AIDA
The Australian Indigenous Doctors' Association
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Nous
On behalf of Department of Health
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To whom it may concern

Re: Distribution Priority Area (DPA) for General Practitioners (GPs) classification system

Thank you for the opportunity to provide some comments on this review, in lieu of our planned consultation on 24 November 2021.

The Australian Indigenous Doctors' Association (AIDA) is the peak body representing Aboriginal and Torres Strait Islander medical students and doctors. Our doctors work across the range of specialities throughout Australia. Our work twofold, working to increase the number of Indigenous students and doctors, and advocating for a culturally safe healthcare system.

Regarding the review of Distribution Priority Area (DPA) and its goal to seek greater equity in the distribution of the General Practitioner (GP) workforce in Australia, AIDA has the following comments.

Effectiveness of the DPA as a distribution indicator for GPs

In considering community need for GP services, the Modified Monash Model (MMM) recognises systemic barriers rural locations face and results in automatic DPA for those areas. However, the corollary of the MMM is that it automatically prescribes low distribution priority for metropolitan areas. DPA is also calculated by actual levels of GP services accessed, and as Aboriginal and Torres Strait Islander people are much less likely to access services than non-Indigenous people, this constitutes a gap in effective measurement of need. The overall impact is that Aboriginal and Torres Strait Islander people in cities and non-rural and regional areas are not benefiting from DPA calculations despite their relatively large demographic numbers and overall higher proportion of disease burden.

In considering the role of DPA in enabling workforce recruitment and service size expansion, we wish to highlight the difficulty in growing a workforce and offering services without available staff to employ. DPA offers health services a pathway for a greater pool of candidates who can deliver subsidised Medicare services. Workforce limitations is a key barrier to providing expansive preventative healthcare, as scarce or limited resources will need to be diverted into crisis response and disease management.

DPA's impact on current programs supporting GP placements in rural and remote Australia

The primary healthcare funding model for does not adequately assess or provide for circumstances unique to rural or remote locations. It is nearly impossible for GP practices to operate in towns with very limited populations; they need a Medicare biller and they cannot rely on locum GPs due to both the inflated cost and their insufficient cultural knowledge. This became evident during COVID-19 in 2020-2021, where closed borders meant that remote areas became dependent on locum GPs for primary health care. One of our members provided an example: their centre paid a locum GP $12,000 per week for their primary health care services. This arrangement did not include weekend service or after-hours service, and the centre also had to pay for a car and accommodation for the locum GP and their family.

Another unsuitable aspect of the primary health care funding model for rural and remote communities is that it excludes specialist care. Specialist areas can be exceedingly difficult to access, a better model would provide specialist services as part of the primary health network. There are hidden structural barriers for Aboriginal and Torres Strait Islander Communities trying to access specialist care outside of their location. Travel to cities to access hospital services can be challenging; parking is costly and access to public transport is difficult for people who are not familiar with navigating these systems.

There are also some more general issues with DPA not providing suitable, sufficient, or culturally appropriate care for Aboriginal and Torres Strait Islander people. Prisoners are a priority area for primary health clinicians and the systems need to exist to support the delivery of appropriate services to these patients. Rural areas are often under-serviced and do not consider people living on properties or in the bush, this was evident in the aftermath of Tropical Cyclone Yasi in Innisvale in 2011. Without services going into the regions or bush areas, people are not getting the care they need. Without a mayor to bring issues to the attention of state governments, issues affecting small rural areas can be also invisible to a clinic located in the most central area. One of our members provided the example that during the wet season, areas can lose power for weeks. Residents will need to open their windows to let the fresh air in, which can lead to outbreaks of Dengue Fever.

When thinking about priority areas, the concept of distributing more GPs of any background, or just increasing the workforce by percentages, is too superficial. Incentives are also insufficient on their own, GPs report they do not know about all the incentives and when they find out they don't apply because they don't have time. It can also be unsuitable to use DPA to place International Medical Graduates (IMGs) in regional or remote communities. Many IMGs have their own cultural bias, which can include the expectation that Aboriginal and Torres Strait Islander people should work with microeconomic support. This is neither culturally appropriate or safe and constitutes a failure of the system.

A more wholistic approach must include a system to identify local GPs and GPs applying to return to their traditional lands, who are otherwise being rejected. This oversight leads to a loss of cultural knowledge that would benefit Community, as well as a loss of support networks for other Aboriginal and Torres Strait Islander GPs placed nearby. Burnout is also a significant issue for rural and remote GP placements. Broader support needs to be structured and embedded into these placements, for example: formal support networks, rotations between Cairns and Broome and oversight by an Aboriginal and Torres Strait Islander Faculty of Health.

Data and methodology used to determine DPA status

As outlined above, the methodology used to determine DPA fails to consider the nuances of Aboriginal and Torres Strait Islander populations and results in uncalculated need. In metropolitan areas, overall gentrification masks actual need and results in automatic de-prioritisation without considering Aboriginal and Torres Strait Islander populations. Our members are concerned that areas automatically deemed low DPA by MMM receive smaller Medicare subsides workforce allocations, reducing their ability to carry out critical health assessments and care assessments, as well as general preventative health care.

Other methodologies that could be considered for metropolitan areas include calculating the Aboriginal and Torres Strait Islander patronage of mainstream organisations and allocating additional resources for services with greater than 3.4% Aboriginal and Torres Strait Islander access.

For rural and remote areas, above we outline broader recommendations to supplement the failings of DPA calculation. We note that methodologies that rely on workforce percentage increases or generally increased distribution do not fully address issues for Aboriginal and Torres Strait Islander people.

Yours sincerely

Monica Barolits-McCabe
Chief Executive Officer

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