supported Place
DESE	Department of Education, Skills and Employment
DPA	Distribution Priority Area
DWS	District of Workforce Shortage
FTE	Full-time equivalent
GP	General practitioner
GPTT	General Practice Training Tasmania
HELP	Higher Education Loan Program
JCU	James Cook University
JFPDP	John Flynn Prevocational Doctor Program
JFPP	John Flynn Placement Program
MBS	Medicare Benefit Schedule
MMM	Modified Monash Model
NHRA	National Health Reform Agreement
NMWS	National Medical Workforce Strategy 2021–2031
NTGPE	Northern Territory General Practice Education
PGPPP	Prevocational General Practice Placement Program
PHN	Primary Health Network
RACGP	Royal Australian College of General Practitioners
rBBi	Rural Bulk Billing Incentive
RGTS	Rural Generalist Training Scheme
RHMT	Rural Health Multidisciplinary Training program
RHOF	Rural Health Outreach Fund
RJDTIF	Rural Junior Doctor Training Innovation Fund
RTO	Regional Training Organisation
RWA	Rural Workforce Agency
SRHS	Stronger Rural Health Strategy
WIP	Workforce Incentive Program

List of Recommendations

Recommendation 1

- 2.98 The committee recommends that the Federal Government further investigates the provision and distribution of general practitioners in rural and regional Australia.

Recommendation 2

- 2.102 The committee recommends that the Government's review of the Modified Monash Model is open to public consultation, including from communities themselves, and is progressed as a matter of priority.

Recommendation 3

- 2.105 The committee recommends that the Department of Health and the Distribution Working Group assess the outstanding exceptional circumstances review applications as a matter of priority.

Recommendation 4

- 2.112 The committee recommends that the Department of Health develops benchmarks for the optimal distribution of primary health professionals.

Recommendation 5

- 2.114 The committee recommends that the Department of Health conducts a comprehensive and wholistic review of the Stronger Rural Health Strategy and that performance benchmarks be established to assess the effectiveness of the overall strategy and of its programs.

Recommendation 6

- 2.123 The committee recommends that the Federal Government investigates substantially increasing the Medicare rebates for all levels of general practice consultations, as well as other general practice funding options.

Recommendation 7

- 3.96 The committee recommends that the Department of Education, Skills and Employment, in collaboration with universities, reviews the primary care components of the medical education curriculum, with a view to ensuring that general practice is a core component of the curriculum.

Recommendation 8

3.100 The committee recommends that the Department of Health expands the John Flynn Prevocational Doctor Program and re-instates the John Flynn Placement Program aimed at attracting medical students to rural and regional general practice.

Recommendation 9

3.105 The committee recommends that the Government investigates the adequacy and suitability of the Australian General Practice Training placements allocated to the relevant general practice training colleges.

Chapter 1

Introduction

- 1.1 The distribution of the primary health workforce is a significant issue in Australia's health system, and it is well known that those living in outer-metropolitan, regional, and rural areas have less access to timely and affordable primary health care and experience worse health outcomes than those in metropolitan areas.
- 1.2 Australians are increasingly accessing primary health care at a rate that is outstripping supply, particularly in relation to appointments with general practitioners (GP). A functioning and well-distributed primary health system can prevent more serious illnesses, reduce presentations at hospital emergency departments, and improve health outcomes for individuals and communities; however, this is failing to occur.
- 1.3 Successive governments have implemented a range of policies aimed to improve the distribution of the primary health workforce with limited success, leaving communities across Australia without appropriate access to primary health care.
- 1.4 This inquiry is examining these issues, namely; the current distribution of primary health services, the policies designed to improve access to primary health professionals, and the impacts these have on Australians living in outer-metropolitan, regional, and rural areas.

Primary health services in Australia

- 1.5 Primary health refers to health services that are delivered without a referral from another health professional. Primary health professionals include GPs, nurses, midwives, allied health professionals, pharmacists, dentists, and Aboriginal health workers and practitioners.¹
- 1.6 Australians living in outer-metropolitan, regional, and rural areas often experience the primary health care sector in a different manner than their metropolitan counterparts. These Australians face difficulty in the accessibility of primary health care professionals, a lack of specialised health services, affordability challenges, and transportation issues.
- 1.7 People living in outer-metropolitan, regional, rural, and remote areas also experience worse health outcomes than their metropolitan counterparts, have a higher burden of disease, are more likely to experience chronic health

¹ NB: There is no nationally agreed definition of allied health. Professions commonly referred to as 'allied health' include: psychology and certain counsellors, physiotherapy, occupational therapy, and optometry. See: Department of Health (DoH), *Submission 38*, pp. 8 and 24.

conditions, and have a lower median age of death than those in inner-metropolitan areas.²

- 1.8 These issues are exacerbated for Aboriginal and Torres Strait Islander populations. Indigenous Australians have lower life expectancies and higher rates of chronic disease than non-Indigenous Australians. Approximately 19 per cent of Indigenous Australians live in remote areas where access to primary health care is severely limited.³
- 1.9 The impacts of the maldistribution of the primary health care workforce on the community and individuals are at the heart of this inquiry and are discussed in-depth in Chapter 4.

Responsibility for primary health services

- 1.10 The provision of primary health services in Australia is governed by a complex system of policies and funding arrangements between Commonwealth, state, and territory governments.⁴ The National Health Reform Agreement (NHRA) 2020-2025 outlines the responsibilities for the Commonwealth, state, and territory jurisdictions.
- 1.11 Under the NHRA, the Commonwealth Government is responsible for the following:
 - maintaining the legislative basis and governance arrangements for independent national bodies, including the Australian Commission on Safety and Quality in Health Care, the Australian Institute of Health and Welfare, the Independent Hospital Pricing Authority, and the Administrator of the National Health Funding Pool;
 - system management, support, policy, and funding for GPs and primary health care services, including for Aboriginal and Torres Strait Islander Community Controlled Health Services;
 - maintaining Primary Health Networks (PHNs);
 - working with each state and PHNs on system wide policy and state-wide planning for GP and primary health care;
 - regulating private health insurance;
 - planning, funding, policy, management and delivery of the national aged care system;
 - reforms in primary care that are designed to improve patient outcomes and reduce avoidable hospital admissions; and

² Australian Institute of Health and Welfare (AIHW), *Australia's health 2020 in brief*, pp. 48–50.

³ AIHW, *Rural and remote health*, 23 July 2020, <https://www.aihw.gov.au/reports/australias-health/rural-and-remote-health> (accessed 20 January 2021); AIHW, *Australia's health 2020 in brief*, pp. 58–67.

⁴ *National Health Reform Agreement – Addendum 2020-25*, p. 60; AIHW, *Australia's health: 2020 in brief*, 23 July 2020, p. 35.

- functions transferred from Health Workforce Australia and the National Health Performance Authority.⁵
- 1.12 The Commonwealth is also responsible for funding the Medicare Benefits Schedule, the Pharmaceutical Benefits Scheme and certain aged care services.⁶
- 1.13 Numerous Commonwealth departments and agencies have responsibilities within the primary health care sector. The Department of Health holds responsibility for policy development and implementation; the Department of Education, Skills and Employment is responsible for agreements between the Commonwealth and universities, and related functions in setting the number of Commonwealth Supported Places for medical degrees; and Services Australia is responsible for issuing Medicare provider numbers and paying Medicare rebates. Other agencies such as the Department of Veterans' Affairs and the National Disability Insurance Agency also have primary health care functions.⁷
- 1.14 The state governments are responsible for:
- system management of public hospitals, including, for example, planning funding and delivering capital, managing Local Hospital Network performance and public hospital industrial relations;
 - management of public health activities; and
 - management of the relationship with Local Hospital Networks.⁸
- 1.15 There are also several aspects of the health care system that Commonwealth and state governments are jointly responsible for, including:
- funding public hospital services;
 - determining funding policy and exploring innovative models of care in the national funding model;
 - establishing and maintaining nationally consistent standards for healthcare and reporting on the performance of health services;
 - collecting and providing patient-level data;
 - working together on policy decisions or areas of the system that impact on each other's responsibilities;
 - closing the gap in Aboriginal and Torres Strait Islander disadvantage and life expectancy;
 - identifying rural and remote areas where there is limited access to health and related services; and
 - maintaining and improving population health.⁹

⁵ *National Health Reform Agreement – Addendum 2020-25*, p. 10.

⁶ *National Health Reform Agreement – Addendum 2020-25*, p. 10.

⁷ DoH, *Submission 38*; Ms Penny Shakespeare, Deputy Secretary, Health Financing, DoH, *Proof Committee Hansard*, 7 March 2022, pp. 8–12; p. 68.

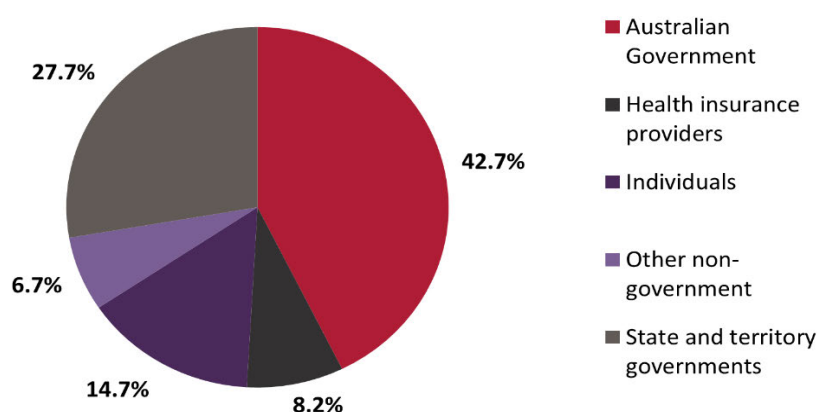
⁸ *National Health Reform Agreement – Addendum 2020-25*, p. 9.

- 1.16 The Commonwealth Government does not directly employ primary health care practitioners. The Commonwealth Government, however, provides most of the income to GPs through the Medicare payments system.
- 1.17 In addition, most primary health care professionals are employed in a private capacity and work for privately run businesses. According to the Department of Health, 82 per cent of GPs, 34 per cent of primary care nurses, and approximately 73 per cent of allied health professionals work in group or solo practice.¹⁰

The cost of primary health services

- 1.18 In 2019-20 total health spending equated to \$202.5 billion. As shown in Figure 1.1 below, approximately 43 per cent of this funding was provided by the Federal Government, 28 per cent by state and territory governments and 30 per cent from non-government sources (such as health insurance providers and individuals).¹¹

Figure 1.1 Percentage of spending on health in Australia by source 2019-20



Source: AIHW, *Health Expenditure Australia 2019-20: Spending trends by source*

- 1.19 Primary health care accounted for approximately 33 per cent or \$66.9 billion of total health spending in 2019-20. Of the \$66.9 billion, \$13.3 billion was spent on unreferral medical services (predominantly on general practice), \$12.9 billion on subsidised pharmaceuticals and \$11.9 billion on other medications.¹²

⁹ National Health Reform Agreement – Addendum 2020-25, p. 8–9.

¹⁰ DoH, *Submission 38*, p. 9.

¹¹ AIHW, *Health Expenditure Australia 2019-20: Spending trends by source*, 12 January 2022, <https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2019-20/contents/spending-trends-by-source> (accessed 18 January 2022).

¹² AIHW, *Health Expenditure Australia 2019-20: Summary*, 24 November 2021, <https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2019-20/contents/summary> (accessed 18 January 2022).

- 1.20 Nationally, the rate of primary health care services claimed per person has increased. For example, the number of GP attendances has risen from 113 million (or 5.3 per person) in 2008-09 to 158 million (or 6.3 per person) in 2018-19.¹³

Geographic classification systems

- 1.21 There are various classification systems used to define the geography of regions throughout Australia and the level of access different regions have to primary health care services.
- 1.22 Following reviews in 2012-13, the Department of Health transitioned from using the Australian Statistical Geography Standard – Remoteness Areas (ASGS–RA) system to the Modified Monash Model (MMM).¹⁴ The MMM was designed to better inform and determine a specific regions' eligibility for incentives by overlaying geographical data with statistical data. The MMM also incorporates differences between isolated small towns, in comparison with small towns that have greater access to larger towns.¹⁵

Modified Monash Model

- 1.23 The MMM classifies all locations in Australia along a spectrum of metropolitan to very remote communities according to geographical remoteness (as defined by the ASGS–RA) and town size.¹⁶ Table 1.1 below provides a description of each MMM category.

¹³ AIHW, *Primary health care*, 23 July 2020, <https://www.aihw.gov.au/reports/australias-health/primary-health-care> (accessed 20 January 2022).

¹⁴ See: Senate Community Affairs References Committee, *The factors affecting the supply of health services and medical professionals in rural areas*, August 2012; Jennifer Mason, *Review of Australian Government Health Workforce Programs*, April 2013.

¹⁵ DoH, *Submission 38*, pp. 38-39.

¹⁶ DoH, *Submission 38*, pp. 38-39.

Table 1.1 Modified Monash Model category descriptions and examples

MM Category	Description	Example
MM1	Metropolitan areas, accounts for 70% of Australia's population All areas categorised ASGS-RA1	Melbourne, Sydney, Brisbane
MM2	Regional centres, areas that are in or within a 20km drive of a town with over 50 000 residents Inner (ASGS-RA 2) and Outer Regional (ASGS-RA 3)	Ballarat, Mackay, Toowoomba, Kiama, Albury, Bunbury
MM3	Large rural towns that are in or within a 15km drive of a town between 15 000 to 50 000 residents ASGS-RA 2 and ASGS-RA 3 areas that are not MM 2	Dubbo, Lismore, Yeppoon, Busselton
MM4	Medium rural towns are in or within a 10km drive of a town with between 5000 to 15 000 residents ASGS-RA 2 and ASGS-RA 3 areas that are not MM 2 or MM 3	Port Augusta, Charters Towers, Moree
MM5	Small rural towns All remaining ASGS-RA 2 and ASGS-RA 3 areas	Mount Buller, Moruya, Renmark, Condamine
MM6	Remote communities, remote islands less than 5km offshore ASGS-RA4	Cape Tribulation, Lightening Ridge, Alice Springs, Mallacoota, Port Headland, Bruny Island
MM7	Very remote communities and remote islands more than 5km offshore ASGS-RA5	Longreach, Coober Pedy, Thursday Island

Source: DoH, Submission 38, pp. 12–13.

Distribution Priority Areas

- 1.24 On 1 July 2019, the Commonwealth Government introduced the Distribution Priority Area (DPA) classification system for GPs. The DPA system is designed to distribute GPs subject to location restrictions to work in areas where there are GP service shortfalls. The Department of Health notes that the DPA system helps to compare relative shortages of GPs between communities, as most communities appear to self-identify that they experience a shortage.¹⁷
- 1.25 If an area is deemed a DPA, employers have access to a broader employment pool as certain doctors (including certain overseas trained doctors and bonded medical students) are restricted to practice in DPA locations.
- 1.26 Regions (categorised as GP catchments) are designated as a DPA based on the availability of GP services to the population, its level of remoteness and other demographic factors. It is benchmarked against the average level of primary care services to patients living in MM2 areas. If an area has less GP services than the benchmark it is classified as a DPA.¹⁸
- 1.27 MM1, inner-metropolitan areas are automatically classified as non-DPA. MM3–7 areas are automatically deemed a DPA, as is all of the Northern Territory. DPA classifications are changed annually on 1 July based on any variations in the characteristics used to determine DPA status.
- 1.28 In September 2021, at the request of the Government, the Department of Health introduced an exceptional circumstances review process that enables practices to apply to have their catchment's DPA status changed. To seek a review, a practice must make an application to their Rural Workforce Agency which will assess the region's needs. Applications are sent to the Distribution Working Group which considers applications on the following criteria: changes to health services, workforce or health systems, patient demographics changes and absence of services, and will determine whether an area should have their DPA status changed.¹⁹

¹⁷ NB: The DPA replaced the Districts of Workforce Shortage (DWS) for general practitioners. The DWS is still in place for other medical specialities including: anaesthetics, cardiology, diagnostic radiology, general surgery, obstetrics and gynaecology, medical oncology, and psychiatry. See: DoH, *Submission 38*, pp. 37; DoH, *District of Workforce Shortage*, 14 December 2021 <https://www.health.gov.au/health-topics/rural-health-workforce/classifications/dws> (accessed 23 March 2022).

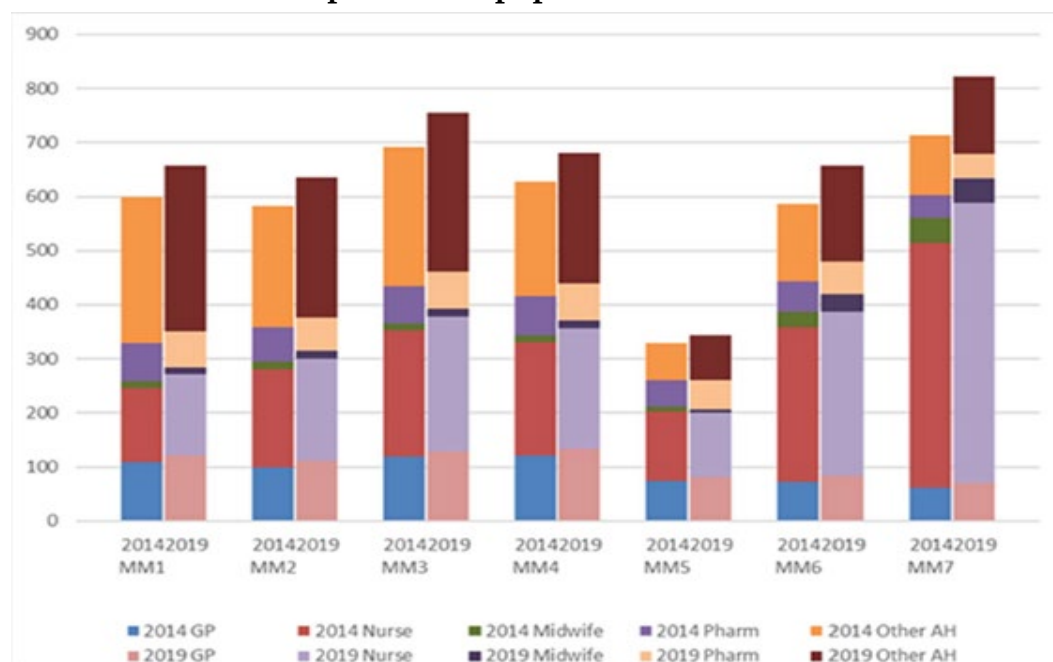
¹⁸ For further information on GP catchments and the DPA see: DoH, *Submission 38*, pp. 13–14 and 40–41.

¹⁹ Mr Matthew Williams, First Assistant Secretary, Health Workforce Division, DoH, Senate Community Affairs Legislation Committee, Additional estimates 2021–22, *Proof Committee Hansard*, 16 February 2022, p. 106.

Composition and distribution of the primary health workforce

- 1.29 Currently there is no single source of workforce data across Commonwealth, state, and territory jurisdictions, and different data sets and methodologies are used to understand workforce supply and undertake planning.²⁰ The Department of Health analyses primary health workforce data according to the MMM.
- 1.30 The primary health care workforce grew from 134 794 full-time equivalent (FTE) in 2014 to 159 801 FTE in 2019.²¹ Despite this growth, the composition and distribution of the primary health workforce varies across the country. For example, the distribution of pharmacists is relatively consistent across MM categories. The number of FTE pharmacists per 100 000 population is between 62 to 74 for MM1 to MM4, with locations in MM5 and MM7 reporting slight increases on 2014 FTE numbers.²²
- 1.31 For primary care nurses, the number of nurses generally increases with increasing levels of remoteness. For other primary health professionals such as allied health professionals and GPs, the numbers decrease with increasing levels of remoteness.²³

Figure 1.2 Composition of the primary care workforce by MMM 2014 and 2019 (FTE per 100 000 population)



Source: DoH Submission 38, p.19.

²⁰ DoH, [National Medical Workforce Strategy 2021-2031](#) (NMWS), p. 28.

²¹ DoH, Submission 38, p. 18.

²² DoH, Submission 38, pp. 29–27.

²³ DoH, Submission 38, pp. 22–25.

- 1.32 In addition, different cohorts of the primary health workforce are facing varied challenges, including in relation to over and undersupply and maldistribution. For example, Aboriginal and Torres Islander health workers are consistently underrepresented in the primary health workforce, and there is an oversupply of paramedics but an undersupply of domestic medical graduates training as GPs.²⁴

General practitioners

- 1.33 GPs are the most frequently accessed primary health care professional.²⁵ According to the Patient Experience Survey, 82.4 per cent of individuals aged 15 years and over saw a GP in the 2020-21 year.²⁶
- 1.34 General practice is a recognised medical speciality in Australia. Following graduation from university level education and the required intern and residency periods, medical graduates can choose to specialise in a particular field of medicine, including general practice.
- 1.35 To become a GP, medical graduates are required to undertake further training through either the Australian College of Rural and Remote Medicine (ACRRM), a four year training program, or the Royal Australian College of General Practitioners (RACGP), a three year training program. Once completed, practitioners are known as 'Vocationally Recognised' GPs and receive a Fellowship with their training college.²⁷ Vocational recognition enables registration with the Medical Board, use of the title 'specialist GP', and access to higher Medicare rebates.
- 1.36 The numbers of GPs in Australia have grown from 2015-16 to 2020-21, however, maldistribution remains a pertinent problem. The number of GPs in the Northern Territory has been declining since 2017 and in the 2019-20 period, New South Wales, Western Australia, South Australia and the Australian Capital Territory all experienced a decrease in the number of GPs.²⁸
- 1.37 Table 1.2 below shows the number of FTE GPs by the MMM.

²⁴ DoH, *National Medical Workforce Strategy 2021-2031*, p. 16; Mr John Brunning, Chief Executive Officer, Australasian College of Paramedicine, *Proof Committee Hansard*, 14 December 2021, p. 35.

²⁵ DoH, *Submission 38*, p. 15.

²⁶ The Patient Experience survey is a topic on the Multipurpose Household Survey conducted throughout Australia from July 2020 to July 2021. See: Australian Bureau of Statistics, *Patient Experiences in Australia: Summary of Findings*, 17 November 2021, <https://www.abs.gov.au/statistics/health/health-services/patient-experiences-australia-summary-findings/latest-release> (accessed 10 February 2022).

²⁷ DoH, *General Practice Training in Australia: The Guide*, February 2020, p. 4.

²⁸ DoH, *Submission 38*, pp. 19–20.

Table 1.2 Number of full time equivalent general practitioners by Modified Monash Model

Category	Financial Year						
	2020/21	2019/20	2018/19	2017/18	2016/17	2015/16	Growth*
MM1	22,799.0	21,859.5	21,587.5	20,889.2	19,996.7	19,268.8	3.4%
MM2	2,651.4	2,512.7	2,491.3	2,436.0	2,344.5	2,260.9	3.2%
MM3	2,130.7	2,025.5	2,023.8	1,983.3	1,947.4	1,915.7	2.2%
MM4	1,320.6	1,277.0	1,280.1	1,239.7	1,213.4	1,184.7	2.2%
MM5	1,468.7	1,403.6	1,395.5	1,352.5	1,314.2	1,312.7	2.3%
MM6	224.7	228.4	233.0	236.8	232.3	228.7	-0.4%
MM7	141.0	148.1	149.6	145.3	135.9	132.6	1.2%
National	30,736.1	29,454.8	29,160.7	28,282.8	27,184.3	26,304.2	3.2%

* Growth refers to a compound annual growth rate. Source: Department of Health, answer to inquiry question on notice: IQ21-000324, received 9 February 2022.

- 1.38 A report by Deloitte Access Economics and Cornerstone Health predicted that by 2030 there will be a 37.5 per cent increase in the demand for GP services. It also found that there will be a shortfall of 9298 GPs or 24.7 per cent of the GP workforce.²⁹ The report found that the deficiency will be most extreme in 'urban' areas with a shortfall of 7535 GPs or 31.7 per cent of the GP workforce.³⁰

Demographics of primary health care

- 1.39 The provision of primary health care varies across Australia. Along the spectrum of the MMM system, communities experience significantly different contexts which affect the provision of primary health care. This includes population characteristics (such as socio-economic status), patient demographics, available infrastructure, available support services, and workforce mix.³¹ The following section provides an overview of generalised characteristics regarding the accessibility of primary health care according to the MMM.

²⁹ Cornerstone Health, *Submission 6: Attachment A*, p. ii.

³⁰ NB: This figure is a prediction based on modelling of demand for GP services across Australia on a per capita basis. Additionally, the report uses the terms urban and regional areas rather than the MMM. See: Cornerstone Health, *Submission 6: Attachment A*: p. ii.

³¹ Primary Health Network Cooperative (PHNC), *Submission 46*, p. 5; DoH, *Submission 38*, pp. 8–9; Cornerstone Health, *Submission 6*, pp. 1–2.

Outer-metropolitan areas (MM1)

- 1.40 Under the MMM, all metropolitan areas are classified as MM1, however, there is variation between inner and outer-metropolitan classifications.³² Outer-metropolitan areas are characterised by high levels of diversity, including a high proportion of recent migrants and refugees, and Aboriginal and Torres Strait Islander peoples.³³ Outer-metropolitan areas are also experiencing high rates of population growth leading to an increased demand for primary health services.
- 1.41 Outer-metropolitan areas have lower numbers of GPs which leads to lengthy waiting periods for appointments and poor health outcomes. The population is reliant on bulk-billing and the cost of seeing a GP can be a barrier to people seeking care.³⁴

Regional and rural areas (MM2–MM5)

- 1.42 There are important distinctions between regional and rural areas in the provision of primary health care, however, these areas share some common characteristics.³⁵ Regional and rural areas experience significant workforce shortages, and it is difficult for primary health practitioners to viably provide services to small rural (and remote) towns.³⁶
- 1.43 It is common for health services in large regional centres to act as a hub for those in outer-regional and rural areas, which means those living in rural areas often must travel extensive distances to receive health care in these locations.³⁷
- 1.44 Regional and rural areas are expected to experience a dual challenge of a declining population and increasingly ageing population. The population in these areas tends to experience higher levels of socio-economic disadvantage, lower rates of literacy, physical activity, and nutrition.³⁸

Remote areas (MM6–MM7)

- 1.45 The population of remote areas is very small and dispersed between large distances. Primary health services are often provided by remote area nurses, Aboriginal Health Practitioners or visiting locums as it is less likely to have a resident GP.³⁹ In remote (and rural) areas it is common for a single health

³² DoH, *Submission 38*, p. 13.

³³ DoH, *Submission 38*, p. 33; PHNC, *Submission 46*, p. 5.

³⁴ PHNC, *Submission 46*, p. 6.

³⁵ Rural Workforce Agency Network, *Submission 50*, p. 4.

³⁶ PHNC, *Submission 46*, pp..

³⁷ PHNC, *Submission 46*, pp. 6–7; Regional Australia Institute, *Submission 71*, p. 3.

³⁸ PHNC, *Submission 46*, p. 6.

³⁹ PHNC, *Submission 46*, p. 7; NSW Outback Division of General Practice, *Submission 115*, pp. 4–5; Rural Workforce Agency Network, *Submission 50*, p. 3.

professional to cover several towns and for doctors to travel to more remote areas, which places pressure both on the local community and the workload of doctors.⁴⁰

- 1.46 Those living in remote areas experience significantly worse health outcomes, with higher rates of chronic disease and preventable illness, high rates of teenage pregnancy, high rates of developmental vulnerability in children, and higher rates of avoidable hospitalisations and mortality rates than experienced in metropolitan areas.⁴¹

Policy levers

- 1.47 The Department of Health recognises that the maldistribution of the primary health workforce, particularly in rural and remote locations, leads to poorer health outcomes for individuals living in these areas. It submitted that a key objective for the Government is to 'have a well distributed primary care workforce able to provide services tailored to community needs, as close to home as possible' and that there is a 'particular focus on improving the distribution of the primary care workforce outside of metropolitan locations'.⁴²
- 1.48 The Commonwealth Government has several policy levers at its disposal to influence the supply and distribution of primary health care professionals. Commonly employed mechanisms relate to education and training policy, immigration policy, Medicare payments, financial incentives and other programs to encourage practitioners to relocate to outer-metropolitan, regional, and rural areas. The following section provides an overview of some of the policies implemented to improve the distribution of the primary health workforce.

Bonded medical programs

- 1.49 Bonded medical programs provide medical students with a Commonwealth Supported Place at an Australian university in return for a commitment to work in eligible regional, rural, and remote areas (known as the 'Return of Service Obligation').⁴³ The current program is a statutory scheme under the *Health Insurance Act 1973* and commenced on 1 January 2020.
- 1.50 Bonded medical students on the statutory scheme must complete a three-year Return of Service Obligation within 18 years following graduation from

⁴⁰ See for example: Rural and Remote Medical Services (RRMS), *Submission 118*, p. 6; Western Australian Local Government Association, *Submission 21*, p. 5; Northern Eyre Peninsula Health Alliance, *Submission 48*, p. 2; South Eastern NSW Primary Health Network, *Submission 116*, p. 6.

⁴¹ RRMS, *Submission 118*, p. 2; PHNC, *Submission 46*, p. 7.

⁴² DoH, *Submission 38*, p.18

⁴³ DoH, *Submission 38*, p. 94

university. This means they must work in an eligible regional, rural or remote area for three years within 18 years of completing their university study. The Return of Service Obligation can be undertaken non-continuously, full-time or part-time, or as fly-in/fly-out.⁴⁴

- 1.51 Participants in the program can also receive a 6-month Return of Service Obligation 'discount' if they work full-time for the first 24 months in a MM4–7 location.⁴⁵

International medical graduates and overseas trained doctors

- 1.52 Australia is reliant on international medical graduates and overseas trained doctors to provide primary health care. This cohort of doctors are often used as a mechanism to fill workforce shortages in outer-metropolitan, regional, rural and remote locations. Under section 19AB of the *Health Insurance Act 1973*, certain international medical graduates and overseas trained doctors are subject to restrictions on their location of practice in their first ten years in Australia (known as the ten-year moratorium).⁴⁶
- 1.53 Those subject to the ten-year moratorium can only provide services eligible for Medicare rebates in a DPA area for GPs or a District of Workforce Shortage (DWS) for other specialities. However, there are no restrictions on practise in salaried positions such as public hospitals, as these services do not attract Medicare rebates.⁴⁷
- 1.54 Between 2014 and 2020, international medical graduates practicing as a FTE GP grew at a faster rate than for Australian and New Zealand graduates, at a rate of 4.3 per cent and 1.6 per cent respectively. The GP FTE for international medical graduates has increased from 48.2 per cent of total GP FTE in 2014 to 52 per cent in 2020.⁴⁸
- 1.55 Table 1.3 below shows the proportion of GP FTE services delivered by overseas trained doctors according to the MMM.

⁴⁴ DoH, *Submission 38*, p. 95;

⁴⁵ DoH, *The Bonded Medical Program: Prospective Student Information Booklet*, December 2021, p. 12.

⁴⁶ DoH, *Submission 38*, pp. 93–94.

⁴⁷ DoH, *Submission 38*, pp. 37

⁴⁸ DoH, *Submission 38*, p. 21.

Table 1.3 Proportion of GP FTE delivered by overseas trained doctors (based on the place of initial medical qualification)

Category	Financial year						Change (%)
	2020/21	2019/20	2018/19	2017/18	2016/17	2015/16	
MM1	51.6%	51.5%	51.2%	50.3%	49.6%	48.6%	3.0%
MM2	56.1%	54.6%	54.5%	54.3%	54.1%	53.7%	2.3%
MM3	53.7%	53.5%	53.7%	53.2%	54.0%	54.9%	-1.2%
MM4	52.0%	51.3%	50.1%	50.1%	50.7%	52.8%	-0.8%
MM5	55.0%	54.0%	54.4%	54.4%	55.1%	55.9%	-1.0%
MM6	46.5%	47.5%	49.4%	51.8%	52.1%	53.4%	-6.9%
MM7	33.4%	36.9%	37.5%	38.2%	38.8%	38.6%	-5.2%
Total	52.2%	51.9%	51.7%	51.0%	50.5%	50.1%	2.1%

Source: DoH, answer to inquiry question on notice: IQ21-00324, received 9 February 2022.

- 1.56 As shown in Table 1.3, nationally, approximately 50 percent of GPs are trained overseas.

Stronger Rural Health Strategy

- 1.57 The Stronger Rural Health Strategy (SRHS) is the key government policy aimed at 'building a sustainable, high quality health workforce that is distributed across the country according to community need'. Announced in the 2018–19 Budget, the SRHS committed \$550 million across the forward estimates. The SRHS is made up of a suite of programs aimed at addressing health workforce quality, distribution, and planning. It also aims to support nurses and allied health professionals in the delivery of more multidisciplinary, team-based models of primary health care. Below is an overview of three key programs and incentives under the SRHS.⁴⁹

Rural Generalist Training Scheme

- 1.58 Following several reviews and recommendations, the Federal Government in conjunction with the National Rural Health Commissioner and the two GP colleges, established the Rural Generalist Training Scheme (RGTS) in 2021. It is a four-year, fully funded GP training program that leads to a Fellowship with ACRRM. Rural generalists are critical to rebuilding the rural health workforce because they can work in both primary care and hospital settings. Up to 100 places are offered annually under this scheme. The Department of Health

⁴⁹ For further information on the range of programs under the SRHS see: DoH, *Submission 38*, pp. 83–104.

notes that the development of the RGTS is recognition of the unique skills of doctors who practice medicine in rural areas.⁵⁰

Workforce Incentive Program (WIP)

1.59 The WIP provides financial incentives to doctors and practices delivering services in rural and remote areas (MM3–7). The program has two streams, the Doctor Stream and the Practice Stream. It aims to improve access to quality medical, nursing and allied health services and team-based care in regional, rural and remote areas. More than 8000 doctors and 5600 practices receive incentives under the WIP each year.⁵¹

Rural Bulk Billing Incentive

1.60 The Rural Bulk Billing Incentive (rBBi) provides extra funding to GPs who accept a patient's Medicare Benefits Schedule (MBS) rebate as full payment for their services. On 1 January 2020, eligibility for the rBBi was aligned to the MMM.

1.61 From 1 January 2022, the rBBi progressively increases as the level of remoteness increases. The Department of Health states the '[rBBi] in MM7 locations is approximately 190 per cent of the standard bulk-billing rate available in metropolitan areas.'⁵² It should be noted that the '190 per cent' figure relates to the \$6.50 bulk-billing incentive which is received on top of the standard Medicare rebate. Table 1.4 below shows the incentive structure and payment rates.

Table 1.4 Rural Bulk Billing Incentive from 1 January 2022

Category	MBS item number		
	10990 (MM 1) 10991 (MM 2–7)	64990 (MM 1) 64991 (MM 2–7)	74990 (MM 1) 74991 (MM 2–7)
MM1	\$6.50	\$6.10	\$6.10
MM2	\$9.80	\$9.20	\$9.20
MM3	\$10.40	\$9.75	\$9.75
MM4	\$10.40	\$9.75	\$9.75
MM5	\$11.05	\$10.35	\$10.35
MM6	\$11.70	\$11.00	\$11.00
MM7	\$12.35	\$12.00	\$12.00

Source: DoH, *Incentives and support for GPs and general practices*, 4 February 2022.

⁵⁰ DoH, *Submission 38*, p. 102.

⁵¹ DoH, *Submission 38*, p. 97.

⁵² DoH, *Submission 38*, p. 96.

Other initiatives

1.62 Further to the initiatives under the SRHS, there are a range of other bodies and policies designed to improve the maldistribution of the primary health workforce, as outlined below.

National Rural Health Commissioner

1.63 In 2017, the Government established the Office of the National Rural Health Commissioner to independently and impartially improve rural health policies, and champion the cause of rural practice. The Office of the National Rural Health Commissioner has the following work priorities:

- Aboriginal and Torres Strait Islander engagement;
- developing Primary Care Rural Innovative Multidisciplinary Models; and
- developing the National Rural Generalist Pathway and recognition of rural generalist medicine as a distinct field of practice.⁵³

Primary Health Networks

1.64 On 1 July 2015, the Government established 31 PHNs across Australia. PHNs are independent primary health care organisations that work to reorient and reform the primary health care system. PHNs have the following three main roles:

- to commission health services to meet the needs of people in their regions and address identified gaps in primary health care;
- to work with GPs and other health professionals to build health workforce capacity; and
- to integrate health services at a local level to create a better experience for patients, encourage better use of health resources, and eliminate service duplication.⁵⁴

Rural Workforce Agencies

1.65 Rural Workforce Agencies (RWAs) are funded by the Commonwealth to work in each state and the Northern Territory to deliver a range of activities aimed at improving the access, quality and sustainability of regional, rural and remote health workforces. The work of RWAs targets MM2 to MM7 locations and Aboriginal Community Controlled Health services in MM1 to MM7. RWAs have broad responsibilities in the following areas:

- Access (Health Workforce Access Program): improve access and continuity of access to essential primary health care, particularly in priority areas,

⁵³ DoH, *Submission 38*, p. 78; DoH, *About the Office of the National Rural Health Commissioner*, 14 December 2021, <https://www.health.gov.au/initiatives-and-programs/onrhc/about> (accessed 10 March 2022).

⁵⁴ DoH, *Submission 38*, p. 80.

through a jurisdictional workforce assessment process involving health workforce stakeholders.

- Quality of access (Improving Workforce Quality Program): build local health workforce capability with a view to ensuring communities can access the right health professional at the right time, reducing the reliance on non-vocationally recognised service providers in rural communities.
- Future planning (Building a Sustainable Workforce Program): grow the sustainability and supply of the health workforce with a view to strengthening the long-term access to appropriately qualified health professionals.⁵⁵

The National Medical Workforce Strategy 2021-2031

- 1.66 The National Medical Workforce Strategy 2021–2031 (NMWS) is designed to ensure that the medical workforce continues to meet Australia's ongoing health needs.⁵⁶
- 1.67 The NMWS notes that Australia has an excellent health system, however, there is an inequality of access to the health services and that the 'optimal' distribution and service mix is not consistently achieved across Australia.⁵⁷
- 1.68 The NMWS identifies the following concerns for Australia's current and future medical workforce: geographic maldistribution; imbalance between specialist disciplines, subspecialisation and generalism; junior doctors' workload and wellbeing; the need for more Aboriginal and Torres Strait Islander doctors; and the reliance on locums and international medical graduates.⁵⁸
- 1.69 The NMWS contains five priorities for the medical workforce, including:
- collaboration on workforce planning and design;
 - rebalancing supply and distribution;
 - reforming the training pathways;
 - building the generalist capability of the medical workforce; and
 - building a flexible and responsive medical workforce.⁵⁹

HELP Debt arrangements for certain rural, remote or very remote health practitioners

- 1.70 In December 2021, the Minister for Regional Health announced that the Commonwealth Government will incentivise medical graduates and nurse practitioner graduates to work in non-metropolitan areas by discounting the

⁵⁵ DOH, *Submission 38*, pp. 75–76.

⁵⁶ DoH, [NMWS](#), pp. iv–v.

⁵⁷ DoH, [NMWS](#), p. iv–v.

⁵⁸ DoH, [NMWS](#), p. iii.

⁵⁹ DoH, [NMWS](#), pp. 2–6.

amount of Higher Education Loan Program (HELP) debt to be repaid. The Education Legislation Amendment (2022 Measures No. 1) Bill 2022 was introduced on 17 February 2022. If passed, from 1 January 2022 (applied retrospectively), the Government will eliminate 100 per cent of an eligible individual's outstanding HELP debt, subject to meeting eligibility requirements.⁶⁰

Previous inquiries and reports

1.71 There have been several inquiries and reports into the provision of primary health services across Australia in the past two decades, including the following:

- Australia's Health Workforce—Productivity Commission (2005);
- Audit of Health Workforce in Rural and Regional Australia—Department of Health and Ageing (2008);
- Internal review of rural health programs and geographical classification systems—Department of Health and Ageing (2008);
- Rural and remote health workforce capacity – the contribution made by programs administered by the Department of Health and Ageing—Australian National Audit Office (2008–2009);
- Review of Undergraduate Medical Education in Australia—Department of Education, Science and Training (2008);
- The factors affecting the supply of health services and medical professionals in rural areas—Senate Community Affairs References Committee (2012);
- Lost in the Labyrinth: Report on the inquiry into registration processes and support for overseas trained doctors—House of Representatives Standing Committee on Health and Ageing (2012);
- Review of Australian Government Health Workforce Programs (known as the Mason Review) (2013);
- Australia's Future Health Workforce reports (2012–2019).

1.72 There have also been reviews conducted into specific programs, such as reviews of the Rural Health Multidisciplinary Training Program and the Rural Health Workforce Support Activity program, and a five-year review of the MBS.⁶¹

⁶⁰ For further information on the eligibility for the program and conditions see: DoH, *HELP debt reduction for rural doctors and nurse practitioners*, January 2022, <https://www.health.gov.au/sites/default/files/documents/2022/01/fact-sheet-help-for-rural-doctors-and-nurse-practitioners-fact-sheet-help-for-rural-doctors-and-nurse-practitioners.pdf> (accessed 3 March 2022).

⁶¹ KBC Australia, *Independent Evaluation of the Rural Health Multidisciplinary Training Program*, June 2020; Department of Health, *Review of the Rural Health Workforce Support Activity – Final report*, November 2020; MBS Review Taskforce, *An MBS for the 21st Century Recommendations, Learnings and Ideas for the Future: Medicare Benefits Schedule Review Taskforce – Final report to the Minister for Health*, December 2020.

- 1.73 In addition, at the time of reporting, several state parliaments were conducting inquiries into the provision of primary health services in regional, rural and remote locations.⁶²

Report structure

- 1.74 This is an interim report that focusses on the provision of GPs and the associated policies relating to the supply and distribution of GPs across Australia.
- 1.75 Following this introductory chapter, which provides an overview of primary health in Australia, the composition and distribution of this workforce, and key programs designed to improve the distribution of primary health professionals and the health outcomes of those living in non-metropolitan areas, this report consists of three chapters:
- Chapter 2: details key issues raised with the current policies and programs designed to correct the maldistribution of the primary health workforce;
 - Chapter 3: discusses how medical education and training influences the supply of GPs and investigates the barriers experienced by primary health practitioners in working in outer-metropolitan, rural and regional areas around Australia; and
 - Chapter 4: details the impacts of the maldistribution of the primary health care workforce on communities and individuals in outer-metropolitan, regional, and rural Australians.

Conduct of inquiry

- 1.76 On 4 August 2021, the Senate referred this inquiry to the Senate Community Affairs References Committee (the committee) with the following terms of reference:

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

⁶² Parliament of New South Wales, *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales*, <https://www.parliament.nsw.gov.au/committees/inquiries/Pages/inquiry-details.aspx?pk=2615> (accessed 20 January 2022); Queensland Parliament, *Committee Details – Inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system*, <https://www.parliament.qld.gov.au/Work-of-Committees/Committees/Committee-Details?cid=0&id=4131> (access 20 January 2022); Parliament of Tasmania, *Legislative Council Sessional Committee Government Administration A Sub-Committee Rural Health Services Inquiry*, https://www.parliament.tas.gov.au/ctee/Council/GovAdminA_RuralHealth.htm (accessed 20 January 2022); South Australian Parliament, *Health Services in South Australia*, <https://committees.parliament.sa.gov.au/committee/361/Health%20Services%20in%20South%20Australia/54/54th%20Parliament%2003%2F05%2F2018%20-%20Current/54> (accessed 20 January 2022).

- (a) the current state of outer metropolitan, rural, and regional GPs and related services;
- (b) current state and former Government reforms to outer metropolitan, rural and regional GP services and their impact on GPs, including policies such as:
 - (i) the stronger Rural Health Strategy,
 - (ii) Distribution Priority Area and the Modified Monash Model (MMM) geographical classification system,
 - (iii) GP training reforms, and
 - (iv) Medicare rebate freeze;
- (c) the impact of the COVID-19 pandemic on doctor shortages in outer metropolitan, rural, and regional Australia; and
- (d) any other related matters impacting outer metropolitan, rural, and regional access to quality health services.

1.77 As noted in the terms of reference, the committee has focussed on the provision of primary health services in outer-metropolitan, regional, and rural communities. However, the committee acknowledges that the issues for remote communities in Australia are exacerbated.

1.78 The Senate set a reporting date of the last sitting day in March 2022. On 8 February 2022, the Senate granted an extension of time for the committee to report by 30 June 2022.⁶³

1.79 The committee received 218 submissions. A list of submitters is available at Appendix 1.

1.80 The committee held the following six public hearings:

- Canberra, Australian Capital Territory, 4 November 2021;
- Erina, New South Wales, 14 December 2021;
- Launceston, Tasmania, 24 January 2022;
- Whyalla, South Australia, 1 March 2022;
- Frankston, Victoria, 7 March 2022; and
- Emerald, Queensland, 17 March 2022.

1.81 A list of witnesses who provided evidence at the public hearings is available at Appendix 2.

⁶³ *Journals of the Senate*, No. 108, 4 August 2021, pp. 3832–3833; *Journals of the Senate*, No. 134, 8 February 2022, p. 4460.

Acknowledgements

- 1.82 The committee thanks the individuals and organisations who made submissions to this inquiry and the witnesses who appeared at public hearings.
- 1.83 The committee greatly appreciates all of the witnesses who took the time to appear at its public hearings and recognises that it heard from many GPs and other health workers who changed their patient schedules to attend.

Chapter 2

Key issues regarding policies to distribute the primary health workforce

- 2.1 As noted in Chapter 1, the distribution of Australia's primary care workforce in outer-metropolitan, regional, and rural Australia has been a critical issue for decades. Unsurprisingly, successive governments have attempted to improve the distribution of Australia's primary care workforce by designing policies and programs aimed at attracting primary care workers to Australia's rural and regional locations. This chapter discusses the key issues raised regarding the distribution classification systems and the associated policies.

Division of federal and state responsibility for primary health

- 2.2 As outlined in Chapter 1, under the National Health Reform Agreement (NHRA) 2020-2025, the provision of primary health services in Australia is divided between the Commonwealth, state, and territory governments.¹
- 2.3 The committee heard from several inquiry participants that the current division of responsibility between the levels of government does not adequately meet the needs of non-metropolitan areas and that a more collaborative approach is required.²
- 2.4 For example, Mr Richard Anicich AM, Chair, Rural and Remote Services, commented on the need for better cooperation at all levels of government:

The other thing that I think needs to be understood at Commonwealth and state level is that we have to move beyond passing the buck between the state and the federal governments as to who is responsible for what. So often you hear the Commonwealth say, 'We're responsible for primary care,' and the state say, 'We're responsible for tertiary care.' Health care in rural and remote areas doesn't fall neatly into one bucket or the other. So there has to be a complete rethink of that Commonwealth-state funding relationship within the health sector to come up with a more community focused level of care and management of the health issues.³

¹ For further information on the NHRA see: Chapter 1 paragraphs 1.10–1.15. See also: National Health Reform Agreement – *Addendum 2020-25*.

² See for example: Mr Richard Anicich AM, Chair, Rural and Remote Services, *Proof Committee Hansard*, 14 December 2021, p. 42; Mr Dean Johnson, Mayor, District Council of Kimba, *Proof Committee Hansard*, 1 March 2022, p. 22.

³ Mr Richard Anicich AM, Chair, Rural and Remote Services (RRMS), *Proof Committee Hansard*, 14 December 2021, p. 42.

- 2.5 Professor Richard Murray, Deputy Vice Chancellor, Division of Tropical Health and Medicine, James Cook University, also commented on a lack common goals and accountability between levels of government:

... what we suffer from now is a lack of clear objectives and accountability and a lack of connectedness across programs, particularly federally but also at the state and territory level, with a common objective in mind. I think this might perhaps be an opportunity to get a clearer lead on what some of that realignment might be to focus on actual delivery of outcomes and accountability for that.⁴

- 2.6 The committee also received evidence from several local councils detailing the lengths they have taken to ensure their communities are provided with access to primary health care, as well as the programs and incentives they have developed to attract and retain health professionals in their communities.
- 2.7 These policies and incentives range from providing doctors with cash incentives, councils purchasing properties for doctors and their families to live in rent-free, paying the running costs to have medical centres open, and funding other items for general practitioners (GPs) such as vehicles and fuel allowances, utilities, phone bills, furniture, and equipment.⁵
- 2.8 For example, in the District Council of Kimba (classified as MM6), the council has estimated that it has spent close to \$2 million to improve health services in the region.⁶ This includes:
- upgrading the council owned medical centre (provided free of charge to doctors);
 - two rent-free houses to doctors willing to relocate to the community;
 - provision of computers, printers, fax machines, medical equipment and office furniture; and
 - costs paid for practice accreditation.⁷
- 2.9 The District Council of Streaky Bay, classified as MM7, also pursued this pathway and purchased the only GP clinic in the area following the retirement

⁴ Professor Richard Murray, Deputy Vice Chancellor, Division of Tropical Health and Medicine, James Cook University (JCU), *Proof Committee Hansard*, 4 November 2021, p. 32.

⁵ City of Karratha, *Submission 8*, p. 1; Shire of Coolgardie, *Submission 9*, p. 5; Shire of Corrigin, *Submission*, pp. 1–3; Western Australia Local Government Association (WALGA), *Submission 21*, p. 2; City of Greater Geraldton, *Submission 42*, pp. 1–3; District Council of Kimba, *Submission 137*, p. 3; Local Government Association of Queensland (LGAQ), *Submission 128*, p. 4; Australian Local Government Association (ALGA), *Submission 147*, pp. 2–3; Regional Council of Goyder, *Submission 14*; City of Greater Geraldton, *Submission 42*; Derwent Valley Council, *Submission 70*; City of Logan, *Submission 121*; Shire of Murray, *Submission 2*; City of Mandurah, *Submission 199*; Isaac Regional Council, *Submission 142*.

⁶ For a discussion on the Modified Monash Model (MMM) see Chapter 1, paragraphs 1.21–1.23.

⁷ District Council of Kimba, *Submission 137*, p. 3; Mrs Debra Larwood, Chief Executive Officer, District Council of Kimba, *Proof Committee Hansard*, 1 March 2022, pp. 21–22.

of a local doctor. The committee heard that without this intervention the town would have been left without access to a GP. In doing so, the council accrued the following costs:

- \$438 407 in staff wages, locum accommodation, and running costs;
- \$79 911 in restructuring and purchase costs;
- approximately \$100 000 on advertising; and
- \$2700 in legal fees.⁸

2.10 Streaky Bay Council also purchased land and built houses for doctors and gave a council car to locums to use during their stay. To partially fund these services, council had to raise the community's rates by one per cent.⁹

2.11 The local councils noted that they are well placed to understand the unique health needs of their communities. However, they expressed concern that it is beyond their scope of authority to fund and provide primary health care services. They further commented that addressing these problems are within the realm federal and state responsibility.¹⁰

2.12 Responding to questions regarding these concerns, Ms Penny Shakespeare, Deputy Secretary, Health Financing, Department of Health, told the committee:

We can certainly talk about how the Commonwealth tries to influence GPs to work in locations, but, under the health system that we have, general practitioners work in private practice; we don't employ them directly in the Commonwealth government. There are some GPs who are employed directly by state health services to provide primary care health services from hospitals, but I wouldn't describe it as a state government responsibility. Some certainly decide to make that investment through the public health system, but generally we operate with the private sector general practice model. That model is funded primarily by Medicare rebates, which are not direct payments to the doctors; they're patient rebates for services.¹¹

2.13 Further, the National Medical Workforce Strategy 2021-2031 (NMWS) recognises that 'understanding the whole picture requires national

⁸ Mr Travis Barber, Mayor, District Council of Streaky Bay, *Proof Committee Hansard*, 1 March 2022, p. 23.

⁹ Mr Travis Barber, Mayor, District Council of Streaky Bay, *Proof Committee Hansard*, 1 March 2022, p. 23.

¹⁰ See for example: ALGA, *Submission 147*, pp. 1–2; City of Karratha, *Submission 8*; Shire of Coolgardie, *Submission 9*; Regional Council of Goyder, *Submission 14*; Western Australian Local Government Association (WALGA), *Submission 21*; City of Greater Geraldton, *Submission 42*; District Council of Kimba, *Submission 137*; LGAC, *Submission 128*; Shire of Murray, *Submission 2*; City of Logan, *Submission 121*.

¹¹ Ms Penny Shakespeare, Deputy Secretary, Health Financing, Department of Health (DoH), *Proof Committee Hansard*, 7 March 2022, p. 66.

collaboration – from data sharing and evidence-based modelling to local and jurisdictional level planning.¹² This means that federal, state and territory governments must work together to improve how they support Australia's primary care workforce.

Transition to college-led training

- 2.14 Another component of jurisdictional issues is the training of primary health professionals, particularly GPs. While the Federal Government has responsibility for the education and training of GPs, medical graduates spend their prevocational years training in the state hospital system.
- 2.15 Historically, the responsibility for training GPs has shifted between the Royal Australian College of General Practitioners (RACGP) and the Department of Health. In 2017, the Minister for Health announced that the responsibility for Commonwealth funded GP training programs, including the Australian General Practice Training (AGPT) program, would transfer from the Department of Health to the RACGP and the Australian College of Rural and Remote Medicine (ACRRM) by 2022.¹³
- 2.16 The committee has received mixed evidence on the transition to college-led training. There is some consensus that the transition to college-led training is a practical reform, particularly regarding the ability for the colleges to play a greater role in the selection and management of candidates for a GP Fellowship.¹⁴
- 2.17 However, several concerns have been raised about the transition, including: the potential impact on the number of students electing to train to be GPs, the impacts on registrars currently undertaking GP training, maintaining and establishing relationships for supervisors and communities, culturally specific training, the focus (or lack thereof) of GP training in regional, rural and remote areas, the closure of successful Regional Training Organisations (RTOs), and the ability for the colleges to successfully manage all aspects of the transition, including staffing requirements.¹⁵

¹² DoH, [National Medical Workforce Strategy 2021-2031](#), p. 7.

¹³ DoH, *Submission 38*, pp. 48–50.

¹⁴ Northern Territory General Practice Education (NTGPE), *Submission 57*; JCU *Submission 144*, pp. 12–13; Murray City Country Coast GP Training, *Submission 154*, p. 4; General Practice Training Queensland (GPTQ), *Submission 145*; Western Australia General Practice Education and Training (WAGPET), *Submission 26*; Mr Paul Viney, Chair, General Practice Training Tasmania (GPTT), *Proof Committee Hansard*, 24 January 2022, pp. 39–40; Dr Brendan Murphy, Secretary, DoH, Community Affairs Legislation Committee, *Proof Committee Hansard*, 16 February 2022, p. 101.

¹⁵ NTGPE, *Submission 57*; JCU, *Submission 144*, pp. 12–13; Murray City Country Coast GP Training, *Submission 154*, p. 4; GPTQ, *Submission 145*; WAGPET, *Submission 26*; Mr Paul Viney, Chair, GPTT, *Proof Committee Hansard*, 24 January 2022, pp. 39–40.

2.18 Northern Territory General Practice Education (NTGPE) submitted that 'the health needs of the NT are unique, reflecting its demographic, geographic and cultural diversity' and is concerned that the colleges will face challenges in delivering consistent and culturally appropriate training. NTGPE further noted that the transition has the potential to negatively impact health outcomes, particularly for the Aboriginal and Torres Strait Islander population.¹⁶

2.19 Similarly, Dr Tony Sherbon, Chair of GPEx, which is a currently an RTO said that:

It's not a decision that we quite understand, but nevertheless we are working with the Department of Health and the colleges to progress that decision. We are sorely disappointed in progress. We can't see and we don't feel involved in the process. We've asked for plans and documentation that have not been provided by the colleges. We don't criticise the college or the department, but it is a complex transition process and it is delayed. As you heard from my earlier report, this not only affects the trainees and supervisors but also affects the workforce. If we don't have a smooth transition, we will affect the rural GP workforce, so it's essential that that transition is not only effected in name but is also efficient and that trainees experience a good transition process.¹⁷

2.20 General Practice Training Tasmania (GPTT) believe that the transition should be paused due to the COVID-19 pandemic. GPTT expressed concerned that proceeding with the current transition timetable will damage the GP training program and reduce the number of candidates.¹⁸

2.21 Similarly, Associate Professor Catrina Felton-Busch, Director, Murtupuni Centre for Rural and Remote Health, James Cook University, told the committee:

We want to point out that the current RTO AGPT delivery system works. Our concern is that there appears to been no clear reason for this major structural reform, and without this there can be no clear way of determining its success in creating a better system. The transition process highlights to us that there is no clear understanding within either the department or the colleges about what RTOs have been doing for the past 20 years. We're also concerned that there is no avenue to transfer our insights, knowledge and experience to the new system. When RTOs have raised concerns about potential problems, we've been accused of obstructing the transition. Our involvement in the transition process has been restricted to a bureaucratic level in answering questions on forms. We

¹⁶ NTGPE, *Submission 57*, pp. 2–3.

¹⁷ Dr Tony Sherbon, Chair, GPEx, *Proof Committee Hansard*, 1 March 2022, p. 2.

¹⁸ Mr Paul Viney, Chair, GPTT, *Proof Committee Hansard*, 24 January 2022, pp. 39–40.

have one RTO representative who has observer status on the transition committee, and that observer is not allowed to speak.¹⁹

- 2.22 The Department of Health (the Department) told the committee that transition agreements have been negotiated with the RTOs and that the RTOs are due to submit their transition outplans by 31 March 2022, which will finalise the handover of operations of the AGPT to the RACGP and ACRRM and the grant agreements with the Department. It also noted that the transition has already been deferred by one year.²⁰

Geographic classification systems

- 2.23 As discussed in Chapter 1, the Department of Health uses the Modified Monash Model (MMM) to classify areas on a scale from metropolitan (MM1) to very remote (MM7) and aims to distribute GPs to areas of need through the Distribution Priority Area (DPA) system. This section will discuss the issues raised regarding these two systems.

Modified Monash Model

- 2.24 Inquiry participants were broadly supportive of the use of the MMM, however, concerns were raised that the model continues to be a blunt tool and fails to adequately distinguish and understand local needs, community disadvantage and the real time availability of primary care services.²¹
- 2.25 For example, Dr Iannuzzi said:
- ... I think it's a fairer ranking of the towns ... I personally would still like to see the smaller inland centres ranked even higher because we are consistently finding that those towns are struggling the most... it's a no-brainer where doctors chasing those incentives are going to go, because you can be one or two hours from Newcastle and a couple of hours from Sydney, as opposed to four or five hours from Newcastle and six hours from Sydney.²²
- 2.26 Others noted that there is an opportunity to further improve the MMM by recognising the unique circumstance of towns.²³

¹⁹ Associate Professor Catrina Felton-Busch, Director, Murtupuni Centre for Rural and Remote Health, JCU, *Proof Committee Hansard*, 17 March 2022, p. 63.

²⁰ Ms Penny Shakespeare, Deputy Secretary, Health Financing, DoH, *Proof Committee Hansard*, 7 March 2022, pp. 76–77.

²¹ See for example: Aboriginal Health Council of Western Australia, *Submission 113*; Tasmanian Government, *Submission 152*; Western Australian Department of Health, *Submission 141*; Australian College of Rural and Remote Medicine, *Submission 110*; Rural Workforce Agency Network, *Submission 50*; Central Queensland Rural Division of General Practice, *Submission 190*.

²² Dr Aniello Iannuzzi, Private capacity, *Proof Committee Hansard*, 14 December 2021, p. 13.

²³ See for example: Shire of Coolgardie, *Submission 9*; WA Primary Health Alliance and Rural Health West, *Submission 41*; National Rural Health Alliance (NRHA), *Submission 95*;

- 2.27 An example of how the MMM could achieve this was provided by Associate Professor Martin Jones, Department of Rural Health, University of South Australia. Professor Jones discussed how research on social and economic disadvantage should be used alongside the MMM system to better support individual community health care needs:

The thing about modified Monash is that it's a measure of location according to geographical remoteness and population size, but alongside that we can use something called [Socio-Economic Indexes for Areas] SEIFA, which in effect is a measure of social and economic disadvantage. We can actually work out, through sophisticated linking with other data sources such as [AHPRA].²⁴

- 2.28 Similarly, the committee was provided with examples from submitters and witnesses who did not agree with their regions' classification under the MMM.²⁵ The Northern Territory Government noted a disparity in Darwin's classification as MM2 when compared to other MM2 locations with closer proximity to a metropolitan city.²⁶
- 2.29 The Western Australian Department of Health said that they were concerned that communities in Western Australia had been given the same classification as other towns in different states, despite these communities being more remote and experiencing greater disadvantage. They noted that Wyndham is classified as 'very remote' and is 3126 km from Perth and 943 km from Darwin, whereas towns such as White Hills in New South Wales is also classified as 'very remote' and are closer to regional centres and capital cities. White Hills is 1051 km from Sydney and 287 km from Broken Hill.²⁷
- 2.30 The Department of Health notes that the MMM is a 'geographic and data-based classification system' that does not have any discretionary elements that enables the Department to change a locations' MMM classification. The categories are, however, updated after every Australian Bureau of Statistics Census, therefore every five years. The last update occurred in 2019, incorporating 2016 Census data.²⁸

Rural Doctors Association of Australia (RDAA), *Submission 109*; Logan City Council, *Submission 121*, Equilibrium Healthcare, *Submission 39*.

²⁴ Associate Professor Martin Jones, Project Director, Department of Rural Health, University of South Australia, *Proof Committee Hansard*, 1 March 2022, p. 53.

²⁵ See for example: St John WA, *Submission 18*; Equilibrium Healthcare, *Submission 39*; City of Greater Geraldton, *Submission 42*; Primary Health Network Cooperative, *Submission 46*; Dr Shamila Beattie, *Submission 135*.

²⁶ Northern Territory Government, *Submission 200*, p. 6.

²⁷ Western Australian Department of Health, *Submission 141*, p. 6.

²⁸ DoH, *Submission 38*, p. 39.

- 2.31 In the 2022-23 Budget, the Government announced that there will be a review of the MMM and an update to the GP catchment boundaries.²⁹

Distribution Priority Area

- 2.32 The DPA system is used to distribute GPs to areas where there is a shortage of GP services.³⁰ If an area is deemed a DPA, employers have access to a broader employment pool of doctors, as certain cohorts of GPs, such as overseas trained doctors and bonded medical students, are restricted to practice in DPA locations.
- 2.33 The committee heard several concerns regarding the current DPA processes. First, the DPA was criticised as a blunt tool that does not appropriately recognise local demographics.³¹ Second, the committee heard concerns about the interaction between the MMM and the DPA, and the flow-on effects from changes to a region's MMM status.³²

Demographic challenges with the DPA

- 2.34 Several submitters told the committee that the DPA does not consider key indicators that a community may be experiencing a GP shortage. For example, practices experiencing an increased demand for services, GPs with 'closed books' and not taking new patients, and community members that travel to other areas to seek help for their medical needs.³³
- 2.35 Many inquiry participants wrote to the committee outlining the reasons as to why their region should be classified as a DPA and calling for an exemption to allow them to recruit from a bigger pool of candidates, such as bonded medical students and international medical graduates.³⁴

²⁹ Department of Infrastructure, Transport, Regional Development and Communications, *Regional Ministerial Budget Statement 2022-23: A secure future for regional Australia*, 29 March 2022, p. 139.

³⁰ For information on the DPA system see Chapter 1, paragraphs 1.24–1.28.

³¹ See for example: Logan City Council, *Submission 121*; Consumers Health Forum, *Submission 49*; WALGA, *Submission 21*; Primary Health Network Cooperative, *Submission 46*; Civic Park Medical Centre *Submission 27*; WA Primary Health Alliance and Rural Health West, *Submission 41*.

³² See for example: Central Coast Community Women's Health Centre, *Submission 24*; Civic Park Medical Centre, *Submission 27*; Equilibrium Healthcare, *Submission 39*; Logan City Council, *Submission 121*; NRHA, *Submission 95*; Better Medical, *Submission 126*; Tamborine Mountain Medical Practice, *Submission 83*.

³³ See for example: Launceston Medical Centre, *Submission 99*; Shire of Coolgardie, *Submission 9*; WA Primary Health Alliance and Rural Health West, *Submission 41*; Northern Eyre Peninsula Health Alliance, *Submission 48*; Civic Park Medical Centre, *Submission 27*; Brisbane North Primary Health Network, *Submission 77*; Dr Philip Ewart, *Submission 132*.

³⁴ See for example: Royal Far West, *Submission 129*; Shire of Murray, *Submission 2*; Caboolture Super Clinic, *Submission 138*; Francis Family Doctors, *Submission 124*; Central Coast Skin Cancer Clinic, *Submission 1*; Dr Shamila Beattie, *Submission 135*; Dr Rohana Wanasinghe, *Submission 178*;

2.36 For example, Shoalhaven Family Medical Centers shared:

We believe that there are significant issues with how DPA catchment areas are currently classified. There is a total lack of transparency in the whole process. DPA is calculated by comparing the actual level of GP services provided to a GP catchment with the level of services the same community should receive if they were receiving benchmark level GP Services. Has anyone in the DOH thought that perhaps the benchmark has been set incorrectly or that the whole algorithm used to decide our fate is broken and collecting bad data giving bad decisions.³⁵

2.37 In September 2021, the Department of Health introduced an exceptional circumstances review process that enables practices to apply to have their catchment's DPA status changed.³⁶

2.38 The committee heard from numerous inquiry participants that they were losing GPs due to a change in their DPA status and subsequently experiencing a shortage of doctors and recruitment difficulties. They further told the committee that they were still awaiting an outcome from their exceptional circumstances review.³⁷

2.39 Since the introduction of the DPA exceptional circumstances review process, the number of outer-metropolitan MM1 catchments classified as a DPA location has increased.

2.40 The Department of Health notes that there is a backlog of applications waiting to be assessed.³⁸ As at 7 March 2022, the Distribution Working Group had received over 160 applications from practices across more than 80 catchments. Of these, 30 have been granted DPA status.³⁹

Civic Park Medical Centre, *Submission 27*; Equilibrium Healthcare, *Submission 39*; Better Medical, *Submission 126*.

³⁵ Shoalhaven Family Medical Centers, *Submission 98*, p. 2.

³⁶ Ms Louise Clarke, Assistant Secretary, Rural Access Branch, DoH, *Proof Committee Hansard*, 7 March 2022, pp. 71-71.

³⁷ See for example: Dr Brad Cranney, Practice Principal, Toukley Family Practice, Warnervale GP Superclinic, Tuggerah Medical Centre and Mariners Medical *Proof Committee Hansard*, 14 December 2021, p. 5; Ms Tegan Whatley, Practice Manager, Langwarrin Medical Clinic, *Proof Committee Hansard*, 7 March 2022, p. 4; Ms Robyn Moore, Board Chair, Central Coast Community Women's Health Centre, *Proof Committee Hansard*, 14 December 2021, p. 17; Ms Mandy Williams, Practice Manager, Hall Road Medical Centre, *Proof Committee Hansard*, 7 March 2022, p. 14; Mr Andrew Cohen, Chief Executive Officer, ForHealth, *Proof Committee Hansard*, 7 March 2022, p. 21; Dr Carolyn Roesler, Regional Clinical Director, South Australia, ForHealth, *Proof Committee Hansard*, 7 March 2022, p. 25; Mrs Martina Stanley, Director, Alecto Australia, *Proof Committee Hansard*, 7 March 2022, p. 47

³⁸ DoH, *Distribution Working Group*, 23 February 2022, <https://www.health.gov.au/committees-and-groups/distribution-working-group> (accessed 7 February 2022).

³⁹ Ms Louise Clarke, Assistant Secretary, Rural Access Branch, DoH, *Proof Committee Hansard*, 7 March 2022, pp. 71-71.

- 2.41 As at 29 March 2022, the Department of Health notes that there are currently more than 50 GP catchment areas under review.⁴⁰

DPA reliance on MMM

- 2.42 As noted above, the DPA and MMM systems work together. For example, inner-metropolitan MM1 areas are immediately classified as non-DPA.
- 2.43 In relation to how the MMM works in conjunction with the DPA, the Western Australian Department of Health submitted that localities such as Mandurah and Pinjarra are considered areas outside of Perth's border. However, these locations had their MM classification changed from a regional centre (MM2) to a metropolitan area (MM1) resulting in overseas trained doctors not being able to work in these areas, as MM1 areas are automatically deemed non-DPA.⁴¹
- 2.44 Moreover, outer-metropolitan communities reported to the committee that their non-DPA classification has caused a shortage of GPs, as existing medical practices are unable to service these growing populations and face challenges attracting GPs.⁴² Mr Andrew Cohen, Chief Executive Officer, ForHealth, commented on the effect of losing DPA in low socioeconomic areas:

There is greater need in many of the lowest socioeconomic areas in outer metropolitan cities with mass populations. These areas were previously part of the DPA system, which was previously [District of Workforce Shortage]. That allowed them to take international doctors, but they've been systematically removed from the DPA system, really, since 2017. The result in these locations is acute shortages and losses of GPs, a 30 per cent drop in after-hours services, extreme wait times in our centres—often of three to four hours—and very distressed local emergency departments, where the number of category four and five cases is growing literally 30 to 40 per cent year on year.⁴³

- 2.45 This issue was also raised by Aboriginal Community Controlled Health Organisations (ACCHOs) in New South Wales where outer-metropolitan locations have been reclassified as MM1 and immediately lost their DPA status

⁴⁰ DoH, *Request a review of a DPA classification*, 17 January 2022, <https://www.health.gov.au/health-topics/rural-health-workforce/classifications/dpa/request-review#:~:text=under%20certain%20programs,-.Exceptional%20circumstances%20reviews,the%20next%20scheduled%20DPA%20review> (accessed 29 March 2022).

⁴¹ Western Australian Department of Health, *Submission 141*, p. 6.

⁴² See for example: Tamborine Mountain Medical Practice, *Submission 83*; Logan City Council, *Submission 121*; Shoalhaven Family Medical Centers, *Submission 98*; Shire of Murray, *Submission 2*; Civic Park Medical Centre, *Submission 27*; WA Primary Health Alliance and Rural Health West, *Submission 41*.

⁴³ Mr Andrew Cohen, Chief Executive Officer, ForHealth, *Proof Committee Hansard*, 7 March 2022, p. 21.

as a result. For example, the Aboriginal Health and Medical Research Council NSW submitted that the current DPA classification system ignores the socioeconomic disadvantage where outer-metropolitan ACCHOs operate, and as a result, these areas are experiencing significant workforce shortages.⁴⁴

- 2.46 Several inquiry participants also raised concerns regarding the 'blanket' nature of DPA status. This refers to areas being either DPA or non-DPA and issues around how this system can effectively balance GPs between outer-metropolitan, regional, and rural locations.⁴⁵
- 2.47 For example, the majority of South Australia is MM5–7 and automatically a DPA. This means that areas experiencing a critical GP shortage are hidden within a singular, far too broad classification.⁴⁶
- 2.48 Similarly, Chinchilla, a small rural community (MM4) in Queensland, has a population of just under 6000 people. It is serviced by two pharmacies, one general practice, a hospital, and a visiting Indigenous health service (3 days each month). The medical practice does not bulk-bill, and currently has five doctors. The hospital has an emergency department which has 1.2 FTE doctors. Despite being in a DPA, Chinchilla Community Centre reported that recruitment of a GP can take over 12 months.⁴⁷

Policies aimed at improving the distribution of the primary health workforce

- 2.49 The Department of Health has stated that its goal is to better distribute the primary health care workforce.⁴⁸ It has a range of policies designed to support, attract, and retain primary health professionals in outer-metropolitan, regional, rural, and remote areas. These policies are often linked to the geographic classification and incentive payments that increase with levels of remoteness.⁴⁹
- 2.50 Dr Brendan Murphy, Secretary, Department of Health acknowledged the challenges of achieving this goal:

To achieve maximum benefit to the community, the medical workforce must be geographically well distributed and have the appropriate mix of

⁴⁴ Aboriginal Health and Medical Research Council NSW, *Submission 143*, p. 2.

⁴⁵ See for example: Northern Eyre Peninsula Health Alliance, *Submission 48*; WA Primary Health Alliance and Rural Health West, *Submission 41*; Consumers Health Forum, *Submission 49*; NRHA, *Submission 95*; Primary Health Network Cooperative, *Submission 46*.

⁴⁶ See for example, Northern Eyre Peninsula Health Alliance, *Submission 48*; Streaky Bay Medical Centre, *Submission 111*; District Council of Kimba, *Submission 137*.

⁴⁷ Chinchilla Community Centre, *Submission 80*, p. 1.

⁴⁸ DoH, *Submission 38*, p. 18; DoH, [National Medical Health Workforce Strategy 2021-2031](#), p. 2.

⁴⁹ For a discussion of these policies see Chapter 1, paragraphs 1.47–1.70.

medical specialties in each location. Currently this optimal distribution and service mix is not consistently achieved across Australia, resulting in service gaps and inefficiencies, and potentially impacting on the quality of patient care and the working life of Australia's doctors.⁵⁰

- 2.51 As noted in Chapter 1, the National Medical Workforce Strategy 2021–2031 (NMWS) acknowledges that the 'optimal' service mix is not consistently achieved across Australia. Furthermore, the NMWS does not define what the optimal distribution of Australia's medical workforce will look like nor does it set how this would be achieved. Several inquiry participants raised that the doctor numbers used by government does not reflect what frontline workers are experiencing.⁵¹
- 2.52 The following section discusses several core concerns raised regarding specific efforts to improve the composition and distribution of primary health professionals.

Stronger Rural Health Strategy

- 2.53 Inquiry participants supported the objectives of the Stronger Rural Health Strategy (SRHS); however, they raised several concerns including: a lack of consistency across programs, incentive payments being too low and not appropriately targeted to health practitioners, barriers to accessing the programs, a lack of awareness of the various incentives, and the effectiveness of the programs.⁵²
- 2.54 For example, the District Council of Kimba highlighted:
- Initiatives proposed in the Stronger Rural Health Strategy somewhat fails to meet the mark given smaller communities inability to provide the supervision some of these initiatives require. A number of these mechanisms are also long-term solutions which do not address the current and urgent needs of communities such as Kimba.⁵³
- 2.55 The committee heard that the SRHS does not address maldistribution issues and the incentives offered are insufficient to encourage GPs into areas of greatest need.⁵⁴

⁵⁰ DoH, [National Medical Health Workforce Strategy 2021-2031](#), p. 30.

⁵¹ See, for example, Mr Andrew Cohen, Chief Executive Officer, ForHealth, *Proof Committee Hansard*, 7 March 2022, p. 22.

⁵² See for example: Consumers Health Forum, *Submission 49*; Northern Eyre Peninsula Health Alliance, *Submission 48*; NRHA, *Submission 95*; RDAA, *Submission 109*; WA Primary Health Alliance and Rural Health West, *Submission 41*; Civic Park Medical Centre, *Submission 27*; Shire of Coolgardie, *Submission 9*.

⁵³ District Council of Kimba, *Submission 137*, p. 3.

⁵⁴ See for example: Francis Family Doctors, *Submission 124*; Ochre Health, *Submission 139*, Shire of Coolgardie, *Submission 9*; Civic Park Medical Centre, *Submission 27*; Wheatbelt Health Network, *Submission 40*; WALGA, *Submission 21*.

- 2.56 Submitters also noted that there is a gap in the SRHS in terms of other incentives, such as access to quality housing, that have an influence on the decision for primary health practitioners to move to regional, rural and remote areas.⁵⁵ These concerns are discussed in greater detail in Chapter 3.⁵⁶
- 2.57 The Department of Health has acknowledged the difficulty with assessing and evaluating the impact of workforce programs and initiatives.⁵⁷ The Department's Workforce Division looked at a range of statistics and found:

The incentives and policies to increase rural and remote work by GPs have not led to equitable provision of services across the country. It could be concluded that these incentives are ineffective, but it is likely that the maldistribution would be much worse if these policies were not in place. Work is needed on what other policies and quantum of incentives could redress the current imbalance.⁵⁸

Location restricted practice

- 2.58 A primary policy lever to influence the supply and distribution of primary health care professionals is to restrict where some doctors can practice. The aim being to encourage these practitioners to relocate to outer-metropolitan, regional, and rural areas.

International medical graduates

- 2.59 International medical graduates are subject to a 'ten-year moratorium' under Section 19(2) of the *Health Insurance Act 1973*. These doctors must work in a DPA to provide services eligible for Medicare rebates.
- 2.60 Several submitters raised concerns about Australia's ongoing reliance on overseas trained doctors to fill workforce shortages, particularly in rural and remote areas.⁵⁹ The committee also heard that the current use of international medical graduates is considered a short-term and unsustainable solution, with overseas trained doctors often moving away from these areas once their

⁵⁵ See for example: WALGA, *Submission 21*, p. 3. Dr Martin Kelly, Senior GP, Nganampa Health Council, *Proof Committee Hansard*, 1 March 2022, p. 7.

⁵⁶ See Chapter 3, paragraphs 3.73–3.81.

⁵⁷ DoH, [National Medical Workforce Strategy 2021-2031](#), p. 28.

⁵⁸ DoH, Workforce Division, *GP Medicare billing data – what does it say about current health workforce policy?*, December 2017, <https://hwd.health.gov.au/resources/data/gp-statistics-calendar-year-2020-commentary.pdf> (accessed 4 February 2022).

⁵⁹ See for example: Australia Medical Association (AMA), *Submission 94*, p. 7; NRHA *Submission 95*; Shire of Coolgardie, *Submission 9*; WA Primary Health Alliance and Rural Health West, *Submission 41*.

service obligations have finished, and this contributes to perpetual workforce shortages.⁶⁰

- 2.61 The committee also heard that those international medical graduates and overseas trained doctors face barriers in moving to rural areas due to lengthy and overly complex approval processes.⁶¹ This included the requirements for specific programs such as the Visas for GPs programs, where in order to recruit international medical graduates, employers must obtain a Health Workforce Certificate from a Rural Workforce Agency.
- 2.62 Several inquiry participants raised concerns about the registration process and the overly complicated supervision requirements as barriers to being able to hire these doctors to fill shortages.⁶²
- 2.63 For example, Ms Liz Hunter, Chief Executive Officer, Westgate Health Co-operative, told the committee that:

We know of at least—I could name them—two international GPs who are sitting at home right now who would come and work with us in a heartbeat, but they cannot get through the maze of the system. They just can't get through...two great female GPs sitting at home not working at all in Melbourne right now.⁶³

- 2.64 Dr Gerard Quigley told the committee that recruiting from overseas was the only option for Lower Eyre Family Practice. Moreover, the recruitment process took three years to complete from when the doctor saw the advertisement to them landing in Australia.⁶⁴
- 2.65 The committee also heard from several international medical graduates and overseas trained doctors regarding their views on the ten-year moratorium.⁶⁵ For example, Dr Shamila Beattie spoke of her experience:

⁶⁰ See for example: Ochre Health, *Submission 139*, AMA; *Submission 94*, Western Australian Department of Health, *Submission 141*; WA Primary Health Alliance and Rural Health West, *Submission 41*; Dr Michael Connellan, *Submission 34*.

⁶¹ See for example: Ms Hunter Liz, Chief Executive Officer, Westgate Health Co-operative, *Proof Committee Hansard*, 7 March 2022, p. 42. Wheatbelt Health Network, *Submission 40*; Western Australian Department of Health, *Submission 141*; St John WA, *Submission 18*; Dr Michael Connellan, *Submission 34*.

⁶² See for example: Francis Family Doctors, *Submission 124*, NRHA, *Submission 95*; Shoalhaven Family Medical Centers, *Submission 98*, WA Primary Health Alliance and Rural Health West, *Submission 41*.

⁶³ Ms Liz Hunter, Chief Executive Officer, Westgate Health Co-operative, *Proof Committee Hansard*, 7 March 2022, p. 41

⁶⁴ Dr Gerard Quigley, Principal, Lower Eyre Family Practice, *Proof Committee Hansard*, 1 March 2022, p. 15.

⁶⁵ See for example: Dr Shamila Beattie, Private capacity, *Proof Committee Hansard*, 14 December 2021, p. 6; Dr Conelio Mafohla, Founder and Working Party Group, Central Coast General Practice Association, *Proof Committee Hansard*, 14 December 2021, p. 24.

I can tell you that, if you're coming from the [United Kingdom] in particular, going rural is scary. It is not something that a lot of [United Kingdom] GPs feel comfortable with, because we're not used to that environment. We were never trained in that environment. There may be a few exceptions, but most places in the UK are not anywhere near the rural environment. There are always people around. There are always services around. Working in the bush, being so remote and cut off from other medical facilities, was never something I would have considered.⁶⁶

- 2.66 In contrast, Mr Mark Burdack, Chief Executive Officer, Rural and Remote Medical Services, told the committee of what motivated a trained doctor to stay and remain in a remote town (MM6):

I've got this wonderful doctor on staff. He's absolutely fantastic. He used to work over in Bourke. He is a fantastic doctor. I went up to him one day—it was in the middle of the drought, and we were standing there looking at a river without any water running through it—and I said, 'Why on earth are you here?' He'd been there for four years and he wanted to stay for a very long time. And I said: 'What's your driver? I need to understand this.' He said, 'Mark, when I came to Australia, I went to the cities and I was looking up all the time. It was so alien to me, because I came from a village in Egypt where I had arid landscapes, where it was hot,' and there he was. He felt comfortable; he was welcomed in that community in a way that you wouldn't get in a metropolitan area, because they genuinely wanted his services and he responded in kind by providing very high-quality care.⁶⁷

- 2.67 It was emphasised to the committee that these doctors play an important role in the provision of services in communities and it is important to ensure that when these doctors are recruited to rural areas they are supported and feel comfortable in the rural environment.⁶⁸
- 2.68 Professor Gary Rogers, Dean, School of Medicine, Deakin University spoke of how international medical students studying in Australia are more likely to work in rural areas than domestic medical students, but that international students are precluded from participating in Commonwealth funded programs such as the Rural Health Multidisciplinary Training program which is specifically designed to provide opportunities for medical students to train in rural locations.⁶⁹

⁶⁶ Dr Shamila Beattie, Private capacity, *Proof Committee Hansard*, 14 December 2021, p. 6.

⁶⁷ Mr Mark Burdack, Chief Executive Officer, Rural and Remote Medical Services (RRMS), *Proof Committee Hansard*, 14 December 2021, p. 46.

⁶⁸ See for example: Western Australian Department of Health, *Submission 141*; HR+ Tasmania, *Submission 4*; Dr Gerard Quigley, Principal, Lower Eyre Family Practice, *Proof Committee Hansard*, 1 March 2022, p. 19. Mr Dean Johnson, Mayor, District Council of Kimba, *Proof Committee Hansard*, 1 March 2022, p. 22, 24, 26.

⁶⁹ Professor Gary Rogers, Dean, School of Medicine, Deakin University, *Proof Committee Hansard*, 7 March 2022, p. 63

- 2.69 The NMWS acknowledges the benefits of self-sufficiency, and the challenge of a continued reliance on international medical graduates, particularly during a pandemic or mass health emergency. The NMWS has developed a goal for Australia to have a domestic medical workforce that is of sufficient size and capability to meet the needs of all Australian communities. However, it is important to note that it is not clear how many GPs are required to ensure national self-sufficiency.⁷⁰

Bonded medical programs

- 2.70 As mentioned in Chapter 1, bonded medical programs provide students with a Commonwealth Supported Place at an Australian university in return for a commitment to work in eligible regional, rural, and remote areas (known as the Return of Service Obligation).⁷¹
- 2.71 The committee received evidence that bonded medical programs were ineffective, have low participation rates, and are associated with lower retention after the period of service.⁷²
- 2.72 Inquiry participants also suggested that those who sign up to bonded medical programs do not intend to practice rurally and use it as a mechanism to secure a position in medical school.⁷³ For example, Rural and Remote Services submitted that:

We have funded more Bonded Medical Places (BMP) despite an independent report finding that for many BMP recipients view the program as a "low cost or interest free loan that can relatively easily be repaid once fully qualified" without a requirement to engage in the return of service obligation in a rural or remote town.⁷⁴

- 2.73 Similarly, Dr Hamish Meldrum, Co-founder, Ochre Health, said:

... but I've asked rurally bonded students questions like: 'What made you want to go rural?' and they kind of don't even understand the question. I have to repeat myself a couple of times. Then they laugh at me and say: 'No. Nobody wants to go rural. We just put down that we want to be rurally bonded students so that we can get into medical school.' They think

⁷⁰ DoH, [National Medical Health Workforce Strategy 2021-2031](#), p. 30.

⁷¹ For further information on bonded medical programs see Chapter 1, paragraphs 1.49–1.51.

⁷² See for example: NRHA, *Submission 95*, p. 10; Shoalhaven Family Medical Centers, *Submission 98*, pp. 5–6; Aboriginal Health and Medical Research Council of NSW, *Submission 143*, p. 4; Australian Medical Student Association, *Submission 151*, pp. 7–8; Dr Kenneth McCroary, *Submission 201*, p. 2; Mr Mark Burdack, Chief Executive Officer, RRMS, *Proof Committee Hansard*, 14 December 2021, pp. 45–46; Dr Hamish Meldrum, Co-founder, Ochre Health, *Proof Committee Hansard*, 24 January 2022, p. 51.

⁷³ See for example: RRMS, *Submission 118*, p. 3; Dr Hamish Meldrum, Co-founder, Ochre Health, *Proof Committee Hansard*, 24 January 2022, p. 51.

⁷⁴ RRMS, *Submission 118*, p. 3.

the question I asked them is quite hilarious: 'Why do you want to go rural?'⁷⁵

- 2.74 Reviews have been conducted into the two legacy bonded medical programs (the Medical Rural Bonded Scholarship Scheme and the Bonded Medical Places). The 2013 review of Australian government health workforce programs (Mason Review) examined both schemes in depth. It found that there was a lack of evidence that the Medical Rural Bonded Scholarship Scheme resulted in longer term positive connections to rural life and provided 'questionable utility' for a program that was expensive and administratively burdensome.⁷⁶
- 2.75 For the Bonded Medical Places scheme, the Mason Review found that as of February 2013 only one participant had commenced their return of service obligation and three participants have bought out of the scheme. It also noted that the 'Department [of Health] was not currently able to adequately monitor and report on completion of [return to service obligation] requirements while graduates are undertaking vocational training'.⁷⁷
- 2.76 A separate report conducted by KPMG in 2020 raised concerns about bonded medical programs and the quality of the data surrounding these programs. This report found that in 2017, less than one per cent of the 9976 rurally bonded students had completed their return of service obligations. Additionally, five per cent of participants had either withdrawn, breached or terminated their programs, or had deceased.⁷⁸
- 2.77 This report notes that due to the issues with the current data and studies '...little can be ascertained in terms of effectiveness for such strategies' and recommended that 'focus should be placed on selecting the student who chooses to participate in rural training as opposed to bonded pathway approaches which have demonstrated limited effectiveness on retention'.⁷⁹

⁷⁵ Dr Hamish Meldrum, Co-founder, Ochre Health, *Proof Committee Hansard*, 24 January 2022, p. 51.

⁷⁶ Jennifer Mason, *Review of Australian Government Health Workforce Programs*, April 2013, pp. 12 and 106.

⁷⁷ Jennifer Mason, *Review of Australian Government Health Workforce Programs*, April 2013, pp. 242–243.

⁷⁸ NB: In March 2020, the Department of Health engaged KPMG to undertake a review of the Rural Health Workforce Support Activity program. This program is a major source of funding for Rural Workforce Agencies. The review investigated several elements of the program and used a mixed-methods approach for its analysis. The Medical Rural Bonded Scholarship Scheme ran from 2001 to 2015 and the Bonded Medical Places Scheme ran from 2004 to 2015. A subset of that scheme ran from 2016 to 2019. See: KPMG, [Review of the Rural Health Workforce Support Activity: Department of Health Final Report, 2020](#), p. 162. Also see: Mr Pat Janek, Acting Assistant Secretary, Workforce Surge Taskforce, DoH, *Proof Committee Hansard*, 7 March 2022, p. 72.

⁷⁹ KPMG, [Review of the Rural Health Workforce Support Activity: Department of Health Final Report](#), 2020, pp. 162 and 174.

- 2.78 Further, the committee heard that there is frustration for medical practices as there is no long-term commitment when engaging a bonded student. Submitters also noted that employers are unaware of individuals on bonded programs, and they cannot directly contact bonded doctors for recruitment.⁸⁰
- 2.79 The Department of Health noted that in total (including the new Bonded Medical Program), there have been 13 521 participants, 597 participants or 4.4 per cent have completed their return-of-service obligations and 779 participants (5.7 per cent) have withdrawn from the program. There are 12 145 remaining active participants and of those 6904 (56.8 per cent) are still studying.⁸¹

Medicare rebate freeze

- 2.80 Another factor contributing to a decline in GPs is the Medicare rebate 'freeze'. The Commonwealth Government provides most of the income for general practitioners through Medicare as a fee for service payment via the Medicare Benefits Schedule (MBS).
- 2.81 A 'freeze' on increases to Medicare rebates was first introduced in the 2013-14 Budget.⁸² The freeze meant that Medicare rebates did not increase annually at an indexed rate between 2013 and 2017, which effectively resulted in GPs not receiving a pay increase for their services. The Government committed in the 2017-18 budget to a 'phased re-introduction of indexation of MBS rebates.'⁸³
- 2.82 Inquiry participants argued that while the costs to provide general practice care increase year on year, successive governments have not matched these increases in patient rebates. Several submitters noted the growing gap between the cost of providing care and the Medicare rebate has had a significant impact on general practice sustainability.⁸⁴
- 2.83 The RACGP reports the 'cumulative value of lost indexation for general practice MBS rebates is estimated to be over \$1.5 billion and growing.'⁸⁵

⁸⁰ Shoalhaven Family Medical Centers, *Submission 98*, p. 5; New South Wales Government, *Submission 193*, p. 9.

⁸¹ Mr Pat Janek, Acting Assistant Secretary, Workforce Surge Taskforce, DoH, *Proof Committee Hansard*, 7 March 2022, pp. 72-73.

⁸² DoH, *Submission 38*, p. 63-64.

⁸³ DoH, *Submission 38*, pp. 63-64.

⁸⁴ See for example: Royal Australian College of General Practitioners (RACGP), *Submission 107*, p. 6; Central Coast Community Women's Health Centre, *Submission 24*; Civic Park Medical Centre, *Submission 27*; Equilibrium Healthcare, *Submission 39*; Tamborine Mountain Medical Practice, *Submission 83*; NRHA, *Submission 95*; Francis Family Doctors, *Submission 124*; Caboolture Super Clinic, *Submission 138*; WALGA, *Submission 21*.

⁸⁵ RACGP, *Submission 107*, p. 6.

- 2.84 Inquiry participants noted the Medicare rebate 'freeze' impacted on the viability of their practices and resulted in GPs not being appropriately remunerated for their time and expertise. Further that these current conditions act as a deterrent to those wanting to enter the profession and contributed to the view that general practice is not a valued career.⁸⁶
- 2.85 An example of issues around the suitability of Medicare rebates that GPs access, was provided by Dr Jerome Muir Wilson, General Practitioner, Launceston Medical Centre:
- For a 19-minute consult with me, you get paid \$39. For a 19-minute consult with a kidney specialist, Medicare pays \$110 for their first appointment. So we're already behind. I think it's got to come back to the fundamental Medicare schedule. Ninety per cent of what we do is a level 3. That could go up and go up incrementally with rural areas. If we're oversubscribed in the capital cities, that could stay where it is, but we could heavily go up in the rural areas. That's the one thing that I think we need to do. It's not just unfreezing for seven years or five years or going up by [Consumer Price Index]. It's a substantial increase.⁸⁷
- 2.86 Witnesses told the committee that the Australian Medical Association (AMA) provides suggested fees for services and that the Medicare rebate has failed to keep up with the expectations of the medical community and stated that general practitioners should charge over \$80 for a standard level B consult, whereas the Medicare rebate is \$39.10.⁸⁸
- 2.87 Submitters and witnesses suggested that the Medicare rebates would need to be doubled or tripled to have any substantial impact on GP income. It was also

⁸⁶ See for example: Dr Johannes Schonborn, General Practitioner and Director, Deloraine and Westbury Medical Centre, *Proof Committee Hansard*, 24 January 2022, p. 12; Professor Neil Spike AM, Director of Medical Education and Training, Eastern Victoria General Practice Training, *Proof Committee Hansard*, 24 January 2022, p. 54; Dr Amanda Bethell, *Proof Committee Hansard*, 1 March 2022, p. 34; NSW Rural Doctors Association, *Submission 109*, p. 5; NRHA, *Submission 95*, p. 16; Australian Federation of Medical Women, *Submission 96*, pp. 5–6; Tristar Medical Group, *Submission 97*, p. 3; RDAA, *Submission 109*, p. 9; Hunter New England and Central Coast Primary Health Network, *Submission 192*, p. 9; Ms Caroline Radowski, Network Director, Clinical and Practice Excellence, Cohealth, *Proof Committee Hansard*, 7 March 2022, p. 3; Professor Lena Sanci, Chair, General Practice and Head, Department of General Practice, University of Melbourne, *Proof Committee Hansard*, 7 March 2022, p. 57; Professor Danielle Mazza, Head, Department of General Practice, Monash University, *Proof Committee Hansard*, 7 March 2022, p. 61.

⁸⁷ Dr Jerome Muir Wilson, General Practitioner, Launceston Medical Centre, *Proof Committee Hansard*, 24 January 2022, p. 11.

⁸⁸ Dr Aniello Iannuzzi, Private capacity, *Proof Committee Hansard*, 14 December 2021, p. 13; Dr Muir Wilson, General Practitioner, Launceston Medical Centre, *Proof Committee Hansard*, 24 January 2022, p. 14

suggested that if pay rates were to be used as a recruitment strategy, an 80 per cent increase in GP income would be required.⁸⁹

2.88 Submitters also commented on the Rural Bulk Billing Incentive (rBBi) which provides an increased level of Medicare funding in line with the increased level of remoteness according to MMM category and is designed to incentivise practitioners to work in MM2–7 locations.⁹⁰

2.89 The committee received evidence that the rBBi is not adequate to cover practice costs. As explained by Dr Aniello Iannuzzi:

... It sounds really great when you say '190 per cent' or '160 per cent', but we're talking about 190 per cent of \$6—big whoop! That's not going to make any difference at all to running a business—sorry. If you were going to apply that 190 per cent to the \$39 rebate, maybe we would be getting somewhere.⁹¹

2.90 The Department of Health said that the scaling of the rBBi is designed to better recognise the higher costs, smaller patient populations, increased complexity in patient care and the greater burden of responsibility that rural and remote doctors face in those communities.⁹²

2.91 In discussing the current Medicare rebate statistics and the issue of GP income generally, Ms Penny Shakespeare, Deputy Secretary, Health Financing, Department of Health, said:

... Medicare statistics at a global level show increasing government investment in GP non-referred attendances. There has been a five per cent increase in benefits paid for GP services just in the last year. Tax office data shows that GPs are routinely amongst the top 10 occupations by average taxable income. There don't seem to be too many indicators that GPs are not able to derive income from Medicare.⁹³

2.92 Despite the view of the Department of Health, the committee heard that the Medicare rebates are still too low, even with the resumption of indexation. Inquiry participants told the committee that many practices are closing due to financial pressures.⁹⁴

⁸⁹ See for example: Dr Aniello Iannuzzi, Private capacity, *Proof Committee Hansard*, 14 December 2021, p. 13; Ms Robyn Moore, Board Chair, Central Coast Community Women's Health Centre, *Proof Committee Hansard*, 14 December 2021, p. 18; Professor Lucie Walters, Director, Adelaide Rural Clinical School, University of Adelaide, *Proof Committee Hansard*, 1 March 2022, p. 55.

⁹⁰ For further information on the rBBi see Chapter 1, paragraphs 1.60–1.61.

⁹¹ Dr Aniello Iannuzzi, Private capacity, *Proof Committee Hansard*, 14 December 2021, p. 15.

⁹² DoH, *Submission 38*, p. 96.

⁹³ Ms Penny Shakespeare Deputy Secretary, Health Financing, DoH, *Proof Committee Hansard*, 7 March 2022, p. 76.

⁹⁴ See for example: Dr Ewan McPhee, Private Capacity, *Proof Committee Hansard*, 17 March 2022, pp. 5-7; Ms Caroline Radowski, Network Director, Clinical and Practice Excellence, Co-Health,

Committee view

- 2.93 The committee recognises that the distribution of primary health professionals throughout Australia is a long standing and complex issue; however, it is not appropriate that Australians living in outer-metropolitan, regional, and rural areas are suffering the consequences of this maldistribution.
- 2.94 The committee supports the Government's objective to improve the distribution of the primary health workforce beyond metropolitan areas and notes that a significant amount of funding provided, and the programs have been developed to address maldistribution. However, the committee is concerned that these policies are failing to assist communities with an immediate need for primary health care workers.

Division of responsibility

- 2.95 The committee recognises that the responsibility for health care is multi-jurisdictional. However, it is clear to the committee that the current division between federal, state and territory governments is failing to recognise and meet the needs of communities. Inquiry participants noted that neither the federal or the state governments have taken proper responsibility for the provision of GPs and other primary health professionals.
- 2.96 The committee was overwhelmed by the evidence received from local councils about the work they are undertaking to ensure their communities have access to basic health services. It commends these councils for their dedication and tireless work to improve the health outcomes of their communities.
- 2.97 The committee is gravely concerned that local councils have been left to fill the gaps caused by a lack of federal and state responsibility to provide primary health services. Local councils should not have to fundraise or impose rate increases on their communities to support these services.

Recommendation 1

- 2.98 The committee recommends that the Federal Government further investigates the provision and distribution of general practitioners in rural and regional Australia.**

Proof Committee Hansard, 7 March 2022, p. 3; Dr Marco Giuseppin, Chair, AMA Council of Rural Doctors, *Proof Committee Hansard*, 17 March 2022, p. 19; Professor Lena Sanci, Chair of General Practice, Melbourne Medical School, University of Melbourne, *Proof Committee Hansard*, 7 March 2022, p. 57; Mrs Claudine Restom, Member, Central Coast General Practice Association, *Proof Committee Hansard*, 14 December 2021, p. 26; Dr Iannuzzi, Private Capacity, *Proof Committee Hansard*, 14 December 2021, p. 9; Ms Jillian Power, Practice Manager, Central Coast Skin Cancer Clinic, *Proof Committee Hansard*, 14 December 2021, p. 29; Associate Professor John Kramer OAM, Board Chair, NSW Rural Doctors Network, *Proof Committee Hansard*, 14 December 2021, p. 51.

Classification systems

- 2.99 The committee notes that the MMM is broadly supported by inquiry participants and that the work of the Department of Health in developing the DPA system is a step in the right direction to better distribute GPs to non-metropolitan areas.
- 2.100 Although the committee notes that the DPA calculation takes into consideration the gender and age demographics, and the socio-economic status of patients living in an area, the committee remains concerned **that the models are a blunt instrument**. The committee is of the preliminary view that these systems require more sophisticated elements to determine a region's level of need.
- 2.101 The committee notes that in the 2022-23 Budget, the Government announced that there will be a review of the MMM. The committee recommends that this review take into consideration other demographic factors and that the review is open to the public for consultation.

Recommendation 2

- 2.102 **The committee recommends that the Government's review of the Modified Monash Model is open to public consultation, including from communities themselves, and is progressed as a matter of priority.**
- 2.103 The committee acknowledges the development of the exceptional circumstances review process for DPA status determinations; however, the committee highlights that this process was only established in September 2021 despite many communities seeking access to location restricted medical practitioners prior to this time.
- 2.104 Further, it is concerning that there is a significant backlog of applications that have yet to be assessed. As the outcomes of these reviews will determine if communities can recruit GPs from a greater pool of applicants to fill critical workforce shortages it is imperative that the Department of Health and the Distribution Working Group clear the backlog of applications.

Recommendation 3

- 2.105 **The committee recommends that the Department of Health and the Distribution Working Group assess the outstanding exceptional circumstances review applications as a matter of priority.**

The transition to college-led training

- 2.106 The committee supports the rationale for the transition to college-led training; however, it is concerned that there has been a lack of communication between the Department of Health, RACGP, ACRRM and the RTOs. The committee shares the concerns of inquiry participants that successful RTOs will close, and

that knowledge of unique educational and training needs of regional, rural and remote communities will be lost.

- 2.107 The committee highlights the risk that if the transition is poorly managed this could have the potential for less medical graduates to pursue a career as a GP.
- 2.108 The committee is greatly concerned that the transition is not being appropriately communicated to key stakeholders and is at risk of being mismanaged. It is vital that the Department of Health clarify what is happening with the transition.
- 2.109 The committee recognises that there is an advisory committee for the transition to college-led training, however, it is deeply concerned to hear that the RTOs do not feel involved in the process and that their views are not being heard. The committee urges the Department of Health to listen to the concerns of RTOs and fully engage with the RTOs to ensure a smooth transition occurs.

Policy effectiveness

- 2.110 The committee is also concerned about the effectiveness of the Government's current programs, including those under the Stronger Rural Health Strategy.
- 2.111 The committee is troubled that there appears to be no standardised national benchmarks for the 'optimal' level of distribution of primary health professionals. It is unclear how the success of programs can be measured without clear benchmarks. These benchmarks should take into account an area's socioeconomic status, alongside other demographic factors.

Recommendation 4

- 2.112 The committee recommends that the Department of Health develops benchmarks for the optimal distribution of primary health professionals.**
- 2.113 The committee also observes that the programs under the SRHS appeared siloed and fail to work with one another. While reviews of programs within the strategy have been conducted, a review of the whole strategy has not occurred.

Recommendation 5

- 2.114 The committee recommends that the Department of Health conducts a comprehensive and wholistic review of the Stronger Rural Health Strategy and that performance benchmarks be established to assess the effectiveness of the overall strategy and of its programs.**

Location restricted practice

- 2.115 The committee is concerned about the use of international medical graduates and bonded medical students as a mechanism to fill workforce shortages in non-metropolitan areas. The committee echoes the views of inquiry participants that this is a short-term solution to a long-term problem.
- 2.116 The committee recognises the crucial work of international medical graduates in providing health services to Australians. However, the committee is worried about successive governments' ongoing reliance on international medical graduates to fill shortages in non-metropolitan areas. The committee considers having an agreed definition of national self-sufficiency will be a key part of any plan to transition away from a reliance on international medical graduates.
- 2.117 The committee also received overwhelming evidence which showed that bonded medical programs do not achieve their purported goals and that only a small proportion of bonded medical graduates complete their return of service obligation.
- 2.118 The committee is of the preliminary view that bonded medical programs are ineffective and should cease taking new applicants.

Medicare rebate freeze

- 2.119 The committee is deeply concerned to hear the current wage structure and remuneration for GPs does not recognise their skill and expertise, nor provide appropriate remuneration for their services.
- 2.120 The committee considers the current rate of Medicare as a disincentive for those considering a career as a GP.
- 2.121 The committee notes that the Government's decision to now allow for indexation on Medicare rebates will not address the now deeply entrenched financial problems facing providers of primary health services. The issues related to the viability of practices appear to be exacerbated in non-metropolitan areas.
- 2.122 The committee supports the use of location-based incentive payments, such as the rBBi, as recognition that GPs operating in non-metropolitan areas experience difficulties in service viability due to the small population size in these communities. However, the scaled rates do not appropriately compensate existing regional, rural and remote GPs nor encourage GPs to move to and practice in these areas.

Recommendation 6

- 2.123 The committee recommends that the Federal Government investigates substantially increasing the Medicare rebates for all levels of general practice consultations, as well as other general practice funding options.**

Chapter 3

Why would you decide to be a GP?

There is a definite crisis in general practice at the moment in Australia. Fewer and fewer young doctors are choosing general practice as a career. There is increasing demand on general practitioners in the role. There is increasing demands on them in the government's expectation and in red tape. As a result, doctors are making the choice not to become general practitioners. Those of us who are general practitioners are finding that the numbers do not add up. The business model is failing, especially if that business model is centred on bulk billing. Whilst well-intentioned, a lot of the schemes that we see that are meant to help general practice in fact just create more red tape and more confusion. Sadly, they are creating a disincentive instead of an incentive.¹

- 3.1 Medical students are increasingly expressing interest in careers in non-general practice specialisations and sub-speciality practice.² The number of medical students expressing an interest in a career in general practice upon graduation has declined from 17.8 per cent in 2015 to 15.2 per cent in 2019, and the committee heard that this decreased from around 50 per cent over the past 30 years.³
- 3.2 Throughout this inquiry the committee received evidence on the factors which influence career choice, in terms of deciding whether to become a general practitioner (GP) or other medical specialisation, and whether to practice in a metropolitan or non-metropolitan area.
- 3.3 This chapter discusses the key issues raised with medical education programs and training pathways, as well as other factors that influence the decision to become a GP and live and work in non-metropolitan areas.

Prevocational medical education and training

- 3.4 This section focusses on the 'prevocational' aspects of medical education and training. This refers to the time an individual spends at university as a medical student and following graduation the time spent training as an intern and resident. It discusses the following issues in relation to prevocational medical education and training:

- the availability of Commonwealth Supported Places (CSPs);

¹ Dr Aniello Iannuzzi, Private capacity, *Proof Committee Hansard*, 14 December 2021, p. 9.

² Department of Health (DoH), *Submission 38*, p. 31.

³ DoH, *Submission 38*, p. 31; Dr Brad Cranney, Practice Principal, Toukley Family Practice, Warnervale GP Superclinic, Tuggerah Medical Centre and Mariners Medical, *Proof Committee Hansard*, 14 December 2021, p. 2.

- the nature of the current prevocational medical education and training system; and
- the lack of exposure to non-metropolitan clinical experience and general practice.

Commonwealth Supported Places

- 3.5 Medical students are generally accepted into university on a CSP. CSPs for university medical school places have fluctuated over the years.⁴ In 2009 the Commonwealth Government commenced removing the caps on the number of university places and from 2012 provided a place for every domestic bachelor student. However, caps were retained for medical degrees.⁵
- 3.6 The current caps are set through agreements between the Commonwealth and universities through the 'Commonwealth Grant Scheme'. For 2022 there are 13 516 CSPs for medical programs at the undergraduate and postgraduate level. This is expected to rise slightly to 13 556 CSPs in 2023.⁶
- 3.7 In relation to other primary health fields, such as nursing, midwifery, pharmacy and allied health professions, universities can choose how many CSPs they offer within their Commonwealth Grant Scheme funding.⁷
- 3.8 The committee received mixed opinions regarding whether the current number of CSPs for medical degrees was sufficient. Some inquiry participants suggested that substantial increases in the number of medical graduates are required to ensure the future workforce, whereas others did not think that increasing the number of places available would solve the problem.⁸

⁴ Cornerstone Health, *Submission 6: Attachment A*, p. 4; DoH, *Review of Australian Government Health Workforce Programs*, p. 388; Dr Rhonda Jolly, *Medical practitioners: education and training in Australia*, Australian Parliamentary Library Research Paper, 15 July 2009, https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/BN/~link.aspx?id=4FB58821DB2B49F58743E7802D1C4ED3&z=z (accessed 21 February 2022).

⁵ Medical degrees are the only degree which have caps on the number of CSPs, however; there are several circumstances which can lead to caps on CSPs for other degrees and higher education providers as set out under the *Higher Education Support Act* 2003. See: Dr Rhonda Jolly, *Medical practitioners: education and training in Australia*, Australian Parliamentary Library Research Paper, 15 July 2009, https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/BN/~link.aspx?id=4FB58821DB2B49F58743E7802D1C4ED3&z=z (accessed 21 February 2022).

⁶ See: Department of Education, Skills and Employment, *Higher education providers' 2021-2023 funding agreements*, <https://www.dese.gov.au/collections/higher-education-providers-2021-2023-funding-agreements> (accessed 21 February 2022).

⁷ DoH, *Submission 38*, p. 11.

⁸ See for example: University of Queensland, *Submission 149*, p. 2; James Cook University (JCU), *Submission 146*, p. 2; Dr Philip Tideman, Vice President Rural Doctors Association of South

- 3.9 The Department of Health stated that the problem is not the number of medical students, but the decreasing number of students picking general practice.⁹ The Department of Health also clarified that the Government's goal is to have 50 per cent of domestic medical graduates become a GP.¹⁰
- 3.10 The Department of Education, Skills and Employment (DESE) explained that the Government regulates CSPs in medicine to manage clinical training capacity, projected workforce requirements, and the impact on the health and education budgets. DESE further said that the Government is projecting a national oversupply of 7000 doctors by 2030.¹¹
- 3.11 While this figure relates to the total number of doctors, it is not broken down by medical speciality. For example, it does not state how many of those doctors are predicted to be GPs.

An education and training system focused on other specialisations

- 3.12 Inquiry participants informed the committee that the current medical education and training system is dominated by non-GP specialists, and that clinical exposure predominantly occurs in secondary or tertiary care settings such as hospitals.¹²
- 3.13 The committee heard that most lecturers in medical school are non-GP specialists and that jurisdictional issues arise both in the employment of GP

Australia, *Proof Committee Hansard*, 1 March 2022, p. 41; Australian Medical Association (AMA), *Submission 94*, p. 2; Professor Lucie Walters, Director, Adelaide Rural Clinical School, University of Adelaide, *Proof Committee Hansard*, 1 March 2022, p. 54; Professor Robyn Aitken, Dean, Rural and Remote Health SA, College of Medicine and Public Health, Flinders University, *Proof Committee Hansard*, 1 March 2022, p. 54; Professor Danielle Mazza, Head, Department of General Practice, Monash University, *Proof Committee Hansard*, 7 March 2022, pp. 60–61; Professor Stephen Trumble, Head of Medical Education, University of Melbourne, *Proof Committee Hansard*, 7 March 2022, p. 61; Professor Gary Rodgers, Dean, School of Medicine, Deakin University, *Proof Committee Hansard*, 7 March 2022, p. 61; Flinders University, *Submission 217*, pp. 6–7; Professor Michelle Bellingan, Dean, School of Health, Medical and Applied Sciences, Central Queensland University, *Proof Committee Hansard*, 17 March 2022, p. 59.

⁹ Dr Brendan Murphy, Secretary, DoH, *Proof Committee Hansard*, 7 March 2022, p. 74.

¹⁰ Dr Brendan Murphy, Secretary, DoH, *Proof Committee Hansard*, 7 March 2022, p. 74.

¹¹ Department of Education, Skills and Employment, answers to written questions on notice, 15 March 2022 (received 21 March 2022).

¹² See for example: Dr Michael Connellan, *Submission 34*, p. 5; Medical Deans Australia and New Zealand (MDANZ), *Submission 79*, p. 8; JCU, *Submission 146*, p. 9; University of Queensland, *Submission 149*, p. 2; Australian Medical Students Association, *Submission 151*, p. 3; Professor Lucie Walters, Director, Adelaide Rural Clinical School, University of Adelaide, *Proof Committee Hansard*, 1 March 2022, p. 55.

specialist training lecturers, as well as the clinical experiences medical graduates receive in a hospital setting.¹³

- 3.14 Dr Toby Gardner, Lecturer in General Practice and Community Care, Tasmania School of Medicine, University of Tasmania, explained that:

The thing about GP teachers in universities is that they're all funded by the universities. All the universities are aligned to a hospital, and all the specialists are paid by the state government to work and do lectures and sell their profession to the students. If the universities are the ones having to cough up the salary of the GP, even though it's not much, they tend not to want to do it. So there are not a lot of GPs in universities, working in academic or influential positions.¹⁴

- 3.15 Professor Lena Sanci, Chair, General Practice and Head, Department of General Practice, University of Melbourne, told the committee that there is a 'crisis of general practice leadership' and that nationally there are approximately seven professors of general practice that have retired and have not been replaced with junior staff.¹⁵

- 3.16 Submitters and witnesses stated that while hospital-based training is important, the dominance of metropolitan based hospital training and the lack of exposure to general practice and community-based care in the early stages of study and professional life can act as a deterrent for choosing a career as a GP.¹⁶

- 3.17 For example, Medical Deans Australia and New Zealand submitted that:

Medical students and prevocational trainees need to be learning in all the environments where health care is provided, and be able to envisage a rewarding and fulfilling career in community-based practice. Longitudinal and well-supported clinical experiences in non-hospital environments

¹³ See for example: Professor Nel Spike AM, Director of Medical Education and Training, Eastern Victoria General Practice Training, *Proof Committee Hansard*, 24 January 2022, p. 55; Dr Ruth Stewart, National Rural Health Commissioner, *Proof Committee Hansard*, 4 November 2021, p. 4.

¹⁴ Dr Toby Gardner, Lecturer in General Practice and Community Care, Tasmania School of Medicine, University of Tasmania, *Proof Committee Hansard*, 24 January 2022, p. 56.

¹⁵ Professor Lena Sanci, Chair, General Practice and Head, Department of General Practice, University of Melbourne, *Proof Committee Hansard*, 7 March 2022, p. 61.

¹⁶ See for example: Dr Hamish Meldrum, Co-founder, Ochre Health, *Proof Committee Hansard*, 24 January 2022, p. 47; GP Synergy, *Submission 72*, pp. 4–5; MDANZ *Submission 79*, p. 3; Australian Medical Student Association, *Submission 151*, pp. 3–4; Western Australia General Practice Education and Training, *Submission 26*, p. 85; WA Primary Health Alliance and Rural Health West, *Submission 41*, p. 16; Rural Workforce Agency Network, *Submission 50*, p. 4; Australian GP Alliance, *Submission 73*, p. 2; National Rural Health Alliance, *Submission 95*, p. 5; Royal Australian College of General Practitioners (RACGP), *Submission 107* p. 3; RDAA, *Submission 109*, p. 5; Professor Michelle Leech, Deputy Dean (Medicine), Health Faculty, Monash University, *Proof Committee Hansard*, 7 March 2022, p. 56.

allow students and prevocational trainees to apply and further develop their skills in a range of settings with a diverse patient mix, particularly as these are the settings where we need more doctors to be working. It also provides access to positive role models for students and trainees to aspire to. Put simply, you cannot be what you cannot see.¹⁷

3.18 Professor Lucie Walters, Director, Adelaide Rural Clinical School, stated that in Australia, medical students could experience as little as two to six weeks of general practice training, whereas in other countries where general practice is required as a part of the internship period, almost 50 per cent of graduates are choosing general practice as a career.¹⁸

3.19 Professor Michelle Leech, Deputy Dean of Medicine, Health Faculty, Monash University, also spoke to the committee about the influence hospital training has over student's specialisation choice:

I speak all the time to medical students in years 1, 2, 3 and 4, who say, 'I want to be a GP.' They really do. They love their GP term. But then it gets '[hospitalised]' out of them, to be completely honest with you. What happens is they then start to be what they see.¹⁹

3.20 These inquiry participants were supportive of increasing the opportunities for medical students and prevocational trainees to gain exposure to general practice but emphasised that these experiences need to be a positive well-support placement to encourage more people into the profession.

3.21 Several inquiry participants also noted that it is common for university students and prevocational trainees to be sent to busy or 'churn and burn' general practice clinics where the student has a negative experience as they are unable to fully experience general practice, or the student is seen as a burden to the clinician. The committee heard that this can turn people away from a career in general practice.²⁰

¹⁷ Medical Deans Australia and New Zealand (MDANZ), *Submission 79*, p. 3.

¹⁸ Professor Lucie Walters, Director, Adelaide Rural Clinical School, *Proof Committee Hansard*, 1 March 2022, p. 55.

¹⁹ Professor Michelle Leech, Deputy Dean of Medicine, Health Faculty, Monash University, *Proof Committee Hansard*, 7 March 2022, p. 59.

²⁰ See for example: Professor Jeanette Ward, *Submission 29*, p. 2; Australian College of Rural and Remote Medicine (ACRRM), *Submission 110*, p. 4; Australian Medical Students Association, *Submission 151*, p. 3; Dr Michael Clements, Rural Chair, RACGP, *Proof Committee Hansard*, 4 November 2021, p. 8; Dr Ruth Stewart, National Rural Health Commissioner, *Proof Committee Hansard*, 4 November 2021, p. 43; Dr Emil Djakic, *Proof Committee Hansard*, 24 January 2022, pp. 2–3; Professor Nel Spike AM, Director of Medical Education and Training, Eastern Victoria General Practice Training, *Proof Committee Hansard*, 24 January 2022, p. 55.

Outer-metropolitan, regional, and rural exposure

- 3.22 In addition to exposure to general practice, submitters and witnesses emphasised the need to increase the opportunities for medical students and prevocational trainees to gain experience of clinical settings in outer-metropolitan, regional, and rural areas. They also raised concerns that these early experiences needed to be positive and well supported.
- 3.23 There is strong evidence which shows that junior doctors from regional and rural backgrounds are more likely to work and live in these areas. Numerous inquiry participants stated that one of the most effective ways to improve the distribution of primary health professionals is to provide positive training experiences in non-metropolitan areas and to support students with a rural origin with rural practice training opportunities.²¹
- 3.24 Dr Toby Gardner reflected on his experience of being exposed to regional general practice and the positive impact this had on his career:

I was sent out of my comfort zone in South-East Queensland to Rockhampton, Gladstone, Bundaberg—places I'd never really spent any time in. As a vegetarian moving into the beef capital of Australia, I was really apprehensive, but it was the best training and inspiration I ever had, and it's what got me to love regional towns. So that exposure, I think, needs to start even at the undergraduate or intern level.²²

- 3.25 Similarly, Dr Ruth Stewart, National Rural Health Commissioner said:

You can turn a rural-origin student who has had six years of rural medical education into an urban doctor by giving them a year of internship in a metropolitan hospital. I put to you that we [are] haemorrhaging the investment that we are putting into the education of these young people by not providing them with rural internships and rural training opportunities. If we can significantly increase—double, triple—the number of internships in rural and remote communities for junior doctors, we would translate

²¹ DoH *National Medical Workforce Strategy 2021–2031*, 20 January 2022, p. 39; Ms Gabrielle O'Kane, Chief Executive Officer, National Rural Health Alliance, *Proof Committee Hansard*, 4 November 2021, p. 25; City of Karratha, *Submission 8*, p. 3; NSW Outback Division of General Practice, *Submission 115*, pp. 4 and 7; Western Australian Department of Health, *Submission 141*, p. 8; Dr Lisa Fraser, *Submission 64*, p. 1; Dr Fiona Kotvojs, *Submission 104*, p. 4; Dr Hamish Meldrum, Co-founder, Ochre Health, *Proof Committee Hansard*, 24 January 2022, p. 51; Professor Alison Jones, Dean, Education, College of Medicine and Public Health, Flinders University, *Proof Committee Hansard*, 1 March 2022, p. 49; Cornerstone Health, *Submission 6, Attachment A*, p. 4; Regional Australia Institute, *Submission 71*, p. 9; MDANZ, *Submission 79*, p. 8; Professor Lucie Walters, Director, Adelaide Rural Clinical School, *Proof Committee Hansard*, 1 March 2022, p. 51; JCU, *Submission 146*.

²² Dr Toby Gardner, Lecturer in General Practice and Community Care, Tasmanian School of Medicine, University of Tasmania, *Proof Committee Hansard*, 24 January 2022, p. 57.

that 35 per cent into a much large cohort of rural doctors within four to five years.²³

- 3.26 Increasing the opportunities to train in outer-metropolitan, regional and rural areas has benefits in terms of the exposure to the lifestyle in these areas as well as critical practical skills, as the work conducted in these areas is often different to the work experienced in metropolitan hospitals.²⁴ For example, Dr Sarah Chalmers, President, Australian College of Rural and Remote Medicine, described how:

To be a doctor in a remote area, you practise medicine differently to what you do in an urban area because you don't have specialists nearby. You don't have access to tests. I used to work out in a really remote community where it took three days to get a normal test result, whereas in the city you can get that back in an hour.²⁵

- 3.27 The committee also heard from several universities which are providing opportunities to students to participate in regional, rural and remote placements. These inquiry participants spoke of the importance of an integrated approach to training in non-metropolitan areas and immersion in communities to create positive training experiences.²⁶
- 3.28 For example, James Cook University (JCU), has an integrated approach to medical education and training. It supports students from regional areas from the commencement of a medical degree through to fellowship. Around 70 per cent of students admitted to the JCU medical program are from non-metropolitan locations. The program provides medical students with extensive exposure to rural clinical practice (around 20 weeks), and as a result approximately 75 per cent of JCU medical graduates go on to work outside of major cities with around half pursuing training as GPs or rural generalists.²⁷

²³ Dr Ruth Stewart, National Rural Health Commissioner, *Proof Committee Hansard*, 4 November 2021, pp. 42–43.

²⁴ See for example: Dr Jay Ruthnam, *Submission 177*, p. 3; Dr Rodney Catton, *Submission 105*, p. 3; Dr Sarah Chalmers, President, ACRRM, *Proof Committee Hansard*, 4 November 2021, p. 22; Professor Lucie Walters, Director, Adelaide Rural Clinic School, University of Adelaide, *Proof Committee Hansard*, 1 March 2022, p. 51.

²⁵ Dr Sarah Chalmers, President, ACRRM, *Proof Committee Hansard*, 4 November 2021, p. 22.

²⁶ See for example: JCU, *Submission 146*; University of Queensland, *Submission 149*; Professor Alison Jones, Dean, Education, College of Medicine and Public Health, Flinders University, *Proof Committee Hansard*, 1 March 2022, p. 49; Professor Lucie Walters, Director, Adelaide Rural Clinical School, *Proof Committee Hansard*, 1 March 2022, p. 52; Professor Michelle Leech, Deputy Dean (Medicine), Health Faculty, Monash University, *Proof Committee Hansard*, 7 March 2022, p. 56; Professor Lena Sanci, Chair, General Practice and Head, Department of General Practice, University of Melbourne, *Proof Committee Hansard*, 7 March 2022, 56–57; Mr Travis Barber, Mayor, District Council of Streaky Bay, *Proof Committee Hansard*, 1 March 2022, p. 27.

²⁷ JCU, *Submission 146*; Mr Kane Langon, Sixth-year Bachelor of Medicine/Bachelor of Surgery student, JCU, *Proof Committee Hansard*, 4 November 2021, pp. 33.

- 3.29 Several programs have been implemented at the Commonwealth level to increase the opportunities for medical students to experience general practice in outer-metropolitan, regional, rural and remote settings. One such program is the Rural Health Multidisciplinary Training (RHMT) program. The RHMT (funded by the Department of Health) currently has 21 participating universities and is targeted at medical, dental and allied health students.²⁸
- 3.30 The committee heard from several representatives of universities and other medical practitioners who participate in this program and were told of the success of this initiative.²⁹ Associate Professor Lara Fuller, Director, Rural Community Clinical School, Deakin University, told the committee that students who have completed their RHMT longitudinal program based in rural primary care and then do a second rural clinical school year are seven times more likely to end up in rural practice.³⁰
- 3.31 In 2019, the Department of Health commissioned the consulting firm KBC Australia to conduct an evaluation of the RHMT. The evaluation found that the RHMT has been an 'appropriate response and important contributor to addressing rural health workforce shortage' and that the program had increased the number of medical students undertaking rural placements. The audit also found that there is 'considerable variability' in the quality of the placements and raised concerns about financial and accommodation support for medical students and the need for high quality supervision and mentorship.³¹

²⁸ NB: The RHMT program has several components including rural clinical schools, university departments of rural health, dental faculties offering extending rural placements, the Northern Territory Medical Program, and regional training hubs. See: DoH, *Submission 38*, pp. 85–87.

²⁹ See for example: Dr Emil Djakic, Private capacity, *Proof Committee Hansard*, 24 January 2022, p. 7; Professor Lucie Walters, Director, Adelaide Rural Clinical School, University of Adelaide, *Proof Committee Hansard*, 1 March 2022, p. 52; Professor Alison Jones, Dean, Education, College of Medicine and Public Health, Flinders University, *Proof Committee Hansard*, 1 March 2022, p. 54; Associate Professor Lara Fuller, Director, Rural Community Clinical School, Deakin University, *Proof Committee Hansard*, 7 March 2022, p. 60; Professor Michelle Leech, Deputy Dean (Medicine), Health Faculty, Monash University, *Proof Committee Hansard*, 7 March 2022, pp. 64–65.

³⁰ Associate Professor Lara Fuller, Director, Rural Community Clinical School, Deakin University, *Proof Committee Hansard*, 7 March 2022, p. 60.

³¹ KBC Australia, [*Independent Evaluation of the Rural Health Multidisciplinary Training Program: Summary of Final Report to the Commonwealth Department of Health*](#), June 2020, pp. 7–11.

General practice prevocational opportunities

- 3.32 Inquiry participants also discussed the impact of the cessation of the Prevocational General Practice Placement Program (PGPPP) in 2014.³² The PGPPP provided short-term supervised placements in general practice for prevocational doctors. Medical students on this program were placed into a rural community for two weeks per year for four years in an effort to encourage engagement with the local community and allow the student to experience life as a rural doctor. At the height of the program, up to 1200 placements were supported annually.³³
- 3.33 Following the Mason Review, the funding for the PGPPP was redistributed to the Australian General Practice Training program (AGPT) as there were concerns about the cost of the program and oversubscription to GP training.³⁴
- 3.34 The cessation of this program left general practice as the only major medical speciality without the ability to offer junior doctors a prevocational training experience before making a career choice.³⁵
- 3.35 In describing the loss of this program, the Australian Medical Association said it had the effect of reducing the 'legitimacy of the general practice' as a career choice.³⁶
- 3.36 Several witnesses spoke of the success of the program in supporting early exposure to general practice and general practice in rural areas. Witnesses commented that without the program there is a lack of funding and opportunity for prevocational doctors to gain these experiences.³⁷
- 3.37 A new program, the Rural Junior Doctor Training Innovation Fund (RJDTIF), was established to replace the PGPPP. The RJDTIF had a core and rural generalist funding stream. The Department of Health submitted that:

³² See for example: Western Australia General Practice Education and Training, *Submission 26*, pp. 91–98; Dr Megan Belot, President, RDAA, *Proof Committee Hansard*, 4 November 2021, p. 18; Professor Alison Jones, Dean, Education, College of Medicine and Public Health, Flinders University, *Proof Committee Hansard*, 1 March 2022, p. 50; Professor Neil Spike AM, Director of Medical Education and Training, Eastern Victoria General Practice Training, *Proof Committee Hansard*, 24 January 2022, p. 55; Professor Michelle Leech, Deputy Dean, Medicine, Health Faculty, Monash University, *Proof Committee Hansard*, 7 March 2022, pp. 58–59.

³³ Jennifer Mason, *Review of Australian Government Health Workforce Programs*, p. 123.

³⁴ DoH, *Submission 38*, pp. 47–48.

³⁵ AMA, *Submission 94*, p. 6.

³⁶ Dr Chris Moy, Vice President, AMA, *Proof Committee Hansard*, 4 November 2021, p. 11.

³⁷ See for example: Professor Alison Jones, Dean, Education, College of Medicine and Public Health, Flinders University, *Proof Committee Hansard*, 1 March 2022, p. 50; Professor Neil Spike AM, Director of Medical Education and Training, Eastern Victoria General Practice Training, *Proof Committee Hansard*, 24 January 2022, p. 55.

The RJDTIF was welcomed by those practices involved but does not provide the same level of funding to enable GP supervisors to provide such intensive supervision of juniors. It is limited to rural areas and at present provides places for fewer doctors.³⁸

3.38 Under the Stronger Rural Health Strategy, the John Flynn Prevocational Doctor Program (JFPDP), has been developed to provide prevocational training opportunities.³⁹ The JFPDP will commence from 1 January 2023 and consolidates the RJDTIF.

3.39 It aims to increase the number of prevocational doctors gaining experience in rural areas and is eligible to doctors in their first five postgraduate years. The JFPDP will support 440 rotations in rural hospitals in 2023, and this is set to increase to 800 rural hospital rotations by 2025.⁴⁰

3.40 Regarding this program and the impact of prevocational training opportunities, the AMA submitted that:

... the [John Flynn Prevocational Doctor] program will only provide up [to] 800 rotations by 2025. Australia currently graduates around 4,000 medical students per year. If more Australian graduates are to pursue general practice as a career, there must be more positive, structured exposure to general practice before doctors in training make decisions about their specialty.⁴¹

Stigma in the medical community

3.41 The committee received evidence that general practice as a profession is viewed as 'lesser' within the medical community and the views of senior medical professionals can dissuade medical students from pursuing a career as a GP.⁴²

3.42 In discussing this issue, Dr Ameeta Patel, Committee Member, Central Coast General Practice Association said that the profession needs to hold itself responsible for the attitude that 'you're just a GP' and that the

³⁸ DoH, *Submission 38*, p. 48.

³⁹ DoH, *Submission 38*, p. 47–48.

⁴⁰ DoH, *Submission 38*, p. 88.

⁴¹ AMA, *Submission 94*, p. 6.

⁴² See for example: Dr John Hall, Past President, RDAA *Proof Committee Hansard*, 4 November 2021, p. 19; Professor Richard Murray, Deputy Vice Chancellor, Division of Tropical Health and Medicine, JCU, *Proof Committee Hansard*, p. 33; Dr Ruth Stewart, National Rural Health Commissioner, *Proof Committee Hansard*, 4 November 2021, p. 43; Dr Ameeta Patel, Central Coast General Practice Association, *Proof Committee Hansard*, 4 November 2021, p. 24; Australian Medical Students Association, *Submission 151*, p. 2; ACRRM, *Submission 110*, p. 5; RACGP, *Submission 107*, p. 4; National Rural Health Alliance, *Submission 95*, p. 5; Rural Workforce Agency Network, *Submission 50*, p. 5; Mr Mark Burdack, Chief Executive Officer, Rural and Remote Medical Services (RRMS), *Proof Committee Hansard*, p. 44; Ms Tegan Whatley, Practice Manager, Langwarrin Medical Clinic, *Proof Committee Hansard*, 7 March 2022, p. 1.

medical profession has 'a lot to answer' including the way that GPs are spoken about and treated by other medical professionals.⁴³

3.43 Several inquiry participants also reflected on their experiences in medical school and how they were told to be 'something special' and not 'just a GP'.⁴⁴

3.44 Many inquiry participants told the committee that the broader medical community needs to recognise the skills of GPs and the value of a career as a GP.⁴⁵ For example, Dr Amanda Bethell, Flinders and Far North Doctors Association said:

... I do think that the biggest problem general practice has, at the moment, is the devaluing of it as a specialty, and that has come from all sorts of places. So the more undergraduate students get to see the cutting edge side of general practice—okay, we don't crack chests open in our GP surgeries, but how cool is it to be able to know somebody well enough to help them decide they want to stop smoking, to figure out what it's going to take for them to do that, such that they don't end up having a stroke, heart attack, lung cancer et cetera down the track that they would otherwise have had? How cutting edge is it to help someone finally lose the weight they've been trying to lose for 10 years and get their HbA1c down so that they're finally off half of their diabetes medications?⁴⁶

3.45 The committee also heard that the 'deficit' narrative around rural practice and living needs to change and that the positive stories about rural general practice need to be pushed.⁴⁷ For example, Dr Megan Belot, President, Rural Doctors Association of Australia, spoke to the committee what rural general practice has to offer:

... to have the time to actually do the teaching, to take them on ward rounds, to take them in to assist to do the [caesarean], to get them to help when you are doing an intubation, to get the hands-on experience. As a rural doctor—or just as a doctor—that's what we crave, that's what we love about medicine. I think it's about making sure that the systems are robust,

⁴³ Dr Ameeta Patel, Committee Member, Central Coast General Practice Association, *Proof Committee Hansard*, 14 December 2021, pp. 24–25.

⁴⁴ See for example: Dr Ruther Stewart, National Rural Health Commissioner, *Proof Committee Hansard*, 4 November 2021, p. 43; Ms Jasmine Davis, President Australian Medical Student Association, *Proof Committee Hansard*, 7 March 2022, p. 51.

⁴⁵ See for example: Dr Christopher Boyle, *Submission 35*, pp. 1–2; Dr Emil Djakic, Private capacity, *Proof Committee Hansard*, 24 January 2022, p. 1; Mr Mark Burdack, Chief Executive Officer, RRMS, *Proof Committee Hansard*, 14 December 2021, p. 44; Dr Gerard Quigley, Principal, Lower Eyre Family Practice, *Proof Committee Hansard*, 1 March 2022, p. 20; Ms Jasmine Davis, President, Australian Medical Students Association, *Proof Committee Hansard*, 7 March 2022, p. 51.

⁴⁶ Dr Amanda Bethell, Chair, Flinders and Far North Doctors Association, *Proof Committee Hansard*, 1 March 2022, p. 36.

⁴⁷ See for example: Mr Richard Colbran, Chief Executive Officer, NSW Rural Doctors Network, *Proof Committee Hansard*, 14 December 2021, pp. 49–50; Mr Travis Barber, Mayor, District Council of Streak Bay, *Proof Committee Hansard*, 1 March 2022, p. 31.

that there is adequate time and adequate remuneration for that to happen. You also look at the social side of being in a rural and remote community, because there is that other element.⁴⁸

3.46 The National Medical Workforce Strategy 2021-2031 (NMWF) recognises that there is a need for cultural change in the medical professional and that a stigma persists that working outside metropolitan areas is:

- less prestigious;
- less intellectually satisfying;
- a form of exile;
- representative of substandard practice; and
- that practitioners in those areas are inferior to their metropolitan counterparts.⁴⁹

3.47 Priority four of the NMWF aims to 'shift the prestige and value perceptions of generalist practice' and 'will encourage colleges and societies to contribute to this through their curricula and training pathways'.⁵⁰ It further notes that:

Medical leaders and the wider health system need to recognise the potentially long-term influence that their values and behaviours can have on the make-up, distribution and capacity of the medical workforce. It takes time for alternative views to influence sector-wide thinking, however participants in the Strategy consultations reported that doctors are increasingly prepared to call out unhelpful views and recognise the need for constructive change.⁵¹

Vocational training – becoming a general practitioner

3.48 There are numerous pathways to become a vocationally recognised GP. The most common pathway is the AGPT which is offered through the Australian College of Rural and Remote Medicine (ACRRM) or the Royal Australian College of General Practitioners (RACGP) and is currently delivered by eleven Regional Training Organisations contracted by the Department of Health. It offers 1500 Commonwealth funding training places each year.⁵²

3.49 The number of applications to the AGPT has been falling for the past five years and in 2020 and 2021, 171 and 66 places were unfilled respectively.⁵³

3.50 The RACGP is allocated 1350 places and ACCRM is allocated 150 places.⁵⁴ The AGPT has two pathways: a rural pathway and a general pathway. The rural

⁴⁸ Dr Megan Belot, President, Rural Doctors Association of Australia (RDAA), *Proof Committee Hansard*, 4 November 2021, p. 20.

⁴⁹ DoH, [National Medical Workforce Strategy 2021-2031](#), 20 January 2022, pp. 20 and 38.

⁵⁰ DoH, [National Medical Workforce Strategy 2021-2031](#), 20 January 2022, p. 4.

⁵¹ DoH, [National Medical Workforce Strategy 2021-2031](#), 20 January 2022, p. 20.

⁵² DoH, *General Practice Training in Australia: The Guide*, p. 4.

⁵³ DoH, *Submission 38*, p. 21.

pathway is designed for those wishing to practice in MM2–7. The general pathway is designed for doctors choosing to practice in inner and metropolitan locations. Participants in this program can train in any MM1–7 location.⁵⁵

- 3.51 Under the AGPT, 50 per cent of registrars must undertake training in MM2–7 areas. Despite this requirement there has not been an increase in the number of registrars returning to practice in these areas.⁵⁶
- 3.52 The committee heard of three core concerns regarding the current vocational training structure which act as a barrier to doctors deciding to become a GP.⁵⁷ These include:
- the lack of portable benefits from the public hospital system to private general practice;
 - negative perceptions of rural general practice; and
 - difficulties in meeting supervision requirements.

Portability of benefits

- 3.53 During a medical graduate's prevocational training as an intern and resident in the public hospital system they are employed by the relevant state government. If a medical graduate pursues training as a general practitioner, they transition to a different employment model, which results in a loss of employment benefits, such as annual leave, sick leave and maternity leave, among others.
- 3.54 The committee has received evidence that this employment model can deter people from specialising as a GP.⁵⁸ As explained by Professor Lucie Walters:
- ... when you're in the hospital setting, you actually accrue long-service leave and, really importantly for women, you're eligible for paid maternity

⁵⁴ ACRRM, *Submission 110*, p. 8.

⁵⁵ For further information on the Modified Monash Model, see Chapter 1, paragraph 1.23. See also: DoH, *Australian General Practice Training Program Policies 2020*, December 2020, p. 2.

⁵⁶ DoH, *Submission 38*, pp. 48–49.

⁵⁷ See for example: ACRRM, *Submission 110*, p. 4; JCU, *Submission 146*, p. 11; Western Australia General Practice Education and Training, *Submission 26*, p. 9; Dr John Hall, Past President, RDAA, *Proof Committee Hansard*, 4 November 2021, p. 19.

⁵⁸ See for example: Dr Michael Clements, Rural Chair, RACGP, *Proof Committee Hansard*, 4 November 2021, p. 6; AMA, *Submission 94*, p. 8; Dr Ewen McPhee, Past President, ACRRM, *Proof Committee Hansard*, 4 November 2021, p.23; ACT Local Government, *Submission 92*, p. 8; Australian Federation of Medical Women, *Submission 96*, p. 2; Professor Lucie Walters, Director, Adelaide Rural Clinical School, University of Adelaide, *Proof Committee Hansard*, 1 March 2022, p. 55; Professor Danielle Mazza, Head, Department of General Practice, Monash University, *Proof Committee Hansard*, 7 March 2022, p. 60; Ms Liz Hunter, Chief Executive Officer, Westgate Health Co-operative, *Proof Committee Hansard*, 7 March 2022, pp. 40–41; Dr Hamish Meldrum, Co-founder, Ochre Health, *Proof Committee Hansard*, 24 January 2022, pp. 46–47; GP Synergy, *Submission 72*, p. 13.

leave, but the way general practice training works at the moment is that you move every three to six months, and each time you move you have a new employer, so you don't even accrue annual leave in the time that you're employed ... I know women who like the idea of community practice and have chosen to do paediatrics or gen med [general medicine] with a view to becoming specialists who work primarily in the outpatient consulting-room environment, but they do that because they can have their children while they're studying, with paid maternity leave, rather than leaving the security of a state-funded, employed position to go and spend four years as a casual employee, basically, with three months here, three months there, and no accrual of those.⁵⁹

- 3.55 Many inquiry participants noted that changes to the employment model, such as the introduction of portable benefits, may improve the number of doctors choosing to become GPs.⁶⁰
- 3.56 The Department of Health submitted information on two employment models that are currently being trialled. The Murrumbidgee Rural Generalist Training Pathway trial (supported by the New South Wales Government) commenced on 1 November 2020. It tests the feasibility of flexible employment arrangements between the hospital system and community primary care settings in MM4–7 locations. Five trainees have commenced training in the locations of Wagga Wagga, Gundagai, Temora, Cootamundra and Young. A maximum of twenty rural generalist trainees will take part in the trial over four years.
- 3.57 Additionally, the Commonwealth Government is providing \$5 million for the Remote Vocational Training Scheme Extended Targeted Recruitment pilot. The pilot will test the success of wage equalisation by offering additional income support funding to recruit and retain doctors working in rural, remote and Aboriginal and Torres Strait Islander communities that have a medical workforce need.

Rural is lesser

- 3.58 Submitters and witnesses raised concern that in addition to the stigma about general practice there is an additional stigma about rural practice and the current structure of the AGPT program contributes to this issue.⁶¹

⁵⁹ Professor Lucie Walters, Director, Adelaide Rural Clinical School, *Proof Committee Hansard*, 1 March 2022, p. 55.

⁶⁰ See for example: RACGP, *Submission 107*, p. 5; Australian Federation of Medical Women, *Submission 96*, p. 5; ACRRM, *Submission 110*, p. 9; Rural Workforce Agency Network, *Submission 50*, p. 11.

⁶¹ See for example: JCU, *Submission 146*, p. 11; Western Australia General Practice Education and Training, *Submission 26*, p. 9; Dr John Hall, Past President, RDAA Australia, *Proof Committee Hansard*, 4 November 2021, p. 19.

3.59 JCU submitted that the Government's requirement that 50 per cent of students on the AGPT train outside metropolitan areas is a 'conscription' method and that lower ranking applicants for the RACGP Fellowship are 'generally allocated an unpopular and inflexible' rural pathway whereas higher-ranking applicants 'win the choice pick' of the flexible general pathway. JCU also highlighted that the features of the AGPT create a perception that 'rural is for losers' and that it makes rural GP training unpopular among domestic medical graduates and junior doctors.⁶²

3.60 Dr John Hall, Past President, Rural Doctors Association of Australia echoed these concerns and said:

We have been critical of the rural pathway in the past. The rural pathway is a part of Australian general practice training that unfortunately has seen a selection process whereby doctors that performed poorly or least well in their selection process were streamlined through the RACGP into the rural pathway. The rural pathway is geographically constricted, so when they go into the rural pathway they can't come back into the city. But it's created a two-tier system where there's a feeling within the industry that if you choose rural you're choosing substandard.⁶³

3.61 ACRRM also raised concerns about the current allocation of places between them and the RACGP. ACRRM submitted that:

[Department of Health] arrangements have restricted ACRRM to no more than 10% of the government-funded General Practice training places with 90% ear-marked for the RACGP. This has made it impossible for the College to grow its programs through the government's funded national framework and to date 45% of trained ACRRM Fellows completed their training outside the nationally funded framework through its self-funded pathway.⁶⁴

3.62 Additionally, ACRRM has a strong track record of training rural GPs and retention of those GPs in rural. ACRRM told the committee that approximately 80 per cent of their fellows continue to practice rurally and over the past 15 years, of over 900 doctors who have received fellowship with the ACRRM, 75 per cent have remained in rural practice five or more years post-fellowship.⁶⁵

Supervision requirements

3.63 The committee heard that it is becoming increasingly difficult for senior GPs to provide supervision for registrars given their high workloads and lack of appropriate remuneration for supervision. Additionally, poor supervisory

⁶² JCU, *Submission 146*, p. 11.

⁶³ Dr John Hall, Past President, RDAA, *Proof Committee Hansard*, 4 November 2021, p. 19.

⁶⁴ ACRRM, *Submission 110*, p. 10.

⁶⁵ ACRRM, *Submission 110*, p. 5.

experiences, particularly in regional, rural and remote areas where these issues are exacerbated, can shift GPs to metropolitan areas.⁶⁶

- 3.64 Dr Peter Rischbieth, President, Rural Doctors Association of South Australia, informed the committee of a recent survey they had conducted across 42 towns in South Australia. He said:

It was one of the saddest surveys that I've ever seen from country doctors in my 35 years. Practices were desperate. Communities were desperate for doctors to stay in their towns. Doctors were saying that they couldn't teach medical students and registrars because their clinical commitments at the hospital and their practices were so much ...⁶⁷

- 3.65 Inquiry participants stated that placing registrars in situations without adequate supervision can lead to negative experiences in rural general practice and doctors choosing to remain in metropolitan areas.⁶⁸
- 3.66 The committee also received concerns that the current payment structure for GP supervisors can deter senior GPs from supervising registrars. Dr Emil Djakic, estimated that a doctor's billings without supervision could be \$1000 whereas if the GP is required to supervise and train students, that would likely reduce their patient contact for the day and therefore reduce income.⁶⁹
- 3.67 On 23 November 2021, the Transition to College-Led Training Advisory Committee discussed a plan for a 'National Consistent Payments Framework'. The framework proposed providing payments which increase according to Modified Monash Model classification system for supervisors, practices, and registrars participating in college-led training programs.⁷⁰
- 3.68 The NMWS recognises the need for positive training experiences and notes that 'investment may be required to increase the number of supervisors to

⁶⁶ See for example: HR+ Tasmania, *Submission 4*, p. 2; Professor Maguire, *Proof Committee Hansard*, 4 November 2021, pp. 8–9; Dr Ewen McPhee, Past President, ACRRM, *Proof Committee Hansard*, 4 November 2021, p. 23; Dr Peta-Ann Teague, Associate Dean, Strategy and Engagement, Division of Tropical Medicine, JCU *Proof Committee Hansard*, 4 November 2021, p. 37; Wheatbelt Health Network. *Submission 40*, p. 4; MDANZ, *Submission 79*, p. 8

⁶⁷ Dr Peter Rischbieth, President, Rural Doctors Association of South Australia, *Proof Committee Hansard*, 1 March 2022, p. 44.

⁶⁸ See for example: Dr Peta-Ann Teague, Associate Dean, Strategy and Engagement, Division of Tropical Medicine, JCU, *Proof Committee Hansard*, 4 November 2021, p. 37; Western Australia General Practice Education and Training, *Submission 26*, p. 6; Office of the National Rural Health Commissioner, *Submission 56*, p. 12; Mr Matthew Chudley, National GP Recruitment and Engagement Manager, Ochre Health, *Proof Committee Hansard*, 24 January 2022, p. 49; Dr Amanda Bethell, Chair, Flinders and Far Norther Doctors Association, *Proof Committee Hansard*, 1 March 2022, p. 35.

⁶⁹ Dr Emil Djakic, Private capacity, *Proof Committee Hansard*, 24 January 2022, pp. 2–3.

⁷⁰ For the full details of the proposed payment structure see: Transition to College-Led Training Advisory Committee: [Communique, 23 November 2021](#).

enable training opportunities' particularly in regional, rural and remote areas. The NMWS also discusses the role that technology and remote supervision could play to assist registrars in meeting their training requirements.⁷¹

Other factors influencing career choice

3.69 The committee heard that there are a range of other factors that influence a doctor's decision to become a GP and their choice of working in a metropolitan or non-metropolitan location, including:

- the current employment model and remuneration for general practitioners;
- lifestyle factors; and
- concerns regarding personal development and isolation.

Employment model and remuneration

3.70 As discussed above, following the prevocational period, if a medical graduate decides to train as a GP they transition to a different form of employment and lose access to benefits such as maternity leave, sick leave, and annual leave. The committee also heard that the current wage structure for GP acts as a disincentive to pursuing this career.

3.71 GPs are one of the lowest paid of all the medical specialities. Inquiry participants informed the committee that a full time GP can expect to earn around \$200 000. In comparison, other medical specialists, such as a specialist geriatrician in a hospital can earn up to \$500 000, and consultant medical specialists can earn up to a million dollars.⁷²

3.72 Inquiry participants also stated that deciding to become a GP leads to a significant reduction in pay. The pay difference between a hospital doctor and a first year GP registrar can be upwards of a \$50 000.⁷³

⁷¹ DoH, *National Medical Workforce Strategy 2021-2031*, pp. 49 and 54.

⁷² See for example: Dr Jerome Muir Wilson, GP, Launceston Medical Centre, *Proof Committee Hansard*, 24 January 2022, p. 10; General Practice Training Queensland, *Submission 145*, p. 4; Dr Michael Clements, Rural Chair, RACGP, *Proof Committee Hansard*, 4 November 2021, p. 6; Professor Danielle Mazza, Head, Department of General Practice, Monash University, *Proof Committee Hansard*, 7 March 2022, p. 61; Dr Philip Tideman, Vice President, Rural Doctors Association of South Australia, *Proof Committee Hansard*, 1 March 2022, p. 46; Dr Aniello Iannuzzi, Private capacity, *Proof Committee Hansard*, 14 December 2021, p. 14.

⁷³ See for example: MDANZ, *Submission 79*, p. 11; ACT Local Government, *Submission 92*, p. 8; Dr John Kramer, Chair of Board, NSW Rural Doctors Network, *Proof Committee Hearing*, 14 December 2021, p. 51; Dr Christopher Boyle, *Submission 35*, p. 1; Dr Michael Connellan, *Submission 34*, p. 2; Dr Rodney Catton, *Submission 105*, pp. 3–4; Mrs Martina Stanley, Director, Alecto Australia, *Proof Committee Hansard*, 7 March 2022, p. 40; Professor Lena Sanci, Chair, General Practice, Head, Department of General Practice, University of Melbourne, *Proof Committee Hansard*, 7 March 2022, p. 57; General Practice Training Queensland, *Submission 145*, p. 4; WA Primary Health Alliance and Rural Health West, *Submission 41*, p. 24; Dr Michael Clements, Rural Chair, RACGP, *Proof Committee Hansard*, 4 November 2021, p. 6.

- 3.73 The committee also heard that many GPs face challenges in running their private practice and prefer to work as an employee in a private practice rather than establish their own business.
- 3.74 Many inquiry participants told the committee that the pressures of the lower salary are compounded with other factors, including, the increasing costs of running a practice can act as a deterrent to a career in general practice.⁷⁴

Lifestyle factors

- 3.75 Renumeration is not the only factor influencing the decision of GPs and primary health professionals to live and work in non-metropolitan areas. Many inquiry participants noted that other factors such as work-life balance and workload, family considerations and access to appropriate housing were core considerations for where doctors ultimately decided to live and work.
- 3.76 The committee heard that GPs across the country are under increasing amounts of stress and pressure, and many are leaving the profession due to burnout.⁷⁵
- 3.77 For example, Dr Christopher Boyle submitted that he has had experience with several high-quality GP registrars who have chosen to leave the primary health care workforce to work in the hospital system as it less stressful and better paid.⁷⁶
- 3.78 ACRRM submitted that their registrars, in comparison to all general practice registrars, reported working 7.2 hours longer per week and were much more likely to report a heavy workload. They were also more likely to report living away from their families and report that their wellbeing was negatively impacted by overwork, unscheduled overtime and relocation.⁷⁷
- 3.79 In addition, the expectations around workload and lifestyles for medical practitioners are changing. Many more GPs are wanting greater work-life balance and are opting to work part-time rather than full-time hours to manage their workload. Further, many GPs no longer want to be on call for

⁷⁴ See for example: ACT Local Government, *Submission 92*; Equilibrium Healthcare, *Submission 39*; Tamborine Mountain Medical Practice, *Submission 83*; Francis Family Doctors, *Submission 124*; NSW Outback Division of General Practice, *Submission 115*.

⁷⁵ See for example: Dr Shamila Beattie, *Submission 135*, p. 1; WA Primary Health Alliance and Rural Health West, *Submission 41*, p. 28; Mr Dean Griggs, General Manager, Derwent Valley Council, *Proof Committee Hansard*, 24 January 2022, p. 19; Mr Ken, Chief Executive Officer, Australian Primary Health Care Nurses Association, *Proof Committee Hansard*, 7 March 2022, p. 31.

⁷⁶ Dr Christopher Boyle, *Submission 35*, p. 1.

⁷⁷ ACRRM, *Submission 110*, p. 9.

after-hours services and are unwilling to undertake overtime to provide services to local hospitals or aged care facilities.⁷⁸

- 3.80 This issue was also raised in the context of regional and rural practice as many doctors have to overcome the 'tyranny of distance' to provide health care services. For example, the Local Government Association of Queensland submitted that in the Barcaldine Region:

The tyranny of distance between outlying communities is a key cause of fatigue for these doctors, where they are often forced to drive for hours into a rising sun, work a very busy clinical day and then drive for hours into a setting sun to return to Barcaldine.⁷⁹

- 3.81 Submitters and witnesses also told the committee that employment for partners and spouses, and appropriate childcare and schooling for children are key barriers for GPs moving away from metropolitan areas to live and work.⁸⁰
- 3.82 The committee also heard that the availability of appropriate housing and accommodation reduces with increasing levels of remoteness. In many rural and remote locations the housing market is in a state of disrepair and health professionals must often share accommodation facilities.⁸¹
- 3.83 Dr Jerome Muir-Wilson, GP, Launceston Medical Centre, aptly summarised all the concerns relating to the disincentives to be a GP in a regional or rural area:

A lot of medical students coming through have got a lot of choice because of demand across the medical area. They can specialise in just the eye and be an eye doctor for \$550,000, as an average, as a kidney doctor for over \$300,000 or as a GP for \$150,000; I went through public school, but most of the doctors that I trained with went through private schools and don't want to live somewhere where they can't adequately school their kids and somewhere where, unless they're married to a doctor, like me, their wife

⁷⁸ See for example: Dr Johannes Schonborn, General Practitioner and Director, Deloraine and Westbury Medical Centre, *Proof Committee Hansard*, 24 January 2022, p. 12; Dr Aniello Iannuzzi, Private capacity, *Proof Committee Hansard*, 14 December 2021, p. 9; Mr Stevenson, *Proof Committee Hansard*, 1 March 2022, p. 27; Mr Dean Johnson, Bord Member, Northern Eyre Peninsula Health Alliance, *Proof Committee Hansard*, 1 March 2022, p. 34; Dr Dominic Frawley, *Submission 133*, p. 1.

⁷⁹ Local Government Association of Queensland, *Submission 128*, p. 3.

⁸⁰ See for example: Aboriginal Health Council of Western Australia, *Submission 113*, p. 4; WA Primary Health Alliance and Rural Health West, *Submission 41*, p. 23; National Rural Health Alliance, *Submission 95*, p. 11; Hunter New England and Central Coast Primary Health Network, *Submission 192 Appendix D*, p. 6; South Eastern NSW Primary Health Network, *Submission 116*, p. 7; RRMS, *Submission 118*, p. 2; Dr Emil Djakic, Private capacity, *Proof Committee Hansard*, 24 January 2022, p. 3; Dr Rod Catton, *Submission 105*, p. 3; Dr John Kramer, Chair, NSW Rural Doctors Network, *Proof Committee Hansard*, 14 December 2021, p. 52; Dr Lisa Fraser, *Submission 64*, p. 3.

⁸¹ See for example: Western Australian Local Government Association, *Submission 21*, p. 3; Dr Martin Kelly, Senior GP, Nganampa Health Council, *Proof Committee Hansard*, 1 March 2022, p. 7.

can't find employment. In general practice in rural areas, you can't overcome schooling, housing and employment. You've got to have a really big carrot, and there are baby carrots out there for working in rural areas.⁸²

Isolation and professional development

3.84 Another factor which influences the decision for GPs to stay in metropolitan areas is the perception of a lack of professional development in regional and rural communities as well as the isolation that professionals face in more remote communities. Several inquiry participants noted that primary health care works best when there is collaboration among all sectors of the primary health workforce.⁸³

3.85 For example, Mr Ken Griffin, Chief Executive Officer, Australian Primary Health Care Nurses Association, told the committee:

I think one thing that's worthwhile noting here is that government policy frequently focuses on general practitioners, not general practice, and that forgets about the team in which they work. Importantly, none of the doctors who have spoken here today will tell you that they prefer to work in isolation, professionally or personally. As you get further outside the city areas, the acute professional isolation they have is quite astounding and directly contributes to us losing them from some of those vital areas. So I would say that we need to be focusing very much on the team aspect there.⁸⁴

3.86 On the issue of isolation, Ms Cathryn Blight, General Manager, Regional Services, Novita, also said:

... Isolation is another big thing that prevents people from moving into regional and remote areas. That would be the same, I imagine, for GPs and their families. One of the other things we try and address in our teams is that they all want to work as part of a team and feel like they have a team around them that is supporting them. That isolation is critical to that. I can imagine that GPs would be more likely to move into some of these regional and remote areas, like Wudinna, if they knew that there was this vibrant team around them that were all working, with their different backgrounds

⁸² Dr Jerome Muir-Wilson, General Practitioner, Launceston Medical Centre, *Proof Committee Hansard*, 24 January 2022, p. 10.

⁸³ See for example: City of Karratha, *Submission 8*, pp. 2–3; WA Primary Health and Rural Health West, *Submission 41*; Rural Workforce Agency Network, *Submission 50*, p. 6; AMA, *Submission 94*, p. 4; National Rural Health Alliance, *Submission 95*, p. 11; Dr Fiona Kotvojs, *Submission 104*, p. 4; Dr Rod Catton, *Submission 105*, p. 4; RRMS, *Submission 118*, p. 2; DoH, *Submission 38*, p. 34; Primary Health Network Cooperative, *Submission 46*, p. 4; Mrs Tanya, Practice Manager, Deloraine and Westbury Medical Centre, *Proof Committee Hansard*, 24 January 2022, p. 11; Ms Jasmine Davis, President, Australian Medical Students Association, *Proof Committee Hansard*, 7 March 2022, p. 53.

⁸⁴ Mr Ken Griffin, Chief Executive Officer, Australian Primary Health Care Nurses Association, *Proof Committee Hansard*, 7 March 2022, p. 32.

and perspectives, to bring real health outcomes to that community. Who wouldn't want that?⁸⁵

Committee view

- 3.87 GPs are the cornerstone of Australia's health system. They are often the first point of call for primary health needs and help to prevent serious illness, reduce avoidable presentations at hospital, and improve health outcomes for their patients.
- 3.88 There are a myriad of factors which influence an individual's career choice and decisions about where they will live and work, including personal preference. However, it is clear that the current culture and education and training environment is actively playing a role in dissuading individuals from becoming a GP and living and working in outer-metropolitan, regional, and rural locations.

Commonwealth Supported Places

- 3.89 The committee received conflicting evidence as to whether the number of CSP for medical degrees should be increased. On the one hand, the Department of Health advised that the problem is not the number of medical students but the decreasing number of students choosing to specialise in general practice. Moreover, predictions from the Department of Education, Skills and Employment indicate that by 2030 Australia will have an oversupply of 7000 doctors.
- 3.90 On the other hand, several universities submitted that an increase in the number of medical graduates is required to ensure future demand and called for an increase in the number of CSP for its university.
- 3.91 The committee has also heard throughout this inquiry that Australia is over reliant on international medical graduates and that the Government has a goal to reduce this reliance. It is not clear if the projected oversupply of doctors considers the Government's desire to reduce Australia's reliance on international medical graduates.

Education and training of medical students

- 3.92 The committee notes that the current education and training system is dominated by non-GP specialists and that clinical exposure predominantly occurs in metropolitan hospitals.
- 3.93 The committee heard anecdotal evidence that medical students are commencing their studies with the desire to specialise in general practice, but years into their degree, this gets 'hospitalised out of them'.

⁸⁵ Ms Cathryn Blight, General Manager, Regional Services, Novita, *Proof Committee Hansard*, 1 March 2022, p. 18.

- 3.94 All evidence to the committee indicates that a lack of exposure to community-based care and general practice is limiting the ability for medical graduates to experience work in these fields and ultimately impacting on the number of medical students who choose a career in general practice.
- 3.95 If Australia is to have a strong primary health care system, the education system needs to ensure that all medical students can learn about and experience primary care. As a result, the committee recommends that a review of the medical education curriculum take place.

Recommendation 7

- 3.96 **The committee recommends that the Department of Education, Skills and Employment, in collaboration with universities, reviews the primary care components of the medical education curriculum, with a view to ensuring that general practice is a core component of the curriculum.**
- 3.97 Similarly, the lack of exposure to primary health care settings in regional and rural environments is also concerning. The committee received overwhelming evidence that one of the most effective ways to increase primary health practitioners in regional and rural areas is to design integrated models to support students from regional and rural areas, and those with rural interest, to have immersive placements and clinical experiences in those areas.
- 3.98 The committee commends the success of previous prevocational training programs, particularly the John Flynn Placement Program (JFPP). While supportive of the new JFPDP, the committee is concerned that it may not include all successful elements of its predecessor. The committee notes that the JFPDP is due to commence in January 2023 with 440 rotations to rural hospitals and up to 800 rotations by 2025. It is further concerned that 800 rotations is a far cry short of the 1200 placements previously offered under the JFPP.
- 3.99 The committee agrees with the view of the Australian Medical Association, that if more medical graduates are to pursue a general practice career, there must be more positive and structured exposure to this career path. The committee considers that the program should be significantly expanded to enable more of the 4000 medical students per year to experience general practice in regional and rural settings.

Recommendation 8

- 3.100 **The committee recommends that the Department of Health expands the John Flynn Prevocational Doctor Program and re-instates the John Flynn Placement Program aimed at attracting medical students to rural and regional general practice.**

- 3.101 The committee is concerned about the current structure and pathway to become a GP, including opportunities to gain exposure to clinical practice in outer-metropolitan, regional and rural areas.
- 3.102 The committee has heard about the negative perceptions of the rural pathway for registrars in the AGPT program. The committee notes that the Royal Australian College of General Practitioners receives 90 per cent of Commonwealth funded places available under the AGPT whereas the Australian College of Rural and Remote Medicine receives 10 per cent.
- 3.103 The committee notes that the current funding model appears to be inconsistent with the Government's policy position to increase the numbers of GPs training and working in non-metropolitan areas.
- 3.104 The committee commends the Australian College of Rural and Remote Medicine for their success in delivery training in rural and remote communities and the retention of registrars in these areas post-fellowship.

Recommendation 9

- 3.105 The committee recommends that the Government investigates the adequacy and suitability of the Australian General Practice Training placements allocated to the relevant general practice training colleges.**

Employment model and other factors

- 3.106 The committee has discussed at length the impact of the current income level of GPs, particularly in relation to current Medicare rebates.
- 3.107 The committee also notes that there is an issue in the training pipeline where medical graduates lose their entitlements if they decide to leave the hospital system and become a GP.
- 3.108 The committee would like to receive further evidence about how portable entitlements and a single employer model could work to improve the numbers of medical graduates deciding to become a GP.
- 3.109 The committee also acknowledges that while income level is important, it is not the only consideration for professionals when deciding to practice in an outer-metropolitan, regional or rural area. Lifestyle factors including work-life balance, family considerations (such as employment for partners and spouses and education for children), along with feelings of isolation and limited professional development can sway people to remain in metropolitan locations.
- 3.110 Many of the current Federal Government incentives to increase the number of primary health professions to outer-metropolitan, regional, and rural areas focus solely on the income side of the equation and do not provide appropriate consideration to other factors.

Stigma about GPs and rural practice

- 3.111 The committee was saddened to hear that a career as a rural GP was viewed as lesser in the medical community and among some of the professionals choosing to become a GP.
- 3.112 The committee also notes that there is a deficiency narrative and negative perception of working life in regional and rural communities. Working in these communities does involve challenges not faced in metropolitan areas but regional and rural areas have strong communities and lifestyles, and these benefits are not being recognised or promoted.
- 3.113 The committee supports the goals of the NMWS which calls for greater leadership and cultural change within the medical community to support the value of GPs. It encourages all of those within the medical community to reflect on their influence on new medical graduates and the importance of general practitioners.

Chapter 4

The impact on communities

Our patients deserve better. When are you driving through Cunnamulla and you have an accident, you deserve the best rural doctors at your bedside. When you are in Walgett, you deserve as good an access to your local GP as you enjoy in the city. We need to realise that promise of quality healthcare in a time of uncertainty is fundamental to Australia, and its more important than ever that we get this right.¹

- 4.1 As discussed in this report, there is a maldistribution of primary health professionals throughout Australia. This maldistribution has devastating impacts on people living in outer-metropolitan, regional, and rural areas, who are experiencing higher rates of hospitalisation and a higher burden of disease than those living in metropolitan areas.²
- 4.2 This chapter discusses the impacts of the maldistribution of primary health workforces on individuals and communities. It covers the following issues:
- the impacts of the maldistribution and barriers to accessing primary health care;
 - the impacts of COVID-19 on primary health care; and
 - the role of networks of primary health professionals.

The impacts of the maldistribution of primary health care

- 4.3 The maldistribution of primary health services leads to a range of difficulties in accessing health care. The committee recognises that the experience of primary health care varies from outer-metropolitan to remote areas, however, the committee received evidence that can be grouped into general themes regarding the impacts of the maldistribution. This section examines the following:
- access and availability of primary health care appointments;
 - impacts of limited access to general practitioners (GP) on continuity of care;
 - the costs of primary health care; and
 - issues regarding distance and transportation.

¹ Dr Marco Giuseppin, Chair, Council of Rural Doctors, Australian Medical Association (AMA), *Proof Committee Hansard*, 17 March 2022, p. 19.

² See for example: Dr Sarah Chalmers, President, Australian College of Rural and Remote Medicine (ACRRM), *Proof Committee Hansard*, 4 November 2021, p. 15; Dr John Hall, Past President, Rural Doctors Association of Australia (RDAA), *Proof Committee Hansard*, 4 November 2021, p. 14; WA Primary Health Alliance and Rural Health West (WAPHARHW), *Submission 41*, p. 11; Services for Australian Rural and Remote Allied Health, *Submission 153*, p 3; Office of the National Rural Health Commissioner, *Submission 56*, p. 4; Mr John Bruning, Chief Executive Officer, Australasian College of Paramedicine (ACP), *Proof Committee Hansard*, 14 December 2021, p. 35.

Access and availability

- 4.4 A primary issue raised with the committee was the lack of access to and availability of GP appointments. Many inquiry participants described:
- the lengthy waiting periods to see a doctor (including to see *any* doctor and not their regular GP);
 - situations where doctors are no longer taking on new patients;
 - irregular surgery opening hours;
 - delays experienced in waiting rooms; and
 - last-minute cancellations.³
- 4.5 The committee heard that individuals were experiencing excessive waiting times to see a GP. Many inquiry participants told the committee that they waited 1–2 weeks or 7–8 weeks or even up to 12 weeks for a GP appointment.⁴
- 4.6 Individuals expressed a sense of frustration that they could not access a GP when they are sick.⁵ This concern was highlighted by Dr Ravi Ravoori, Practice Principal, MyHealth Medical Centre, who said '[i]n the community we need GPs to be available for the day we want them to be—not a week later or 10 days later'.⁶

³ See for example: Cornerstone Health, *Submission 6*; Shire of Coolgardie, *Submission 9*, p. 6; Central Coast Community Women's Health Centre (CCCWHC), *Submission 24*, p. 2; Meryl Swanson MP, *Submission 66*, p. 3; Youth Action NSW, *Submission 69*, p. 13; Brisbane North Primary Health Network, *Submission 77*, p. 3; MS Australia, *Submission 89*, p. 17; Jupiter Health and Medical Services Group, *Submission 136*; Name withheld, *Submission 160*; Name withheld, *Submission 162*, p. 1; Name withheld, *Submission 164*; Name withheld, *Submission 170*; Northern Queensland Primary Health Network, *Submission 191*, p. 6; Hunter New England and Central Coast Primary Health Network, *Submission 192*; New South Wales (NSW) Government, *Submission 193*, p. 4; Singleton Doctors, *Submission 208*, p. 5.

⁴ Australia Health Alliance (AHA), *Submission 3*, p. 2; Health and Medical Services Collective, *Submission 10*, p. 2; Mr John Williams, *Submission 30*, p. 1; Meryl Swanson MP, *Submission 66*, p. 3; Emma McBride MP, *Submission 68*, p. 1; Brisbane North Primary Health Network, *Submission 77*, p. 3; ZONTA Club of Biloela, *Submission 84*; Shoalhaven Family Medical Centers, *Submission 98*, p. 3; Pat Conroy MP, *Submission 100*; Brian Mitchell MP, *Submission 101*; Ali King MP, *Submission 103*, p. 3; Logan City Council, *Submission 121*, p. 2; Asthma Australia, *Submission 123*, p. 3; Name withheld, *Submission 157*, p. 2; Name withheld, *Submission 160*, p. 1; Name withheld, *Submission 161*, p. 1; Name withheld, *Submission 163*; Name withheld, *Submission 164*; Name withheld, *Submission 167*; Name withheld, *Submission 169*; Name withheld, *Submission 170*; Name withheld, *Submission 171*; NSW Government, *Submission 193*, p. 4; Mr Bob Katter MP, *Submission 196*; Singleton Doctors, *Submission 208*, p. 5; Latrobe Health Advocate, *Submission 210*, p. 13; Ms Theresa Cosgrove, *Submission 214*; Fiona Phillips MP, *Submission 215*.

⁵ See for example: WAPHARHW, *Submission 41*, p. 7; Emma McBride MP, *Submission 68*, p. 3; Pat Conroy MP, *Submission 100*, p. 6; Ali King MP, *Submission 103*, Appendix 2; Fiona Phillips MP, *Submission 215*, Attachment A.

⁶ Dr Ravi Ravoori, Practice Principal, MyHealth Medical Centre, *Proof Committee Hansard*, 7 March 2022, p. 22.

4.7 The delay in accessing a GP appointment has several consequences for health outcomes. Many inquiry participants told the committee that people become sicker and sicker while they wait to see a GP. The delay in timely appointments can also lead to the exacerbation of acute conditions, delayed diagnosis of illness (which in turn can impact the success of treatment and survival rates) and avoidable presentations at hospital emergency departments.⁷

4.8 One individual discussed how the lengthy waiting times for a GP impacts their health:

Having to wait this long for appointments and discussions of appropriate tests and treatment options has exacerbated these conditions and delayed diagnosis and the implementation of treatment and management plans, causing me increased periods of pain and an inability to work as a result. I have sacrificed my choice of preferred GP to more urgent issues, however the wait for any GP has still often been a minimum of a week, and this results in an inconsistent approach to managing emerging issues with consideration to my chronic health conditions.⁸

4.9 Similarly, Dr John Denness told the committee that:

... we tend to find that people leave things, so they come in quite sick. Someone who had a mild urinary tract infection, for example, called up to tell us, 'It's an emergency right now.' We said, 'We'll try and fit you in in three days time,' so they came in in three days and they had fevers; it had gone, basically, to a kidney infection, and they were quite unwell. If they'd been seen at the start, then it would have been a lot [inaudible], but the person was quite polite, realising that there was a doctor shortage, which took our wait to three days. We see things like that quite frequently, and the community is quite concerned about it. Trying to find doctor's appointments, care and those sorts of things is quite difficult for them. It's quite common for them not to even bother calling up the practice in town; they'll just drive straight to Cairns for help.⁹

4.10 The committee also heard of the impacts when there is no available GP or the GP surgery closes. One case study explained:

⁷ See for example: WAPHARHW, *Submission 41*, p. 11; Dr Lisa Fraser, *Submission 64*, p. 5; ACP, *Submission 75*, p. 2; Pharmacy Guild of Australia (PGA), *Submission 81*, p. 10; Health Consumers Tasmania, *Submission 93*, p. 8; Dr Fiona Kotvojs, *Submission 104*, p. 3; Royal Australian College of General Practitioners (RACGP), *Submission 107*, p. 1; Western Australian Department of Health, *Submission 141*, p. 4; Tasmania Government, *Submission 152*, p. 4; Dr Jerome Muir Wilson, General Practitioner, Launceston Medical Centre, *Proof Committee Hansard*, 24 January 2022, p. 10; Ms Angela Fredericks, Club Member, Zonta Club of Biloela, *Proof Committee Hansard*, 17 March 2022, p. 44.

⁸ Name withheld, *Submission 165*.

⁹ Dr John Denness, Private capacity, *Proof Committee Hansard*, 17 March 2022, p. 8.

After the recent shut down of Brighton Medical Centre, our family has been left in panic. I have spent days ringing as many GPs as I could as new patients with no luck at all and to only be told we are not taking new patients or we can place you on a waiting list. My husband is now left without a GP to monitor his heart and blood pressure condition, my 17-year-old daughter has now been left without mental health support for her medication. My 11-year old son had his appointment for a mental health plan cancelled due to the closure and now unable to get him assistance. I was halfway through testing to find out what was wrong with my own health with the possibility of Chron's disease and now unable to continue or find out without a new GP. The stress has been tremendous and the likelihood of getting a GP anytime soon seems impossible.¹⁰

- 4.11 GPs and other practice staff told the committee that they are struggling to meet the demand from communities for regular and urgent appointments, and that they regularly have to turn away patients.¹¹
- 4.12 For example, the Australia Health Alliance submitted that that their clinics are turning away up to 100 patients per day.¹² Dr Bradley Cranney, who owns and manages four general practices, also described that it is common that across these practices over 200 people who need appointments on a daily basis are turned away.¹³
- 4.13 Similarly, Ms Tegan Whatley, Practice Manager, Langwarrin Medical Clinic, told the committee:

We've had days where we have shut the doors and just said, 'We don't have anybody today.' What that then means, obviously, for the ongoing care for the patients is: (1) we can't offer any appointments; and (2) we can't offer consistent care to those with chronic conditions or complex health issues. I was explaining before that we have a three-day wait for a male GP for our existing patients—not new families or anyone who had moved down this way during the pandemic—and a seven-day wait for a female GP. So the need is there, but we can't provide the service.¹⁴

¹⁰ Mr Brian Mitchell MP, *Submission 101*, p. 6.

¹¹ See for example: AHA, *Submission 3*, p. 2; Riverlink Family Practice, *Submission 12*, p. 2; Ali King MP, *Submission 103*, p. 11; Dr Shamila Beattie, *Submission 135*, p. 1; Susan Templeman MP, *Submission 150*, p. 2; Dr Bradley Cranney, Practice Principal, Toukley Family Practice, Warnervale GP Superclinic, Tuggerah Medical Centre and Mariners Medical, 14 December 2021, *Proof Committee Hansard*, p. 1; Mrs Claudine Restom, Managing Director, Saratoga Medical Care, *Proof Committee Hansard*, 14 December 2021, p. 23; Dr Conelio Mafohla, Founder and Working Party Group, Central Coast General Practice Association (CCGPA), *Proof Committee Hansard*, 14 December 2021, p. 25

¹² AHA, *Submission 3*, p. 2.

¹³ Dr Bradley Cranney, Practice Principal, Toukley Family Practice, Warnervale GP Superclinic, Tuggerah Medical Centre and Mariners Medical, *Proof Committee Hansard*, 14 December 2021, p. 1.

¹⁴ Ms Tegan Whatley, Practice Manager, Langwarrin Medical Clinic, *Proof Committee Hansard*, 7 March 2022, p. 4.

Pressure on the hospital-system

- 4.14 The committee heard that when people are unable to access timely GP appointments, they will present to hospital emergency departments.¹⁵ According to the Productivity Commission, in 2020–21 there were approximately 3.2 million potentially avoidable GP-type presentations to public hospital emergency departments. This is a 12 per cent increase from 2019–20.¹⁶
- 4.15 Dr Gordon Reid, Emergency Career Medical Officer, Wyong District Hospital Emergency Department, told the committee that the Wyong District Hospital has experienced a 37.1 per cent increase in the number of emergency department presentations, including presentations which are more suitably managed by GP.¹⁷ Dr Reid further explained that many of the patients he sees in emergency who should be seen by a GP are those who cannot afford it or are unable to make a timely appointment and as a result their illness 'has spiralled out of control and become quite an acute illness'.¹⁸
- 4.16 Dr David Molhoek, Acting Director of Medical Services, Central Highlands, Central Queensland Hospital and Health Service, told the committee of the situation in Queensland:

For the calendar year of 2021, the No. 2 diagnosis code for all the [emergency departments] within the 4-to-5 triage category was Z00, which is general examination and investigation of persons without a complaint or reported diagnosis. I'll elaborate briefly on what that means. This was 4,961 presentations for the calendar year, but the diagnosis code when people put the diagnosis through on the ED system includes diagnoses like scheduled follow-up examination, administration of medication, surgical dressings, blood collection—those diagnosis codes that would very much fall within the remit of primary care. This was our top diagnosis code for a

¹⁵ See for example: Mr John Bruning, Chief Executive Officer, ACP, *Proof Committee Hansard*, 14 December 2021, p. 35; Mr Matt Jones, Chief Executive Officer, Murray Primary Health Network, *Proof Committee Hansard*, 4 November 2021, pp. 44–45; Western Australian Department of Health, *Submission 141*, p. 4; Dr Brad Cranney, *Submission 171*, p. 3; Chinchilla Community Centre, *Submission 80*, p. 3; Name withheld, *Submission 161*, p. 1; Ms Robyn Moore, Board Chair, CCCWHC, *Proof Committee Hansard*, 14 December 2021, p. 19; Dr Ameeta Patel, Committee Member, CCGPA, *Proof Committee Hansard*, 14 December 2021, p. 25; Dr Conelio Mafohla, Founder and Working Party Group, CCGPA, *Proof Committee Hansard*, 14 December 2021, p. 25; Mr Gavin Pearce MP, *Submission 32*, p. 3.

¹⁶ Productivity Commission, *Report on Government Services 2022 – Part E, Section 10: Primary and community health – Potentially avoidable presentation to emergency departments*, 1 February 2022, <https://www.pc.gov.au/research/ongoing/report-on-government-services/2022/health/primary-and-community-health> (accessed 2 February 2022).

¹⁷ Dr Gordon Reid, Emergency Career Medical Officer, Wyong District Hospital Emergency Department, Private capacity, *Proof Committee Hansard*, 14 December 2021, p. 11.

¹⁸ Dr Gordon Reid, Emergency Career Medical Officer, Wyong District Hospital Emergency Department, Private capacity, *Proof Committee Hansard*, 14 December 2021, p. 10.

lot of our rural hospitals— Baralaba, Biloela, Emerald, Blackwater, Mount Morgan, Woorabinda and Springsure. In Biloela, for example, last year, when they had approximately 7,000 presentations per year, up to 30 per cent of these presentations were within that diagnosis code: scheduled follow-up exam, 458; administration of medication, 260, or four per cent; dressings, 200, or three per cent; blood collection, 195; UTI, 105; and ankle sprain, 98.¹⁹

- 4.17 The increasing rate of presentations at emergency departments also comes at a cost to the broader health system. The Australasian College of Paramedicine estimates that the increased presentation of low and mid-acuity patients in hospitals costs approximately \$2.1 billion per year.²⁰
- 4.18 The committee heard that it is cheaper and more cost-effective to service these patients by a GP than to treat them at a hospital. For example, if an individual presents to the emergency department, it can cost upwards of \$500. If the individual is admitted to hospital this rises to over \$1000. In contrast, a standard consultation with a GP, the Medicare rebate is \$39.10.²¹

Access to culturally appropriate care

- 4.19 An important part of the primary health workforce are Aboriginal and Torres Strait Islander health professionals. These professionals have unique skills that ensure Indigenous Australians receive culturally safe and responsive health care; however, Aboriginal and Torres Strait Islander health professionals are underrepresented in the primary health workforce.²²
- 4.20 Aboriginal and Torres Strait Islander people continue to have worse health outcomes and are more likely to have higher levels of chronic disease and other pre-existing health conditions when compared to non-indigenous populations.²³
- 4.21 The committee heard preliminary evidence that there are challenges in the funding of Aboriginal Community Controlled Health Organisations, a lack of

¹⁹ Dr David Molhoek, Acting Director of Medical Services, Central Highlands, Central Queensland Hospital and Health Service, *Proof Committee Hansard*, 17 March 2022, p. 51.

²⁰ ACP, *Proof Committee Hansard*, 14 December 2021, p. 35.

²¹ Dr Christopher Boyle, *Submission 35*, p. 1; Dr Shamila Beattie, *Submission 135*, p. 2; Dr Karen Price, President, RACGP, *Proof Committee Hansard*, 4 November 2021, p. 5; Dr Patel, CCGPA, *Proof Committee Hansard*, 14 December 2021, p. 25.

²² Australian Institute of Health and Welfare (AIHW) and National Indigenous Australians Agency, *Aboriginal and Torres Strait Islander people in the health workforce*, 20 November 2020, <https://www.indigenoushpf.gov.au/measures/3-12-atsi-people-health-workforce> (accessed 23 March 2022).

²³ AIHW, *Indigenous Australians*, 7 December 2021, <https://www.aihw.gov.au/reports-data/population-groups/indigenous-australians/about> (accessed 23 March 2022); National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners, *Submission 87*, p. 3.

Aboriginal and Torres Strait Islander health workers, and a lack of consultation that occurs regarding Indigenous health.²⁴

Continuity of care

- 4.22 The maldistribution of GPs can lead to a disruption in a patient's continuity of care. Impediments to continuity of care can occur when there is no regular doctor available, there are extensive waiting times to see a preferred GP, when the regular GP moves away or retires, or in circumstances when there is a reliance on the use of locums. The committee also heard that continuity of care in relation to access to a GP reduces hospital admissions and increases life expectancy.²⁵
- 4.23 Submitters and witnesses expressed several concerns with a lack of continuity of care, including the sense of frustration at explaining issues multiple times to different practitioners, inconsistent treatment approaches, worsening of health conditions and the difficulty in building trust with new medical professionals.²⁶
- 4.24 The issue of continuity of care was particularly raised in relation to ongoing and chronic health conditions. For example, Ms Kirsty Briggs, Provisional Psychologist, Central Queensland Rural Division of General Practice Association said:

The high turnover in staff means that a lot of my clients aren't actually able to see the same GP again, which means having to discuss their situation with someone new, having to expose themselves again to someone new...The downside to that is that clients are walking away feeling that they haven't been heard. They're feeling that they've been dismissed, and they sometimes feel quite lost and abandoned. And the downside to that is that either they cut ties with services completely, and they go out into the community and their condition worsens, or they are forced to present to

²⁴ See for example: Aboriginal Health and Medical Research Council NSW, *Submission 143*, p. 2; Aboriginal Health Council of Western Australia, *Submission 113*, pp. 3-4.

²⁵ Department of Health (DoH), *Submission 38*, p. 31.

²⁶ See for example: Civic Park Medical Centre, *Submission 27*, p. 1; Australian Dental Association, *Submission 47*, p. 3; Rural Workforce Agency Network, *Submission 50*, p. 11; Office of the National Rural Health Commissioner, *Submission 56*, p. 14; Shoalhaven Family Medical Centers, *Submission 98*, p. 4; Name withheld, *Submission 165*, p. 1; District Council of Kimba, *Submission 137*, p. 2; Chinchilla Community Centre, *Submission 80*, p. 2; Derwent Valley Council, *Proof Committee Hansard*, 24 January 2022, p. 19; L Taylor, *Submission 203*, p. 3; Mr T Harpley, *Submission 36*, p. 1; Latrobe Health Advocate, *Submission 210*, p. 3; Steph Ryan MP, *Submission 106*, p. 2; Ali King MP, *Submission 103*, pp. 13, 18 and 24; Pat Conroy MP, *Submission 100*, p. 3; Fiona Phillips MP, *Submission 215*, p.2; Ms Lucinda Shannon, Deputy Chief Executive Officer, Women's Health Tasmania, *Proof Committee Hansard*, 24 January 2022, p. 27.

the emergency department, because that is the only avenue they have for services.²⁷

4.25 Another individual explained:

I am now on my 6th GP in 5 years. They keep leaving [the] area. Most good GP's have closed their books and will not accept new patients and [I] wait weeks for an appointment sometimes. I have breast cancer and now on my 3rd Medical Oncol [specialist] since early 2019. They are either retiring or not seeing public patients at the Cancer centre anymore. I just want the same GP/Specialist to see me [through] this medical journey.²⁸

Use of locums

4.26 Locums are relief primary health professionals and are often used to fill critical workforce shortages in outer-metropolitan, regional, rural and remote areas. Locums provide welcome relief to doctors and provide valuable services in areas where a doctor taking leave can mean that the community is without access to health services. Locums can sometimes also be the only doctor servicing a community.

4.27 While acknowledging that locums fill a critical workforce shortage, the committee heard that the high rates of locum turnover leads to an inconsistent and fragmented approach to care and creates difficulties for individuals to build trust with the doctor.²⁹

4.28 For example, Dr Michael Clements, Rural Chair, RACGP, stated that the locum system can be abused:

... but you're getting mercenaries that come and go from that town with no continuity. They don't have any ownership to the community or to the practice. They stop making discharge summaries. They kick them out of the [emergency department] as soon as they can because it's no longer their problem.³⁰

4.29 A similar situation was described by Mr Travis Barber, Mayor, District Council of Streaky Bay, who said:

²⁷ Ms Kirsty Briggs, Provisional Psychologist, Central Queensland Rural Division of General Practice Association, *Proof Committee Hansard*, 17 March 2022, pp. 28–29.

²⁸ Fiona Phillips MP, *Submission 215*: Attachment, p. 9.

²⁹ See for example: Civic Park Medical Centre, *Submission 27*, p. 1; DoH, *Submission 38*, p. 53; National Rural Health Alliance (NRHA), *Submission 95*, pp. 7–8; Shoalhaven Family Medical Centres, *Submission 98*, p. 5; RDAA, *Submission 109*, p. 10; NSW Outback Division of General Practice, *Submission 115*, p. 3; Local Government Association of Queensland, *Submission 128*, p. 2; Ms Josephine Flanagan, Chief Executive Officer, Women's Health Tasmania, *Proof Committee Hansard*, 24 January 2022, p. 25; Shire of Coolgardie, *Submission 9*, p. 6; Dr Chris Moy, Vice President, AMA, *Proof Committee Hansard*, 4 November 2021, pp. 10–11; Mr Dean Johnson, Mayor, District Council of Kimba, *Proof Committee Hansard*, 1 March 2022, p. 31.

³⁰ Dr Michael Clements, Rural Chair, RACGP, *Proof Committee Hansard*, 4 November 2021, p. 7.

I have a personal experience that I want to talk about, as Deb spoke about two of hers. Mine's personal; it was my daughter. We took her up to the hospital. She'd been feeling unwell for a few days. We had a locum who said there were kids with gastro and sent her home. She got very unwell over the next 24 hours. We took her up to see another locum—because there had been a changeover and there had been no reporting or any history of what had happened the night before—who also sent her home with gastro. At nine o'clock that night, she became unconscious. We raced her to the hospital and were on SAVES, which possibly saved her life, and found out she had actually got diabetes and we had no idea. The vomiting and the water drinking were all gastro signs, but she had diabetes. She spent 10 days in the ICU.³¹

4.30 Concerns were also raised about the costs of locum services.³² The daily rate for a locum doctor can be upwards of \$2000. This does not include the cost of travel and accommodation which is often borne by the general practice. Witnesses commented that this discrepancy in the pay between what an average GP can earn in a day compared with a locum acts as a disincentive to people taking on positions and staying long-term in an area.³³

4.31 For example, Dr Gerard Quigley, Principal, Lower Eyre Family Practice, stated:

So if you were to do locum at Port Lincoln Hospital ED, you would get paid \$2,500 for a 12-hour shift. I don't know what business could possibly afford that. The other problem that then causes for us is the people who have the skills we want, the rural generalist who has ED skills and inpatient care skills, is going to look at it and say, 'Why would I go and work somewhere like Streaky Bay or Cummins or wherever and get paid much less than that when I can—as you say—work three months of the year and make that money?' A market has been created that I can't compete with.³⁴

³¹ NB: SAVES stands for 'South Australian Virtual Emergency Service'. It links doctors with patients in country emergency departments via existing telehealth networks. See: Mr Travis Barber, Mayor, District Council of Streaky Bay, *Proof Committee Hansard*, 1 March 2022, p. 23.

³² See for example: NRHA *Submission 95*, pp. 7–8; Dr Rod Catton, *Submission 105*, p. 4; RDAA, *Submission 109*, p. 10; ACRRM *Submission 110*, p. 2; NSW Outback Division of General Practice, *Submission 115*, p. 3; Francis Family Doctors, *Submission 124*, p. 5; Associate Professor Catrina Fetlon-Busch, Remote Indigenous Health and Workforce, James Cook University, *Proof Committee Hansard*, 4 November 2021, p. 37.

³³ See for example: ACRRM, *Submission 110*, p. 7; Mr Jonas Woolford, Chair, Streaky Bay Medical Clinic, *Proof Committee Hansard*, 1 March 2022, p. 12; Dr Gerard Quigley, Principal, Lower Eyre Family Practice, *Proof Committee Hansard*, 1 March 2022, p. 19; Mr Travis Barber, Mayor, District Council of Streaky Bay, *Proof Committee Hansard*, 1 March 2022 p. 23; Mr Dean Johnson, Board Member, Northern Eyre Peninsula Health Alliance, *Proof Committee Hansard*, 1 March 2022, p. 38; Dr Michael Clements, Rural Chair, RACGP, *Proof Committee Hansard*, 4 November 2021, p. 7.

³⁴ Dr Gerard Quigley, Principal, Lower Eyre Family Practice, *Proof Committee Hansard*, 1 March 2022, p. 19.

- 4.32 This view was echoed by other inquiry participants. For example, Mr Matthew Cooke, Chief Executive Officer, Nhulundu Health Service, told the committee that in the last five years, the organisation had spent \$3.5 million on part time locums and that in total, they are spending 75 per cent of their funding from the Commonwealth paying for locums.³⁵
- 4.33 To improve continuity of care in communities reliant on locum services, one solution proposed to the committee was to implement a system where the same locum regularly visits the community.³⁶
- 4.34 A submission from the Western Australian General Practice Education and Training described that in the Pilbara region a pool of specialists has been recruited and rotate through the region alongside a resident specialist. This has ensured that 'the specialists rotating through the region are familiar with the services and networks and how the region operates' and has been 'highly successful and ensures a level of stability, while not being reliant on a single resident specialist for all services'.³⁷
- 4.35 The Department of Health submitted that there is a planned evaluation of the Rural Locum Assistance program in 2021–2022.³⁸ This program supports locums in MM2–7 locations.³⁹
- 4.36 The Department of Health further submitted that, while data is limited, the consultations on the National Medical Workforce Strategy 2021–2031 (NMWS), indicated that there is growing concerns about the over-reliance on locums and the risk this poses to continuity and quality of care, cultural appropriateness of care, and longer-term workforce sustainability.⁴⁰
- 4.37 The NMWS has listed as an action item to 'determine and monitor optimum use of locums'.⁴¹ This is expected to occur over a 2–5 year timeframe and to use data to 'determine a nationally agreed but locally responsive approach to the optimum use of locum workforce, taking account of patient, community and

³⁵ Mr Matthew Cooke, Chief Executive Officer, Nhulundu Health Service, *Proof Committee Hansard*, 17 March 2022, p. 16.

³⁶ Dr Toby Gardner, Lecturer, General Practice and Community Care, Tasmanian School of Medicine, University of Tasmania, *Proof Committee Hansard*, 24 January 2022, p. 61; Moura District Health Care Association, *Submission 188*, p. 2

³⁷ Western Australian General Practice Education and Training, *Submission 26*, p. 167.

³⁸ DoH, *Submission 38*, p. 54

³⁹ For a discussion on the Modified Monash Model see Chapter 1, paragraph 1.23.

⁴⁰ DoH, *Submission 38*, p. 33.

⁴¹ DoH, [National Medical Workforce Strategy 2021-2031](#), p. 5.

service needs'.⁴² During consultation on the strategy the following ideas were offered as potential solutions to the use of locums:

- standardise and cap locum pay levels and terms to rebalance usage of locums versus permanent positions;
- address recruitment and staffing models such as approval requirements for permanent staff recruitment, to allow hospital administrators more flexibility in recruiting doctors without the need to rely on locums;
- create incentives that encourage limiting locum use by health services; and
- implement new locum management models.⁴³

Costs of accessing a general practitioner

4.38 For some, the cost for an appointment with a non-bulk-billing GP can be prohibitive.

4.39 The average out-of-pocket costs for GP non-referred attendances where a co-payment is charged has increased in the past ten years. In the 2011–12 financial year, the national average for out-of-pocket costs was \$27.65 and in the 2020–21 financial year this increased to \$41.12.⁴⁴ The highest out-of-pocket costs were experienced in MM6 and MM7 locations at \$43.48 and \$43.44 respectively.⁴⁵

4.40 Bulk-billing rates and out-of-pocket costs also differ across the country by region. According to the Department of Health, in 2020–21, the bulk-billing national average was 88.75 per cent and the highest bulk-billing rate was in MM7 locations at 91.14 per cent.⁴⁶ Table 4.1 below shows the bulk-billing rates for non-referred GP attendances by Modified Monash Model (MM) classification.

Table 4.1 GP non-referred attendances bulk billing rates (percentage)

Financial year	MM1	MM2	MM3	MM4	MM5	MM6	MM7	National average
2018-19	87.22	82.70	83.11	83.52	84.67	83.66	89.90	86.24
2019-20	88.46	84.03	84.60	85.17	86.20	84.47	90.17	87.54
2020-21	89.56	85.39	86.09	87.00	87.95	85.38	91.14	88.75

Source: DoH, *Submission 38*, p. 67.

⁴² DoH, [National Medical Workforce Strategy 2021-2031](#), p. 43.

⁴³ DoH, [National Medical Workforce Strategy 2021-2031](#), pp. 76–77.

⁴⁴ DoH, *Submission 38*, p. 68.

⁴⁵ DoH, *Submission 38*, p. 68.

⁴⁶ DoH, *Submission 38*, p. 16.

4.41 In contrast, the committee heard that the number of bulk-billing GPs is declining and that it is exceedingly difficult for individuals to find a GP that will bulk-bill. The committee also received evidence that individuals are delaying health care due to costs and that this leads to worse health outcomes.⁴⁷

4.42 The Consumers Health Forum of Australia submitted that gap payments deter people from receiving care and that this has implications for the individual:

The gap keeps people away. For country people, it means they have to go to the city to get treatment and they have to leave their families and businesses and supports ... that means they leave things for too long and end up with major health problems and that is also a huge cost to the system.⁴⁸

4.43 One submission provided accounts of individuals who delayed their health care due to cost:

As a pensioner it is deflating and an insult that I have to regulate my Dr's visits due to them not Bulk Billing as they once used to. I had to change Dr's due to that reason only to find 12 months later my new Dr is no longer Bulk Billing. I feel like now I have to write a list of things that I need to ask the Dr about as I cannot afford to go when I need to see him.⁴⁹

4.44 Many GPs and practice managers discussed the difficulty in balancing affordable health care for their patients while meeting practice costs. Many GPs told the committee that they cannot viably operate a practice on the current Medicare rebates and must charge a co-payment to meet the costs of practice.⁵⁰

⁴⁷ See for example: Consumers Health Forum of Australia, *Submission 49*; Australian Physiotherapy Association, *Submission 63*, p. 3; Youth Action NSW, *Submission 69*, pp. 4 and 10–12; Brisbane North Primary Health Network, *Submission 77*, p. 3; MS Australia, *Submission 89*, p. 17; ACT Local Government, *Submission 92*, p. 5; Tasmania Government, *Submission 152*, p. 7.

⁴⁸ Consumers Health Forum of Australia, *Submission 49*, p. 9.

⁴⁹ Pat Conroy MP, *Submission 100*, p. 3.

⁵⁰ See for example: Name withheld, *Submission 157*, p. 2; Ms Jillian Power, Practice Manager, Central Coast Skin Cancer Clinic (CCSCC), *Proof Committee Hansard*, 14 December 2021, p. 29; Mr Goran Mujkic, Chief Executive Officer and Director, Deloraine and Westbury Medical Centre, *Proof Committee Hansard*, 24 January 2022, p. 14; Ms Lucina Wilk, Director, Total Care Medical Centre, *Proof Committee Hansard*, 7 March 2022, p. 17; Ms Caroline Radowski, Network Director, Clinical and Practice Excellence, Cohealth, *Proof Committee Hansard*, 7 March 2022, p. 11; Mr Jonas Woolford, Chair, Streaky Bay Medical Clinic, *Proof Committee Hansard*, 1 March 2022, p. 12.

4.45 For example, one GP submitted that:

...much to the disappointment of our GPs, who used to pride themselves in offering services at no cost to patients given the area's low socio-economic demographic; we are gradually introducing co-payments to patients who can barely afford to pay.⁵¹

4.46 Similarly, Ms Lucina Wilk, Director, Total Care Medical Centre told the committee:

I work in a low socioeconomic area. I have been encouraged—RACGP, AMA—to bring in private fees. They can't afford it. They just can't. Last week I had two patients that came out. They didn't have money for scripts. I went into my wallet and gave them the money to go and buy the scripts and buy their injections. This is the type of area that I'm working in. I have just recently put out that any new patients coming in that don't have a pension card or a health card have to pay a private consultation fee. As soon as they hear that, they're out the door.⁵²

4.47 The Department of Health submitted that in the 2017–18 Budget, the Government announced a \$1 billion commitment to re-introduce the indexation of Medicare Benefits Schedule (MBS) rebates and noted that for standard GP consultations indexation has occurred annually since 1 July 2018.⁵³ However, as discussed in Chapter 2, the re-introduction of indexation and current Medicare rebates are insufficient to meet patient needs and the rising cost of running a practice.⁵⁴

Distance and transportation

4.48 Travelling for health care is a particular concern in smaller outer-regional, rural, and remote areas. The vast distances required to travel to receive primary health care causes disruptions to the individual and their family, and creates difficulty for the management of conditions as there is little or no local services available for follow-up appointments.⁵⁵

4.49 Access to appropriate transportation was also raised as an issue in the availability of primary health care. Witnesses told the committee that a lack of

⁵¹ Name withheld, *Submission 157*, p. 2. Ms Power, CCSCC, *Proof Committee Hansard*, 14 December 2021, p. 29.

⁵² Ms Lucina Wilk, Director, Total Care Medical Centre, *Proof Committee Hansard*, 7 March 2022, p. 17.

⁵³ DoH, *Submission 38*, p. 64.

⁵⁴ See Chapter 2 paragraphs 2.77–2.89.

⁵⁵ See for example: Office of the National Rural Health Commissioner, *Submission 56*, p. 12; AHA, *Submission 3*, p. 5; Western Australian Local Government Association (WALGA), *Submission 21*, p. 1; DoH, *Submission 38*, p. 32; WAPHARHW, *Submission 41*; Clermont4Doctors, *Submission 19*, p. 1.

available public transport and high costs involved with travelling large distances can be prohibitive to individuals receiving health care.⁵⁶

- 4.50 The Department of Health notes there are several programs that encourage health professionals to travel to regional, rural, and remote communities to provide health care.
- 4.51 One program is the Rural Health Outreach Fund (RHOF). The RHOF aims to improve access to GPs, allied and other health providers, and other medical specialists in regional, rural, and remote areas of Australia by subsidising the cost of travel, facility hire and equipment leasing. It has four priority areas, including maternity and paediatric health, eye health, mental health, and support for chronic disease management. In the 2019–20 year, 206 797 patients used RHOF services.⁵⁷

The impacts of COVID-19

- 4.52 The COVID-19 pandemic has impacted all aspects of health care in Australia. In relation to the provision of GPs and related primary health services, the COVID-19 pandemic has exacerbated issues of accessibility and availability of health professionals and resulted in difficulties for individuals to receive timely health care, preventative health care, and management of chronic conditions.

Preventative health care and management of conditions

- 4.53 Submitters and witnesses told the committee that the COVID-19 pandemic intensified the issues of access and availability of GP appointments. Many told the committee that waiting times for a GP appointment increased as doctors were engaged in the pandemic response and that this led to a decrease in the level of preventative health care and management of chronic conditions.⁵⁸
- 4.54 Dr Michael Clements, Rural Chair, RACGP, told the committee:

We got a taste of what it's like when people don't see GPs, with the COVID lockdowns. I had 60-, 70- and 80-year-olds too scared to leave their house for months. They didn't come and see us, because of the COVID fear. We saw what happened. We saw later diagnoses of cancer. We saw people with abdominal pain for four months present with metastatic colorectal

⁵⁶ See for example: Mr Dean Griggs, General Manager, Derwent Valley Council, *Proof Committee Hansard*, 24 January 2022, p. 20; Dr Amanda Bethell, Chair Flinders and Far North Doctors Association, *Proof Committee Hansard*, 1 March 2022.

⁵⁷ DoH, *Submission 38*, p. 52.

⁵⁸ See for example: Royal Australasian College of Surgeons, *Submission 22*, p. 2; CCCWHC, *Submission 24*, p. 2; Equilibrium Healthcare, *Submission 39*, p. 1; Bawrunga Medical Service, *Submission 62*, p. 3; Alecto Australia, *Submission 76*, p. 6; ACON, *Submission 86*, p. 13; ACT Local Government, *Submission 92*, p. 10; Jupiter Health and Medical Services, *Submission 136*. Tamborine Mountain Medical Practice, *Submission 83*, p. 4; Name withheld, *Submission 164*, p. 1.

cancer. One of my GP friends' partners is a pathologist and said: 'Oh my gosh! I've never seen such advanced cancer. Normally I see cancer much earlier. Now I'm doing pathology samples on things that are a lot further.' We are seeing the health burdens. We are seeing a cancer increase. We're seeing the mental health burden when people don't have access to GPs for that preventive aspect. We are seeing it already, and it's just going to get worse.⁵⁹

- 4.55 The Latrobe Health Advocate also submitted that during the COVID-19 response people were not having routine screening and pathology tests and this caused health professionals to be concerned about the impacts for preventative health and the management of long-term health conditions.⁶⁰

Telehealth services

- 4.56 In response to the COVID-19 pandemic the Federal, state and territory governments implemented a range of measures designed to improve accessibility of health care while reducing the risk of transmission. One key policy response was the creation of MBS numbers for COVID-19 telehealth appointments. These were introduced across a range of primary and specialist health professions.⁶¹
- 4.57 According to the Department of Health, in 2019 GPs claimed 0.05 million MBS telehealth items. In 2020 this increased to 36.96 million and the number of face-to-face consultations decreased from 100.86 million in 2019 to 77.99 million in 2020.⁶²
- 4.58 Many inquiry participants welcomed the telehealth initiative and expressed the view that such technology is beneficial to accessing primary health care; however, concerns were raised about the potential impacts on continuity of care and to ensure that telehealth is not the only way of accessing health services. This was particularly raised in the context of allied health services as MBS telehealth rebates for these services are minimal or non-existent.⁶³

⁵⁹ Dr Michael Clements, Rural Chair, RACGP, *Proof Committee Hansard*, 4 November 2021, p. 5.

⁶⁰ Latrobe Health Advocate, *Submission 210: Attachment A*, pp. 10 and 12.

⁶¹ DoH, *Submission 38*, p. 106.

⁶² DoH, *Submission 38*, p. 107.

⁶³ See for example: Dr Michael Clements, Rural Chair, RACGP, *Proof Committee Hansard*, 4 November 2021, p. 4; Dr Chris Moy, Vice President, AMA, *Proof Committee Hansard*, 4 November 2021, p. 12; City of Karratha, *Submission 8*, p. 2; WALGA, *Submission 21*, p. 2; WAPHARHW, *Submission 41*, pp. 12–13; MIGA, *Submission 61*, p. 1; Regional Institute Australia, *Submission 71*, p. 5; Dr Emil Djakic, Private capacity, *Proof Committee Hansard*, 24 January 2022, p. 5; Dr Martin Kelly, Senior GP, Nganampa Health Council, *Proof Committee Hansard*, 1 March 2022, p. 9.

Border closures

- 4.59 International and state border closures due to COVID-19 also impacted on the accessibility of primary health care. This particularly occurred in communities that regularly rely on locums, as the border closures and quarantine requirements created difficulties in recruitment.⁶⁴
- 4.60 The WA Primary Health Alliance and Rural Health West explained that Western Australia relies heavily on international medical graduates and visiting locums from interstate to fill workforce shortages. They explained that COVID-19 severely impacted on the ability to recruit health professionals:
- COVID-19 has resulted in [a] reluctance of medical professionals to travel, and the controlled interstate border conditions have limited WA's access to interstate doctors. GPs and allied health professionals are now remaining in their home countries and Australian States as they are unwilling to accept the risks of remaining in two weeks' isolation as they enter and exit WA. Furthermore, the major attraction of providing locum services within WA was for GPs and other medical and health professionals to experience a working holiday. This is now much more difficult given the COVID-19 related complexities and constraints.⁶⁵
- 4.61 In South Australia, the Northern Eyre Peninsula Health Alliance, described a similar situation during the pandemic in which the region was unable to recruit locums to supplement resident GPs who cover a population of 5151, despite the increase in demand for GP services. They stated that general practices across the country were 'fighting over a limited talent pool' due to COVID-19 border closures.⁶⁶
- 4.62 The Department of Health submitted that the decrease in the number of GPs working in New South Wales, Western Australia, South Australia, the Australian Capital Territory, and in MM3–7 locations may be due to the COVID-19 travel restrictions. The Department also notes that these restrictions are expected to result in fewer than usual international medical graduates entering the primary health care system for the 2020–21 year.⁶⁷

⁶⁴ Healthlink Family Medical Centre, *Submission 5*, p. 2; Cornerstone Health, *Submission 6*, p. 4; St John WA, *Submission 18*, pp. 6–7; WALGA, *Submission 21*, p. 4; Civic Park Medical Centre, *Submission 27*, p. 2; Western Australian Primary Health Alliance and Rural Health West, *Submission 41*, p. 31; Queensland Nurses and Midwives Union, *Submission 45*, p. 9; Northern Eyre Peninsula Health Alliance, *Submission 48*, pp. 3–4; Rural Workforce Agency Network, *Submission 50*, p. 14; Myhealth Medical Group, *Submission 60*, p. 3; Regional Australia Institute, *Submission 71*, p. 6; Brecken health care, *Submission 74*, p. 1; Medical Deans Australia, *Submission 79*, p. 12; NSW Rural Doctors Network, *Submission 90*, p. 6; NRHA, *Submission 95*, p. 19; Western Australian Department of Health, *Submission 141*, pp. 9–10; Central Queensland Rural Division of General Practice *Submission 190*, p. 4–5.

⁶⁵ WAPHARHW, *Submission 41*, p. 31

⁶⁶ Northern Eyre Peninsula Health Alliance, *Submission 48*, pp. 3–4.

⁶⁷ DoH, *Submission 38*, pp. 106 and 110.

- 4.63 A range of other measures were also introduced, such as developing a short-term pandemic sub-register to enable qualified and experienced, but not currently practising, doctors, nurses, midwives, pharmacists and Aboriginal and Torres Strait Islander Health Practitioners, to return to the workforce.
- 4.64 Further, the Department of Health introduced a number of automatic extensions to the *Health Insurance Act 1973*, such as a 6-month extension for international medical graduates to continue to use their Medicare provider number, enabling them to practice in areas of need.⁶⁸

Scope of practice and a network of primary health professionals

- 4.65 Throughout the inquiry the committee also heard from other primary health professionals who spoke about the need for GPs to be better supported by strong networks of primary health practitioners.⁶⁹
- 4.66 These primary health professionals discussed the importance of enabling health care workers, such as nurses, to be working to their full scope of practice to improve health outcomes for individuals and relieve pressure on GP workload. For example, Mr Ken Griffin, Chief Executive Officer, Australian Primary Health Care Nurses Association, told the committee:

Our universities are training truly world-class nurses, but Medicare does not allow them in general practice to use all of their skills, which is madness when you're talking about the largest workforce in that part of the health system. Nurses are qualified, trained and experienced and are able to provide quality team based care; however, currently, 34 per cent of them, according to our annual survey—that is, one-third of primary healthcare nurses— say that they are not being fully utilised to the extent of their skills and experience. You wouldn't design a health system that way. Thirty per cent of nurses who asked to do more complex tasks are told no. The main reasons they're told no is: 'There isn't funding for it' or 'We're not used to doing it that way.' This needs to change. Nurse practitioners, who are our highest trained nurses, can do so much. They can work autonomously, diagnose and prescribe, but the current policies that surround this particular profession actually restrict their capacity as well. Data suggests that 30 to 40 per cent of nurse practitioners in primary health care work part time and only do a fraction of their scope.⁷⁰

⁶⁸ DoH, *Submission 38*, pp. 109–110.

⁶⁹ See for example: Health and Medical Services Collective, *Submission 10*, p. 7; Western Australia General Practice Education and Training, *Submission 26*, p. 116; Queensland Nurses and Midwives' Union, *Submission 45*; Rural Workforce Agency Network, *Submission 50*, p. 6; Australian Physiotherapy Association, *Submission 63*; p. 7; NRHA, *Submission 95*, p. 8; Australian College of Nursing, *Submission 108*, p. 1; Allied Health Professions Australia, *Submission 114*, p. 6; Occupational Therapy Australia, *Submission 120*, p. 8; Dr Michael Clements, Rural Chair, RACGP, *Proof Committee Hansard*, 4 November 2021, p. 4.

⁷⁰ Mr Ken Griffin, Chief Executive Officer, Australian Primary Health Care Nurses Association, *Proof Committee Hansard*, 7 March 2022, p. 33.

- 4.67 The committee heard similar views from Ms Claire Bekema, Senior Pharmacist, Clinical Governance and Workforce, Pharmacy Guild of Australia, in relation to pharmacists.⁷¹
- 4.68 The Australasian College of Paramedicine told the committee that currently there is an oversupply of paramedics in Australia and there is scope to better utilise paramedics in primary care settings. Mr John Brunning, Chief Executive Officer, Australasian College of Paramedicine, discussed the role that a 'community paramedic' could perform to support GPs:
- Community paramedics can provide urgent, acute, mid- and low-acuity care to patients in consultation with a GP. The paramedic could be engaged to undertake house calls, manage acute and urgent patients and undertake after-hours care to provide a more complete service, removing those patients from the ED system.⁷²
- 4.69 The Department of Health submitted that the Government funds Services for Australian Rural and Remote Allied Health to administer the Allied Health Rural Generalist Workforce and Education Scheme. This scheme is a pilot scholarship program to support graduate and early career allied health professionals.
- 4.70 The Department of Health notes that this scheme will directly contribute to expanding the scope of practice of allied health professionals and provide rural and remote communities with increased access to a highly skilled specialist generalist allied health workforce.⁷³

Committee view

- 4.71 Access to health care services and treatment is a right of all Australians, regardless of where they live. It is unacceptable that Australians living in outer-metropolitan, regional, and rural locations do not receive the same quality of care and experience worse health outcomes than their metropolitan counterparts.
- 4.72 The committee recognises that the Government has implemented several well-intentioned policies in an attempt to improve the distribution of primary health care professionals across the country; however, these policies are failing to have a substantial impact and as a result individuals and communities are left with limited or no access to primary health care.

⁷¹ Ms Claire Bekema, Senior Pharmacist, Clinical Governance and Workforce, PGA, *Proof Committee Hansard*, 4 November 2021, p. 38.

⁷² Mr John, Brunning, Chief Executive Officer, ACP, *Proof Committee Hansard*, 14 December 2021, p. 35.

⁷³ DoH, *Submission 38*, p. 117.

Access to primary health professionals

- 4.73 The committee was shocked to hear that individuals are waiting weeks or months to make an appointment with their GP. It is clear that these delays result in poorer health outcomes. Individuals are getting sicker as the wait for an appointment, and this can lead to the exacerbation of health conditions and delayed diagnoses.
- 4.74 The committee acknowledges that there is recognition by the Government of the GP shortages in regional, rural, and remote Australia. However, the committee is concerned that the Government and the Department of Health are unaware of the full scale of the shortages and that they do not recognise the lengthy waiting times many people experience in their assessment of GP workforce data.
- 4.75 The committee acknowledges that Indigenous Australians experience worse health outcomes compared to non-Indigenous Australians and that one way to improve health outcomes is to ensure that Indigenous Australians receive culturally appropriate care.

Continuity of care

- 4.76 The committee acknowledges that continuity of care is a real issue for Australians living in outer-metropolitan, regional and rural areas, and that a lack of continuity of care causes difficulty in building trust with a medical professional. It can also lead to other perverse outcomes such as an exacerbation of chronic and complex conditions, misdiagnosis, and can leave otherwise treatable conditions untreated.
- 4.77 The committee notes this issue was particularly raised in relation to use of locum doctors, and recognises that locums are sometimes the only option for communities to receive primary health care.
- 4.78 The committee acknowledges that the Department of Health has a planned review of the Rural Local Assistance Program for 2021–22 and it awaits the results of this review
- 4.79 The committee further notes that the NMWS has an action to item to 'determine and monitor optimum use of locums' over a two to five year period. The committee is also concerned that this issue requires immediate action and that a further two to five year waiting period for consultation and review is too long when communities are already struggling.
- 4.80 The committee is, however, supportive of this overarching objective and the proposals suggested during the consultation on the NMWS, including the proposals to:
- standardise and cap locum pay levels and to rebalance usage of locums versus permanent positions;

- address recruitment and staffing models such as approval requirements for permanent staff recruitment to allow hospital administrators more flexibility in recruiting doctors without the need to rely on locums;
 - create incentives that encourage limiting locum use by health services; and
 - implement new locum management models.
- 4.81 The committee supports the suggestion that many communities would benefit from a locum system in which the same locum GP was able to visit the same community regularly and repeatedly. This would ensure that individuals would benefit from continuity of care and that the locum would become aware of the broader context and health needs of their patients.

Costs of accessing a GP

- 4.82 Individuals are struggling to find GPs who will consistently bulk-bill them for their appointments, and the committee is deeply troubled that individuals are delaying health care due to cost.
- 4.83 Medicare was designed to ensure that every Australian can access affordable health care; however, the current rates are forcing GPs to implement gap payments to meet their costs, and this is leading to negative impacts on individual health outcomes.
- 4.84 The committee was distressed to hear that many people are delaying their health care as they are unable to find a GP that solely bulk-bills.
- 4.85 The committee reiterates its recommendation to substantially increase the Medicare rebates, as discussed in Chapter 2.

Telehealth

- 4.86 The committee acknowledges that the introduction of Medicare rebates for telehealth has led to improvements to accessing primary health care, particularly in the context of the COVID-19 pandemic. The committee notes that some telehealth MBS items have been made permanently available while others have been removed.
- 4.87 The committee also heard several concerns about the use of telehealth and the importance of maintaining face-to-face consultations. The committee further notes that the Medicare rebates for telehealth services predominantly focus on GPs and do not extend to other primary health professionals.

Networks of primary health professionals

- 4.88 Throughout the inquiry the committee heard that it is important to consider the full range of primary health professionals and their scope of practice when discussing the health outcomes for individuals and the broader environment of the primary health care sector.

- 4.89 The committee also acknowledges that there is variation in the distribution of other primary health professionals. The levels of access to certain primary health professionals, such as those in the allied health sector, generally decline with increasing levels of remoteness.
- 4.90 It is clear to the committee from the evidence received thus far that the primary health system works best when there is collaboration amongst multiple primary health professional. There is a clear need to improve the distribution of other health professionals and increase their role in supporting GPs in delivering health care. The committee is interested in receiving further evidence from this sector, particularly in relation to different primary health network models that could provide a solution to the maldistribution of the primary health workforce across Australia.

Senator Janet Rice
Chair

Appendix 1

Submissions and additional information

Submissions

- 1 Central Coast Skin Cancer Clinic
- 2 Shire of Murray
- 3 Australia Health Alliance
- 4 HR+ Tasmania
- 5 Healthlink Family Medical Centre
- 6 Cornerstone Health
 - 3 Attachments
- 7 Shire of Corrigin
- 8 City of Karratha
- 9 Shire of Coolgardie
- 10 Health and Medical Services Collective
- 11 Wollongong Medical Service Co-Op
- 12 Riverlink Family Practice
- 13 Habitat Therapeutics Private Hospital
- 14 Regional Council of Goyder
- 15 Northern Territory General Practice Education
- 16 Central Australian Rural Practitioners Association
- 17 Family Planning NSW
- 18 St John WA
- 19 Clermont4Doctors
- 20 Australian College of Paramedic Practitioners Ltd
- 21 Western Australian Local Government Association
- 22 Royal Australasian College of Surgeons
- 23 TeamMed Medical Centres
- 24 Central Coast Community Women's Health Centre
- 25 DXC Medical Recruitment
- 26 Western Australia General Practice Education and Training
 - 3 Attachments
- 27 Civic Park Medical Centre
- 28 Medical Consumers Association
- 29 Prof Jeanette Ward
- 30 Mr John Williams
- 31 Dr Mike Freeland MP
- 32 Mr Gavin Pearce MP
- 33 Ms Trevellyn Evans
- 34 Dr Michael Connellan
- 35 Dr Christopher Boyle

- 36 Mr Travis Harpley
- 37 Dr Janice Nelson
- 38 Department of Health
- 39 Equilibrium Healthcare
- 40 Wheatbelt Health Network
- 41 WA Primary Health Alliance and Rural Health West
- 42 City of Greater Geraldton
- 43 Wesley Medical Research
- 44 Melanoma & Skin Cancer Advocacy Network
- 45 Queensland Nurses and Midwives' Union
- 46 Primary Health Network Cooperative
- 47 Australian Dental Association
- 48 Northern Eyre Peninsula Health Alliance
- 49 Consumers Health Forum
- 50 Rural Workforce Agency Network
- 51 Mental Health Australia
- 52 Remote Vocational Training Scheme
- 53 New England Virtual Care Network
 - 1 Attachment
- 54 Continence Foundation of Australia
- 55 LGBTIQ+ Health Australia
- 56 Office of the National Rural Health Commissioner
- 57 Northern Territory General Practice Education
- 58 Australian Diagnostic Imaging Association
- 59 Deloraine & Westbury Medical Centre
- 60 Myhealth Medical Group
- 61 MIGA
- 62 Bawrunge Medical Service
- 63 Australian Physiotherapy Association
- 64 Dr Lisa Fraser
- 65 Mrs Peter van Tilburg
- 66 Meryl Swanson MP
- 67 Amanda Rishworth MP
- 68 Emma McBride MP, Member for Dobell
 - 1 Attachment
- 69 Youth Action NSW
- 70 Derwent Valley Council
- 71 Regional Australia Institute
- 72 GP Synergy Ltd
- 73 Australian GP Alliance
- 74 Brecken health care
- 75 Australasian College of Paramedicine
- 76 Alecto Australia

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- 77 Brisbane North Primary Health Network
 - 78 Sonic Clinical Services
 - 79 Medical Deans Australia and New Zealand
 - 80 Chinchilla Community Centre
 - 81 Pharmacy Guild of Australia
 - 82 Tresillian
 - 83 Tamborine Mountain Medical Practice
 - 84 ZONTA Club of Biloela
 - 85 General Practice Training Tasmania
 - 86 ACON
 - 87 National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners
 - 88 Novartis Pharmaceuticals Australia Pty
 - 89 MS Australia
 - 2 Attachments
 - 90 NSW Rural Doctors Network
 - 91 Australian Federation of AIDS Organisations
 - 92 ACT Local Government
 - 93 Health Consumers Tasmania
 - 94 Australian Medical Association
 - 95 National Rural Health Alliance
 - 96 Australian Federation of Medical Women
 - 97 Tristar Medical Group
 - 98 Shoalhaven Family Medical Centers
 - 99 Launceston Medical Centre
 - 100 Pat Conroy MP
 - 101 Brian Mitchell MP
 - 102 Kristy McBain MP
 - 103 Ali King MP - State Member Pumicestone
 - 104 Dr Fiona Kotvojs
 - 105 Dr Rod Catton
 - 3 Attachments
 - 106 Steph Ryan MP, Victoria
 - 107 The Royal Australian College of General Practitioners
 - 108 Australian College of Nursing
 - 109 Rural Doctors Association of Australia
 - 110 Australian College of Rural and Remote Medicine
 - 111 Streaky Bay Medical Clinic
 - 112 Moura MPHS Community Advisory Group
 - 113 Aboriginal Health Council of Western Australia
 - 114 Allied Health Professions Australia
 - 115 NSW Outback Division of General Practice
 - 116 South Eastern NSW Primary Health Network

- 117 The Society of Hospital Pharmacists of Australia
- 118 Rural and Remote Medical Services
- 119 Mental Health Commission NSW
- 120 Occupational Therapy Australia
- 121 Logan City Council
- 122 The Australian Population Research Institute
 - 3 Attachments
- 123 Asthma Australia
- 124 Francis Family Doctors
- 125 Carers Australia
- 126 Better Medical
- 127 Australian Breastfeeding Association
- 128 Local Government Association of Queensland
- 129 Royal Far West
- 130 Varian
- 131 Adjunct Associate Professor Ray Bange OAM
- 132 Dr Philip Ewart
 - 7 Attachments
- 133 Dr Dominic Frawley
- 134 Dr Adam Heaton
- 135 Dr Shamila Beattie
- 136 Jupiter Health and Medical Services Group
 - 8 Attachments
- 137 District Council of Kimba
- 138 Caboolture Super Clinic
- 139 Ochre Health
- 140 Central Coast General Practice Association
- 141 Western Australian Department of Health
- 142 Isaac Regional Council
- 143 Aboriginal Health and Medical Research Council of NSW
- 144 Save Our Sons Duchenne Foundation
 - 2 Attachments
- 145 General Practice Training Queensland
- 146 James Cook University
- 147 Australian Local Government Association
- 148 Royal Flying Doctor Service of Australia
- 149 University of Queensland
- 150 Susan Templeman MP
- 151 Australian Medical Students' Association
- 152 Tasmanian Government
- 153 Services for Australian Rural and Remote Allied Health
 - 1 Attachment

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- 154 Murray City Country Coast GP Training
- 155 Exercise & Sports Science Australia
- 156 *Name Withheld*
- 156.1 Supplementary submission
- 157 *Name Withheld*
- 158 *Name Withheld*
- 159 *Name Withheld*
- 160 *Name Withheld*
- 161 *Name Withheld*
- 162 *Name Withheld*
- 163 *Name Withheld*
- 164 *Name Withheld*
- 165 *Name Withheld*
- 166 *Name Withheld*
- 167 *Name Withheld*
- 168 *Name Withheld*
- 169 *Name Withheld*
- 170 *Name Withheld*
- 171 *Name Withheld*
- 172 *Name Withheld*
- 173 *Name Withheld*
- 174 Mr Brian Connor
- 175 Dr Bradley Cranney
- 176 Dr Hamish Meldrum
- 177 Dr Gonasagaran Ruthnam
- 178 Dr Rohana Wanasinghe
- 179 Dr John Stanford
- 180 Dr Eoin McDonnell
- 181 *Confidential*
- 182 *Confidential*
- 183 Dr Ewen McPhee
- 183.1 Supplementary submission
- 184 *Confidential*
- 185 *Confidential*
- 185.1 Confidential
 - 185.2 Confidential
- 186 *Confidential*
- 187 *Confidential*
- 188 Moura District Health Care Assoc. Inc.
- 189 Doctors&Co
- 190 Central Queensland Rural Division of General Practice
- 191 Northern Queensland Primary Health Network

- 192 Hunter New England and Central Coast PHN
- 193 NSW Government
- 194 Peta Murphy MP
- 195 N&M Services Pty Ltd.
- 196 Bob Katter MP
- 197 Australian Primary Health Care Nurses Association and Australian College of Nurse Practitioners
- 198 Practice Managers Network, Facebook group
- 199 City of Mandurah
- 200 Northern Territory Government
- 201 Dr Kenneth McCroary
- 202 Dr Gordon Reid
- 203 Ms Lynette Taylor
- 204 Mr Craig Davies
- 205 Dr John Denness
- 206 *Name Withheld*
- 207 *Name Withheld*
- 208 Singleton Doctors
- 209 Seniors Dental Care Australia
- 210 Latrobe Health Advocate
 - 3 Attachments
- 211 Mr Bob Bensley
- 212 Dr Jaime Pena
- 213 Dr Michael Pentin
- 214 Ms Theresa Congrave
- 215 Fiona Phillips MP, Federal Member for Gilmore
 - 215.1 Supplementary submission
- 216 *Confidential*
- 217 Flinders University
- 218 FCD Health Limited

Additional Information

- 1 Correspondence from the Mental Health Commission of NSW, 11 October 2021
- 2 Letter regarding evidence received during a hearing on 4 December 2021, sent from General Practice Training Queensland, 9 December 2021
- 3 A letter regarding an application to review the Distribution Priority Area for the Warnervale GP Super Clinic, submitted by Dr Brad Cranney, 14 December 2021.
- 4 Overview of the GP registration process with AHPRA for Overseas Trained Doctors, provided by Deloraine & Westbury Medical Centre, 25 January 2021.
- 5 Report 'Diagnosing a rural doctor deficiency: Symptoms of labour shortages in Shepparton general practice' prepared by Madeline Pentland for Ms Suzanna Sheed MLA for Shepparton, received 17 January 2022

- 6 Additional information provided by Ochre Health following the hearing on Monday 24 January 2022, received Friday 18 February 2022
- 7 Slideshow, received from Professor Lucie Walters, Adelaide Rural Clinical School, 2 March 2022
- 8 The Australian Remote Medicine Academy – Concept paper, received from Professor Lucie Walters, Adelaide Rural Clinical School, 2 March 2022
- 9 Research article on the perceptions of primary care provided by Professor Lucie Walters, received 4 March 2022
- 10 Research articles provided by Associate Professor Martin Jones, received 7 March 2022
- 11 Correspondence from Peta Murphy MP regarding joint application for DPA status for Frankston catchment, 8 March 2022
- 12 Additional information provided by Australia Health Alliance following the hearing on 1 March 2022, received 8 March 2022
- 13 Survey of rural doctors, provided by the Rural Doctors Association of South Australia, received 9 March 2022
- 14 Additional information provided by Ms Tegan Whatley following the hearing on 7 March 2022, received 11 March 2022
- 15 Needs assessment and recommended model for the Northern Eyre Peninsula, provided by the Northern Eyre Peninsula Health Alliance, received 25 March 2022
- 16 Additional information provided by Dr John Saul following the hearing on 17 March 2022, received 25 March 2022
- 17 Opening statement from Frankston hearing, provided by cohealth, received 28 March 2022
- 18 Additional information provided by Dr Matt Masel following the hearing on 17 March 2022, received 29 March 2022.

Answers to Questions on Notice

- 1 Answers to questions taken on notice during 4 November public hearing, received from Rural Workforce Agency Network, 18 November 2021
- 2 Answers to questions taken on notice during 4 November public hearing, received from James Cook University, 25 November 2021
- 3 Answers to questions taken on notice during 4 November public hearing, received from Department of Health on behalf of the Primary Health Network Cooperative, 1 December 2021
- 4 Answers to written questions on notice, received from the Hunter New England and Central Coast Primary Health Network, 16 December 2021
- 5 Answer to question taken on notice during 14 December public hearing, received from Australasian College of Paramedicine, 21 December 2021
- 6 Answer to question taken on notice during 14 December public hearing, received from the NSW Rural Doctors Network, 13 January 2022.

- 7 Answer to question taken on notice during 4 November public hearing, received from the Department of Health, 28 January 2022
- 8 Answer to question taken on notice during 4 November public hearing, received from the Department of Health, 9 February 2022.
- 9 Answer to written questions on notice, received from the Department of Health, 10 February 2022
- 10 Answer to question taken on notice during 7 March 2022 public hearing, received from Associate Professor Lara Fuller, Deakin University, 7 March 2022
- 11 Answer to question taken on notice during 7 March 2022 public hearing, received from Allied Health Professions Australia, 10 March 2022
- 12 Answer to question taken on notice during 1 March 2022 public hearing, received from Rural Doctors Workforce Agency, 15 March 2022
- 13 Answer to question taken on notice during 1 March 2022 public hearing, received from GPEx, 15 March 2022
- 14 Answers to written questions on, received from the Department of Education, Skills, and Employment, 21 March 2022

Media Releases

- 1 Media Release- Inviting submission to Inquiry, 9 August

Tabled Documents

- 1 Opening statement, tabled by Rural and Remote Medical Services, at Erina public hearing, 14 December 2021
- 2 GP survey report of the Grey electorate, South Australia, tabled by Senator Grogan, at Whyalla public hearing, 1 March 2022
- 3 Adelaide Rural Clinical School, tabled by Professor Lucie Walters, at Whyalla public hearing, 1 March 2022
- 4 ADIA Workforce Survey, tabled by Dr Julian Adler, at Melbourne public hearing, 7 March 2022
- 5 Correspondence between Ms Peta Murphy MP and office of the Hon. Greg Hunt MP, tabled by Lucina Wilk, Total Care Medical Group, at Melbourne public hearing, 7 March 2022
- 6 Australian Medical Association Council of Rural Doctors opening statement, tabled by Dr Marco Giuseppin, at Emerald public hearing, 17 March 2022
- 7 Central Queensland Hospital and Health Service opening statement, tabled by Dr David Molhoek, at Emerald public hearing, 17 March 2022
- 8 Royal Flying Doctor Service opening statement, tabled by Mr Frank Quinlan, at Emerald public hearing, 17 March 2022
- 9 Rural Health Management Services, tabled by Central Queensland Rural Division of General Practice, at Emerald hearing, 17 March 2022

Appendix 2

Public Hearings

Thursday, 4 November 2021

Committee Room 2S1

Parliament House

Canberra

The Royal Australian College of General Practitioners

- Dr Karen Price, President
- Dr Michael Clements, Rural Chair

Australian Medical Association

- Dr Chris Moy, Vice President
- Associate Professor Peter Macguire, Council of Rural Doctors

Australian College of Rural and Remote Medicine

- Dr Sarah Chalmers, President
- Dr Ewen McPhee, Past President

Rural Doctors Association of Australia

- Dr Megan Belot, President
- Dr John Hall, President

National Rural Health Alliance

- Ms Gabrielle O'Kane, Chief Executive Officer
- Ms Clare Fitzmaurice, Policy and Data Analytics Officer

Rural Workforce Agency Network

- Mr Chris Mitchell, Chair
- Mr Edward Swan, Executive Officer, Representation and Engagement

James Cook University

- Professor Richard Murray, Deputy Vice Chancellor of the Division of Tropical Health and Medicine
- Associate Professor Peta Anne Teague, Associate Dean, Strategy and Engagement, Division of Tropical Health and Medicine
- Professor Sabrina Knight AM, Director, Murtupuni Center for Rural and Remote Health
- Associate Professor Catrina Felton-Busch, Remote Indigenous Health and Workforce
- Mr Kane Langdon, James Cook University 6th Year Bachelor of Medicine, Bachelor of Surgery Student

Pharmacy Guild of Australia

- Mr Simon Blacker, ACT Branch President and Chair of Community Pharmacies for Rural and Indigenous Australia Sub-committee
- Ms Claire Bekema, Senior Pharmacist Clinical Governance and Workforce

Office of the National Rural Health Commissioner

- Professor Ruth Stewart, National Rural Health Commissioner

Primary Health Network Cooperative

- Mr Matt Jones, Chief Executive Officer

Department of Health

- Ms Penny Shakespeare, Deputy Secretary, Health Resourcing Group
- Mr Matthew Williams, First Assistant Secretary, Health Workforce Division
- Dr Susan Wearne, Medical Advisor, Health Workforce Division
- Mr Martin Rocks, Assistant Secretary, Health Training Branch
- Ms Louise Clarke, Assistant Secretary, Rural Access Branch
- Mr Nick Pascual, Assistant Secretary, Bonded Taskforce
- Ms Teresa Gorondi, Assistant Secretary, Health Workforce Reform Branch

Tuesday, 14 December 2021

Frank Edwards Room

Erina Leagues Club

18 Ilya Avenue

Erina

Dr Shamila Beattie, Private capacity

Dr Bradley Cranney, Private capacity

Dr Gordon Reid, Private capacity

Dr Aniello Iannuzzi, Private capacity

Central Coast Community Women's Health Centre

- Ms Robyn Moore, Board Chair

Central Coast General Practice Association

- Dr Con Mafohla, Founder
- Dr Ameeta Patel, Member
- Mrs Claudine Restom, Member
- Dr Adam Moody, Member

Central Coast Skin Cancer Clinic

- Ms Jillian Power, Practice Manager

Australasian College of Paramedicine

- Mr John Bruning, Chief Executive Officer
- Ms Michelle Murphy, Advocacy and Government Relations Lead

Rural and Remote Medical Services

- Mr Mark Burdack, Chief Executive Officer
- Mr Richard Anicich AM, Board Chair

NSW Rural Doctors Network

- Mr Richard Colbran, Chief Executive Officer
- Associate Professor John Kramer OAM, Board Chair

Monday, 24 January 2022

Hotel Grand Chancellor

Chancellor room 6

Launceston

Dr Emil Djakic, Private capacity

Launceston Medical Centre

- Dr Jerome Muir Wilson, Practice Principal

Deloraine & Westbury Medical Centre

- Dr Johannes Schonborn, Medical Director
- Mr Goran Mujkic, Chief Executive Officer
- Ms Tanya Barrett, Practice Manager

Derwent Valley Council

- Mr Dean Griggs, General Manager

Women's Health Tasmania

- Ms Jo Flanagan, Chief Executive Officer
- Ms Lucy Shannon, Deputy Chief Executive Officer

Health Consumers Tasmania

- Professor Judi Walker, Board Chair

General Practice Training Tasmania

- Ms Judy Dew, Chief Executive Officer
- Mr Paul Viney, Board Chair

HR+ Tasmania

- Mr Peter Barns, Chief Executive Officer

Ochre Health

- Dr Hamish Meldrum, Director and Founder
- Mr Matthew Chudley, National GP Recruitment & Engagement Manager

Professor Neil Spike AM

- Director of Medical Education & Training, Eastern Victoria GP Training

Dr Toby Gardner

- Lecturer General Practice and Community Care School of Medicine, University of Tasmania

Tuesday, 1 March 2022

The Conference Room

The Alexander Motel

Whyalla

GPEX

- Dr Tony Sherbon, Chairman
- Ms Stephanie Clota, Chief Executive Officer

Nganampa Health Council

- Dr Martin Kelly, Senior Medical Officer

Streaky Bay Medical Clinic

- Mr Jonas Woolford, Chair

Novita

- Ms Cathryn Blight, General Manager Regional Services

Dr Gerard Quigley

- Principal, Lower Eyre Family Practice

Regional Council of Goyder

- Mr David Stevenson, Chief Executive Officer
- Mr Peter Matthey OAM, Mayor

District Council of Kimba

- Mrs Debra Larwood, Chief Executive Officer
- Mr Dean Johnson, Mayor

District Council of Streaky Bay

- Mr Travis Barber, Mayor

Australia Health Alliance

- Mr John McMahon, Director
- Ms Gemma Gough, Senior Operations Manager

Northern Eyre Peninsula Health Alliance

- Mr Shane Gill, Board Member
- Mr Dean Johnson, Board Member

Dr Amanda Bethell

- Chairperson, Flinders and Far North Doctors Association

Rural Doctors Association of South Australia

- Dr Peter Rischbieth, President
- Dr Gerry Considine, Vice President
- Dr Phil Tideman, Vice President
- Dr Dianna Carr, Vice President

Rural Doctors Workforce Agency - South Australia

- Ms Lyn Poole, Chief Executive Officer

Flinders University

- Professor Robyn Aitken, Dean, Rural and Remote Health South Australia
- Professor Alison Jones, Dean, Education, College of Medicine and Health
- Associate Professor Christine Dennis, Rural and Remote Health South Australia

University of Adelaide - Adelaide Rural Clinic School

- Professor Lucie Walters, Director

University of South Australia - Department of Rural Health

- Associate Professor Martin Jones, Director

Monday, 7 March 2022

The Peninsula Room
Frankston Arts Centre
Melbourne

Wallan Family Practice

- Dr Dennis Holland, Principal GP
- Ms Julie Briggs, Practice Manager

Mediq Wallan Medical Clinic

- Dr Selim Shubbar, Clinic Director
- Mrs Manar Shubbar, Practice Manager

Langwarrin Medical Clinic

- Ms Tegan Whatley, Practice Manager

Co-Health

- Dr Kim Webber, Executive Lead, Strategy, Impact and Development
- Ms Caroline Radowski, Network Director, Clinical and Practice Excellence

- Dr Nicole Allard, General Practitioner

Total Care Medical Clinic

- Ms Lucina Wilk, Director

Hall Road Medical Centre

- Dr Ahmed Tilly, Practice Principal
- Ms Mandy Williams, Practice Manager

Balnarring Medical Centre

- Mr Simon Spalding, Nurse, Administration

ForHealth (including Young St Medical Clinics)

- Mr Andrew Cohen, Chief Executive Officer, ForHealth
- Mr Andrew Crow, Director, ForHealth Victoria
- Dr Carolyn Roesler, Regional Clinical Director, South Australia

MyHealth Bayside

- Dr Ravi Ravoori, Practice Principal

Ballarto Road and St Mary's Medical Centre

- Mrs Rachael Hatzopoulos, Operations Manager
- Dr Ehab Mostokly, Principal GP
- Dr Awad William Ghattas, Principal GP
- Dr Li Yan, Principal GP
- Dr Jaspreet Gill, Former Employee of Ballarto Road and St Mary's Medical Centre

Allied Health Professions Australia

- Mrs Claire Hewat, Chief Executive Officer
- Dr Chris Atmore, Manager, Policy and Advocacy

Australian Primary Health Care Nurses Association and Australian College of Nurse Practitioners

- Mr Ken Griffin, Chief Executive Officer, Australian Primary Health Care Nurses Association
- Ms Leanne Boase, President, Australian College of Nurse Practitioners

Australian Diagnostic Imaging Association

- Mr Slade Carter, Director of Policy
- Dr Julian Adler, President
- Mr Chris Kane, Chief Executive Officer

Alecto Australia

- Ms Martina Stanley, Director
- Ms Megan Lewis, Registration Manager

Westgate Community Health

- Ms Liz Hunter, Chief Executive Officer
- Dr Stephen O'Shea, Doctor
- Dr Kay Whitfield

Australian Medical Student Association

- Ms Jasmine Davis, President

Monash University

- Professor Michelle Leech, Deputy Dean, Medicine
- Professor Danielle Mazza, Head, Department of General Practice
- Associate Professor Michael Nowotny, Director of Gippsland Regional Training Hub, Monash Rural Health
- Dr Cylie Williams, School of Primary and Allied Health Care

The University of Melbourne

- Professor Lena Sanci, Chair of General Practice, Melbourne Medical School
- Dr Steve Bismire, Deputy Director, Medical Education Rural Clinical School
- Professor Steve Trumble, GP and Head, Department of Medical Education
- Professor Lisa Bourke, Director, Department of Rural Health

Deakin University

- Professor Gary Rogers, Dean of Medicine
- Associate Professor Lara Fuller, Director, Rural Community Clinical School
- Dr Eldon Lyon, Senior Lecturer, Rural Medicine Education General Practice

Department of Health

- Dr Brendan Murphy, Secretary
- Ms Penny Shakespeare, Deputy Secretary, Health Financing
- Mr Matthew Williams, First Secretary, Health Workforce
- Mr Martin Rocks, Assistant Secretary, Health Training
- Ms Louise Clarke, Assistant Secretary, Rural Access
- Mr Pat Janek, Acting Assistant Secretary, Health Workforce Surge Taskforce
- Ms Teresa Gorondi, Assistant Secretary, Health Workforce Reform Branch
- Dr Susan Wearne, Medical Officer
- Ms Maureen McCarty, Director

Department of Education, Skills, and Employment

- Mr Dom English, First Assistant Secretary, Higher Education Division
- Ms Kate Chipperfield, Assistant Secretary, Funding and Students Branch

Thursday, 17 March 2022

Mayfair Ridge Tavern

7/11 Mayfair Drive

Emerald, QLD

Dr Ewan McPhee, Private capacity

Dr John Denness, Private capacity

Nhulundu Health Service

- Mr Matthew Cooke, Chief Executive Officer
- Ms Jennifer Kerr, Clinical Practice Manager

Woorabinda Aboriginal Shire Council

- Councillor Joshua Weazel, Mayor

Headspace

- Ms Hayley Mattson-Finger, Manager of Children, Youth and Families

Australian Medical Association

- Dr Marco Giuseppin, Chair, Council of Rural Doctors
- Dr John Saul, Tasmania Vice President and GP Council Representative

Services for Australian Rural and Remote Allied Health

- Ms Catherine Maloney, Chief Executive Officer
- Ms Lisa Baker, Board Director
- Mr Allan Groth, Director of Policy and Strategy

Central Queensland Rural Division of General Practice

- Ms Sandra Corfield, Chief Executive Officer
- Ms Margo Purcell, Board Chair
- Ms Kristy Briggs, Provisional Psychologist

Royal Flying Doctor Service of Australia

- Mr Frank Quinlan, Chief Executive Officer
- Ms Lauren Gale, Director, Programs and Policy

Rural Doctors Association of Queensland

- Dr Matt Masel, President-Elect

Isaac Regional Council

- Councillor Anne Baker, Mayor

Gladstone Regional Council

- Councillor Matt Burnett, Mayor

Central Highlands Community Services

- Mr Blake Repine, Chief Executive Officer

Moura MPHS Community Advisory Group

- Ms Debbie Elliott, Chair
- Ms Nancy Rowe, Secretary

ZONTA Club of Biloela

- Ms Angela Fredericks, Club Member
- Ms Genevieve Dippel, Club Member

Central Highlands Development Corporation

- Mr Arjan Bloemer, Chief Executive Officer
- Mr Peter Dowling, Manager, Business and Investment Attraction

Central Queensland Hospital and Health Service

- Dr David Molhoek, Acting Director of Medical Services

Central Queensland University

- Professor Michelle Bellingan, Dean, School of Health, Medical and Applied Sciences

James Cook University

- Professor Richard Murray, Deputy Vice Chancellor, Division of Tropical Health and Medicine
- Professor Sabina Knight, Director, Central Queensland Centre for Rural and Remote Health
- Ms Emma-Lee May, Student
- Associate Professor Catrina Felton-Busch, Director, Murtupuni Centre for Rural and Remote Health
- Dr Mitchell Christensen, Graduate

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- Ms Kathie Sadler, Chief Executive Officer
- Dr Eleanor Chew, Chair