Urgent Care

Senate enquiry into the provision of GP services throughout Australia

St John W.A.

Urgent Care submission
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Context

- St John Urgent Care is a large clinical service based in Perth, WA. It runs 14 hrs per day, 365 days per year at metro and outer-metro sites selected for maximal ED avoidance impact.

- St John Urgent Care centres include digital X-ray, nursing and allied health support, surgical theatres for wound care, and specialist pathways for orthopaedic and plastic surgery injuries. The centres stock crutches, splints, plaster casting materials and equipment to stabilise injuries.

- These large facilities and their clinical workflows have been designed from the ground up to minimise wait times and maximise their appeal to Triage Category 4/5 patients (semi-urgent/non-urgent) who otherwise attend ED in large numbers.

- The Federal Government partnered with St John in April 2019 to roll out and evaluate new Urgent Care Centres over a 4-year period, given the popularity of the model and its recognised potential to reduce pressure on EDs.

- St John Urgent Care currently caters to 105,000 patient visits annually. This will climb to 220,000 annual visits by 2023, when the construction of new Federal sites is complete. The majority of these patients will revert to using WA EDs for their urgent care needs if the Urgent Care service cannot be adequately staffed with GPs.

Executive Summary

- The St John Urgent Care service is delivered by vocationally registered GPs. Despite its transformative potential for the pre-hospital care system, St John Urgent Care centres are currently experiencing severe workforce shortages, which are approaching crisis levels.

- This staffing crisis has been precipitated by a raft of measures which:
  - artificially restrict the movement of international medical graduate (IMG) GPs into Australia
  - severely curtail the ability of IMG GPs to practice in metro or outer metro areas

- These changes to MMM status, DPA and Rural Health Workforce Certificate (HWFC) allocation have ensured that there is no mechanism by which to meet the growing demand for clinical services in metro and outer metro areas in Perth, despite record demand for health services.

- These changes make no allowance for specialised services such as St John Urgent Care, which require sessional access to a large pool of GPs to operate reliably. The changes also appear to overlook the specific workforce challenges unique to Western Australia. The situation encountered by St John is common across the state.

- When coupled with the new workforce and demand pressures of the 'post-COVID' world, the net effect is that GP-delivered services such as St John Urgent Care are severely and chronically understaffed. A relaxation of provider number, DPA and HWFC restrictions is

urgently required, together with higher visa quotas for incoming IMGs, to address this staffing crisis and ensure patient care needs can be met.

1. Current state of outer metropolitan, rural, and regional GPs and related services

St John WA operates urgent care centres at Cockburn Central, Armadale, Joondalup, Midland and Cannington, and will open new centres at Mandurah and Osborne Park in 2022 as part of the Federal Urgent Care project. These large centres incorporate Urgent Care, Dental and GP services, along with allied health, imaging, and visiting specialists. Located across the Perth metro and outer metro area, these centres engage with over 150 GPs daily. Most of these GPs have practices of their own across the broader Perth area, and many also work in rural and remote locations semi-regularly.

The current state of General Practice, revealed from operating the St John Urgent Care service, and engaging with such a large sample of the GPs in the state reveals the following:

- Regardless of statistical classifications, there is a significant and worsening net shortage of GPs in metro and outer metro WA, and in the regional and rural areas.
- The tendency for GPs to hold an array of open provider numbers and work occasional shifts in multiple locations is felt to be artificially inflating apparent doctor FTE numbers.
- The number of individual doctors needed to make up one FTE has increased substantially in recent years due to changing demographics and work practices of younger GPs.
- GPs are feeling burnt out and saturated with a continually expanding workload.
- Many GPs report a 'tipping point', whereby their own workload is becoming unsustainable as their colleagues increasingly opt out of clinical roles. This is a common scenario described by GPs in private practice. It is also apparent in St John Urgent Care, where staff shortages are deterring GPs from taking up shifts, and demoralising those who remain.
- GP practice owners and operators, both large and small, are feeling an intense pressure to recruit new doctors to cope with demand. However, they are frequently unable to do so due to DPA/MMM/Rural Health Workforce and PEP scheme requirements.
- Many owner-operators are abandoning plans to expand their services, and even re-considering the overall viability of General Practice due to recruitment pressures.
- There is an escalating 'race to the bottom' wherein GP services feel compelled to out-compete each other to recruit from the dwindling pool of available doctors. Out of desperation, salaries are being offered which are not sustainable.
- This last-ditch strategy is not achieving any net increase in doctor numbers, but rather paying an increasing premium to disrupt and re-distribute the existing pool of GPs. This is fundamentally undermining the commercial viability of general practice, and converting a short-term staff supply problem into a devastating legacy for the future.
- Perversely, doctors in WA who are willing to take up additional work typically find themselves unable to secure a provider number for their desired location. Hence, one

cohort of doctors is burnt out and unable to recruit, while another is willing to work more but unable to do so.

2. Current state and former Government reforms to outer metropolitan, rural and regional GP services and their impact on GPs

Flawed premise

A range of restrictions came into place simultaneously in 2019 to reduce the headcount and mobility of IMG GPs in Australia. The motivations behind these measures included the desire to re-distribute GPs to rural areas of need, to improve training pathways, and to reduce Medicare spending. However, the starting premise for all these measures was incorrect, namely that a surplus of GPs existed in Australia. For WA at the very least, the opposite was the case even in 2019. Consequently, the measures merely served to compound a pre-existing workforce problem.

The Visas for GPs initiative from 2019[1] states: *"Australia faces a potential oversupply of around 7,000 medical practitioners by 2030. Data shows that the majority of growth in the numbers of medical practitioners has been in well-serviced major capital cities and metropolitan areas rather than rural and remote areas where there is greater need."* This is factually inaccurate, particularly for WA.

A 2019 review of the Australian GP workforce by Deloitte[2] concluded precisely the opposite. This is merely one of many staffing reviews which have reached an identical conclusion. Due to changing GP demographics, population growth, and increased care requirements amongst an ageing population, all indicators in 2019 were predicting a shortfall of GP FTEs nationwide.

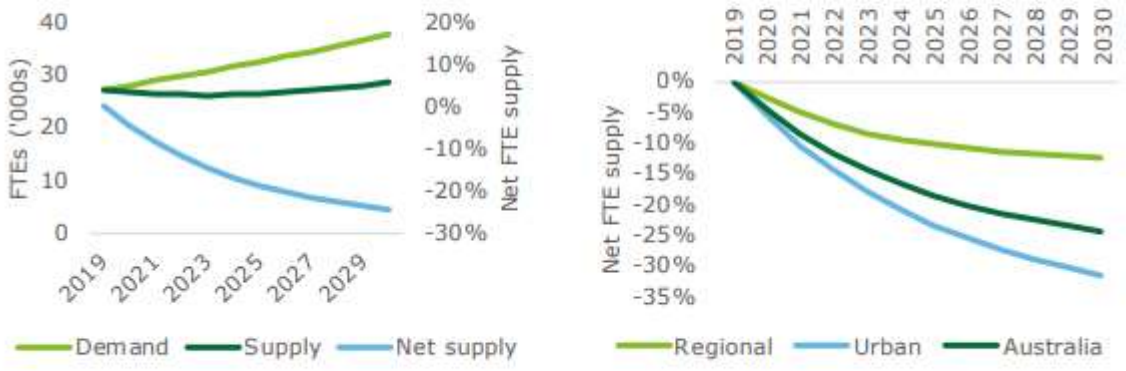
In 2019, this shortfall was already being acutely felt in WA, which had a lower-than-average headcount and FTE of GPs versus the national average. The trend has only worsened in the intervening years, fuelled by the restrictions placed on IMGs, and further compounded by COVID.

Deloitte General Practitioner workforce report 2019

Comparison of supply and demand

Starting from an initial equilibrium in 2019, demand for GP services is forecast to outpace supply, resulting in a widening shortfall of full-time equivalent (FTE) GPs from 2020 onwards. By 2030, there is projected to be a shortfall of 9,298 FTE GPs, or 24.7% of the workforce (see Chart i).

Chart i Supply and demand for FTE GPs in Australia (LHS) (by region, RHS), 2019 to 2030



Source: Deloitte Access Economics analysis. Net supply refers to supply minus demand.

IMG visa quotas cut

The 2018-19 federal budget announced a plan to cut 800 visas for IMGs over a 4-year period with expected savings of $400m through reduced Medicare billing. Since 11th March 2019, a Health Workforce Certificate has been required as part of an employer sponsored visa nomination for IMGs. These certificates are only granted for rural GP roles and are not interchangeable between roles. Urban and outer metro locations are not eligible for Health Work Force Certificates.

Automatic RACGP fellowship replaced with onerous PEP scheme

The RACGP announced their intention to remove the up-front award of fellowship to IMGs from September 2019 onwards. IMGs holding specialist qualifications that would previously have garnered automatic recognition are now required to complete a PEP scheme in a rural/remote location for a minimum of 6 months, but more typically for 1 year.

DWS replaced with more restrictive DPA system

The District of Workforce Shortage map was decommissioned as of July 1st 2019. The DWS system referenced the national average for the ratio of GPs to population as a benchmark – meaning that some metropolitan areas were classified as DWS. The DWS classification has been replaced by the concept of Distribution Priority Areas, based on the Modified Monash Model. Based on this new model, IMGs are only granted provider numbers for locations which have GP ratios lower than MMM2 areas. Metropolitan and outer-metro Perth is designated MMM 1 and thus IMGs are no longer granted provider numbers to work in these areas.

Over-correction with unintended consequences

Even if there had been an oversupply issue for WA in 2019, the simultaneous introduction of these measures would have constituted an over-correction. The measures resulted in fewer incoming GPs, fewer GPs eligible to work in metro and outer metro areas in WA, and severely restricted movement of existing IMG GPs between roles.

The mandatory requirement for IMGs to work remotely and complete an additional year of supervision (despite holding a recognised specialist qualification) has been a major deterrent to GPs choosing to work in Australia. Rather than re-distributing GPs to areas of need, it has stopped many GPs from moving to Australia at all. Consider Perth as an example- this is already the most geographically isolated city in the world. Fully trained GPs from Europe have a host of international employment options at their disposal. Requiring them to move to an even more remote location in WA is simply a non-starter in many cases.

3. Impact of COVID-19 on doctor shortages in outer metropolitan, rural, and regional Australia

Fewer doctors overall

The absolute number of doctors in WA has reduced because of COVID. International borders are closed, severely limiting the ingress of GPs to Australia. Interstate borders are frequently closed, or in flux, deterring interstate movement of GPs. Many IMGs have returned to their home country to manage COVID related issues in their family or community, often with no plan or prospect of return.

Staff with chronic health conditions have opted to reduce their hours of work or withdraw from face-to-face care entirely due to COVID risks. Staff nearing retirement age have opted to retire earlier than planned, to avoid the complexities of the new COVID world.

Mandatory vaccination policies (though supported by St John) have alienated a cohort of staff who oppose mandatory vaccinations.

Collectively, these factors are compounding staffing shortages triggered by DPA/MMM/HWFC changes described previously.

COVID changes have increased GP workload

GPs have taken on a large increase in workload due to the COVID vaccination rollout. The pressure on GP services attempting to deliver two additional rounds of vaccination (beyond the normal vaccination schedule) is substantial, particularly given the tight timeframes involved. The requirement to educate staff and the entire patient base is particularly onerous, given vaccine hesitancy and generally increased anxiety around this topic.

Apart from the vaccine programme itself, the new challenges of running a practice in the context of COVID have substantially added to GP workload. Doctors now need to manage numerous logistical, legal, staffing and operational risks in order to safely provide basic care. The implementation of COVID-safe policies, along with workflow and structural modifications to medical centres has been necessary to safeguard staff and protect the clinical service itself.

The overlay of COVID-related changes has reduced the time efficiency of each GP consultation, and increased complexity. Notable changes include COVID-symptom questionnaires, temperature screening, social distancing, PPE usage, physical changes to the practice environment and the use of non-standard consultation settings (telehealth, isolation rooms, car-park consultations etc.)

New clinical presentations are also occurring, including consultations to address patient 'COVID-anxiety', requests for mask exemptions, and letters for employers. The large backlog of (often

worsened) chronic disease presentations in patients who avoided healthcare settings during initial lockdowns, is also contributing to longer, more complex consultations.

Dilutional effect of new GP roles

GPs are being drawn into new settings and forms of work as a consequence of COVID. This reduces their availability for normal patient care services. For example, GPs are working in COVID clinics, GP Respiratory Clinics, Resources-sector COVID avoidance services, Hotel Quarantine and ED shifts.

Increased absenteeism due to COVID-safe advice

Historically doctors have one of the lowest work absenteeism rates of any profession. However, in the new COVID context, clinical and support staff have joined the broader community in following advice to "stay home and get tested."

Thus, the absenteeism rate in primary care has been significantly increased in the past 18 months. Staff who would previously have worked with minor head-cold symptoms are now absent from work until their symptoms have fully resolved. Staff are routinely out of work pending the results of COVID tests for even the most minor symptoms, due to the fear of inadvertently transmitting COVID to patients or colleagues. Higher rates of absenteeism add to the challenge of providing GP services in the COVID setting.

Summary

St John WA is operating a group of large clinical services throughout long hours, customised to achieve ED avoidance. The model is popular and successful in its aims, at a time of unprecedented pressure on the hospital system.

Despite being run in partnership with the Federal Government, the Federal Urgent Care programme is being severely jeopardised by GP workforce shortages in WA, triggered by restrictions introduced by the Federal Government itself, in 2019.

The net deficit of GPs in WA resulting from these changes has been further compounded by the system-wide upheaval caused by COVID, which has further reduced the effective availability of GPs while simultaneously increasing their overall workload.

There is an urgent need to review restrictions on IMG Visas, DPA and MMM classification, the Rural Health Workforce Certification process and the onerous RACGP PEP scheme requirements, in order to rapidly alleviate the growing workforce crisis in WA general practice.

This need is particularly acute in St John's case, but appears to be common to the majority of GPs in WA, across rural, regional, outer metro and metro locations.

References

1. Visas for GPs initiative - March 2019 STRONGER RURAL HEALTH STRATEGY

https://www.aapm.org.au/Portals/1/documents/Latest_News/Factsheet%20-%20Visas%20for%20GPs%20initiative%20V3.pdf

2. General Practitioner Workforce Report 2019, Deloitte Australia

https://www2.deloitte.com/content/dam/Deloitte/au/Documents/Economics/deloitte-au-economics-general-practitioners-workforce-2019-021219.pdf