Asthma Australia Submission to the Senate Community Affairs References Committee

Inquiry into the provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians

October 2021

ABOUT ASTHMA AUSTRALIA

Asthma Australia is a for-purpose, consumer organisation which has been improving the lives of people with asthma since 1962.

Asthma is an inflammatory condition of the airways, which restricts airflow and can be fatal. There is no cure, but most people with asthma can experience good control of their condition.

Asthma affects one in nine Australians, or 2.7 million people. It has various degrees of severity (mild to severe) and affects people of all ages, from childhood to adulthood. Asthma can appear at all ages and stages of life.

Asthma Australia's purpose is to help people breathe better so they can live freely. We deliver evidence-based prevention and health strategies to more than half a million people each year. To ensure people can access effective treatments and best practice healthcare for their asthma, we work directly with people with asthma, their family and friends, health professionals, researchers, schools and governments. This way, we can ensure people with asthma are supported with education and access to high-quality information and care where they live, work and play in all stages of life.

Introduction

Asthma Australia welcomes the opportunity to submit to the Senate Community Affairs References Committee (the committee) inquiry into the provision of general practitioner (GP) and related primary health services to outer metropolitan, rural, and regional Australians.

This submission has been drafted in consultation with our Professional Advisory Council and our Consumer Advisory Council. We also sought feedback on this inquiry from our Asthma Champions, whose experiences are included as quotes throughout this submission.

Asthma Australia is aware that, for people with asthma, there are several barriers to accessing healthcare in non-metropolitan areas. Barriers include the delays in accessing appointments, the need to travel long distances for GP and specialist appointments, and the cost of this healthcare. Although governments have attempted to address these barriers with the introduction of various schemes designed to incentivise GPs to relocate to non-metropolitan areas, these schemes prove to be less effective in the long term. These barriers to GP access are felt acutely for people with chronic conditions, like asthma, who require greater access to healthcare and more specialised care, when compared to people without such conditions.

Asthma in Australia

Asthma is one of the most common chronic conditions in Australia, with high prevalence rates by international comparison. Around 2.7 million Australians (11% of the total population) have asthma.[1] Asthma affects people of all ages.

There is generally a higher prevalence of asthma for people living in inner regional areas (12.9%) or outer regional and remote Australia (12.7%) compared with those living in major cities (10.6%),[2] but as the table below indicates this varies across jurisdictions.[3]

	Major city	Inner regional area	Outer regional and remote areas
New South Wales	9.7%	14.1%	13.7%
Victoria	10.9%	13.6%	13%
Queensland	11.9%	11.9%	11.7%
South Australia	11.4%	15%	18.1%
Western Australia	10.1%	7.7%	9.4%
Tasmania	n/a	11.9%	14.4%
Northern Territory	n/a	n/a	7.5%
National prevalence	10.6%	12.9%	12.7%

People with asthma experience poorer health outcomes and quality of life.[4] People with asthma may live for a long period of time with its associated disability, and experience reduced participation in the workforce, school, childcare, sports and social events. Asthma is the 10th leading contributor to the overall burden of disease in Australia and the leading cause of burden of disease for people aged 5-14 years.[5]

In 2020, there were 410 deaths due to asthma in Australia.[6] Approximately 400 people die each year due to asthma.[7] Asthma mortality[8] and hospitalisations[9] in Australia are high by international standards. Hospitalisations due to asthma are costly: on average, each emergency department presentation for asthma costs $443, an uncomplicated hospital admission costs $2,591 (approximately 1.5 hospital days) and a complicated admission costs $5,393 (approximately three hospital days).[10] The estimated cost of asthma in Australia in 2015 was $28 billion.[11] This equates to

$11,740 per person with asthma and includes $24.7 billion attributed to disability and premature death.[12]

Defining outer metropolitan, rural, and regional Australia

There are multiple and varying definitions of outer metropolitan, rural, and regional Australia. The Australian Institute of Health and Welfare identifies three major classification systems for non-metropolitan Australia, however, no one classification system refers to all of the classes 'outer metropolitan', 'rural' and 'regional':[13]

- The Accessibility/Remoteness Index of Australia (ARIA) refers to the categoric classification and consists of five classes: Highly Accessible, Accessible, Moderately Accessible, Remote and Very Remote.
- The Australian Standard Geographical Classification (ASGC) consists of six remoteness area classes: Major Cities, Inner Regional, Outer Regional, Remote, Very Remote and Migratory. Each ASGC Remoteness Area class, excluding Migratory, consists of a range of ARIA+ index values.
- The Rural, Remote and Metropolitan Areas (RRMA) classification system consists of three broad zones: metropolitan, rural and remote, and seven finer classes.

We note that access to primary health care services is not consistent across these classes. Indeed, the National Rural Health Alliance (NRHA) recently identified that life expectancy goes down with remoteness.[14] It is therefore important that the committee is aware of the discrepancy between these classes and bears this in mind in making its recommendations.

For the purpose of this submission, we consider that outer metropolitan, rural, and regional Australia, or non-metropolitan Australia, encompasses the ARIA, ASGC and RRMA classification systems, and we make no distinction between these classes.

The significance of pharmacists for people in outer metropolitan, rural, and regional Australia

Asthma Australia has been informed by a member of our Professional Advisory Council who operates as a pharmacist on locum in non-metropolitan areas that there are significant barriers to people accessing pharmacists in these areas.

We note the terms of reference do not explicitly identify pharmacists, however these healthcare professionals play a critical role in the delivery of primary health care. This is particularly so in areas where it may take weeks or months to get a GP appointment, where these appointments are limited by significant time restraints and/ or where the costs to access a GP are too prohibitive. Pharmacists offer a critical service to the community in circumstances where access to a GP may not be possible. Indeed, pharmacies are often an individual's first point of contact with the primary health care system.

For people with chronic conditions, including asthma, pharmacists play an even more critical role in the delivery of health care. The most common asthma medications are self-administered with devices, which can require an additional level of patient education. Pharmacists may be the only available health professionals that have both the requisite amount of time and expertise to talk to

people with asthma about how to use the necessary devices required to administer medication.

Outer metropolitan, rural, and regional Australian communities face particular difficulties retaining pharmacists. There are various reasons for this, including lack of incentives to work in these communities (in contrast to the many programs to incentivise GPs), and a higher renumeration rate offered to locum pharmacists which leads to a casualisation of the workforce. As a result of these issues, a high number of pharmacists in these communities are often on locum, living in the community for a short amount of time. This means there is a lack of continuity of care for patients, particularly those with chronic conditions.

We therefore urge the committee to seek out and consider evidence from pharmacists operating in non-metropolitan Australia as well as peak pharmacist organisations, including those representing non-metropolitan pharmacists, so that the committee can gain a more fulsome insight into the issues affecting Australians in outer metropolitan, rural, and regional areas.

> **RECOMMENDATION 1: Asthma Australia recommends the committee seek out the input of pharmacists to comment on the issue of access to healthcare in outer metropolitan, rural, and regional Australia.**

The responsiveness of outer metropolitan, rural, and regional GPs and related services to people with asthma

> I have had asthma for many [y]ears. I am a farmer's wife and, unfortunately, am allergic to many aspects of farming. I was desensitised over 20 yrs ago and this meant many long trips of 500km round trips to see the Specialist. Then there was the expense of the [biologic medication] injections. I did find it very successful and helped for several years. I still have asthma but can manage it with preventers. Drs are happy to give you new medication but do not always explain the best way to use them. I found the Respiratory Nurse was a great help.
>
> *Person with asthma, October 2021*

GP services in outer metropolitan, rural, and regional Australia are generally not sufficient to meet the needs of the communities they serve. The NRHA recently identified:

- Rural areas have up to 50% fewer health providers than in major cities (per capita); and
- Rural doctors have lower bulk billing rates and are not catching up with major cities.[15]

Asthma Australia has been informed by members of our Consumer Advisory Council and our Asthma Champions who live in non-metropolitan areas that they are facing significant barriers to timely access to GPs. Some people with asthma have to wait weeks or months for a GP appointment. Some people with asthma have reported waiting a year for an appointment with a specialist. For people with asthma, waiting to access healthcare can have severe effects on their condition and can also lead to an unnecessary burden on hospital Emergency Departments.

Barriers to accessing GPs in non-metropolitan communities extend beyond waiting weeks or months for an appointment, or the cost of the appointment, because the issues faced by non-metropolitan

communities in accessing healthcare can be different to the issues that are faced in metropolitan Australia. In some of these non-metropolitan communities, there is no GP or pharmacist available, and people are therefore required to travel to another town to access healthcare. Some people also elect to travel to another town to access healthcare in order to discuss sensitive medical issues with someone who is not part of their small community. Some people with asthma, or who care for a person with asthma, may decide to travel because they don't feel their local GP is adequately trained in asthma. This demand on the healthcare services of another town could have the effect of overburdening already overburdened services in that town. There are also barriers to healthcare where a GP, perhaps the only GP in a small community, is not sensitive to the cultural perspectives of Culturally and Linguistically Diverse patients.

> I am fortunate that despite being in a rural area I only have to travel one hour to my primary medical care and respiratory specialist. I wouldn't expect our local town of 1400 people to have specialist services. Having said that, I'm informed today that there is 12 month wait to get an appointment to see my respiratory specialist as a new patient.
>
> *Person with asthma, October 2021*

The lack of access to specialists is also a significant issue of concern, particularly to those people with asthma who require appointments with respiratory specialists to manage their chronic condition. Some specialists do travel to non-metropolitan communities, but such visits are infrequent and patients will therefore travel to see specialists. Depending on the distance to the specialist, patients may have to drive long hours, fly to a major centre or stay overnight in this location. Not only is this an increased time burden on patients, but these travel and accommodation costs, as well as the costs required to keep things running at home and the time taken from paid work, can amount to a large financial burden on an individual. This has significant implications for people with asthma: people may have to travel to several specialist appointments and wait several years to receive the correct medication, putting people with asthma in non-metropolitan areas at a disadvantage compared to their metropolitan counterparts.

> After living in Sydney (Western Suburbs) for around 40 years, it was very easy to see a GP, this was also bulk billed. I also had easy access to a specialist and if my appointment needed to be brought forward, due to additional exacerbation only my asthma, this was also easy. I was also able to arrange appointments around my work schedule sometimes without the need to take any time off work. Since moving to a regional area (Central Coast) over 10 years ago, seeing a GP was relatively easy, however, bulk billing was not available, so cost to see the GP for checkups, scripts etc became expensive. Access to a specialist was also easy, however, it has been difficult to change or move my appointments, if required, as there are less specialists available in this area. Additionally, I sometimes have to take time off work to attend due to the limited appointment times/dates available.
>
> *Person with asthma, October 2021*

As a result of this inconsistent primary health care workforce, there is generally a lack of continuity of care in outer metropolitan, rural, and regional Australia. For people with chronic conditions, like

asthma, consistency of GPs and pharmacists is extremely important for the management of their condition: it is important that health care professionals are familiar with patient history. Continuity of care helps with the ongoing management of chronic conditions, and decreases the risk of preventable exacerbations of these conditions, that in turn prevents burden on the hospital system.

In order to address these barriers and provide people in non-metropolitan Australia with a consistently reliable primary health care system, it is necessary to increase investment to primary health care services in these areas.

RECOMMENDATION 2: Asthma Australia recommends increased investment in non-metropolitan primary health care services.

Reforms to outer metropolitan, rural and regional GP services and their impact on GPs

> In my town (Peterborough) we rely on locums as there is no doctor service that permanently covers our town. This week there is actually no locum either. So if I was to make an appt I'd have to wait probably weeks to get in to Jamestown or [O]rroroo (Both half an hour away) or alternatively in an emergency present at A&E. (The doctors at Jamestown will not attend, so people would need to get flown out for any priority medical attention.) I would have to organise an appt during their business hours plus allow for the travel time and waiting time for appt.
>
> *Person with asthma, October 2021*

There have been many reforms to incentivise GPs to move to outer metropolitan, rural and regional Australia. While these reforms for GP retention have been welcome, as the NRHA has noted these "range of strategies" that governments have pursued "to address these poorer health outcomes over many years" reveals "that these interventions are having limited success".[16]

It is therefore important for the committee to consider whether the current funding model is fit for purpose. The committee may wish to explore funding models that include incentives for a focus on the health of the population, promote safety and quality and reduce preventable hospitalisations through primary and secondary prevention.

RECOMMENDATION 3: Asthma Australia recommends the committee consider whether the current funding model is fit for purpose and explore funding models that include incentives for a focus on the health of the population, promote safety and quality and reduce preventable hospitalisations through primary and secondary prevention.

With respect to pharmacists, there are very few schemes in place to incentivise pharmacists to work in non-metropolitan areas. It is important to consider whether pharmacists should be offered incentives, similar to those offered to GPs and nurses (noting that these schemes nevertheless require some improvements), as a means by which to encourage pharmacists to take placements in non-metropolitan areas and potentially relocate to these areas. Incentives could also be offered to more experienced pharmacists to undertake placements in order to ensure quality and safe care, and to provide guidance to undergraduates. As discussed, pharmacists are often the first point of

contact with the primary health care system for an individual and are particularly critical to the provision of health care in non-metropolitan areas where access to a GP may be limited.

RECOMMENDATION 4: Asthma Australia recommends the committee consider the need to establish schemes for undergraduate pharmacy placements in non-metropolitan Australia, similar to those offered for GPs and nurses. The committee could also consider incentives for more experienced pharmacists to take placements in order to ensure quality and safe care, and to provide guidance to undergraduates.

The Medicare freeze

The Medicare Benefits Schedule lists the services that are subject to a rebate from the Australian Government. Where a GP bulk bills, a patient will not pay for an appointment, and GPs are directly reimbursed by government. Those GPs who don't bulk bill are free to set their own prices for their services, and patients will have to claim a rebate through Medicare.

Since Medicare's introduction in 1984, fees have been subject to annual indexation. The freeze was first introduced as a budget-saving measure by Labor in the 2013–14 Budget as a temporary measure to July 2014. The Coalition reimposed the freeze in Mid-Year Economic Fiscal Outlook 2014–15 and then extended in subsequent budgets to July 2020. It was forecast to achieve total savings of around $3.9 billion to 2020.

The reintroduction of indexation has been applied in phases:

- From 1 July 2017, bulk billing incentives for general practitioners (GPs) will be indexed
- From 1 July 2018, standard GP consultations and specialist attendances will be indexed
- From 1 July 2019, specialist procedures and allied health services will be indexed
- From 1 July 2020, certain targeted diagnostic imaging services will be indexed.

Despite the reintroduction of indexation, this has not necessarily led to a benefit to GPs and patients in non-metro areas. As the NRHA notes:

> *Rural Australians do not access Medicare or the Pharmaceutical Benefits Scheme at the same rate as metropolitan Australians. This means there is a deficit in health expenditure in rural Australia. The Alliance has calculated that this "rural health deficit" is now around $4 billion per annum.*[17]

The impact of COVID-19 on people with asthma in outer metropolitan, rural, and regional Australia

> My appointment with my respiratory specialist was changed 3 times in 2020 and ended up being a phone consultation. My appointment this year was again short. I travel 2 hours to see him. My GP has[n't] done any asthma checks in over 12 months
>
> *Person with asthma, October 2021*

COVID-19 has revealed the flaws in Australia's health system. Asthma Australia conducted a survey of people with asthma and their carers in June-July 2021, in response to concerns raised by people with asthma about their access to healthcare, and to better understand attitudes towards the COVID-19 vaccination among people with asthma.

A total of 1,263 people responded to the survey, 89% were people with asthma and 11% completed the survey on behalf of someone they care for who has asthma. Almost half of respondents (44%) were from a regional/ remote area.

Respondents from a regional/ remote area reported significant challenges accessing healthcare in the previous 3 months, and experienced at least one of the following challenges:

- 29% of respondents reported they have been unable to see their doctor in person until returning a negative COVID-19 test due to asthma symptoms looking like COVID-19
- 34% of respondents reported they had been unable to see their doctor in person due to asthma symptoms looking like COVID-19
- 48% of respondents reported they had put off going to my GP about their asthma due to asthma symptoms looking like COVID-19.
- 27% of respondents reported they had put off going to see my GP because they were required to get a COVID-19 test.

Seventy-nine per cent of people from regional or remote areas identified that experienced at least one of these barriers, compared to 74% from a major city.

Although the data varied across jurisdictions, the experience of people with asthma in a major city was similar compared with those in a regional or remote area.

Statement	NSW	QLD	SA	Victoria	Major city	Regional / remote
Have been unable to see their doctor in person until returning a negative COVID-19 test due to asthma symptoms looking like COVID-19	34%	28%	34%	28%	31%	29%
Have been unable to see their doctor in person due to asthma symptoms looking like COVID-19	34%	35%	39%	35%	35%	34%
Have put off going to my GP about their asthma due to asthma symptoms looking like COVID-19.	50%	50%	51%	44%	48%	48%
Have put off going to see my GP because they were required to get a COVID-19 test	30%	25%	34%	25%	28%	27%

The COVID-19 situation has also had a negative effect on locum pharmacists. Locum pharmacists often relocate to pharmacies in non-metropolitan communities in response to emergency situations. These pre-pandemic emergency situations are still occurring, but so too is an increase in COVID-19 related emergency situations. Indeed, Asthma Australia has been informed that "it has never been more difficult" to arrange for locum pharmacists, and this is because of a number of issues:

- border closures make travelling interstate difficult and/ or undesirable

- many locum pharmacists are engaged in administering the COVID-19 vaccine in vaccination centres, and are therefore unavailable for locum; and
- the risk posed to locum pharmacists of contracting COVID-19 leads to some pharmacists turning down locum opportunities.

Telehealth services

Asthma Australia welcomes the introduction of MBS-subsidised telehealth during the COVID-19 pandemic, and notes that this service has been critical for people with asthma accessing care. It has increased access to Medicare and to flexible, comprehensive care, particularly for those in rural and remote areas where geography is a barrier to accessing health care, and for people who have difficulty leaving their home, such as older people or those with disabilities. There are, however, also barriers to using telehealth services, such as digital literacy, as well as access to required technology, unreliable internet access and non-awareness of the option.[18]

Asthma Australia welcomes the Australian Government's announcement that universal whole-of-population telehealth will now be permanent. However, telehealth is only effective if it delivers good outcomes. It is therefore important to address a number of issues in order to ensure a high standard of healthcare is maintained where consumers opt to use telehealth services in place of face-to-face services, including:

- the above-mentioned barriers to accessing the service, namely: digital literacy, access to required technology, unreliable internet access and non-awareness of the telehealth option
- monitoring and evaluating the impact on access and health outcomes with appropriate indicators of health need and consultation outcomes; and
- identifying factors that improve telehealth outcomes.

Another issue that is important to address with respect to telehealth is understanding the circumstances in which telehealth is not ideal. People with asthma benefit from face-to-face appointments, because these allow GPs to observe a patient and watch for cues which may lead the GP to recommend certain testing, such as chest auscultation or spirometry. For the patient, the feeling of being seen and heard is important. However, telehealth can also be useful for people with asthma for more routine asthma-related appointments, such as prescribing.

RECOMMENDATION 5: Asthma Australia recommends addressing current barriers to and ongoing monitoring and evaluation of MBS-subsidised telehealth for all people in Australia.

Summary of recommendations

RECOMMENDATION 1: Asthma Australia recommends the committee seek out the input of pharmacists to comment on the issue of access to healthcare in outer metropolitan, rural, and regional Australia.

RECOMMENDATION 2: Asthma Australia recommends increased investment in non-metropolitan primary health care services.

RECOMMENDATION 3: Asthma Australia recommends the committee consider whether the current funding model is fit for purpose and explore funding models that include incentives for a focus on the health of the population, promote safety and quality and reduce preventable hospitalisations through primary and secondary prevention.

RECOMMENDATION 4: Asthma Australia recommends the committee consider the need to establish schemes for undergraduate pharmacy placements in non-metropolitan Australia, similar to those offered for GPs and nurses. The committee could also consider incentives for more experienced pharmacists to take placements in order to ensure quality and safe care, and to provide guidance to undergraduates.

RECOMMENDATION 5: Asthma Australia recommends addressing current barriers to and ongoing monitoring and evaluation of MBS-subsidised telehealth for all people in Australia.

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