Health Workforce Inquiry

INTRODUCTION

After qualifying from the University of Tasmania in 1981 I spent 3 years gaining hospital experience and now 20 years in general practice .I am one of three practice principals that run a quality general practice, that cares for about 12000 patients . We give quality care to all our patients . Quality general practice remains the government's best value for money in the health system, yet remains under the threat of extinction. Although 8 doctors work at our practice , we add up to less than 4 full time equivalents. We are constantly 2 full time equivalents short every day.

General practitioners have to access all parts of our health system every day .eg. public and private hospitals, specialists, aged care, allied health , mental health, radiology, pathology etc. This leaves us in the unique and perhaps the best position to comment on workforce issues.

Working in Tasmania also puts our practice in a unique position. Tasmania has an ageing population of about 1/2 a million people . This is a significant number, but at the same time it is easy to be aware of not only the deficiencies in our workforce but also the thoughts, concerns and plans of the majority of our remaining workforce.

I hope in this submission to raise awareness amongst our decision makers of not only the magnitude, but also the urgency of the problems we face in our health system from the workforce shortage they have created.

I must state that I have no political preferences . It is impossible however to comment on some aspects of workforce shortage without commenting on the political policies that have created it.

WORKFORCE OVERVIEW

Our health system is only as good as its workforce. The quality of our workforce has been greatly reduced during the past decade. We must not forget that it was only 10 years ago that politicians and bureaucrats moved to significantly reduce the number of medical students and create much of the problems we have today. At that time many practices like ours were pleading for more doctors. This mistake was compounded by an astonishing delay in first recognising the mistake and then considerable delay in correcting it. The questions that need to be asked are

1- How can politicians and bureaucrats be so out of touch with the demands of our health system ?

2- How can the opinions of experienced professionals actually working in the system be so completely ignored?

3- Are we still making similar decisions based on politics and ignoring health care?

The population was ageing in 1996 when this decision was made and we were already looking at an increase in our part-time workforce. The government and its representative body the Australian Divisions of General Practice (ADGP) are now saying that there is no way we can produce enough doctors in this country. They like to produce graphs with little detail showing the past few years of doctors produced against the number of doctors required. Their solution is to introduce a massively bureaucratic system involving doctor substitutes. A simple question would be . What would be the shortage of doctors in Australia now if between 1996 and 2005

the number of medical students was raised ,consistent with an ageing population and increasing part time workforce ?

This should also take into account the government's preoccupation with the workforce they don't have and ignoring the workforce they do have . A good analogy is it is like trying to fill a bucket full of holes. Many are leaving the profession feeling frustrated and under valued. The doctors we are losing are highly skilled and best qualified to teach our new workforce. We still struggle with a dysfunctional state /federal system ,weighed down by red tape, indemnity issues and bureaucracy.(see specific comments).In general practice our work has become much more complex and slower. This is a direct result of the absence of specialists to refer to and appallingly under funded public hospitals. In Tasmania our major teaching hospital the Royal Hobart Hospital has had no services at times in areas such as ENT, Neurology, Urology and many others have waiting lists which make them unusable for GP's .

The result is we continue to lose doctors to overseas, less stressful and more financially rewarding jobs such as mole scan, acupuncture, laser therapy and sadly early than planned retirement . We have lost many doctors who have just completed their general practice training to similar pursuits. The frustrating thing for those who remain is the government still thinks up policies eg. safety net which only encourage doctors to leave general practice. The doctors remaining are actually deskilling at an alarming rate.

Of similar concern is the number of doctors now giving up general practice as a result of mental and stress related illness.

Many of the workforce measures so far are politically driven rather than well planned workforce measures.

Medical Students

In many of our universities the quality of training has dropped dramatically. Teaching hospitals struggle to run clinics and care for patients. This leaves little time for teaching and in some cases specialties are not even covered in a clinical setting . I have been approached by many medical students over the past 2 years concerned with the appalling level of their clinical teaching. Some going nearly a term with no lectures.! To criticise is difficult as it threatens accreditation and therefore further compromise our dwindling workforce. Students themselves are reluctant to speak out for fear of retribution and the closure of their medical school is not in their best interest.

Despite this in order to prop up university funding we are still teaching huge numbers of overseas fee paying students. Can we continue to teach overseas fee paying students with our limited teaching resources and massive workforce shortage? Surely workforce measure number one should be to call a moratorium on OS fee paying students.

Overseas Trained Doctors.(OTD's)

It must be stated that not all OTD's are bad doctors . Problems have arisen as a result of the obscene haste amongst administrators ,bureaucrats and politicians to plug holes in our health system . OTD's are sent "to areas of need" with little if any screening.

Incidents like the situation in Bundaberg Hospital are the tip of the iceberg. Doctors with similar training as ours eg. UK ,SA Nth America and parts of Europe are now becoming few and far between. We are now taking doctors from countries such as Sudan ,Afghanistan ,Iraq and Tsunami hit countries. They often come from countries with different disease profiles eg. tropical diseases like malaria ,typhoid etc . We need doctors who have a background in diseases such as childhood asthma, multiple sclerosis, Ischaemic Heart Disease etc. We will be spending valuable resources in retraining . Studies have clearly shown that Australian Trained Doctors prescribe less, investigate less and refer less. Unlike OTD's , Australian trained graduates are required to undergo rigorous postgraduate training and supervision. Is it any wonder that the health of remote and rural Australia compares so poorly with the people living in our larger cities .

Alternative Workforce Suggestions -"Anything but a GP"

Many of the suggestions arise from politicians and administrators ,who are completely ignorant of what a GP does .How often do we hear a politician say we need to get the coughs and colds out of our casualties and back to general practice. In our practice it is rare to see someone for a cough or a cold. Equally to just check a blood pressure is rarely a consultation performed in our practice. Creating a workforce to cater for these misconceptions will do nothing to help our workforce crisis. Why is it that when we are crying out for more Australian Trained doctors, those in a position to do something about it think of any substitute they can ?

1-Nurse Practitioners.

Who has the right to sentence the less affluent and rural areas of this country to a lower standard of health care? As a direct result of less training they will prescribe more and have an increased rate of referral to specialists . This will further reduce the dwindling number of specialists appointments available to GP's. The legal profession must be rubbing their hands with anticipation. Our practice for one would avoid getting involved with the continuation of a patient's management .We certainly would not get involved with phone consultations. A decision to substitute doctors with nurse practitioners should only be put forward at a time of absolute crisis eg. when the country is at war ! Patients who are able , or can afford to see a doctor, will do so. They will be healthier and have an increased life expectancy ! Is this fair ?

2-Practice Nurses.

Pushed strongly by the ADGP/Government. Nurses play an important role in helping GP's but they do not replace GP's. As mentioned I have read articles where they will be able to check patients blood pressures. This is not a general practice consultation now. We will actually be creating work to fill our new workforce profile. Has anyone asked general practitioners whether they wish to supervise large numbers of practice nurses ? Key Care Provider is the catch phrase from the ADGP. Imagine the stunned response from our year 12 students when on a recruiting drive for general practice we ask them "Who wants to be a key care provider. " We wont be knocked over in the rush! What will this new job be ,where the doctor gets to see only the difficult cases that nobody else wants. Will the GP have time to then focus on managing the team ,or will that role then fall to the recently promoted nurse manager

or administrator. Has anyone asked GP's whether they are happy to supervise nurses performing work away from their surgeries ? Will the Australian Nursing Federation be happy for GP's to have input into their training and complete control of them in the workplace? Imagine the mismatch of the appropriately strong ANF against general practice which has no representation. Who will indemnify them? Will they need a car, a mobile phone, superannuation, long service leave, maternity/paternity leave, sick leave ,compassionate leave, study leave , holiday pay etc.? If so perhaps many GP's will come out of early retirement and apply. Perhaps we will see the return of much of our lost female workforce.

3- Pharmacists

Our practice has just completed a rigorous and outrageously expensive accreditation assessment . Crucial to this were issues such as confidentiality, continuation of care etc. Is the front counter of a pharmacy shop the place to be discussing a patient's diabetic management or warfarin result? Has anyone asked practicing GP's if they wish to fragment patient care in this manner? Has anyone asked working GP's if they will be receptive to taking calls during consulting hours to sort out any problems arising from such an appalling system of health care.

It is hard to explain the frustration working GP's feel as a result of this persistent desire by politicians and bureaucrats to find doctor substitutes . A good analogy would be a frontline soldier who is running out of ammunition being told by high command he only needs another helmet. It reinforces to us the opinion that the decision makers neither understand the situation nor care about quality health care for all Australians.

GENERAL PRACTICE -SPECIFIC ISSUES i.e. Things that slow us down and drain our existing dwindling workforce.

1- Red tape

A Red Tape task force was set up to look at this issue . At last report they were bogged down in red tape and by their own admission had achieved very little .The task force was made up of red tape manufacturers. The amount of form filling, authority prescription requests, cumbersome hospital referrals ,etc continues to grow at an alarming rate .Our practice alone would "create " many more clinical sessions per week if this was seriously addressed .

2-Indemnity

One of the major reasons for referral to a specialist and for ordering investigations is because of the fear of litigation. This decision is not based on patient care . The indemnity issue was tackled just far enough to get it out of the newspapers. A considerable part of the day is now wasted recording copious notes for minor problems stating all the negatives . In court a doctor's word stands for nothing against the word of a patient. It is no longer the responsibility of patients to attend appointments ,even when they are handed a referral. A doctor must check they have been . This is all time consuming.

3- Poorly functioning Hospitals .

It would be an interesting trial to see how many times a patient is seen in general practice while waiting for an appointment to see a specialist. It would be even more interesting to see how many times they are seen while waiting on surgery lists. You could also add on the costs of investigations and medications during those waiting times. The unfortunate thing is politicians do not see this as a problem as one system is federal and the other is a state issue.(see 4- Dysfunctional system)

4- Dysfunctional System.

The state /federal boundary is a luxury of our politicians. My patients and their diseases do not have this luxury. A disease like diabetes does not know the difference between a state and federal system . At a time of workforce shortage to be running two systems is disgraceful. Patients are discharged early with only a few days medication. The patient frequently unwell has to make an appointment to see their GP to get further medication . This shifts costs from state to federal. The aged care /hospital interface also suffers from this state /federal divide.There are of course many other examples .

5- Computers.

Computers are now an essential part of general practice. They will improve health care. Unfortunately they also make our work slower. They are also very expensive to update and there are still many frustrating faults in medical software.

6- "Representative Bodies"

In recent years we have seen further layers of government bureaucracies with organisations such as ADGP. Much is spoken of the loss of funding from general practice to fund these organisations. It must also be noted that they have been a huge drain on our workforce. Many doctors now attracted to less stressful and better government remunerated administrative positions . Leaving less doctors actually involved in patient care.

The point we must ask now is who does represent General Practice ?

The ADGP is a government organisation with a government agenda .To say it represents GP's is dishonest. Working GP's views are not considered .

The AMA focus is on boosting the private hospital and private health systems. It avoids pushing for much needed reform in case it rocks the boat. Its representation of general practice remains amateurish and half hearted. This leaves our primary health care system vulnerable and more importantly jeopardises patient care.

The RACGP remains out of touch with mainstream general practice. Recent initiatives have resulted in increasing practice costs and more red tape. A recent self funded assessment confirmed the RACGP to be irrelevant and out of touch.

In summary the government would be better informed and we would not be facing such a crisis in Primary Care if General Practice was better represented. It is also important to note how much better the specialties are compared to general practice . Many of the specialties will soon be calling for an increased number of training positions. This will be heavily backed by politicians who have little regard or understanding of general practice. There will be a strong call for more surgeons to improve hospital waiting lists. There will be a call for more obstetricians to practice

in rural areas. Given there is a shortfall of 450 applicants to positions at present , who will speak up for general practice? The best value specialty (GP's) will not only be overlooked, but it is likely we will be looking at reduced numbers. This, coupled with the fact that many applying will soon have massive HECS debts, makes general practice an unlikely choice. Imagine looking at part time general practice with a $ 60,000.00 debt to repay.

Some specific areas to be discussed are

PRACTICE STAFF

Practice managers and receptionists perform one of the most difficult and stressful jobs in our health system. It is also one of the least recognised . With the unavoidable trend in our workforce, their job will become more stressful. Their remuneration is appalling with an hourly rate not dissimilar to many untrained junior positions . Despite paying above award wages our staff would have little difficulty moving elsewhere and doubling their income. eg. call centres. While the government fails to even look at the costs of running a general practice it is unlikely their award will improve . Will we be able to attract quality practice staff in the future? If we cannot who will be there to sort out who needs to be seen when our health system reaches its lowest levels of doctors?

PRACTICE PRINCIPALS

This must be the group most under threat of extinction in our health system. Who would run a general practice that practices quality care? With the government refusing to look at the real costs of running a quality general practice, many practices are closing . It is much less stressful and more financially rewarding to become a contractor or a permanent locum. This results in the rise of the super clinics run by entrepreneurs . The result is massively expensive to the government with higher referrals ,prescribing and investigating . Will the government then want to take practices over? What will be the output and cost of government run clinics ? Imagine the bill for stress leave alone?

OUR "LOST" WORKFORCE .

There are many doctors who have recently left the system. There are many doctors who if conditions improved would increase the number of sessions worked. Many female doctors have left the workforce after having children . Reluctant to return to a workforce that is undervalued ,poorly remunerated and not family friendly. Many older doctors now retire earlier due to unresolved indemnity issues and the poor remuneration for those working intermittently or just a few sessions per week. The loss here of experienced teaching GP's is a tragedy. WE MUST LOOK AFTER THE WORKFORCE WE HAVE.

THE CONSEQUENCES OF POLITICAL" HEALTH " POLICIES

Is there any other area of government that has undergone as many policy changes as health. In less than 2 years we have had Fairer Medicare ,Medicare Plus Mk1, Medicare Plus Mk 2, Strengthening Medicare and more!! The message going out to a

frustrated and undervalued workforce is a government that has no idea what it is doing . Massive, poorly directed funding . Reinforcing the idea that health cannot be fixed. Workforce initiatives that go little further than OTD's and a belated minor increase in medical school places available to Australian year 12 students. While at the same time introducing policies that have the reverse affect. A good example is the unsustainable safety net . General practice is now losing good GP's to acupuncture clinics, mole scan clinics ,laser clinics etc. because they can easily profit from the safety net.

"GP clinics" attached to hospitals.

This is of course not general practice . The quality of care will be poor . There will be no continuity of care. Patients will see different doctors with no understanding of their past history, family supports etc. Given the proximity there will be easier access to specialists ,radiology and pathology. This measure will be expensive and deliver an appalling level of health care.

Recent budget initiatives aim to pressure single mothers and the disabled back into the workforce. Has anyone thought of the impact this will have on general practice with increased certificates and medical examinations.

SOLUTIONS

1- LEADERSHIP

This is the most important solution to our workforce crisis.

We need to stop the continued loss of our existing highly trained workforce. The political leadership i.e. PM ,Minister for Health etc. need to get the message to general practice that they value what we do and they actually have an overall plan for health care in this country. I would challenge anyone to find a politician in this country State/Federal Liberal/Labor who has shown any leadership in health policy making. This is truly a time for a " LINE IN THE SAND ,HANG IN THERE ,WE VALUE WHAT YOU DO AND WE HAVE A PLAN" speech from our Prime Minister.

2-MEDICAL SCHOOL PLACES

Increased medical school places for Australian year 12 students. Rising each year to reflect our ageing population. Immediate moratorium on overseas fee paying students . Reintroduced only when we have adequate numbers of Australian trained graduates.

3-RESTRUCTURED REBATE SYSTEM

A payment system that reflects the way we train our general practice registrars. We train our registrars to see 4 patients per hour. The government rewards GP's to see 10 patients per hour. Even more so since the last election. This would attract back much of our lost Australian trained work force. It would encourage disease prevention. It would lead to less prescribing ,less referring and less investigations. It would recognise that many GP's across this country are working in areas with little if any access to specialists. The government has money available to GP's by way of care plans, asthma plans etc. which GP's are ignoring .This results in a massive underspend of government money. GP's do not access this money as the majority of

GP's do not have either the time or the desire to jump through the hoops the government requires to receive it. All these blended payments should be scrapped immediately and the money put into restructuring the rebate system.

4-RETENTION GRANTS

At present there is a ridiculous system where doctors going to an area of need are paid grants of about $ 20,000.00 provided they agree to stay 2 years. Doctors who have practised there for decades receive nothing. we need our doctors to stay in areas of need more than we need doctors who are staying for a short time. LOOK AFTER THE WORKFORCE WE HAVE !

5- BETTER FUNDING FOR THE RUNNING OF GENERAL PRACTICES

We need to retain our practice principals. Linking payments to WCI 5 underlines the government's deliberate head in the sand attitude to the running costs of a quality general practice. There should be funding made available immediately to finance the Infrastructure costs of running a general practice .eg a realistic assessment of computer costs, running a recall system etc.

6- OUR DYSFUNCTIONAL HEALTH SYSTEM

A GENUINE attempt by our politicians STATE/FEDERAL -LIBERAL/LABOR to address a system far beyond its use by date.

7-GOVERNMENT FUNDED SURGERIES/HOUSE /INFRASTRUCTURE PACKAGES TO RURAL AND REMOTE AREAS.

This would facilitate the move of city doctors to country areas. It would increase the chances of locum and short stay doctors.

8-RED TAPE AND INDEMNITY

A genuine attempt to resolve both these issues,with significant input from "grassroots" general practice.

9-A BAN ON POLITICAL HEALTH POLICIES

SUMMARY

FIRSTLY WE NEED TO HAVE POLICIES THAT RETAIN THE WORKFORCE WE HAVE.
WE NEED STRONG LEADERSHIP.
WE NEED POLICIES THAT AIM AT GIVING QUALITY HEALTH CARE TO ALL AUSTRALIANS.

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