Chapter 5

Related issues

5.1 This chapter examines various other important issues which have been raised in evidence since the committee's first interim report. The specific issues covered in this chapter are:

- General Practice training;
- Workforce matching;
- Patient transport; and
- Paramedics.

General Practice training

5.2 Several GP training providers told the committee of their concerns over the compounding impacts of the government's proposed changes to Medicare, the surfeit of medical graduates compared to the paucity of training positions, and the cancellation of important GP training programs. The evidence demonstrates that these issues are particularly acute in regional and rural areas.

Diminishing attraction of General Practice

5.3 Dr Hespe, a General Practitioner and also an academic at Notre Dame University, foreshadowed the waning interest of medical graduates in becoming general practitioners due to practical consideration of costs, potential income and status:

> At the moment, when I talk to my medical students, they say, 'I love the concept of primary health care. I love how you sell it to me. For me, it is the best specialty I could ever be in. I love the fact that we are involved in the whole part of a patient's health.' We are not just involved in a silo of one bit; we actually very much manage complexity. It is incredibly complex, it is very challenging, and it is a fantastic specialty.
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> But we are not recognised. We get paid a pittance in comparison to the other specialties which, from my perspective as a personal thing, is not the problem; the problem is about attracting future doctors. They have big debt from going to university. They look at a range of specialties which all interest them. You go through hospitals and you have the specialty silos in front of you. You do not have the primary care in front of you. That is off to the side.[1]

5.4 These mounting disincentives appear to have been compounded by the government's recent detrimental policy changes in primary care. The committee heard evidence from Dr Jomini Cheong, the Chair of the General Practice Registrars

1 Dr Charlotte Hespe, private capacity, *Committee Hansard*, 19 February 2015, p. 30.

Australia which demonstrates that medical students are being dissuaded from specialising in General Practice due to the uncertainty created by the government's proposed co-payment:

> …I think there has been an impression that that [the proposed co-payment] has not been a good sign of government support for general practice. Fortunately, it did not go ahead, and that is a good sign; however, the mere fact that even came up signalled a potential issue to future general practice registrars and future general practitioners in that, if this has come up once, will come up again in the future? That is a thought that is going on in many people's heads and they are all wondering: is it better if I just hang on and do another specialty because the funding will not be as threatened, especially with regard to my ballooning student expenses? Will this be better for me and my family in the long run?[2]

5.5 Dr Cheong's comment about 'ballooning student expenses' was put into perspective by Dr Saxon Smith, the President of the AMA NSW:

> …We are very fearful of the [government's] policy around user pays in an extreme way for university education. For graduates to come out with $100,000 or $150,000 debt to pay back it will make general practice a less attractive option, and you will see a further decline in our ability to provide quality care in that community setting in general practice. We have long said that—since it was on the table, proposed in May 2014. That is a great concern for us.[3]

5.6 Dr Cheong also highlighted similar concerns with the government's proposal to freeze the regular indexation of the MBS for four years:

> …the Medicare rebate freeze...is also a sign that there may be insufficient support for general practice. I know it applies to other specialties, but one of the things that people are thinking is: 'Look, it's going to become a pay cut in the future. Do we want to get into this specialty, knowing that this is going on at the moment and there is currently no support for ceasing that as such?'[4]

Medical graduate numbers compared to training positions

5.7 Although not confined to general practice, significant concerns were raised about the growing number of medical graduates and the looming bottleneck due to a lack of medical training positions. In describing the 'perfect storm' created by the government's recent health policy decisions, Dr Stephen Parnis, the Vice President of the AMA explained in detail the looming challenges for Australia's medical workforce:

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2 Dr Jomini Cheong, Chair, General Practice Registrars Australia, *Committee Hansard*, 9 June 2015, p. 26.

3 Dr Saxon Smith, President, AMA NSW, *Committee Hansard*, 11 March 2015. p. 50.

4 Dr Jomini Cheong, Chair, General Practice Registrars Australia, *Committee Hansard*, 9 June 2015, p. 26.

> Thrown into that storm is an emerging medical workforce crisis. Unlike the position we were in 10 years ago, the crisis we see is not one of too few doctors. Rather, we have a crisis of too many junior doctors for too few training positions. There is a crisis of the Commonwealth government's own making. It is a crisis driven by an absence of planning and coordination and a lack of appreciation of what it takes to train a medical practitioner. We have seen a big increase in medical student numbers across the country. In 2004 there were 1,500 medical graduates per year. It is now 3,732. However, medical training does not end when a student graduates from medical school…
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> Medical graduates need to go on to complete intern training and one or more prevocational years and then go on to a specialist training program that can last from three to six years—or longer in certain cases. The bulk of medical training is delivered in the public hospitals sector. The former Health Workforce Australia had started to make real progress towards improving medical workforce planning and coordination, delivering two national medical workforce reports and forming the National Medical Training Advisory Network. However, before it could realise its full potential, HWA was disbanded in the 2014-15 [Federal] budget. Its functions were moved into the Department of Health and, in terms of progress, we are yet to recover from that decision. Momentum has been lost and, while the work program continues, it has been considerably delayed.
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> Health Workforce Australia final medical workforce report…looked ahead until 2030. It said we should be focused on improving the distribution of medical workforce and encouraging future medical graduates to train in the specialties where they are needed—something fully supported by the AMA. That same report also made it clear that Australia is struggling to provide adequate numbers of training positions for junior doctors. In terms of specialist training positions, HWA's workforce modelling said that by 2018 there would be a shortfall of 569 first-year advanced training positions, rising to 689 places in 2024 and rising further to 1,011 places by 2030. HWA did not recommend that Australia needed more doctors. Indeed, its most likely modelling scenario showed that Australia would not have a shortage of doctors by 2030.[5]

5.8 Dr Parnis went on to explain the AMA's concerns regarding the government's recent announcement of $20 million to fund a new medical school at Curtin University in Western Australia:

> …the AMA was extremely disappointed to see the government announce funding to support a new medical school at Curtin University. That decision ignores the previous advice of HWA, and we know the government did not seek the advice of its own medical workforce advisory body, the National Medical Training Advisory Network, before taking that decision. Putting more medical students into the medical training pipeline will just make the above shortages worse; rather than fix the pipeline, it will flood it, particularly if the public hospital funding is inadequate to meet patient

5 Dr Stephen Parnis, Vice President, AMA, *Committee Hansard*, 9 June 2015, pp 1–2.

> demand, let alone train our future doctors. It is a decision that has been criticised by the AMA, medical students, the medical deans of Australia and other medical organisations.
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> This criticism is not born of self-interest. It is backed by a body of evidence, independent modelling and robust advice. In short: the government has failed to address the key challenges identified by HWA and instead will be pumping funding into a medical school that is not needed. It is money that could be better spent supporting other parts of the medical training pipeline and helping to make sure that our future medical workforce is meeting community need.[6]

Cancellation of GP training programs

5.9 Several witnesses raised concerns about the government's decision to abandon programs which directly promoted the specialisation of General Practice. For instance, Associate Professor David Campbell of the Australian College of Rural and Remote Medicine echoed the sentiment of many witnesses regarding the government's decision to cease the Prevocational General Practice Placement Program (PGPPP):

> It was a major [shock] to the whole sector when that program [the PGPPP] was removed… It had been such a successful program, and there is well-documented evidence about how successful it was and has been. The rationale for the removal of the program was that the Commonwealth was no longer going to pay for junior doctors, who are the responsibility of the states, to undertake community practice. That was the rationale for the decision.[7]

5.10 Professor Campbell highlighted the negative impacts to rural general practice that will flow from the cessation of PGPPP and the government's proposed changes to Medicare:

> The combination of that decision [to cease the PGPPP] and the decision about Medicare co-payments or a reduction in the Medicare rebate creates not only issues around the viability of rural general practice as a small business, but it also creates major disincentives within the training system, particularly when we have graduates who may be, if we have the changes to tertiary education structures that are being promoted, emerging with a $100,000 debt that they have to pay back once they graduate as doctors. With that level of debt they are going to be more attracted to the high income sub-specialities. They are not going to be interested in rural practice, which the evidence shows generates a lower income, and particularly rural general practice.[8]
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> …

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6 Dr Stephen Parnis, Vice President, AMA, *Committee Hansard*, 9 June 2015, p. 2.

7 Associate Professor David Campbell, Censor-in-Chief, Australian College of Rural and Remote Medicine, *Committee Hansard*, 13 February 2015, p. 27.

8 Associate Professor David Campbell, Censor-in-Chief, Australian College of Rural and Remote Medicine, *Committee Hansard*, 13 February 2015, p. 27.

> The other concerning data is that more 50 per cent of rural doctors are now over the age of 50 and are considering their retirement decisions. So how are we going to replace those doctors when they do retire over the next decade to 15 years when we are not steering the increased number of graduates? We have increased the number of medical school places, but we are not incentivising the system to encourage those doctors to undertake rural practice and rural careers.[9]

5.11 Similar concerns were raised about the abolition of a program known as General Practice Training or GPET and the function being taken up by the Department of Health. Dr Saxon Smith told the committee that:

> We have to also take it in the broader construct that [the government has] dissolved the current structure for general practice training in Australia as a whole. Previously we have had education organisations. Sometimes they were Medicare Locals who had that second hat. Sometimes they were stand-alone entities with purely educational viewpoints, which is GPET, the general practice training. That has also had a line put through it—slashed, gone and absorbed back into the department of health and ageing at a federal level. We have great concerns as an organisation for the quality of training, the ability of people to train in general practice, with those training options gone.[10]

5.12 In fact the committee heard the same views everywhere in Australia it held public hearings and spoke to GPs. For example, Dr Emil Djakic, a GP from Ulverstone, Tasmania, told the committee:

> I will speak to capacity in general practice. We have held concern for some time about the workforce that we have available to us. Fortunately, through strategies over the past five to six years federally, there has been increasing training availability, although the loss of the PGPPP program I think represents a large threat to our industry due to the lack of exposure of doctors resident within the hospital system that get to experience a taste of general practice before they choose to move into it as a commitment to a vocational stream. So we lament that loss, but we appreciate the increase in formal general practice training.[11]

Workforce matching

5.13 Coupled with the disruption to training and succession planning caused by the loss of the PGPPP and the GPET has been the loss of the workforce planning work undertaken by the now abolished Health Workforce Australia.

5.14 Dr Parnis, Vice President AMA, told the committee that with only a very few staff from Health Workforce Australia being retained as the remains of the agency transitioned to the Department of Health, much momentum in workforce planning had

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9 Associate Professor David Campbell, Censor-in-Chief, Australian College of Rural and Remote Medicine, *Committee Hansard*, 13 February 2015, p. 28.

10 Dr Saxon Smith, President, AMA NSW, *Committee Hansard*, 11 March 2015, p. 53.

11 Dr Emil Djakic, GP, Ulverstone, Tasmania, *Committee Hansard*, 17 April 2015, p. 25.

been lost. Dr Parnis believed that now the Department of Health is struggling to capture the data needed for workforce planning, particularly in regards to specialties:

> There are many specialities, for example, across the medical workforce in Australia and, as I understand it, the Department of Health is now methodically trying to work through each of those specialties to put data to the decisions that governments at all levels need to make, as well as individuals. We know that that data, in an incredibly complex area, is really important. We have got it wrong decade after decade in Australia with boom and bust—for example, the perception 25 years ago that there were too many doctors and within a decade the acknowledgement that we were profoundly short. That information is really important. Looking specialty by specialty, I believe the department is looking at about three specialties at the moment: psychiatry, general practice and anaesthetics. It would seem to me that the resourcing available to them to pursue these issues is such that it will take many years to get the specialty by specialty information that is required.[12]

5.15 Dr Parnis explained that without information about specialties, there can be little useful work done in collaboration with the states and territories about planning for gaps in numbers of specialists. As a result Dr Parnis feared that the current work was continuing, but very slowly:

> As I said, it is of practical importance. It says to states and territories where they need to resource so that you can get, for example, appropriate numbers of psychiatrists in regional Victoria and so that you can encourage people aspiring to a career in anaesthetics to recognise that they are less likely to get a job if they want to stay in the centre of Sydney or Melbourne. These are the things that, again, we are very supportive of. Doctors are clever people if they recognise, as a junior doctor planning their career, they have a much easier career path if they aspire to general medicine and geriatrics rather than interventional cardiology—that makes sense. The AMA is very supportive of that. So this is again a negative. I am very impressed with the work that is coming out of that area now but, unfortunately, I think is it still taking longer than it should and I think it is a function of the resourcing available and the fact that it lost momentum in the transition.[13]

5.16 An example of Dr Parnis' concerns about the impact on states and territories can been seen in the evidence the committee heard in Burnie from the Rural Clinical School, University of Tasmania. Associate Professor Lizzi Shires, Co-Director, Rural Clinical School, University of Tasmania told the committee that recruitment and retention of doctors and specialists in rural areas is a constant problem:

12 Dr Stephen Parnis, Vice President RACGP, *Committee Hansard*, 9 June 2015, p. 3.

13 Dr Stephen Parnis, Vice President RACGP, *Committee Hansard*, 9 June 2015, p. 3.

> One issue that we always have in rural areas is around recruitment and retention of doctors—that is, both for the emergency departments and in general practice…It just takes a long time to recruit and retain doctors.[14]

5.17 Associate Professor Shires explained that the University of Tasmania was looking at ways in which to try and mitigate the problems with recruitment and retention of doctors to rural Tasmania:

> Most of the research now coming out of rural clinical schools or areas where they train people in rural areas is showing that that is working. I suppose the next step is also around doing more specialty training in rural areas so that we have got general specialists working in rural areas as well.[15]

5.18 Some of the approaches the University of Tasmania Rural Clinical School had tried included:

> One thing we do as part of the rural clinical school with the training here…is to encourage more people to come and work here. I think looking at the long term, the best way of increasing access is to increase the number of doctors here and reduce the number of locums.
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> …I think training is one of the big solutions. I would say that because I am from the rural clinical school and we are part of a movement to train people in rural areas. We have been going for about 10 years. In the olden days, or prior to that, doctors were always trained in cities and then many came from cities and therefore they only chose to work in cities. Over the last decade we have tried to change that so that there is more training in rural areas so that people come out to the rural areas early on in their careers and hopefully will stay on. We know that that works.
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> Another thing that we know works is recruiting people from rural areas. If we can get more of our young people to do medicine—other health professions as well, but more particularly we are talking about medicine today—we know that they are more likely to come back into the rural areas. These are all long-term solutions, but I think we have not addressed the rural issue in the short term by lots of other measures. So I think we need to take a long-term view on it.[16]

Patient transport

5.19 Witness concerns with the adequacy of patient transport recurred throughout the hearings. For instance Mrs Diana Aspinall, who is a member of the Consumer Reference Group GP Network, Blue Mountains, revealed the cost of transport to be an

14 Associate Professor Lizzi Shires, Co-Director, Rural Clinical School, University of Tasmania, *Committee Hansard*, 17 April 2015, p. 3.

15 Associate Professor Lizzi Shires, Co-Director, Rural Clinical School, University of Tasmania, *Committee Hansard*, 17 April 2015, p. 3.

16 Associate Professor Lizzi Shires, Co-Director, Rural Clinical School, University of Tasmania, *Committee Hansard*, 17 April 2015, p. 3.

overlooked but vital element in the complex interplay of health costs for people with and without a healthcare card:

> We are starting to see that there is a difference and a disparity between urban health consumers and regional and rural consumers in terms of these transport costs and access costs to actually get to the services. Consumers are telling us that increases in the payment of [a] gap for any health service means that they will not be able to afford the service, and we have got clear evidence from our consumers that they are just not going to the doctor. The increases in the gaps are for all sorts of services—we are not just talking about one particular service. Wherever they have to pay a gap on top of the transport costs it means they just do not go. There is plenty of evidence that they just go back to the GP and they have not followed up the referral at all.[17]

5.20 Parts of the disability sector also raised concerns about the challenges posed to access to health services by a lack of adequate and affordable public transport. The CEO of the Central Coast Disability Network, Mrs Jenny MacKellin explained the problems associated with long travel times and delays experienced in accessing Sydney based services from the NSW Central Coast. The cost of transport was also identified as a significant issue. Making reference to the government's co-payment proposal, Mrs MacKellin stated that if patients with a disability 'cannot afford the $2.50 bus fare, they cannot afford a $7 co-payment':

> We are constantly hearing from families who cannot access services here on the Central Coast and are required to travel to Sydney or Newcastle for those services. It is very difficult if you have a child who has sensory needs, who cannot travel on public transport and who cannot wait for long periods of time, and you are told that you have to go to Westmead Children's Hospital or other hospitals to receive services on a very regular basis. If mum or dad do not have access to their own transport to transport the child, or if the child cannot be transported safely in the car with just one person, which is often the case, then they are reliant on other means of travel. Community transport is not affordable to all. Community transport is an expensive form of transport for many people. It is a great service, but you do need to book and plan in advance. If that is your means of transport to get to a medical appointment, you need to be aware of that appointment in advance, which is not always the case.
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> So people often find that transport is an issue when accessing medical services. Here on the Central Coast, if you live on The Entrance and you need to access a service in Gosford, it is a three-hour bus ride. That is a reality. If we are going to focus services in Gosford and our constituents are at Summerland Point, which is right up on the northern end of the area, that is not a possibility, so they simply will not attend the appointments. They cannot afford the $2.50 bus fare, they cannot afford a $7 co-payment, and they cannot sit for three hours on a bus to get to an appointment to then sit

17 Mrs Diana Aspinall, Consumer Reference Group GP Network Blue Mountains, 12 March 2015, *Committee Hansard*, pp 39–40.

> for two hours waiting for a doctor and then get on another bus to get back home. And it is not one bus; it is two or three buses, so they have to be able to use those buses. We provide support to people for [train travel] and the like. We offer various services where we can assist people with accessing transport to get to medical appointments, but it is very limited.[18]

Paramedics

5.21 The Australian Paramedics Association (APA) told the committee of the serious impacts that increasing resource pressures are having on paramedics. Due to at-capacity emergency departments, ambulances are being forced to 'ramp' until an emergency bed becomes available.[19] Mr Jeff Andrew, Vice President of the APA explained that a two hour ramp at peak periods is not unusual, and that a recent experience of a six hour 'ramp' would become common.[20] Mr Andrew went on to state that 'it is fair to say the whole system is overwhelmed.'[21]

5.22 When asked what additional pressure would result from government's decision to cut $50 billion over 10 years from the hospital system combined with the government's interventions in primary care, Mr Andrew responded:

> I think we will get more sick patients if the primary health care is not attended to. I mentioned some patients, like asthma patients and patients with a chronic disease like emphysema, who have been better managed because there are good strategies and care plans in place for them. Any budget cuts in that area will only reflect to us getting them at a sicker state. There will be a higher burden on the presentations in the health system. On the other end with the co-payment, I know that Medicare Locals on the coast put in advertisements [explaining to patients] that has not happened yet, because immediately the numbers dropped off of people attending.[22]

Committee observations

5.23 The issues outlined in this chapter demonstrate that the government's healthcare policies impact all areas of the healthcare system.

5.24 General practice training and workforce matching not only affect consumers' access to healthcare now, but also into the future. The evidence in this chapter shows that if mechanisms are not in place now, shortages of doctors and specialists will be felt in the future and acutely in rural areas.

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18 Mrs Jenny MacKellin, CEO, Central Coast Disability Network, *Committee Hansard*, 11 March 2015, pp 23–24.

19 In this context "Ramp" refers to an ambulance waiting with a patient until the patient can be received by the Emergency Department.

20 Mr Jeff Andrew, Vice President, Australian Paramedics Association, *Committee Hansard*, 11 March 2015, p. 43.

21 Mr Jeff Andrew, Vice President, Australian Paramedics Association, *Committee Hansard*, 11 March 2015, p. 43.

22 Mr Jeff Andrew, Vice President, Australian Paramedics Association, *Committee Hansard*, 11 March 2015, p. 45.

5.25 Patient transport appears at first not to be directly related to healthcare, but in fact it is an exemplar of the issues which can surround access to healthcare. As examined in Chapter 2, without adequate access to healthcare, the management of chronic conditions and preventative health cannot be delivered appropriately. The consequence is that greater stress is placed on acute care, causing more expense to be shifted to state funded facilities. Similarly, the issue of 'ramping' identified by paramedics shows the consequences of an overburdened and underfunded hospital system.

5.26 The committee urges the government to have regard to the evidence such as that outlined in this chapter. This evidence is a timely reminder that the healthcare system is complex and policy change should be considered, evidence-based, consultative, and implemented appropriately, with proper attention given to the consequences on all parts of the system.

Senator Deborah O'Neill

Chair