Australian Multicultural Health Collaborative

OUR CULTURES OUR LANGUAGES OUR HEALTH

RACGP General Practice Crisis Summit

Response to draft White Paper

Prepared on behalf of the Australian Multicultural Health Collaborative by

FECCA

Federation of Ethnic Communities' Councils of Australia

World Wellness Group

World Wellness Group

Background

The Federation of Ethnic Communities' Councils of Australia (FECCA) would like to acknowledge and thank the Royal Australian College of General Practitioners (RACGP) for inviting two representatives to the General Practice Crisis Summit held on 5 October 2022.

The Australian Multicultural Health Collaborative had, however, been launched in June 2022.

An initiative of FECCA, the Collaborative arose from a substantial consultation process when it became clear through the impact of COVID-19 that the establishment of a new national health peak focussing on multicultural health and wellbeing was required to address health inequities impacting on Australia's culturally and linguistically diverse (CALD) communities which have not been sufficiently addressed for decades.

Its individual and organisational members include:

- consumers;
- health services and social care/wellbeing services;
- practitioners and their professional organisations;
- researchers and research institutions.

A range of specific issue health peaks have joined as national affiliates.

The main objective of the Collaborative is to provide a national voice, leadership and advice on policy, research, data and practice to improve access and equity, address systemic racism, and achieve better health and wellbeing outcomes for Australians from culturally and linguistically diverse (CALD) backgrounds.

The Collaborative is co-chaired by FECCA and World Wellness Group, a specialist multicultural primary health care service and national multicultural health organisation, currently delivering the Multicultural Health Connect telehealth support service.

It was determined that the most effective input to the Summit would be delivered through representation from the Collaborative, rather than from FECCA alone.

Representatives of FECCA and World Wellness Group attended.

The Multicultural Perspective

We suggest that the White Paper does not sufficiently respond to issues arising for general practice as a result of Australia's increasing culture and language diversity.

It should be noted that the 2021 census indicated that:

1. Australia is more culturally and linguistically diverse than ever with more than 250 ancestries and 350 languages.
2. Australia is now a majority migrant nation with 51.5 per cent of our population born overseas or having a migrant parent.
3. Almost half of the population (48.2 per cent) are either first or second-generation migrants – having at least one parent born overseas.
4. 5.5 million (24.8 per cent of the population) speak another language at home other than English with Mandarin, Arabic and Punjabi being the top three languages.

It is therefore imperative that any discussion about health system reform, including the first point of access in terms of primary health care, needs to address appropriate responses to cultural, ethnic, language and faith/religion diversity when considering:

- funding (including the provision of language services);
- models of service delivery (providing flexible, comprehensive and culturally responsive services people from CALD backgrounds) ;
- workforce (ensuring career paths for both overseas trained practitioners and those born in Australia of diverse culture, ethnic, language and faith/religion backgrounds); and
- data collection and reporting
  (addressing national deficits in relation to culture and language diversity).

Only then can we hope for improvements in timely access to primary health care services, quality and culturally responsive services, and health outcomes.

This necessary focus is, in our view, implied in the White Paper, but is not sufficiently explicit. We consider that this is also true of the RACGP publication *General Practice Health of the Nation 2022* which, whilst containing imagery on the front cover and elsewhere that implies culture and language diversity, does not meaningfully address the issues in the text.

The Collaborative strongly suggests that the use of the term '**vulnerable communities'** in the document is not particularly helpful.

It is not cultural and/or linguistic diversity that makes our communities 'vulnerable'. Rather, it is the health system itself that causes suboptimal outcomes for these communities. As evidenced by the work of the national Culturally and Linguistically Diverse Communities COVID-19 Health Advisory Group (established as a result of FECCA advocacy) and many other local front-line services, when properly resourced and, above all, appropriately engaged and listened to, these communities were demonstrably resilient.

Whilst there is a real crisis in primary health care that needs to be addressed, solutions need to be inclusive of those in our society whom the system often excludes from the discourse around health policy in Australia. Left unaddressed this invisibility leaves CALD communities in Australia more susceptible to poorer access to public health care messaging, less timely access to affordable healthcare services which in turn results in inequitable health care outcomes.

To illustrate the point about excluding CALD communities, the COVID-19 mortality rates in Australia are a stark reminder of the implications of health inequity and mortality rates. Data released by the Australian Bureau of Statistics as recently as 31 January 2022, which included part of the Delta and Omicron waves, showed that people born overseas faced 6.8 deaths per 100,000 people as compared to 2.3 per 100,000 for people born in Australia. The rates of mortality were even greater for those born in the Middle East at 23.9 per 100,000 or more than ten times more than those born in Australia.

Meaningful reform should be achievable and, although there are challenges ahead there are useful models in this context, such as funding for community controlled health services which are an integral part of the Australian health system for Aboriginal & Torres Strait Island communities which must continue and be further strengthened in the context of section 19(2) of the *Health Insurance Act* (1973) which allows Aboriginal controlled health services access to Commonwealth funding, even if they are funded by state governments.

Case Study

This is intended to demonstrate the funding issues and other complexities involved in delivering comprehensive and responsive primary health care services to CALD patients.

World Wellness Group's GP related work with asylum seekers and patients not enrolled or eligible to access Medicare is completely unfunded. It should also be noted that this unfunded work extends to nursing and allied health practitioners which also impacts on our ability to provide integrated team-based care. In addition, the cost of medications, pathology testing and X-rays for patients without access to PBS/Concession Cards is also completely unfunded.

Beyond the unfunded work we do more broadly, the Medicare billable services we do deliver are often for the most disadvantaged and invisible in society. This means our service cannot operate under a '5-minute medicine model'.

Effectively this means that whilst we are a bulk billing clinic we cannot operate solely as a Medicare billable funded only general practice clinic. The only way we have been able to work around this to meet our vision and mission is by providing additional wrap around community supports and services with external grant funding and philanthropy to fund asylum seeker/non-Medicare billable healthcare.

Our ability to deliver services on a sustainable basis is compounded by increased wait times to see GPs due to the necessary length of consultations and the complexity of care, and the lack of availability to fill GP vacancies at our clinic.

Being unable to engage international medical graduates, given we are in a metropolitan area, also precludes us from growing our GP workforce. The rules around area of need and seeking approvals from multiple organisations and layers of government are convoluted, complex and unclear which means our ability to manage waitlists and provide timely care further constrain our ability to provide timely access to culturally responsive and safe primary healthcare to some of the most disadvantaged groups in the community.

Response to Focus Area 1: Funding

We support the proposals as follows:

Timeframe	Solution
Short-term	Raise MBS patient rebates for general practice care by at least 20%. **Supported.** **The Collaborative supports this approach and would like an explicit item number and weighting in Medicare item numbers for General Practitioners to work on a team-based care model inclusive of nursing, allied health, bicultural support workers and interpreters to enable integrated care and support those factors cultural and linguistic diverse beliefs and considerations in respect to healthcare.** **For people with limited English proficiency, consultations and quality care require additional time, both in terms of cross-cultural clinical practice with further time and complexity involved where interpreting services are required. Expectations, training and funding remuneration models do not factor in or cost the provision of care adequately in this regard.**
	Increase the bulk-billing incentives by two to three times. **Supported. With due consideration of the point above.**
	Lower the Extended Medicare Safety Net threshold from $717.90 to $500. **Supported and indexed in line with health care concession card rates.**
	Adjust standard general practice consultation MBS items to reweight time tiers, reduce the time intervals and ensure longer consultations are appropriately valued. **Supported. With due consideration of the first two proposed solutions above.**
	Uncap and properly index general practice incentive payments, including those paid under the Practice Incentive Program and Workforce Incentive Program. **Supported along with a requirement for Commonwealth payment mechanisms via Medicare or Primary Health Networks to consider and publish data on CALD populations in each of the 31 PHN catchment areas in respect to demographic profiles, health status and inequity data. These datasets should then be utilised to inform the development of localised targeted incentives on a systemised basis as part of funding schedule service agreements and performance reviews of PHN's. Examples around this type approach were around PHN funding of COVID-19 vaccination clinics and vaccination uptake by CALD populations as an approach that could be built upon. In proposing this approach, the Collaborative would place the caveat that a co-designed approach would be needed with multicultural health sector service delivery agencies to formulate a workable model of service.**
	Uncap MBS Item 10997 to allow for more than 5 services per patient in a calendar year. **Supported.**
	Introduce VPE as the gateway to supporting ongoing telehealth, care continuity, and primary care reform funding, with equitable allocation to both practice and practitioner. **Supported – in keeping with the principles outlined against the first solution.**

Timeframe	Solution
Medium-term	Introduce an Independent General Practice Pricing Authority to evaluate and set pricing for general practice activities, on which MBS patient rebates and other payments will be fixed. **Qualified support. We believe more integration of funding across a continuum of care across care settings is required. As such we would favour one body that looks at hospital care, primary care and other social supports including the NDIS and Aged Care on a more integrated basis with requirements to address health inequity considerations and tailored supports where applicable as it relates to CALD populations and other specified priority population groups. De-centralised, fragmented multiagency models lacking mandate, accountability, and ability to amass expertise and engage with priority population groups is an enduring feature and an area that needs to be addressed to ensure the needs of CALD populations are factored in as routine practice rather than an as an afterthought.**
	Regular and appropriate indexation of MBS rebates and other general practice payments, as overseen by the Independent General Practice Pricing Authority. **Qualified support as outlined in previous response.**
	Set aside 10% of state and territory health funding for general practice-led preventive health, and hospital and emergency department avoidance activity, held external to state governments. **Qualified support as outlined in previous responses.**
Long-term	Consider pooled funding and co-commissioning approaches that include general practice input and appropriate remuneration, inclusive of all practices within the region. **Not supported at this stage. Further detail around how this would work so as not to detract from specialist capability in delivering multicultural services is something the Collaborative would wish to explore.**
	Consider salaried models of care for vulnerable communities and areas of market failure with ongoing evaluation and benchmarking. **Qualified support as outlined in previous responses.**

The Collaborative agrees that consecutive years of cost-cutting and contracting health funding in real terms has left general practice on the brink of collapse.

This complexity is even more amplified when running general practice services focused on CALD communities with a significant cohort of unfunded asylum seeker patients.

For example, World Wellness Group, as a specialist multicultural general practice primary health care service, would not be a viable service model without other wrap around programmes. In addition, without the wrap around supports we have in place in primary health, our patients would face even greater access barriers resulting most likely in them avoiding accessing healthcare due to cost.

Response to Focus Area 2: Career path and sustainability

We support the proposals as follows:

Timeframe	Solution
Short-term	Increase the base salary for GPs in training to be commensurate with equivalent hospital-based positions. **Supported.**
	Reduce red tape in general practice and realign Medicare compliance approach to be less punitive and more educational/preventive. **Supported.**
	Introduce reliable and cost-effective locum schemes, including to support general practitioners to upskill. **Supported.**
	Designate the general practice workforce support as a top priority for Primary Health Networks. **Qualified support on the basis that this is complemented with other specific PHN and state-based wrap around supports that take a holistic approach with an emphasis on culturally safe and responsive models of care focused on wellness and prevention of illness.**
Medium-term	Introduce a program to increase exposure to general practice in prevocational training years (such as the Prevocational General Practice Placements Program). **Supported.**
	Consider a national body, independent of State and Territory governments, to protect GP registrar entitlements, ensure salary parity with hospital-based registrars, and improve the attractiveness of a career in general practice. **Supported.**
	Introduce an integrated strategy for IMGs that incorporates more incentives and support, reducing red tape and administrative barriers. **Supported. In particular the area of need requirement complexities, moratorium and red tape require urgent review in particular where priority populations are underserviced.**
	Consider a single entity that streamlines IMGs introduction, employment and retention. **Qualified support on the basis that this includes curriculum training and pathways around working with priority population groups with complex health care needs and barriers posed through structural inequities e.g. patients with unresolved asylum seeker claims.**
	Increase leadership opportunities for GPs in health, education and research. **Qualified support as outlined above. In addition, education and research should have a dedicated focus around multicultural health noting disparities and solutions cannot be advocated, tracked or progressed as a matter of routine practice as exposed during the COVID-19 pandemic.**

Long-term	Build infrastructure according to local needs. **Supported along with a requirement to publish data on CALD populations in each of the 31 PHN catchment areas in respect to demographic profiles, health status and inequity data. These datasets should then be utilised to inform the development of localised infrastructure and responses to meet community need and reduce inequities.**
	Develop general practice networks which provide tailored support to meet individual needs, including cultural and lifestyle support, mentoring and leadership. **Supported as per the response above.**
	Introduce flexible employment structures for vulnerable communities and areas of market failure. **Qualified support on the basis that there is a requirement for Commonwealth payment mechanisms via Medicare or Primary Health Networks to consider and publish data on CALD populations in each of the 31 PHN catchment areas in respect to demographic profiles, health status and inequity data. These datasets should then be utilised to inform the development of localised flexible employment structures on a systemised basis as part of funding schedule service agreements and performance reviews of both PHN's and state funded local health services.** **Such arrangements also need to consider local workforce needs, national skills shortages datasets, immigration requirements, overseas skills recognition by accreditation bodies and streamlined pathways for clinical supervision, assessment and registration to practice in an Australian health care context. Consideration also needs to be given around flexible approaches to settings and locations where general practitioners can practice including a requirement to use telehealth to service areas of need to address regional and remote health workforce shortages and potential for FIFO rather than restrictive and complex mortarium and area of need arrangements currently in place.** **An integrated approach between key agencies at all levels of government, health, education and immigration regulatory bodies is required to tackle this issue in an integrated and coordinated way.**

The Collaborative is of the view that the discourse around International Medical Graduates (IMGs) needs to change from focusing on deficit, e.g. "Australia continues to depend heavily on IMGs … making up 52% of the workforce" (General Practice, Health of the Nation 2022) given that such discourse places value on IMGs only as part of the solution to workforce shortages.

The emphasis of the discourse should shift to promoting the benefits of culture and language diversity in the GP workforce (both IMGs and Australian medical graduates) as being reflective of the Australian population and contributing to health service delivery which is culturally appropriate and safe as outlined in our preamble response.

Response to Focus Area 3: Data

We support all proposals

Timeframe	Solution
Short-term	Introduce overarching data strategy for general practice
	Create standards to assist with interoperability of information transfer between parts of the health system.
	Support a significant uplift in the Clinical Information Systems to be able to seamlessly present and share data about the patients we care for.
	Introduce funding to support general practice staff to collect and code data gathered within their practice.
	Create general practice networks to create local learning systems which can promote learning from their data to facilitate quality improvement
	Increase research in general practice through greater investment from the National Health and Medical Research Council. **The Collaborative suggests that there are significant gaps in research into the provision of general practice services to CALD patients, including costs.**
Medium-term	Apply a national approach to data governance, transparency and security structures to promote trust.
	Adopt a central approach to improving the data and digital health curriculum in medicine, from undergraduate to specialty training and ongoing.
	Implement greater incentives for all participants to support quality data capture and working towards real-time data extraction to support quality improvement and research.
	Upscale key data linkage projects, incorporating robust security and privacy measures.
	Introduce robust monitoring and reporting on GP and staff satisfaction with data measures and digital health implementations.
	Implement support for practices and GPs to participate in general practice research, including funding of scholarships, fellowships and grants.
	Re-introduce funding for high-quality longitudinal studies in general practice.
Long-term	Support robust data linkage through an overarching national approach that incorporates data from various sectors, including health, justice, social services, and education

In addition, it should be noted that in general practice software systems there are significant deficits in data capture relating to culture and language diversity. This lack of standardised expectation and approach is further exacerbated by inconsistencies in the offerings of different developers and systems.

These deficits are not confined to general practice but are common across government administrative data sets, social and health-related surveys, and social/health and medical research, including clinical trials. See FECCA 2020 Issues Paper:
If we don't count it, it doesn't count.

The most common and often sole indicator of culture and language diversity is 'country of birth' which is not particularly useful. Consider that a person born in Singapore may be of Chinese, Malaysian, Indian and many other ancestries. Similarly, a person born in the UK, may be of Caribbean, African or Asian ancestry.

The Australian Government has committed to working towards addressing these issues to ensure administrative, survey and research data are reflective of Australia's culture and language diversity. It is recommended that the RACGP participate in this process as it evolves and forms an aligned position with the Collaborative in this regard.