Aboriginal Health and Medical Research Council of NSW

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

The AH&MRC Acknowledges the Traditional Owners of the lands on which the AH&MRC stands, the lands of the Bidjigal and Gadigal people of the Eora Nation. The AH&MRC pays respect to Elders past, present and emerging.

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About the AH&MRC

The AH&MRC is the peak body for Aboriginal Health in New South Wales, representing the 47 Aboriginal Community Controlled Health Organisations (ACCHOs) across the state. The AH&MRC works with the ACCHOs to ensure that they have access to an adequately resourced and skilled workforce to provide high-quality health care services for Aboriginal communities.

The AH&MRC is committed to the delivery of four key priorities including:

- Aboriginal Community Control and Innovation;
- Education and Workforce;
- Research and Data; and
- Governance and Finance.

The AH&MRC welcomes the opportunity to make a submission to this inquiry on behalf of its members.

AH&MRC Position

It is the position of the AH&MRC and its 47 Member Services that current Government policy with regards to GP provision should be reformed to reflect the needs of all areas outside metropolitan regions. Further to this, the underlying resourcing of the Aboriginal Community Controlled sector must be improved to ensure the availability of a long-term medical workforce in outer metropolitan, regional, and rural areas.

Access to consistent GP services within ACCHOs is imperative to primary health care delivery. Aboriginal communities deserve to have access to high-quality health services that meet their needs. Addressing the misalignment of GP provision will significantly improve health outcomes in Aboriginal communities.

System wide changes are needed to address GP shortages and mitigate the impending consequences of these shortages. The AH&MRC recommends that:

1. **All ACCHOs be considered organisations of need, with this reflected in strategies to provide critical GP workforce.**

2. **A review of funding arrangements for ACCHOs be undertaken to ensure that the funding allocated to ACCHOs is commensurate with the level of primary health care they deliver and proportionate with that of mainstream services.**

Background

Access to culturally safe and integrated primary health care is vital to the health and wellbeing of Aboriginal communities. General Practitioners (GPs) are a key component of primary health care delivery and are fully enabled to provide diagnosis, treatment, and management of complex medical needs. However, in rural, regional, and outer metropolitan areas, consistent access to General Practitioners is limited. The impacts of these shortages have been particularly felt by ACCHOs who provide primary health care to Aboriginal communities. Services are often overburdened, and many Aboriginal people left unable to access a GP.

Aboriginal people are hospitalized 2.3 times more than their non-Indigenous counterparts.[1] There are high rates of emergency department and urgent care presentation for Aboriginal people with chronic disease and preventable illness. The 2018/19 National Aboriginal and Torres Strait Islander Health Survey identified that 22% of Aboriginal and Torres Strait Islander people did not see a GP when needed, despite 50% of respondents having one or more chronic condition.[2] Access to primary health care is essential to ensure that illness is managed at early stages and does not lead to unnecessary fatality.

Our Members Services have reported wait lists for GP appointments and difficulty employing full time GPs, with supply unable to keep up with demand. The AH&MRC acknowledges that these shortages have been felt across the health sector. Deloitte's 2019 GP workforce report forecasted supply to outgrow demand by 31.7% in the next ten years, significantly outpacing the forecasted 6% growth of GPs.[3] While the government has made efforts to ensure that the health sector is equipped to meet this growing demand, they have not been effective in meeting the unique needs of ACCHOs. This is in part due to an emphasis on financially incentivising rural placements and attracting but not retaining staff. Moreover, there has been a failure to engage ACCHOs in reform processes, particularly those placed in less rural areas and not considered areas of need despite serving communities with high socioeconomic disadvantage.

The current health system set up requires the presence of GPs to enable the clinical scope of other staff. In smaller community's Aboriginal health workers, nurses, and other allied health professionals fulfil a significant component of the workforce demand where GP distribution is scarce. Therefore, the provision of GPs must also reflect the team-based care employed within ACCHOs.

The AH&MRC has identified two key system barriers which must be addressed to better support ACCHOs including:

Significant gaps in the classification of the Modified Monash Model (MMM) and the Area of Need program that do not reflect the health demands of Aboriginal communities outside major metropolitan areas

The distribution of GPs across NSW is reliant on the Distributed Priority Areas (DPA) to identify areas of medical practitioner shortages. This classification system, which uses the Modified Monash Model (MMM) to automatically classify specific areas as a DPA, is not reflective of the available resourcing and demand on ACCHOs. ACCHOs operate across all areas of New South Wales. Many of our outer metropolitan ACCHOs are classified as MMM1 and not considered to be in areas of need, therefore not classified as a DPA. This has significant flow on effects for these services who are unable to access exemptions to attract employment of full time GPs.

DPA classification has ignored the outer metropolitan ACCHOs who are facing significant workforce shortages, many of whom are ranked high on socioeconomic disadvantage. It should be noted that the number of registered GPs in NSW does not account for GPs who are available for full-time employment, with many entering the recruitment pool for ACCHOs seeking part-time

[1] AIHW. (2016). *Australia's health 2016.* Australia's health series no. 15. Cat. No. AUS 199. Canberra. https://www.aihw.gov.au/getmedia/01d88043-31ba-424a-a682-98673783072e/ah16-6-6-indigenous-australians-access-health-services.pdf.aspx

[2] ABS. (2019). *National Aboriginal and Torres Strait Islander Health Survey.* https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/national-aboriginal-and-torres-strait-islander-health-survey/latest-release

[3] Deloitte. (2019). *General Practice Report.* Cornerstone Health Pty Ltd. https://www2.deloitte.com/content/dam/Deloitte/au/Documents/Economics/deloitte-au-economics-general-practitioners-workforce-2019-021219.pdf

of short-term arrangements. In addition, the MMM accounts for the number of GPs in a geographic area but does not account for the inaccessibility of mainstream GP practices for Aboriginal communities. Therefore, ACCHOs remain organisations of workforce shortages without the appropriate government resourcing.

At present, Aboriginal Medical Services have anywhere from five to thirteen GPs working on a part time basis. Over-reliance on part time GPs places strain on both the workforce and service to accommodate the demand for appointments within smaller availabilities. ACCHOs have to rely on locum agencies to source GPs on a temporary basis, creating significant costs through maximum rates, accommodation and other expenses. Locum GPs have not been able to provide relief to the rural workforce as initially intended. Instead, shortages have meant that locum GPs are hired to meet the minimal demand for services. This is unsustainable. Other programs such as the Bonded Medical Program and Medical Rural Bonded Scholarship have also been ineffective.

ACCHOs are often the only primary health care providers accessible to Aboriginal communities, particularly in regional areas. They should be recognised as organisations of need and the Distributed Priority Areas amended to ensure that they are adequately resourced to provide high quality primary health care.

Inadequate funding arrangements are stagnating the capacity for ACCHOs to attract and retain GPs.

In a recent AIHW report, there were 31 remaining full time equivalent (FTE) vacancies for doctors within ACCHOs.[4] Further to this, there are 1.0 FTE vacant position per 1,000 clients within ACCHOs, doubling for remote areas. This indicates an unmet need within these critical services. Additionally, government funding has not adequately reflected the level of services that ACCHOs provide to communities. Recently released data identified that less than 2% of Aboriginal and/or Torres Strait Islander people are accessing mainstream practices for care.[5] Despite the number of Aboriginal people who access ACCHOs for their care, the Primary Health Networks (PHN) do not proportionately fund ACCHOs to the same capacity as they do mainstream practices. This impacts the scope of services that each of these organisations are able to deliver. There is high variation in the services offered by ACCHOs which reflect the inconsistent resourcing across the sector. Some ACCHOs are larger and able to employ several doctors, while others rely heavily on other allied health professionals and nurses.

The Bonded Medical Program offers a Return of Service (ROS) obligation for junior doctors to work in areas of workforce shortages. However, this has not effectively addressed the issue of GPs retention within these areas. Instead, very few doctors are fulfilling their ROS period and those who do often relocate once their obligation is fulfilled.[6] This does not contribute to the sustainability of the rural health workforce nor support ACCHOs in retaining high quality staff.

Financial incentives have failed to attract and/or retain GPs in rural and remote areas. Regardless, they have remained the Government's preferred approach to workforce distribution. Over reliance on this model creates a revolving door of young, inexperienced doctors moving in

[4] AIHW. (2021). *Aboriginal and Torres Strait Islander specific primary health care: results from the nKPI and OSR collections.* https://www.aihw.gov.au/reports/indigenous-australians/indigenous-primary-health-care-results-osr-nkpi/what-are-indigenous-specific-primary-health-care-organisations/workforce/vacancies-fte

[5] AIHW. (2021). *Practice Incentives Program Quality Improvement Measures: National report on the first year of data 2020-21.* https://www.aihw.gov.au/getmedia/16e286a7-7a21-42d9-ac39-1aba0e33c8f1/Practice-Incentives-Program-Quality-Improvement-Measures-National-report-on-the-first-year-of-data.pdf.aspx?inline=true

[6] Grattan Institute. (2013). *Access all areas: new solutions for GP shortages in rural Australia*. Access all areas: new solutions for GP shortages in rural Australia - Grattan Institute

and out of under-resourced practices. Workforce planning should consider the impact of promoting siloed retention strategies to services that are under-resourced and consider the importance of appropriate funding allocation.

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