Witness Statement

Name: Dr Michael Bonning

Occupation: General Practitioner

1. This statement sets out the evidence that I am prepared to give as a witness to the Special Commission of Inquiry into Healthcare Funding.
2. This statement is true to the best of my knowledge and belief.

A. Role

3. I am a General Practitioner (**GP**) and currently work in a general practice in Balmain where I am the medical director. I also the immediate past President of the Australian Medical Association (NSW) (**AMA(NSW)**).

B. Changing role of GPs

4. GPs play a key role within the healthcare system. They have a critical role in managing patients across their lifecourse and manage large numbers of patients who would otherwise flow into the state healthcare system by presenting to hospital. Almost 9 in 10 Australians see a GP in any given year. Although there is benefit in having a regular GP as a single point of contact, this is becoming less common, particularly in lower socio-economic areas. The reasons for this are many but include an undersupply of general practitioners especially in outer metro, regional and rural areas, decreasing bulk-billing due to Commonwealth government Medicare Benefits Schedule rebates not keeping pace with health inflation and the cost of delivering care, increasing patient desire for convenience-driven medicine, and the increasingly part-time nature of the general practice workforce.
5. Australia's health system and structures are built around a historical archetype of patient presentations; that is, a patient would present to hospital with an acute problem, that was solved, and they would not be seen again for several years. That model of care was effective when most concerns were communicable disease or injury which had clear courses of

treatment. Modern patient presentations commonly include exacerbations of manageable chronic disease such as diabetes, osteoarthritis, cardiovascular disease, cancer and degenerative neurological conditions. The Australian Bureau of Statistics estimate that 12.7 million Australian's (50%) had at least one of 10 selected chronic conditions in 2022. This long-term trend of increasing chronic disease is expected to continue, further challenging hospital capacity as our ageing population means people are living longer with chronic conditions, and modifiable risk factors such as obesity continue to become more prevalent. A GP is now more central to care, because of chronic disease, than ever before. From 1984 until 2022, the yearly GP services attendance rate has increased from 3.8 to 6.8 visits per person. The complexity of care needs now mean that patients are often less likely to attend the "right" form of care - good and efficient healthcare is predicated on "right patient, right doctor, right setting, right resources".

6. A hospital is important for its contributions to care in all chronic conditions however the long-term care of the patient primarily through a hospital model is expensive and inefficient. What has been shown to work is consistent community care that optimises function and meaningful management advice being given by hospital-based doctors to support their community colleague GPs. Preventing deterioration in chronic conditions is key to healthy ageing. Many patients who have unexpected deteriorations requiring hospitalisations take many months to recover fully if they manage to do so at all and the experience of hospital is confronting and often counter-productive to the person's wishes.

7. Given the increase in the extent and complexity of patients' comorbidities, and the duration that patients live with those health issues, the environment of 30 or 40 years ago is no longer a reality, and therefore, the system must adapt accordingly.

8. I see that adaption as requiring better integration within the system, with a focus on ensuring that GPs can access enough longitudinal information to make the most informed decisions as to the treatment of their patients, whether or not they have been the patient's

long-term GP. This can largely, but not exclusively, be driven by the way data is collected, used and shared in the system.

9. Better integration and a focus on prevention requires better systems to support general practices, which are often small businesses, and for which population-level prevention activities are challenging without this data and an operating framework that allows general practice to engage effectively with the hospital system.
10. One of the opportunities, in my view, for substantial efficiency savings in the system is if integration allows GPs to access the opinions of specialists without the necessity of referring the patient. An example of this is set out below.

C. Balmain Hospital's General Practice Casualty (GPC)

11. The Balmain GPC is a community, triage-based acute care service, overseen by specialist Fellow of the Australasian College for Emergency Medicine (ACEM) but primarily staffed by GPs and nurses. Multiple GP colleagues from our practice work at the GPC and I interact with the GPC daily. It is a well understood part of care delivery in Balmain and surrounding suburbs and provides urgent care for patients with more serious issues than are suitable for general practice, but not necessarily requiring a hospital emergency department, where these patients would otherwise usually attend. Around 30% of the patients are children.
12. The GPC is very clear about its role in the community and has strong links to local general practice and other community services. They work actively to engage with local general practices for complex patient care and ensure that chronic disease management, non-emergency referrals and treatment plans remain the purview of a community general practitioner. It is not an Emergency Department, so does not have capacity for the management of major trauma or serious illness, such as heart attacks or strokes.
13. The GPC also includes a fracture clinic, x-ray, a wound clinic and a Hospital in the Home clinic.

14. Due to the long history of this community GPC, local practitioners (many who work at the GPC) and the community appear to have a sufficient familiarity with the GPC to assess whether it or Royal Prince Alfred Hospital is the appropriate place to attend. The GPC operates in a similar manner as country general practice might, in that the GPs that work there are linked into the community through their own practice.
15. As it is part of the SLHD, the Balmain GPC is well resourced as well as being very efficient and able to manage urgent patient issues that would otherwise have required escalation to Royal Prince Alfred.

D. "SUSTAIN" pilot program

The Program

16. Through our general practice, I am currently participating in a pilot program called "SUSTAIN" in collaboration with the Sydney Children's Hospital Network (**SCHN**). The program, which is a randomised controlled trial, was funded under the Translational Research Grants Scheme on 1 July 2022.
17. The program aims to strengthen GP-provided paediatric care closer to home in an equitable and scalable fashion and was adapted from the Strengthening Care for Children (SC4C) study. A copy of this study is annexed hereto and marked **"A"**. The program comprises: virtual fortnightly paediatrician-GP co-consultations; monthly online case discussions; and weekday paediatric email/telephone support. As a GP operating as part of the program, I get direct access to, and co-consult with paediatricians as well as regular case reviews.
18. The program is funded for five days per week, with general paediatricians on-call to consult with GPs.
19. For example, one of my patients has a diagnosis of serious epilepsy. I had been the family's GP since the child was born and have remained so since they moved to the Blue Mountains area. The Nepean Hospital does not have all the services this family needs, so a link to the

Children's Hospital at Westmead has been critical. With the assistance of the SUSTAIN program, I can seek second opinions and advice from paediatricians as to the management of the patient, in addition to the specialist neurology care they are already receiving. As a result, my patient has only had to visit the ED three times, whereas other children with refractory epilepsy might need to go 20 times per year. This has also been through strong relationships with the child's parents, so they are capable of home based care and preventative actions to reduce epileptic presentations.

20. The SUSTAIN program is also useful for preventing simpler issues, such as secondary nocturnal enuresis (later onset bedwetting), from needing to escalate to hospital outpatient departments. Primarily, through brief telephone or email advice there can be a safe and effective diagnostic plan and management techniques employed to support the child and parents through their trusted GP. While something like this might seem trivial, there are many serious causes of bedwetting re-emerging once toilet training has been successful and having easy access to advice and decision support is critical.
21. For a program like SUSTAIN to function effectively, it needs to be resourced from both the GP and specialist side. GPs need to buy into this program. From a GP perspective, this is difficult under a fee for service model where it takes more of my time to consult with these patients. The SCHN has been gracious to recognise the potential of the SUSTAIN model and assigning excellent, experienced paediatricians to the grant-funded program. These paediatricians are diligent and respond quickly to support GPs in real time.
22. The SUSTAIN program addresses issues of availability of specialists to consult with GPs through the funding of an on-call paediatrician. This also greatly supports increasingly busy general practices, with GPs able to get timely advice from paediatricians and/or planned co-consultations.

Potential for Similar Models of Care

23. There are opportunities for similar initiatives to be established in different contexts, with aged care and chronic disease management being clear options.
24. For example, the positive outcomes arising from the SUSTAIN program above can be contrasted with my experience working at a general practice near Liverpool, where access to specialists in the community was much more difficult.
25. With increasing levels of chronic disease there are a growing number of patients who are not acutely ill enough to be treated in an emergency department but do not have the means to see a private specialist. The process for those patients to access specialist care is referral for a specialist outpatient appointment, and then a waiting period to see the specialist for the next available public outpatient appointment. For certain services available appointments were often not for months or years. This is referred to as the "hidden waiting list" for if the patient requires a surgical procedure, then it is only after they have seen the appropriate specialist that they then enter the formal waiting list for surgery. Such long waiting list to see a specialist in a public outpatient clinic is often the equivalent to there being no service at all as patients disconnect from care or become disenfranchised by the health system.
26. Hospital outpatient services are very busy often with patients who have been under care for many years. It is critical that the highly trained hospital specialists are clear about discharging patients from outpatient care back to care under their GP, with a management plan and the process for seeking future advice if needed. Many patients on three- or six-monthly review within the hospital system could be adequately cared for by their GP if the GP was provided with a management plan and advice on what to do in the event of deterioration. To assist in delivering better and more timely care to the community the utilisation of hospital-based specialists to provide advice rather than take over management is often the most efficient and effective way to leverage highly specialised knowledge at

scale. This is a model where the GP is primarily responsible for the patient's care and the hospital specialist only sees the patient by exception and if other forms of co-consultation have not managed to alleviate the problem.

E. Decreasing number of GPs

27. While there has been a steady increase in the total number of GPs in NSW with more people studying medicine, there has been a decrease in the percentage of medical students choosing the GP pathway, resulting in a relative decrease in the proportion of GPs as a percentage of the total number of doctors in the system.

Summary Statistics, Medical Profession

Last Updated: 22 Apr 2024

Summary tables were generated using a statistical package that uses different rounding methodologies to the Health Workforce Data Tool. Percentages and/or averages may differ slightly to those extracted from the Health Workforce Data Tool.

Registered and Employed in Australia 2019 to 2023

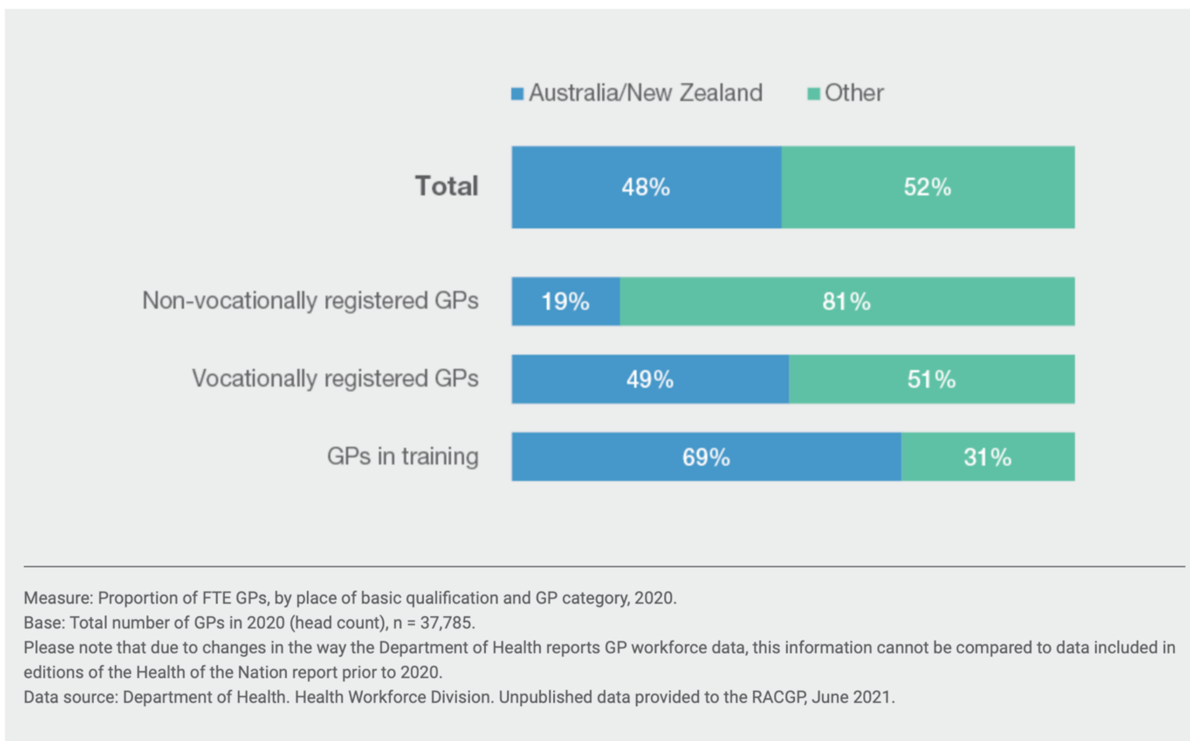
Clinician Status	Area	2019	2020	2021	2022	2023
Clinician	General practitioner (GP)*	31,102	31,620	31,842	31,926	26,599
Clinician	Hospital non-specialist	12,098	13,161	13,671	14,260	14,228
Clinician	Specialist	35,024	36,189	37,421	39,582	44,312
Clinician	Specialist-in-training	16,526	17,001	17,735	18,736	17,240
Clinician	Other clinician	2,289	2,289	2,527	2,553	2,576
Clinician	Medical practitioner working in General Practice	.	.	.	.	6,881
Other		4,802	5,033	5,305	4,851	4,774
Total		101,841	105,293	108,501	111,908	116,610

*General Practitioners refer to General practitioners using the NHWDS as defined in the method papers under Main job area : General practitioners in Australia: Headcount & workload methods - Summary

[Source: https://hwd.health.gov.au/resources/data/summary-mdcl.html]

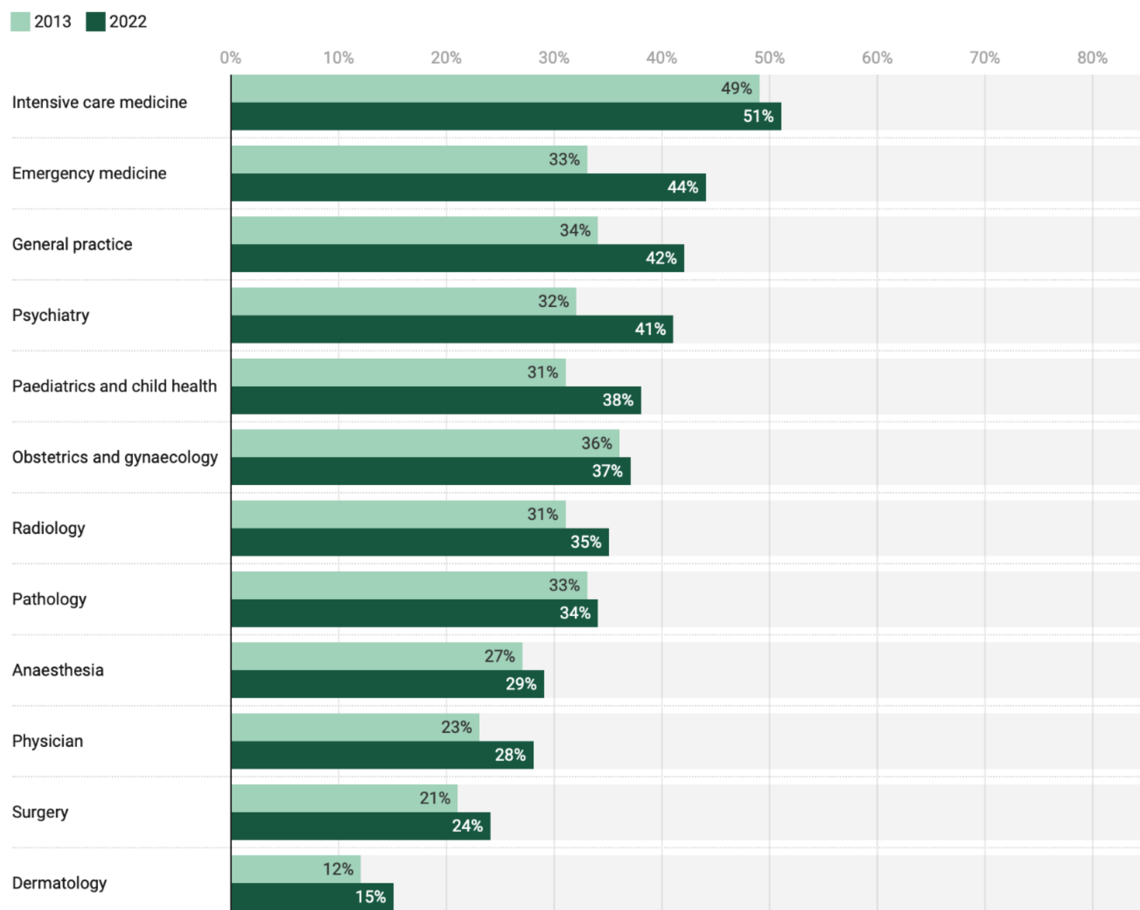
28. There has also been a decrease in Australian-trained GPs. The shortfall is made up with international medical graduates.

Figure 22. A higher proportion of GPs attained their basic qualification overseas than in Australia or New Zealand



Measure: Proportion of FTE GPs, by place of basic qualification and GP category, 2020.
Base: Total number of GPs in 2020 (head count), n = 37,785.
Please note that due to changes in the way the Department of Health reports GP workforce data, this information cannot be compared to data included in editions of the Health of the Nation report prior to 2020.
Data source: Department of Health. Health Workforce Division. Unpublished data provided to the RACGP, June 2021.

29. This is an issue across multiple specialties in Australia and not limited to general practice as reported by the AIHW in 2024.



In New South Wales, while there are many GPs in metropolitan areas, there is a deficit in the outer metropolitan areas that is perhaps on a par with shortages per capita in regional and rural areas. The Productivity Commission's Report on Government Services (2022) reported on the number of FTE GPs per 100,000 people in Australia as follows:

Major cities	117.3
Inner regional	114.3
Outer regional	99.2
Remote	78.8
Very remote	66.4

Table 1: Key workforce statistics by health profession, 2013 and 2022

Profession	Measure	2013	2022	% change
Allied health [(a)]	Number of practitioners	108,680	180,924	66.5
	FTE total	98,545	169,526	72.0
	FTE per 100,000 population	426	652	53.1
Dental Practitioners [(b)]	Number of practitioners	17,874	22,964	28.5
	FTE total	16,604	21,157	27.4
	FTE per 100,000 population	72	81	12.5
Medical Practitioners (excluding GP)	Number of practitioners	56,173	79,273	41.1
	FTE total	62,676	85,189	35.9
	FTE per 100,000 population	271	328	21.0
General Practitioner (GP)	Number of practitioners	26,235	32,635	24.4
	FTE total	25,706	29,626	15.2
	FTE per 100,000 population	111	114	2.7

30. In rural and regional area hospitals, it is important to engage practitioners who work within their general practice rooms within the hospital system so they can develop their skills as a VMO. In my opinion it is beneficial for a hospital to support a junior doctor working within its confines to also work as a GP in the community. In regional and rural areas, care delivered in general practice rooms and that which occurs in the hospital are even more closely linked as there is a smaller pool of practitioners. Efficient use of a small pool of practitioners can be achieved by their input, for patients they know, being achieved by having a role in their care in the hospital as well as in the community.

F. Increasing the number of GPs

31. In my view, a significant factor in the relative decrease in the number of GPs in NSW is an embedded perception that working as a GP is an inferior option to working as a hospital-

based specialist. [1] There are perceptions, heard from GPs and non-GP specialists alike that the work of GPs is often held in lower regard than that of their hospital colleagues. In my role with the AMA (NSW) I spoke with thousands of doctors across NSW and heard this from many.

32. In my view, a root cause of that perception is that medical students and doctors in training are not sufficiently exposed to general practice, because the overwhelming majority of study and training is done in a hospital setting in specialty areas. Students and trainees exposed to that part of the system are actively encouraged to stay in that area and are not well placed to assess if general practice is an option that appeals to them.
33. That view becomes more and more entrenched as trainees progress through specialist pathways. They then instil their views on the next generation of students and trainees, who are similarly inducted into the system through specialist care delivered in a hospital setting.
34. In my view, there needs to be a cultural shift to attract students and doctors to generalist pathways. I see that cultural shift as being driven by increased opportunities for students and trainees to see the work that GPs do. Current and former models of high-quality general practice exposure through medical school and prevocational training (Pre-Vocational General Practice Placement Program, John Flynn Placement Program, extended primary care and rural cohort programs) have all shown increase in career decisions that include general practice. That should lead to a direct uptake as people will be able to properly assess the different options available to them, including the benefits of general practice. That will also drive uptake of general practice indirectly, as even clinicians that have decided to take up a specialist pathway would have had exposure and experience to general practice, which they can share with students and junior clinicians.

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[1] https://www1.racgp.org.au/newsgp/professional/general-practice-denigrated-to-most-students-poll

35. A further pathway to increasing GP numbers is to reduce barriers to those who wish to transition out of hospital work into general practice or into a mixed mode of work between hospital and general practice. The single employer model works well regionally as it eases the transition for clinicians to general practice training while retaining the benefits they were entitled to in the hospital system. Hospital or general practice specialist training occurs when hospital-based benefits have been accrued or are in the process of being accrued such as long service leave and the right to employer based parental leave. These benefits do not transfer into the private environment of general practice training and models that allow those benefits to support a transition for doctors out of the hospital system would remove a barrier to doctors starting general practice training.

36. I understand Victoria has also done some work on increasing financial incentives for doctors transitioning out of hospital jobs, so that doctors can retain a similar level of pay as a GP as they had in a hospital setting. The Victorian Government is supporting medical graduates to choose general practice as their specialty training through a special grant.

    The Victorian Department of Health GP Trainee grants program aims to:

    - increase the number of GP trainee enrolments in 2024 and 2025;
    - provide a top-up payment for first year trainees of $30,000; and
    - provide $10,000 to support the costs of exams to be undertaken during GP training.

37. The RACGP is funded by the Victorian Government to deliver a total of 356 grants in 2024 and 355 grants in 2025.The grants comprise a maximum of $40,000 and will be delivered in three instalment payments over 24 months.

38. There is also a similar grants program in Queensland.[2]

[2] https://statements.qld.gov.au/statements/100672#:~:text=Queensland%20doctors%2C%20including%20those%20in,across%20the%20state%2C%20including%20Mackay

39. A reduction in the administrative burden on clinicians, which is potentially most acutely felt by GPs, would also enable clinicians to focus on delivering care and reduce burn out. Current administrative workload has been estimated to represent an opportunity cost for more than 14 million face-to-face consultations per year (GPs spent 5.1 hours or 14.2% of their time, on non-billable activities).[3] Examples include the following:

    - Government agencies and medical software providers must continue to streamline forms and increase the utilisation of pre-populated forms.
    - The Federal Government should remove the PBS authority system altogether.
    - Improvements in the management of chronic disease by cutting paperwork and streamlining GP-coordinated access for patients to multi-disciplinary care and other support services.
    - Administrative work (which is not generally remunerated under face-to-face rules from the Medicare Benefits Schedule) is a free service that GPs provide to patients and one that is becoming more onerous and frustrating for GPs including the access requirements to government systems at both a state and commonwealth level. This drives dissatisfaction with work and for many GPs burnout.

40. Furthermore, it would assist if GPs were given reasonable access to the Single Digital Patient Record to avoid duplication of work. Currently, care inside the hospital is essentially invisible to GPs and in the future a SDPR could allow at least read only access for GPs to understand the care their patient received and to interact more easily with the treating team in the hospital about discharge planning and services for the community. Tests ordered in the hospital are often not available to GPs and are subsequently repeated (and this happens in

[3] https://www1.racgp.org.au/getattachment/4f596068-36e8-438d-b4b4-fe0b90cd549b/MABEL-data-examining-workload.aspx

the reverse direction for hospitals as well) and there are insights from the patient's community health care providers that can be of great assistance during a hospital admission (especially in areas of mental health care and chronic disease exacerbation)

Signature:

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