RACGP
Royal Australian College of General Practitioners

RACGP national workforce strategy 2025–30

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We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.

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Contents

Foreword

Dr Michael Wright
President

I am pleased to present this landmark *RACGP national workforce strategy 2025–30*.

This document marks a step-change in the College's commitment to long-term medical workforce planning.

Backed by evidence, guided by data, and driven by purpose, it creates clarity and charts a path for the growth of general practice training. Its goal is to build the general practice workforce to meet the evolving needs of our communities.

I would like to acknowledge and thank my predecessor, Dr Nicole Higgins, whose vision and leadership were instrumental in initiating and shaping this body of work.

I also acknowledge the work of the Commonwealth in creating the National Medical Workforce Strategy (2021–2031) which has stimulated new levels of debate, problem-solving and collaboration in pursuit of long-term medical workforce planning.

As a health economist and advocate for a resilient primary care system, I endorse this strategy and commend it to all stakeholders. This is more than a roadmap—it is a call to action to move from reacting to workforce pressures to proactively designing long-term solutions, to provide equitable, and sustainable primary care across Australia. It is a significant achievement and a powerful first step toward a better future for general practice and for the health of Australia.

Ms Georgina van de Water
Chief Executive Officer

I join in celebrating the launch of this inaugural workforce strategy for the College—a significant milestone that reflects dedication and collaboration across the sector.

This strategy, which will be updated annually, marks a new chapter in how we shape and sustain our general practice workforce. My leadership roles in general practice training over the past two decades have consistently underscored the urgent need for long-range workforce planning to deliver a sustainable general practice workforce for Australia.

This strategy places general practice at the heart of health system reform, where it belongs. It is thoughtful in its design, purposeful in its direction, and practical in its recommendations. Above all, it embodies our shared commitment to a smarter, fairer and stronger future for general practice in Australia. I endorse this document as a bold yet balanced step forward, grounded in evidence and committed to delivering real impact.

*For any enquiry in relation to this strategy please contact Ms Nicole Brigg, RACGP National Planner, GP Training Workforce - Nicole.Brigg@racgp.org.au

Part 1. Executive summary

A new initiative built on 60 years of expertise

The **Royal Australian College of General Practitioners (RACGP) national workforce strategy 2025–30** is a transformative initiative that builds on six decades of leadership in general practice. As the healthcare landscape continues to evolve, the RACGP is strengthening its role in workforce planning, advocacy, and system reform. This strategy aims to drive meaningful change by shaping solutions, informing government policy and action, and ensuring a sustainable and thriving general practice workforce.

A strategic, evidence-based approach

To deliver real impact, the strategy is aligned with key RACGP frameworks, including the RACGP 2025–29 strategy, RACGP Advocacy plan 2024–2025, and the RACGP Aboriginal and Torres Strait Islander Cultural and Health Training Framework. This ensures a holistic approach that focuses on:

- growing and sustaining a strong general practice workforce across metro, regional, rural and remote Australia
- future-proofing the profession
- cultural safety, health, and workforce support
- embedding general practice at the heart of the healthcare system.

The strategy leverages insights from the **RACGP's workforce planning team**, integrating for the first time external workforce forecasts with the RACGP's own data analytics and modelling capabilities. This approach ensures a robust and evidence-based foundation for policy recommendations and workforce planning.

A legacy of advocacy and action

For over 60 years, the RACGP has championed the health and wellbeing of all Australians by supporting general practitioners (GPs), registrars, and medical students through high-quality **education, training, research, and ongoing professional development**.

The RACGP is committed to addressing rural disadvantages with actions that lead to more equitable access to healthcare. This commitment is reflected in our ongoing efforts to develop, lead and drive better health outcomes for rural communities - including rural generalist training, and tailored education and advocacy for the rural medical workforce. This holistic approach is demonstrated through attraction, training, retention and response to rural GPs. By fostering a robust rural workforce and addressing the specific needs of these communities, the RACGP aims to bridge the gap in healthcare disparities and contribute to the overall wellbeing of rural Australia.

Speed of delivery is required and relationships with stakeholders are paramount. Advocacy to maintain and improve the sector is a vital part of what we do, and thoughtful diplomacy with governments at all levels is necessary to produce effective outcomes. This strategy aims to understand the context in which the RACGP operates (as both a membership organisation and training institution) providing clarity and enabling innovation.

This work is taking place as part of a rich ecosystem

The Australian health system is in a significant reform environment following recommendations from the Strengthening Medicare Taskforce Report, Unleashing the Potential of our Health Workforce - Scope of Practice Review, GP Incentives Review and the Working Better for Medicare Review, with the profession tackling issues on many fronts.

Add to this the overarching strategic direction provided by the Australian Government's National Medical Workforce Strategy 2021–2031 (NMWS) which proposes 50 workforce solutions (drawn from 40 workshops with 400 stakeholders) and we have a range of external impacts on our work. The RACGP is already collaborating with the Federal Government to work on a range of key solutions which we have used to inform this plan including:

- developing a national medical workforce data strategy harmonised with the priorities of the NMWS
- adopting consistent demand-and-supply modelling methodologies to inform a national perspective on workforce planning
- aligning college decision making in joint planning for accreditation and training numbers using data and modelling outputs to inform decision making
- considering salaried and single-employer models for GPs, with incentives to maintain service levels, access and quality
- developing mechanisms to support the portability of employment benefits to minimise disadvantages, enabling doctors to work across different employers, regions and/or health services throughout their careers
- optimising distribution outcomes by incentivising registrars to train in areas of workforce need
- working to increase accreditation of non-metropolitan training posts through governance processes and innovative supervision approaches
- growing the training pathway to meet the GP shortfall.

Balancing evidence with real-world impact

Effective advocacy for the general practice workforce must be **evidence-based, data-driven, and strategically focused, while identifying viable solutions at scale**. The **RACGP national workforce strategy 2025–30** is designed to cut through uncertainty, set clear priorities, and establish a structured operational plan that defines timelines, resource allocation and measurable outcomes. The strategy will be updated annually to reflect the current rapid rate of reform driven by both government and the College.

The RACGP's approach to workforce planning is both **strategic and operational**—it supports the College's long-term vision while ensuring tangible, real-world impact. By leveraging global and local health sector intelligence the strategy identifies emerging challenges and delivers **practical, scalable solutions** that support the profession's long-term sustainability.

While data, modelling, and forecasts are essential tools, workforce planning is about **people, not just numbers**. Behind every statistic is a **GP, a registrar, a junior doctor or a medical student**—each with ambitions, challenges and aspirations. Whether serving in **remote communities or busy metropolitan centres**, these individuals are at the heart of Australia's healthcare system. A successful workforce strategy must not only address supply and demand but also respect the **lived experiences and career aspirations** of those who dedicate their lives to patient care.

The power of a consumer perspective

Listening to the voices of patients, families and communities builds an equitable and sustainable primary healthcare system. When people are involved in shaping the healthcare services they use, those services are more likely to meet real needs – whether that's being able to see a GP close to home, feeling culturally safe, or getting care that is tailored to their personal circumstances.

Importantly, the consumer perspective is not one-size-fits-all. It varies depending on where you live, your financial situation, and your health. For example, people living in urban areas are more likely to visit their GP up to 10 times a year, while those in rural and remote areas access services far less often – highlighting stark differences in health service use across the country.

Similarly, with a growing proportion of Australians living with chronic conditions – often not just a single diagnosis but a cluster of complex and interrelated issues – access to general practice and allied health care becomes even more critical. These experiences shape how people engage with and perceive primary care, particularly where bulk billing is limited, or services are unavailable. Embedding these diverse community perspectives into policy and planning ensures that decisions about the medical workforce and service delivery reflect the lived reality of Australians everywhere.

A vision for the future

By planning for a **resilient, well-supported and future-ready general practice workforce**, the RACGP national workforce strategy 2025–30 is a vital step toward achieving a healthcare system that meets the needs of all Australians. With collaboration, data-driven planning and a commitment to excellence, we are shaping the future of general practice—ensuring it remains the foundation of our healthcare system for generations to come.

Summary of key findings

1.1 The general practice shortfall in Australia 2025–40

Projected baseline demand (projections if health utilisation remains steady) and unmet demand (projections if health utilisation grows in line with historical year on year growth) for GP services outpaces the current GP supply projections if no policy changes or market adjustments occur (for example increased AGPT places, increased international medical graduates, or increased GP remuneration). Australia is already experiencing a GP shortfall. The RACGP's analysis broadly aligns with the Australian Medical Association (AMA) and Deloitte on the potential demand range dependent on population health utilisation. The RACGP's analysis undertaken in 2024 was able to use more recent population projections which forecast a slower growth in Modified Monash (MM) 2-5 *.

In the baseline demand scenario in 2025 (Table 1 and Figure 1) there is a current shortfall of 3010 GP full-time employees (FTE). The shortfall is expected to increase to 5540 FTE by 2035 and 6400 FTE by 2040. In the emerging demand scenario, the shortfall could increase to higher than the baseline demand levels of 6860 GP FTE by 2030, 9980 GP FTE by 2035 and 13,240 GP FTE by 2040. In the unmet demand scenario, the shortfall could increase even higher again to 8420 GP FTE in 2030, 12,910 GP FTE in 2035 and 17,760 GP FTE in 2040.

*Modified Monash (MM) categories are based on the Modified Monash Model (MMM) definition of whether a location is metropolitan, rural, remote or very remote. Accessed from: https://www.health.gov.au/topics/rural-health-workforce/classifications/mmm

Table 1. Baseline demand, emerging demand and unmet demand shortfall 2025–40

	2025	2030	2035	2040	15-year increase
Baseline shortfall	3010	4500	5540	6400	113%
Emerging shortfall	3620	6860	9980	13,240	266%
Unmet shortfall	4020	8420	12,910	17,760	342%

The Department of Health, Disability and Ageing (DoHDA) has been actively addressing the shortage of GPs in Australia. A significant initiative in this effort is the introduction of the Expedited Specialist pathway in October 2024. This pathway allows specialist international medical graduates (SIMGs) with qualifications deemed substantially equivalent to Australian standards to apply directly for specialist registration. If Australia seeks to achieve a sustainable home-grown general practice workforce over the medium to long term, the RACGP annual GP training numbers need to increase from 1350 to 1850 at a minimum over the next 5 years. A commitment to invest in growth over this period will go a long way to filling the projected shortfall.

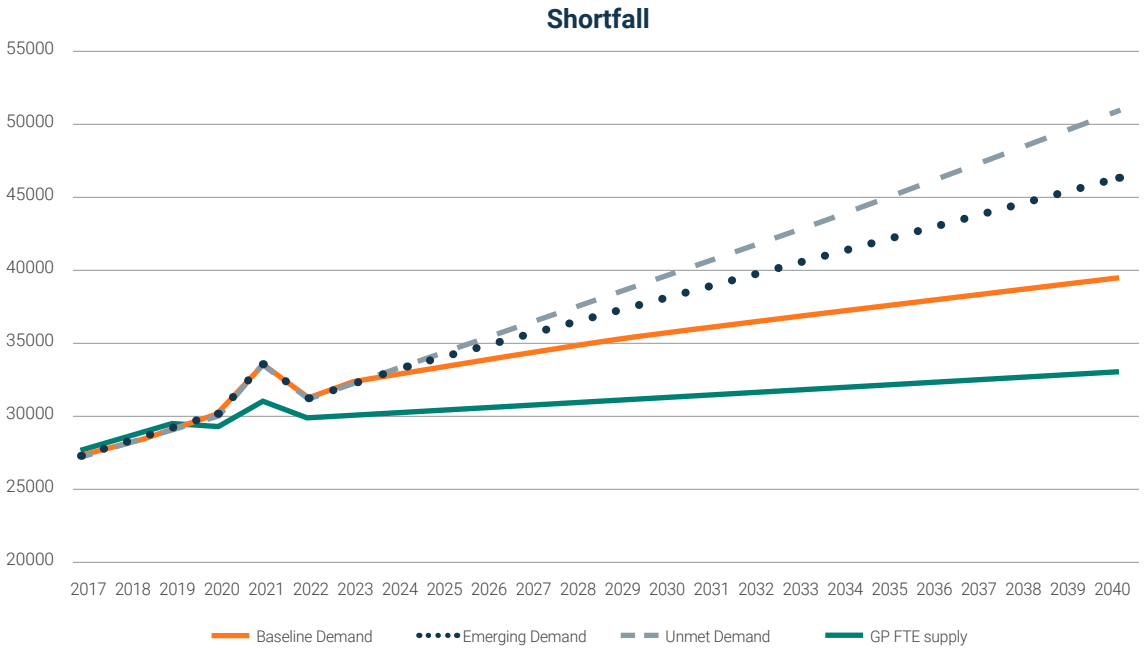


Figure 1. Baseline demand, emerging demand and unmet demand 2017–40

Understanding the drivers causing the imbalance of demand

Population

The key driver of demand is varying population projections across MMs, not overall national population growth. Demand is further analysed at the GP catchment level and by other metrics like FTE GP per 100,000 population.

Demographics

Demand for GPs is trending to grow on the basis of the following demographic factors:

- An aging population and one of the highest life expectancies in the world
- An increasing prevalence of chronic conditions and multimorbidity
- Deferred and suspended medical care due to the COVID-19 pandemic resulting in the diagnosis of further progressed conditions

Societal

Other causal factors influencing demand may include:

- increased unaffordability and inaccessibility of timely healthcare
- declining access to tertiary care (eg rural airline cost/collapse)
- structural changes in the economy (eg declining mining and agricultural sectors)
- advancements in pharmaceuticals (eg new treatments are increasing the need for ongoing GP management)
- emergence of artificial intelligence (AI) in healthcare (eg reduction in non-clinical hours for GPs).

Demand projections assume a constant rate of healthcare utilisation while **unmet demand projections** assume healthcare utilisation increases based on historical growth trends. Estimating unmet demand has been based on historical utilisation of GP services across Modified Monash Model (MMM) classifications. This can present an underestimation of demand in regional and rural areas where access to healthcare is limited.

We infer from Commonwealth policy documents, such as the *National Medical Workforce Strategy* (2021–2031) and the *Supply and Demand Study* released in 2024, that the Commonwealth is seeking to provide 'reasonable' levels of access to GP services largely within the confines of the current education and training paradigm. Notably, the modelling used in the Supply and Demand Study assumes no exogenous growth in per capita service utilisation.[1] It does not account for potential increases in healthcare demand driven by factors such as rising chronic disease, greater complexity of care, or rising patient expectations. The Commonwealth modelling approach may therefore underestimate future unmet demand for general practice services.

Understanding the drivers causing the imbalance of supply

Analysis of supply data

The base case (the expected case based on historical trend forecasting where no policy changes are introduced) shows the forecasted supply not growing at the necessary rate to keep pace with Australia's population growth.

GP FTE numbers are expected to stagnate despite slow and steady growth of GPs in the next 15 years (Figure 2). GP headcount however, has estimated positive growth across all MMM classifications. This overall growth trend in headcount indicates GPs are changing their ways of working, moving to part-time careers or reducing clinical hours.

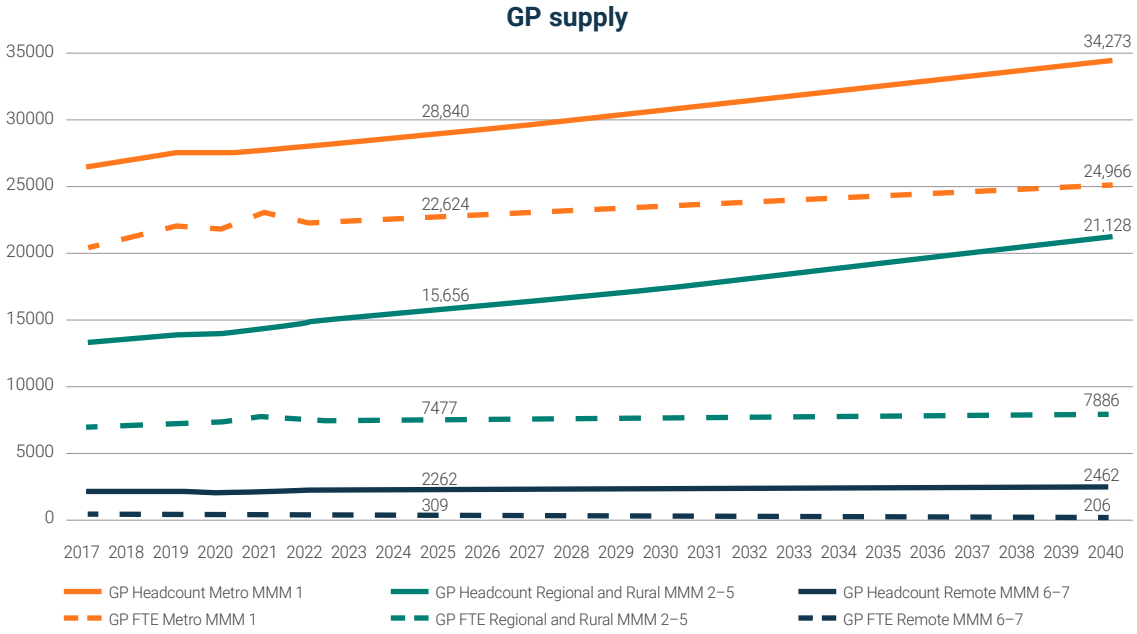


Figure 2. GP supply - headcount and FTE 2017-40.

Deciphering the distribution dilemma

Distribution is a complex challenge in Australia's highly urbanised and geographically dispersed landscape. The bulk of the population and most medical students and GPs live in urban locations (MM1). While a wide range of incentives and regulatory requirements exist, there is limited success in achieving long-term workforce distribution, with short-term distribution (registrars) largely achieved through directive placements under GP training programs. Fellowed GPs who are trained in areas of high workforce need are not remaining in those areas in high enough rates when training is completed.

There are multiple factors that impact the effectiveness of distribution including the following:

- Perceived viability of training location including geographical isolation, financial viability and personal safety
- Distance required to travel for access to primary care services
- Access to transport and infrastructure (airports, vehicles, hospitals, accommodation, internet)
- Access to services (childcare, education, social hubs)

Quantifying these impacts at a GP catchment level remains a significant challenge in workforce planning and the design of distribution strategies.

1.2 Pathways to a GP career

1.2.1 University

While job satisfaction has increased and more GPs are recommending general practice as a future career, there are still challenges attracting new graduates to specialise in general practice. One of the obstacles is a clear pay disparity compared to other specialties and lower financial incentives like paid parental leave. Australia trains a large cohort of GPs every year, with the RACGP training around 90% of GPs, but more is needed to keep up with the country's growing workforce needs for GPs, particularly in regional, rural and remote areas.[2]

In the past 50 years medical graduate outcomes have gone from 50% of all junior doctors pursuing general practice specialisation[3] to 17.5% 'intending' to pursue general practice/rural generalism (MSOD data).

The RACGP's review of what can be learned by the aspiring medical students and their families with respect to the university sector's delivery of medical education (degree types, funding streams, selection processes, graduate outcomes) has highlighted multiple areas of concern. An analysis of GP pathways and in particular, rural GP pathways, highlights where structural reform may be needed to ensure enough GPs in the pipeline to meet the needs of Australia's general practice workforce.

Of note is:

- The complexity of the selection landscape and the disadvantage students, particularly those in regional, rural and remote Australia and from underrepresented cohorts, may experience in trying to navigate the selection processes
- The continuing reliance of selection on academic merit as the primary criteria, recognising the utility of this method for universities, but its tendency to exclude underrepresented cohorts
- The varying lengths (and consequently costs) of student journeys via different degree pathways which range from 5 to 8 years duration
- The variance across universities and degrees in terms of exposure to GP curriculum, GP clinical experiences and GP role models
- The effectiveness of different funding streams (fee-paying, CSP, bonded program, rural program)
- The effectiveness of rural selection strategies and investment in rural clinical schools in achieving a sustainable rural medical workforce and a sufficiency of primary care doctors

1.2.2 Hospital training

Australia's training hospitals are predominantly in metro areas, creating challenges for the training and subsequent retention of doctors in regional, rural and remote settings.

Further, the tertiary medical system is operationally administered by state health departments making it challenging to coordinate medical workforce training and distribution strategies across primary (Commonwealth) and tertiary (state) jurisdictions. Competing to offer attractive remuneration and supportive working environments, state health systems and their hospitals appear to be retaining growing numbers of junior doctors who might otherwise have progressed to general practice training. To ensure junior doctors see general practice as a stimulating, attractive and secure career path, the renumeration and status assigned to general practice must meet those of hospital specialties.

The role of training hospitals in strengthening the general practice workforce is a particular area of ongoing work. The university sector is expanding the number of end-to-end rural clinical schools and recruiting regional, rural and remote origin students into these programs. The rate at which these students progress into rural internships and then into rural specialist training requires further analysis.

1.3 The role of international medical graduates in our medical workforce

Australia has been one of the world's leading international education providers for the past twenty years, including training approximately 800,000 international students per annum generating over AUD $50 billion per annum.[4,5] Australian universities offered 864 places for international students to undertake medical degrees in 2024. Foreign Graduates of Australian Medical Programs (FGAMP) are eligible to remain in Australia on the post-study work visa (485) and generally have options to progress to permanent residency. It appears there has been no evaluation of the effectiveness of this pipeline in contributing to Australia's medical workforce.

More significantly, Australia's skilled migration program has long attracted international medical graduates (IMGs) to both train and practice in Australian primary and tertiary health sectors. These doctors have played a critical role in short-term policy responses to Australia's medical workforce shortfalls. Skilled migration remains a cornerstone of current medical workforce strategy as demonstrated by recent Commonwealth reviews, such as the Kruk Report (2023), implementation of the expedited pathway for medical specialists, and ongoing efforts to attract IMG doctors to Australia.[6]

In the 2023–24 financial year, IMGs made up 54.5% of the Australian general practice workforce FTE.[7] The role of IMGs in the medical workforce over the next 20 years is a priority area of ongoing analysis. It is noted that peer countries, such as the United Kingdom (UK), are launching long-term medical workforce strategies that aim to significantly increase the domestically trained medical workforce to reduce reliance on skilled migration.[8] This strategy conversation is nascent in the Australian context.

1.4 General practice remuneration and attractiveness

The Commonwealth monitors the future training intentions of Australian medical graduates through the Medical Students Outcomes Database (MSOD), managed by Medical Deans Australia and New Zealand (MDANZ). This data offers insight into the attractiveness of general practice as a career pathway. The intent to study general practice has shown a steady decline over recent years, dropping significantly from 13.0% to 10.5% in 2023. From 2021, the MSOD survey also included the Rural Generalist program as a separate specialty option. When general practice and rural generalist responses are combined, this broader category becomes the preferred discipline with 17.5% of respondents selecting either GP or rural generalist as their preferred specialty.

Restoring the status of general practice is a priority for the RACGP, but it is also the responsibility of all key stakeholders including universities, training hospitals, state and Commonwealth health departments and all medical colleges. Articulating and amplifying a GP positive culture across all stakeholders will be an area of ongoing focus.

Portability of entitlements and parity of remuneration with other medical registrars is a necessity if junior doctors are to seriously consider general practice as a specialisation.

The introduction of the Medicare triple bulk-billing incentive has strengthened the concept of location specific remuneration, but further reform is needed to adequately address remuneration disparity. This is not a new strategy, but it addresses inequity at its source and if well designed can be highly effective in compensating GPs for practicing in areas of workforce need.

Organisation for Economic Co-operation and Development (OECD) data indicates that Australian GPs are remunerated below other Australian medical specialties. In the strategy's international country comparison, the imbalance between general practice and other medical specialties features consistently in many countries.[9,10]

1.5 International country comparison

An RACGP driven international comparison study (Denmark, Canada, the United Kingdom, France, the Netherlands and New Zealand) identified that many countries are seeking to both grow and optimise their primary health workforce by reform and expansion of their medical training programs, consideration of GP-led scope of practice reforms and better alignment between hospitals and community training. This comparative analysis identifies emerging strategies and innovative solutions that have been successful in addressing similar challenges faced by these countries and Australia.

Understanding different approaches to recruitment, retention, training, and systemic support across diverse healthcare systems can highlight effective strategies and potential pitfalls. By examining the successes and limitations of the medical education and GP training models in these countries, Australia can adapt, implementing tailored strategies to enhance its general practice workforce, ultimately improving healthcare access and quality for all Australians.

Work is currently underway to consider the following strategies that we see emerging in our international comparison:

- The impact of setting a target of 50% of all graduating medical students progressing to general practice training
- The impact of increasing the RACGP's general practice training places from 1350 to 1850 per annum over the next five years
- The need to both increase and improve medical education considering selection, degree types, funding models and costs, and outcomes for primary care and distribution etc
- Distribution of IMGs to areas of workforce need at a jurisdictional level

In summary

This RACGP national workforce strategy 2025–30 is dynamic by necessity, as our knowledge base grows, and we respond to our rapidly changing ecosystem. The strategy is the big picture/long-term vision for the general practice workforce. It outlines the goals and priorities needed to ensure the right number of GPs are in the right places to meet future workforce demand. The strategy identifies gaps, trends and challenges in the workforce and suggests solutions. It provides an overarching direction, aligning with broader College goals articulated in the RACGP 2025–29 Strategy.

Together, these key strategic documents address:

- Evidence-driven solutions identified by the profession
- Development of key messages for changes/opportunities we want to see/will support the aim
- Preferred funding mechanisms/costings
- Data and modelling capability

Building a strong and sustainable future general practice workforce will require a combination of regulatory and structural reforms and government-funded initiatives. These need to be co-designed by the RACGP in collaboration with the DoHDA and other relevant stakeholders.

Leadership and support are needed from governments to address challenges and provide sustainable solutions. The RACGP national workforce strategy will provide analysis and strategic input to health system reform discussions and reviews. It aims to build urgency for targeted government action and promote a consistent, influential, and positive national narrative. **The key goal of this strategy is to move the RACGP from a reactive to a proactive stance on general practice workforce issues where the College is deploying its influence to formulate and shape the solutions.**

Recommendations

On behalf of our members, the RACGP is asking the Federal Government to work with the College to:

- **Acknowledge the size of the GP shortfall** and continue to expand engagement with the College to identify structural reforms and strategies that will address this shortfall in the short, medium and long term.
- **Lead planning for structural adjustments** to ensure the sustainability of a domestic-trained general practice workforce. This begins with the articulation of a long-term plan to return Australia to a position of medical workforce sustainability through the expansion of onshore medical education and training. Specifically, this means:
  - expanding university medical education places for those universities who demonstrate a commitment to primary care and rural workforce outcomes
  - considering linking Commonwealth supported places (CSP) specifically to GP outcomes
  - setting GP quotas (tied to future CSP) for universities
  - a commitment from states/hospitals to work more closely with universities and the RACGP to improve the transitions (particularly for rural doctors) from education to hospital training and from hospital training to general practice training.
- **Incentivise and attract GP registrars** by ensuring that junior doctors choosing general practice as a career have the same remuneration outcomes, including portable entitlements, as those remaining in hospitals – paid parental and study leave entitlements and long-service leave. This would alleviate the significant reduction in remuneration package and entitlements experienced by registrars during their training and remove the perceived drop in income which prevents many junior doctors from considering entry into GP training. **With this strategy now funded**, the RACGP looks forward to monitoring its implementation and effectiveness.
- **Moderate potential earning inequity to improve the ability of GPs across Australia to generate competitive incomes**, irrespective of the socio-economic and cohort characteristics of the GP catchment in which they practice. The profession will not be able to attract as many junior doctors as other specialties if it cannot provide assurance of a satisfactory income, irrespective of the location of practice. While recent Medicare reform has addressed this by scaled bulk-billing incentives across the MM2-7, this is not sufficient in the medium to long term.
- **Acknowledge the RACGP's efforts to distribute registrars in training, when planning and allocating health funding**. The RACGP has strenuously sought to achieve distribution in the AGPT not just between general and rural training pathways, but within the rural pathway across regional, rural and remote Australia.
- **Set national workforce expectations** in partnership with the Department of Education, universities and the RACGP, to identify national workforce targets (for medical student selection, for rural training participation, for graduate outcomes etc). Identifying and nurturing GP specific cohorts much earlier on the pathway will contribute to a more engaged general practice registrar workforce who have clarity and focus for their career purpose.
- **Seek Commonwealth collaboration with the RACGP** in the development of a joint workforce strategy for general practice whose goal is the creation of a sustainable Australian trained general practice workforce that meets the nations' needs and incorporates the areas of action outlined above.

The RACGP provided the Minister for Health and Ageing, the Hon Mark Butler, with a pre-budget submission that addressed many of the recommendations laid out above. The College was very pleased to note the following funding commitments, which were subsequently matched by the leader of the opposition.[11]

The four-year investment announced by the Albanese Labor Government includes:

- $265.2 million to expand GP training, with an extra 200 training places per year from 2026, increasing to an extra 400 places per year from 2028
- $204.8 million for salary incentives for junior doctors to specialise in general practice
- $43.9 million to provide paid parental leave and study leave for trainee GPs
- $44.0 million for an extra 200 rotations for junior doctors in primary health care per year from 2026, increasing to an extra 400 per year from 2028
- $48.4 million for an extra 100 Commonwealth supported places for medical students per year from 2026, increasing to 150 per year by 2028, and demand driven places for First Nations students to study medicine.

Next steps

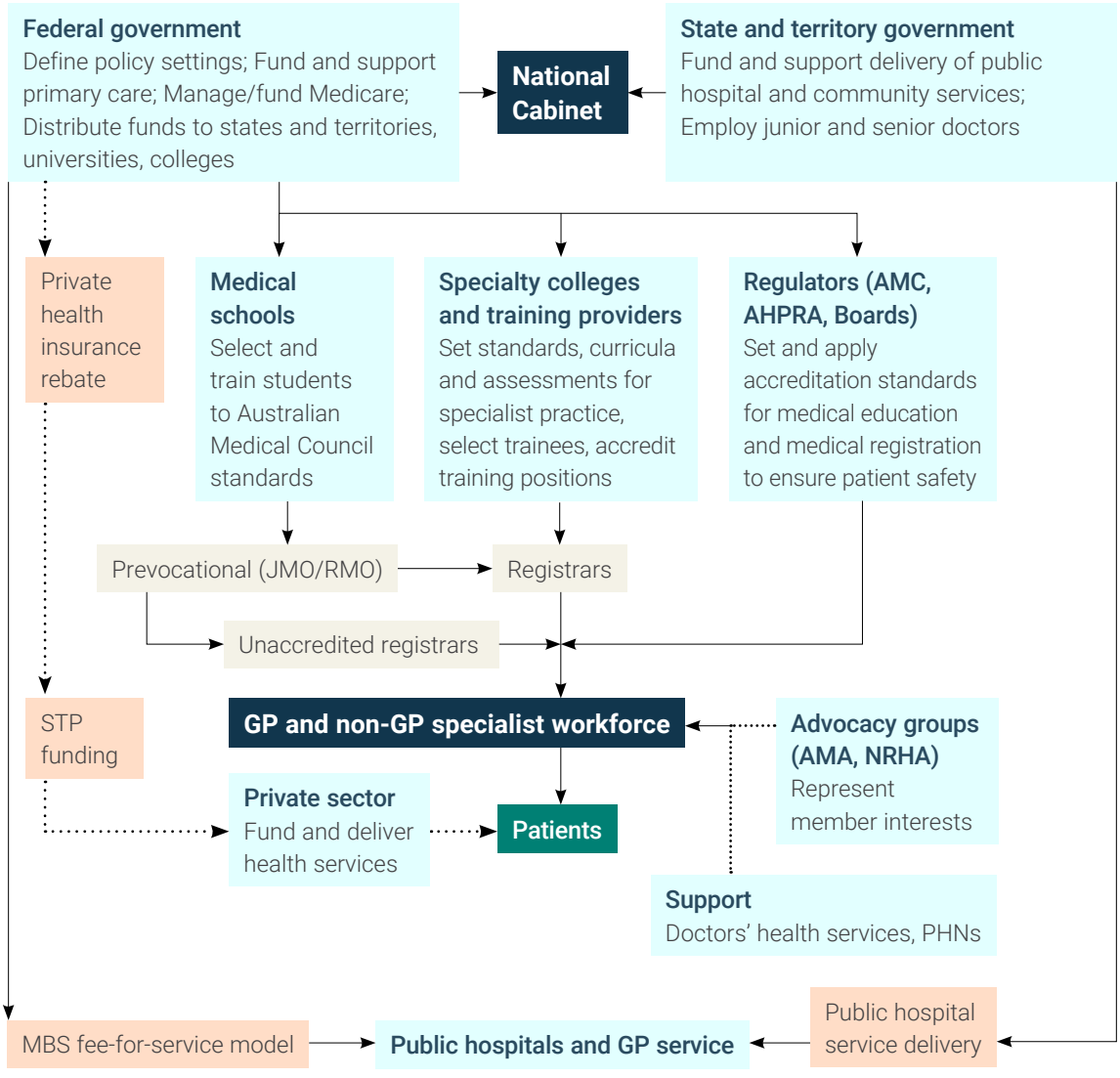
The RACGP will accelerate work underway on the following to inform and scaffold the action areas recommended above:

- Develop options for new and innovative approaches to GP training
- Research how to further optimise the significant contribution to distribution made by IMGs
- Undertake further analysis and economic modelling on:
  - understanding how different universities are contributing to primary care workforce and to regional, rural and remote workforce outcomes
  - where to target increases in the number of medical degree places (CSP and domestic fee paying)
  - the effectiveness of pre-vocational programs as pre-cursors to general practice training
  - the rate of growth required in the number of GP training places over the next 15 years to close the GP shortfall
  - the extent of concentration or build-up of service registrars in hospitals
  - the alignment of university rural clinical schools with state health rural internships and rural pre-vocational training leading to rural GP training outcomes
  - the flows across Australia from medical student to intern to pre-vocational program to specialist training programs.
- Continue to collaborate on workforce demand and supply analysis – one of the most significant achievements of the National Medical Workforce Strategy (2021–2031) has been to secure the commitment of most stakeholders to the aggregation of workforce data. Increasing transparency and availability of data has already lifted the quality of debate and design of strategies.
  - Continue working with DoHDA to utilise the National Assessment Tool and Supply and Demand model.
  - Continue to share its data appropriately through key relationships with DoHDA, MDANZ, state health departments and other stakeholders.

Part 2. Environmental scan

National environmental scan

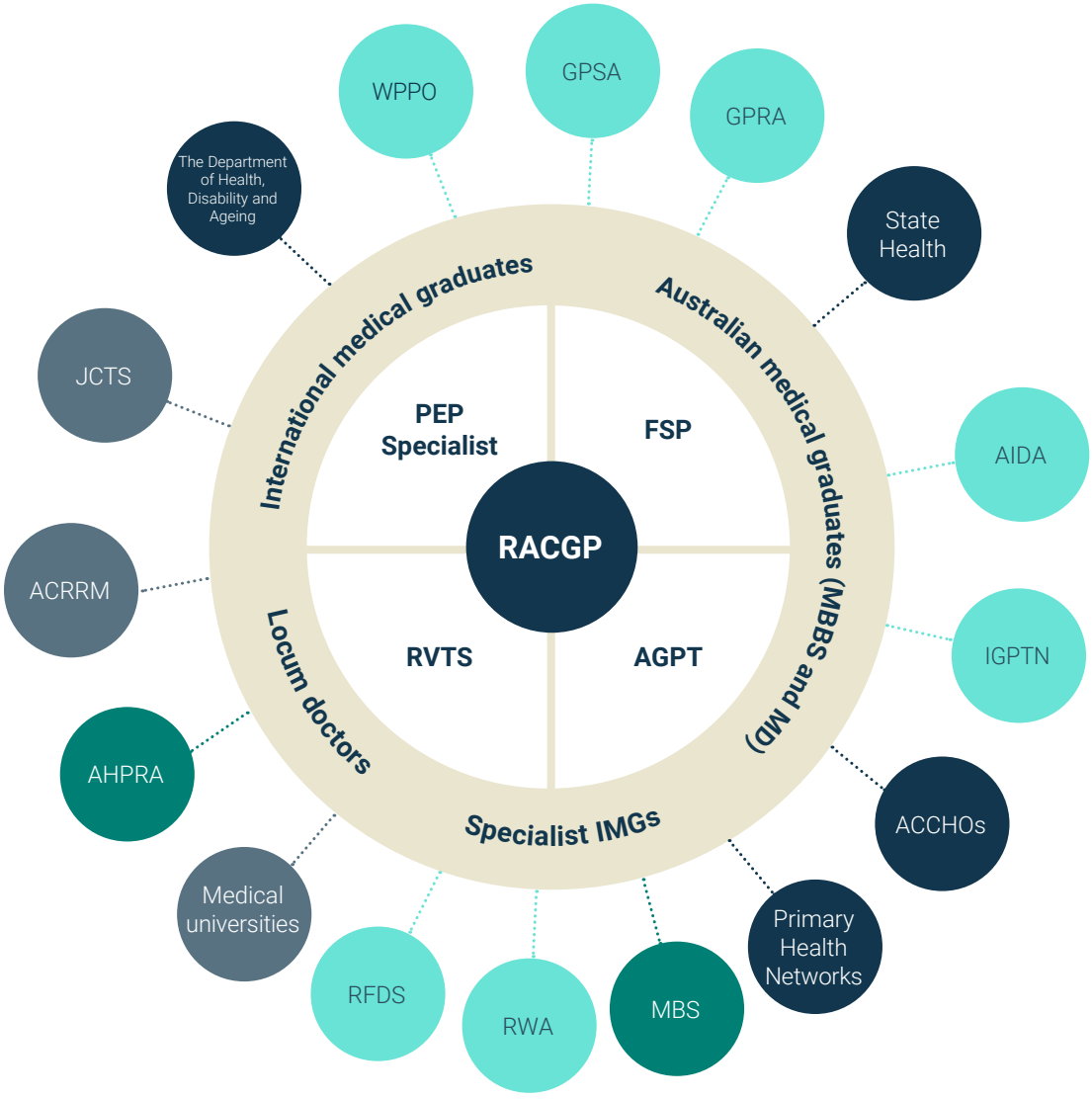
The general practice workforce is part of a broad and complex health ecosystem in Australia. The schematic below illustrates the key agencies and entities influencing general practice.



JMO: Junior Medical Officer, RMO, Resident Medical Officer, STP, Specialist Training Pathway, MBS: Medicare Benefit, Scheme, AMC: Australian Medical Council, AHPRA: Australian Health Practitioner Regulation Authority, PHN: Primary Health Network, AMA: Australian Medical Association, NRHA: National Rural Health Alliance

2.1 GP training key stakeholders

The schematic below maps the stakeholder environment impacting the RACGP's training programs, workforce planning and advocacy (refer to page 31-32 for glossary of terms/acronym full titles).



Part 3. Research to support the development of the RACGP national workforce strategy

Aligning with the Commonwealth's National Medical Workforce Strategy 2021–2031 (NMWS), the key focus of research has been identifying and then investigating those areas of concern most relevant to consideration of the general practice medical workforce.

While much work has already been done within the RACGP, the Workforce Secretariat for the strategy identified a range of relevant areas where there was insufficient data or research on hand and so implemented a research program to address these needs.

Table 2 illustrates research completed in the preparation of this first edition of the strategy (darker tone tiles), and work planned or underway which will be reflected in the second edition published in early 2026 (lighter tone tiles).

Table 2. RACGP national workforce strategy

Summary of recommendations						
RACGP national workforce strategy overview (First edition received board approval, 20 March 2025)						
The general practice shortfall in Australia 2025–2040	Population demographics analysis (priority populations)	University pipelines – effectiveness for general practice	International country case studies	Cross-cutting themes in Australian general practice	The role of IMGs in our medical workforce	General practice remuneration and entitlement, and the 'portfolio career'
Evaluating the sufficiency of training capacity - as the RACGP moves to a growth mindset	PGY1 and PGY2 - the role of the hospital training years in selection and distribution for GP Training	Evaluating the medical degree - selection, duration, cost, GP content	A review of pre-vocational programs and their contribution to GP training outcomes	Analysis of the rural generalist pathway and pipeline	Analysis of fellowship rates across all GP training pathways	A holistic approach to health workforce planning and distribution

Completed research overview

3.1 The general practice shortfall in Australia 2025-40

The RACGP's general practice shortfall analysis (utilising its own modelling), the DoHDA's Supply and Demand Study, and external reports (Australian Medical Association and Deloitte) identify workforce shortfalls to 2032/2033 of between 5560 and 11,392 GP FTE. However, only the RACGP's work considers the shortfall at the MM level to 2040.

While the future gap is most acute for patient access in MM6-7 (an additional 50.2 GP FTE per 100,000 estimated resident population, equivalent to 310 GP FTE by 2040), it is in fact largest in terms of GP FTE in the MM1 (an additional 41.2 GP FTE per 100,000 estimated resident population, equivalent to 9740 GP FTE by 2040).[12]

3.1.1 Testing other stakeholder forecasts and research with our data analytics and modelling capability

The RACGP has now built its own capacity to undertake workforce data analysis and modelling. We can significantly enhance the precision and relevance of our workforce strategies by utilising these tools to test other stakeholders' forecasts and research. This approach allows the RACGP to critically evaluate the assumptions and methodologies underpinning their forecasts, ensuring that our policies are based on robust, evidence-based insights. Additionally, leveraging our advanced analytics capabilities enables us to identify and address potential discrepancies or gaps in stakeholder research, fostering more accurate and comprehensive workforce planning and contribute to the evidence base for general practice. Integration of cutting-edge data analysis not only enhances the credibility of our recommendations but also supports more informed decision-making processes, ultimately leading to improved outcomes for GPs, their teams and the broader healthcare system.

Australia is already experiencing a GP shortfall with an estimated additional 3620 GP FTE (3010–4020 GP FTE) required to meet current demand in 2025 (Table 3). This gap is estimated to increase to 6860 (4500–8400 worst case) by 2030 and 13,240 GP FTE (6400–17,800 GP FTE) by 2040.

A range of 3670 to 5780 additional GP FTE are required across Australia within the next Federal Government term by 2027 to keep pace with demand and unmet demand of Australia's primary health care needs.

Table 3. Baseline demand, emerging demand and unmet demand shortfall 2025-40

	Metro GP FTE			Regional/rural GP FTE			Remote GP FTE			National GP FTE		
	Baseline demand shortfall	Emerging demand shortfall	Unmet demand shortfall	Baseline demand shortfall	Emerging demand shortfall	Unmet demand shortfall	Baseline demand shortfall	Emerging demand shortfall	Unmet demand shortfall	Baseline demand shortfall	Emerging demand shortfall	Unmet demand shortfall
2025	2200	2630	2950	750	920	1000	60	70	70	3010	3620	4020
2040	4770	9740	13,340	1400	3190	4070	230	310	350	6400	13,240	17,760
Percentage increase	117%	270%	352%	87%	247%	307%	283%	343%	400%	113%	266%	342%

3.1.2 Understanding and addressing the drivers causing the imbalance of demand

Demand in general practice refers to the total number of individuals seeking medical consultations with a GP within a specific period. This demand is influenced by factors such as the population's health needs, awareness of healthcare services, socio-economic conditions, and the availability of GPs. High demand indicates a significant portion of the population is actively seeking GP consultations, which may fluctuate based on seasonal variations (eg during flu season), demographic shifts, or public health campaigns.

Unmet demand, on the other hand, represents the portion of this demand that is not adequately addressed by the healthcare services available. Unmet demand occurs when patients are unable to secure timely GP appointments due to factors such as insufficient numbers of GPs, long waiting times, or geographic barriers. This unmet demand reflects a gap in the healthcare system where the existing capacity is inadequate to meet the community's healthcare needs. It can lead to negative outcomes, such as delayed diagnoses, worsening of conditions, or increased pressure on emergency services.

Between the lower and upper limits of demand, there are pragmatic midpoints that represent more robust demand targets than simply aspiring to meet baseline demand. Utilising chronic disease prevalence as an indicator of overall health demand, we offer a mid-range demand target: emerging demand.

Emerging demand refers to the evolving need for healthcare services prompted by the progression of chronic diseases. It sits between baseline demand (routine care requirements) and unmet demand (unaddressed care needs) and reflects the gradual increase in healthcare requirements as chronic conditions increase over time. This type of demand highlights a population's increasing reliance on healthcare resources due to chronic disease progression, requiring proactive management to prevent escalation. Chronic disease places substantial and growing pressure for access to GPs in primary healthcare systems, leading to higher patient volumes in GP clinics.

General practice workforce supply and demand between 2025 and 2040 has been modelled using pragmatic scenarios based upon Medicare utilisation data (Figure 3). We used ABS population statistics, a baseline demand scenario with general practice services per capita remaining steady, an unmet demand scenario with services growing in line with historical growth, and data on general practice workforce participation. The unmet demand scenario assumes that the existing 7.3 services per capita (MM1), 6.6 services (MM2-5), 3.6 services (MM6-7) grow to 9.4, 8.5, and 4.6 respectively. We also offer a mid-range demand target for emerging demand, utilising chronic disease prevalence as an indicator of overall health demand. The emerging demand scenario assumes that the existing 7.3 services per capita (MM1), 6.6 services (MM2-5), 3.6 services (MM6-7) grow to 8.4, 7.9, and 4.3 respectively based on the percentage of the population utilising additional services due to their chronic conditions.

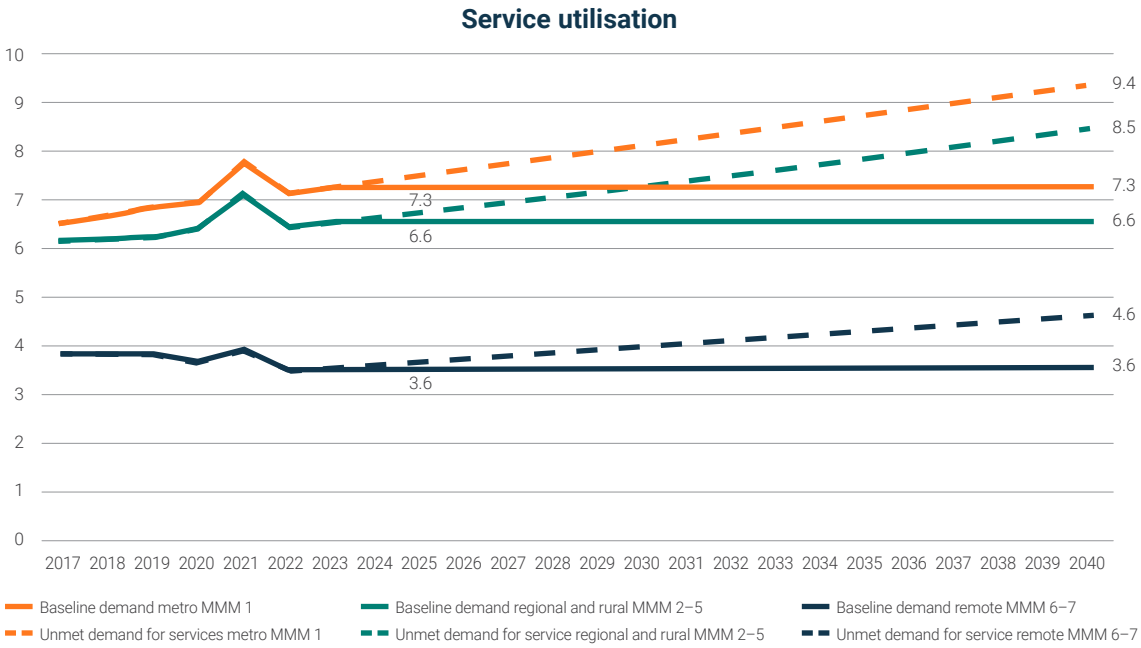


Figure 3. Baseline demand and unmet demand - number of GP visits per capital

In summary, while demand refers to the overall need for GP services, unmet demand highlights the shortfall between this need and the healthcare system's ability to provide timely access to those services. Understanding and addressing unmet demand is crucial for improving healthcare delivery and ensuring that the population's health needs are met effectively.

3.1.3 Understanding and addressing the drivers causing the imbalance of supply

Shown in Figure 4, rural areas (MM6) have the largest estimated negative growth of GP FTE (-4.0%) year on year, followed by MM7 (-1.2%) and MM4 (-0.4%).[13] GP headcount however has estimated positive growth across all MMM classifications, with MM2 projected to have the highest growth (2.3%) and MM6 with the lowest growth (0.2%).[14] This overall growth trend in headcount indicates that GPs are changing their ways of working, moving to part-time careers or reducing clinical hours.

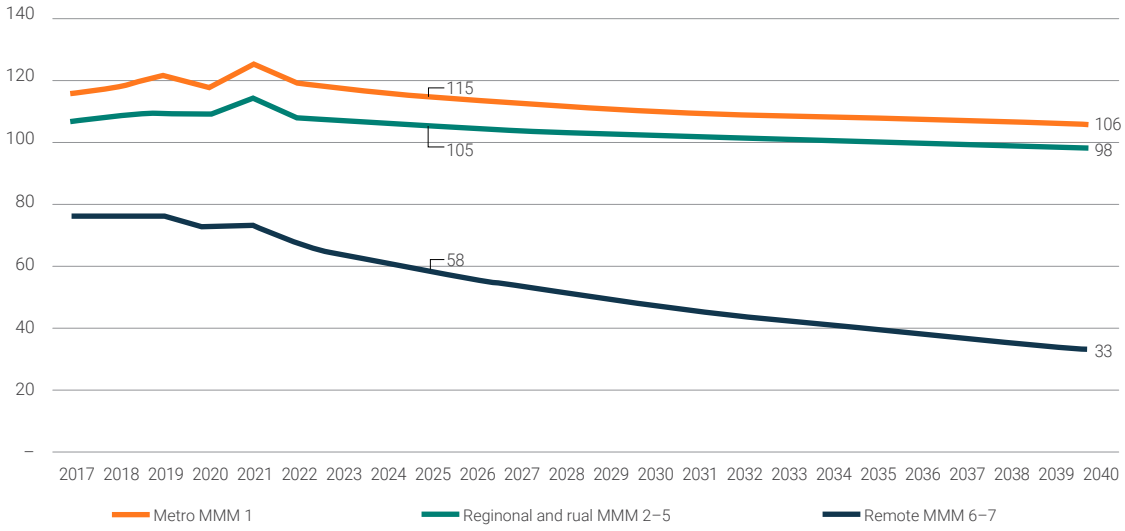


Figure 4. GP FTE per 100,000 estimated resident population 2017–40

The number of GP FTE per 100,000 estimated residential population is decreasing across all regions, with Metro regions expected to see a decrease of 8% over 15 years while remote regions are projected to decrease by 43% over the same period. The stark contrast between the metro areas and remote regions highlights a growing inequality in access to GP services. This could exacerbate existing health disparities between urban and rural populations.

The declining number of GPs per 100,000 people across all areas, especially in rural and remote regions, could lead to longer waiting times, reduced availability of services, and increased pressure on emergency departments and other healthcare providers. Urgent measures may be needed to attract and retain GPs in regional and remote areas to counter this trend. Incentives, better support, and targeted training programs could be essential to address these shortages.

3.1.4 The distribution dilemma

In 2024 there were 1500 Commonwealth funded general practice training places per year – the RACGP received 1350 and ACRRM 150. The RACGP's allocation was further divided into 635 for rural places and 715 for (as guided by DoHDA) metro places including 90 places for intrastate composites.

Previously the RACGP has been unable to make offers to all eligible doctors who applied for the AGPT General Pathway, specifically in metro areas as they were above the agreed DoHDA allocation. These candidates were not able/willing to consider general practice on a rural training pathway. Our data suggests sufficient supply for current metro training places, and the concern here is our demand analysis identifies growing shortfalls in the MM1 but insufficient training places to absorb current levels of supply.

It is important to note that 25.8% of all RACGP AGPT registrars are IMGs.[15] Participation of IMGs on the rural pathway is currently at 46.5%, while on the general pathway IMGs account for 14% having secured a 19AB exemption to allow them to train in the MM1.[16]

The supply of registrars for regional training places is insufficient with several hundred places not being filled each year for the past seven years. Metro training numbers have been constrained, to drive demand into the rural program, but this strategy is not filling available places.

3.2 University pipelines – evaluating effectiveness for general practice

3.2.1 Key findings

Australian universities play a crucial role in securing future medical workforce through their selection of which students gain a place in a medical degree and through their delivery of medical degrees which achieve both workforce and education objectives.

Most universities are engaged with the need to improve graduate workforce outcomes for primary care and for regional, rural and remote workforce. All universities create pathways into medical degrees for students from underrepresented groups including regional, rural and remote students and students from Aboriginal and Torres Strait Islander backgrounds. While considerable progress has been made, the following ongoing challenges have been identified.

3.2.2 A complex pathway

Over time, Australian universities have designed a range of pathways into medical degrees with varying entry requirements. This creates significant complexity for aspiring students to navigate (56 pathways offered across 35 programs by 22 universities).[17] This complexity means selection processes favour those applicants with financial resources and access to concierge support, impacting negatively on wider participation in medical programs by underrepresented cohorts. Further, despite much discussion of innovations in selection methodology, the primary selection tools continue to be based on ranking of applicants through academic merit. Undergraduate entry is typically determined by the University Clinical Aptitude Test (UCAT) followed by the Australian Tertiary Admissions Rank (ATAR). Postgraduate entry is typically determined by a combination of Grade Point Average (GPA) combined with the Graduate Medical School Admission Test (GAMSAT) and multiple mini interviews (MMIs) and/or situational judgement tests such as CASPER. Interviews and portfolios are also used by a number of universities.

3.2.3 Demand and supply of places in medical education

Commonwealth funded places (CSP) in medical degrees are controlled by the Government and the subject of funding agreements between the Commonwealth and each university. Numbers of full fee-paying domestic places and international fee-paying places are at the discretion of each university. Demand for medical education in Australia appears to significantly exceed the number of available places,[18] with some universities advertising no more than 6% of applicants will be successful in gaining a place. There is no readily available information on the number or characteristics of applicants applying to medical schools or taking the UCAT and GAMSAT. University admission centres in each jurisdiction hold undergraduate application data, test companies (UCAT and GAMSAT) have test related data, and GEMSAS the postgraduate application portal has application data, but this is not shared, aggregated or publicly available.

Figure 5 documents all available places in medical degrees over the last 10 years.[19] In 2024 and 2025 a total of 160 additional Commonwealth supported places (CSP) were added and in 2026 a further 100 places have been committed. Further, new medical schools are opening at Charles Darwin University in 2026 and at the Queensland University of Technology in 2027, with commencing CSP cohorts of 40 and 48 respectively.

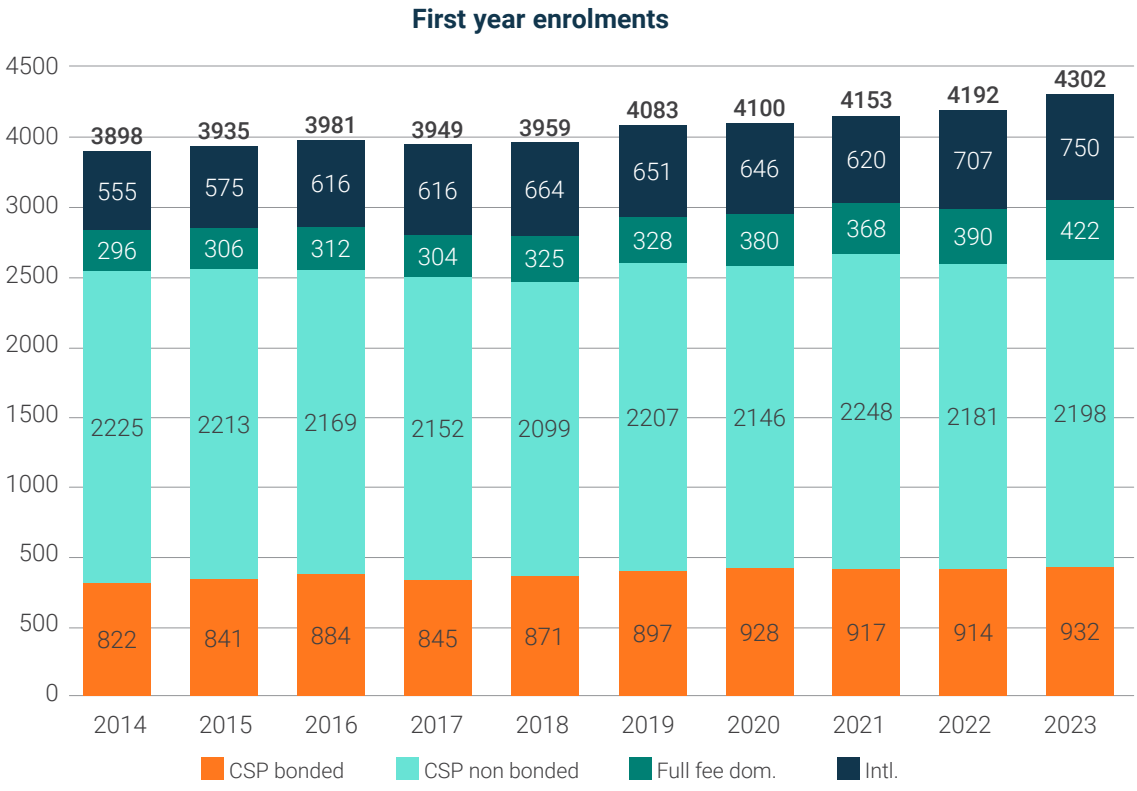


Figure 5. First year medical degree enrolments 2014-23

Unlike other countries, such as the UK, there are no widening access requirements other than a criterion for 25% of enrolments for Commonwealth supported places to be from a rural background, for universities with RCS funding which has been defined in several ways over time, most recently as residence anywhere in the MM2-7 for 5 consecutive years or 10 cumulative years.

3.2.4 The three types of medical degrees

At a national level the wide variety of offerings by universities, for medical degrees, would benefit from a greater level of transparency (Table 4).

The University of Melbourne introduced the Doctor of Medicine (MD) in 2011 following the Commonwealth's adoption of the Bradley Review (2009) recommendation that no fee-paying undergraduate degrees could henceforth be offered – the regulation did not apply to postgraduate degrees.[20] Other universities followed suit arguing postgraduate students would have better experience in achieving medical school outcomes.[21] The Australian Qualification Framework (AQF) is often cited as a concern, with the Bachelor of Medicine, Bachelor of Surgery (MBBS) being an AQF Level 7 award while the MD is an AQF Level 9 award – with the key difference being the volume of research undertaken within each degree.

Since 2011 most of Australia's medical degrees have shifted from the undergraduate MBBS to:

- packaged degrees made up of different arrangements of undergraduate degrees usually in biomedical or clinical science with guaranteed entry to the MD subject to a GPA hurdle, or
- a standalone postgraduate entry to the MD.

Australia now has only two remaining undergraduate medical programs offered at James Cook University (JCU) and Curtin University (Bachelor of Medicine/ Bachelor of Surgery [MBBS]). The largest group of medical

places are offered in the packaged undergraduate/postgraduate (BClinical Science + Doctor of Medicine [MD]), with this package offered in five-year, six-year and seven-year formats. The packaging of undergraduate degrees with the MD was introduced several years after the MD first arose and would appear to negate the argument that the MD produces better outcomes by selecting mature applicants with life experience.

The postgraduate Doctor of Medicine (MD) is consistently a 4-year degree with selection managed through the Graduate Entry Medical School Admissions System (GEMSAS) – an online application portal that manages applications for 9 out of the 12 universities offering the standalone MD (University of Sydney, Monash University and Flinders University abstain from using GEMSAS).

The shift since 2011 from the MBBS to the packaged and standalone MD has extended the length of completing a medical degree by up to 2 years without any demonstrable improvement in the calibre of graduates. From the perspective of general practice, the advent of the MD has coincided with a steady decline of junior doctors intending to specialise in general practice, and older cohorts entering GP training who are less able and/or willing to relocate to meet rural training requirements. The costs are also greater for student contribution payments, when factoring in the additional undergraduate degree costs. Many students find it difficult to ascertain the difference between the various medical degrees or pathways, despite the significant difference in the time required to achieve the same awards.

Table 4. Length and cost of CSP places in medical degrees in Australia, 2024

Course type and CSP cohort proportion	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Annual course CSP fees (for all course types)	Range of CSP program funding + (student contribution)	Full fee-paying tuition fee
MBBS (5–6 years) 7%	MBBS 5 and 6 – year degrees								Total CSP government contribution: $31,641	$224,410 – $269,292 ($66,205 – $79,446 HELP debt)	$395,760 – $402,000
Packaged (5–7 years) 47%	BClinSci 2 and 3 – year degrees			MD 2, 3, and 4 – year degrees					Total student contribution: $13,241	$224,410 – $314,174 ($66,205 – $92,687 HELP debt)	$436,000 – $447,000
MD (4 years) 46%	UG Degree			GAMSAT + Applications	MD 4 - year degrees				Total CSP cost per year: $44,882	$179,528 ($52,964 HELP debt) + UG degree cost	$273,216 – $439,436 + UG degree cost

3.2.5 Success of rural selection strategies

Australia has long understood the importance of selecting genuinely regional, rural and remote students and training them to the greatest extent possible in situ, to provide workforce for these areas. For over 20 years the Commonwealth has invested in rural clinical schools with 2023/2024's investment identified as $200M. At the same time, there has been little evaluation to determine the effectiveness of selection, retention and subsequent distribution of graduates trained in rural settings. Noting the one evaluation that is publicly available, a lot more work is needed in this area to determine the success of both the funding and the strategies.[22]

Extensive research in Australia and abroad has established that medical students from regional, rural and remote backgrounds have a predisposition to both train and subsequently practice in regional, rural and remote locations.[23,24] Over the last 20 years much research has been done to identify and examine the evidence that supports this thesis and work is ongoing.[25,26]

The RACGP's tracking data indicates declining participation of Australian medical graduates on the AGPT rural training pathway. While more work needs to be done to understand this trend, there are lines of inquiry including:

- Growth of Australian cities has seen MM1 and MM2 merging in many areas, meaning students recruited as 'rural' from MM2 regions may have a low preference to work outside the MM2
- Continuing to utilise medical degree selection processes that are predominantly merit based hinders efforts to recruit students from underrepresented cohorts who are most likely to return to these areas to train and practice[27,28,29]

3.2.6 The Bonded Medical Program (BMP)

The BMP requires medical graduates to complete a return of service obligation by working for three years in eligible regional, rural and remote areas in exchange for their CSP. Selection into the program is based on ranked academic merit, with all universities required to bond 28.5% of their allocated CSP. Using academic merit is contrary to the extensive body of research that confirms rural background is one of the strongest predictors of future rural work retention.[30]

Previous iterations of the program have not demonstrated success in supporting the training and retention of doctors in regional, rural and remote Australia.[31] The BMP's 18-year return of service obligation period (only half of which can be completed prior to fellowship), and current low completion rates, have made it difficult to evaluate. More effective and immediate strategies should be considered, such as a program revamp to improve completion rates, selection methodologies and general practice workforce outcomes.

3.2.7 Monitoring interest in general practice

The MDANZ MSOD survey indicates that over the past decade, between 14% and 19% of final-year medical students have expressed interest in pursuing a career in general practice. Meanwhile, the RACGP has observed a decline in the number of Australian medical graduates entering general practice training, with the 2025 intake comprising just 67% Australian graduates—the lowest proportion to date—down from a stable range of 74–76% between 2021 and 2024.[32]

In 2025, only 43% of the RACGP's rural training places (MM2-7) were filled by Australian medical graduates (AMGs), with IMGs now comprising over 57% of the rural cohort. In contrast, the general pathway (MM1) saw a significantly higher proportion of AMGs, at 83%, with IMGs making up the remaining 17%.[33]

3.2.8 Medical education and the need for a long-term medical workforce strategy

The Australian government has yet to outline a long-term strategy to address the growing shortage in the general practice workforce. While additional CSP has been allocated in 2024, 2025 and for 2026, there is as yet no formal plan articulated to progress towards medical workforce sufficiency for Australia.

Australia's health system remains one of the most heavily reliant on skilled migration, with IMGs accounting for 42% of the general practitioner workforce (headcount) in 2023 and projected to exceed 50% by 2031.[34] While skilled migration has long been a cornerstone of Australia's economic and social fabric, the failure to develop a self-sustainable health workforce is incongruent with our status as a world class education and training destination.

4. The role of international medical graduates in our medical workforce

4.1 Australia's reliance on international medical graduates

Training a GP in Australia typically takes 10 to 15 years. In the short to medium term, it is not possible to rely solely on Australian-trained doctors, as there will continue to be a significant workforce shortage. Australia heavily depends on IMGs as a temporary solution to address gaps in areas with the highest workforce demand. However, focusing exclusively on attracting IMGs without investing in developing a larger Australian trained medical workforce, is not a prudent strategy. The COVID-19 pandemic highlighted the risks of overreliance on skilled migration to meet workforce needs.

Currently, IMGs make up 32.2% of the medical workforce which ranks Australia as the 6th highest OECD country for reliance on foreign-trained doctors.[35] While this helps address immediate workforce shortages, especially in rural and remote areas, it is not considered a sustainable long-term strategy.

4.1.1 Pathways for IMGs to practice in Australia

There are currently three main pathways for IMGs to obtain both specialist registration and gain Fellowship in Australia: specialist pathway, competent authority pathway, and the standard pathway. Each pathway has different requirements, timelines, and costs.

Undertaking GP training in Australia provides IMGs with a scaffolded entry to practicing in Australia which increases the likelihood of success at all levels.

4.1.2 Challenges and reforms in the IMG registration process

Navigating the regulatory requirements and processes to practice medicine in Australia can be challenging. With global health workforce shortages, skilled migration has become highly competitive. Health professionals are choosing countries with simpler, more transparent, and less stringent regulations and migration procedures, such as the UK, New Zealand, and Canada. To attract experienced and high-quality practitioners, Australia seeks to remain competitive in this challenging landscape.

The Independent Review of Overseas Health Practitioner Regulatory Settings (Kruk Review) made recommendations to improve the IMG registration process, including fast-tracking applications for certain specialisations and making Australia more competitive in attracting skilled migrants. This review led to the introduction of the expedited specialist pathway providing an alternative pathway to specialist registration.

4.1.3 Ethical considerations regarding skilled migration

There are ongoing debates about the ethics of recruiting healthcare professionals from countries that may be facing even worse workforce shortages. This practice can negatively impact the healthcare systems of the IMGs' home countries. Developed countries such as Australia benefit economically by recruiting trained professionals without bearing the cost of their education and early career development, while the professionals' home country sees no return on the investment made in developing that talent.

As a first world nation, Australia should aspire to train the majority of its medical workforce. As one of the world's four largest exporters of education, it is a paradox that Australia is unable to train a sustainable medical workforce and instead relies on skilled migration for more than half its GP FTE.

4.1.4 Australia needs a comprehensive workforce strategy

Australia needs a medical workforce strategy that outlines the dual objective of meeting the nation's medical workforce needs through growing and investing in our capacity to educate and train general practice workforce for Australia and reducing reliance on IMGs over time. A long-term workforce strategy should also address improved support for IMGs and optimising policies like the 10-year moratorium to achieve even more effective workforce distribution.

5. General practice remuneration and attractiveness

Restoring the status of general practice is the responsibility of all key stakeholders (universities, training hospitals, health departments and medical colleges). Portability of entitlements and parity of remuneration with other medical registrars is a necessity if junior doctors are to seriously consider general practice specialisation.

An OECD pay rate data comparison indicates that in common with most OECD countries, Australian GPs are remunerated lower in comparison with other medical specialties.[36] In our international country comparison, this imbalance between general practice and other medical specialties is a consistent feature with few exceptions.[37]

Recent DoHDA studies add to the visibility of the large variance across GP take home pay which is a corollary of worked hours, billing patterns and practice geography.[38] The RACGP is seeking access to data sets that will inform and improve our understanding of the dynamics behind remuneration.

In the GP medical workforce there is a growing variance between headcount and FTE as an increasing number of GPs create what is colloquially called a 'portfolio' career. The RACGP seeks to understand the nature and extent of this trend, which will be influenced by factors such as seeking work-life balance, new and emerging opportunities to work as a primary care doctor, opportunities to focus on areas of special interest (general practitioners with a special interest, GPSI) and other such factors.

Research into general practice remuneration and attractiveness is vital for ensuring a sustainable and appealing workforce. Current work is underway to examine remuneration models, practitioner entitlements, and the growing appeal of 'portfolio careers', which offer flexibility, varied roles, and career longevity. These themes will be explored further in the second edition of this strategy, helping to reflect the evolving realities and aspirations within general practice.

6. International country case studies

A six-country comparison of general practice workforce challenges and solutions was undertaken looking at Denmark, Canada, the United Kingdom, France, the Netherlands and New Zealand, identifying relevant insights to inform the RACGP's strategy.

6.1 Reasoning for chosen comparator countries

Canada – geographically and politically and in terms of distribution of population Canada is the country most like Australia. There is much of interest to learn from the Canadian model of GP training and workforce management.

Denmark was selected because in 2023 the RACGP GP conference invited a plenary speaker from Denmark who stimulated interest in the unique Danish response to health challenges and solutions for the GP system, particularly through remuneration and practice management strategies.

France because the Napoleonic education system offers an alternative training model that has considerable influence over many other countries. France is smaller geographically but interestingly, still has distribution model challenges and is active in reforming its GP equivalent training and approaches to medical workforce.

The Netherlands, while a smaller European country it is representative of similar GP shortfall and long-term workforce supply challenges to Australia and actively pursues solutions. Interestingly the Netherlands reports high levels of GP satisfaction.

New Zealand included due to its similar developed-nation contexts, healthcare challenges and their medical graduates being considered as domestically trained doctors in the Australian system.

The UK was the model for Australia's higher education system and medical training program and while we have evolved to be a unique and distinct system, Australia tends to track closely developments in the UK. The UK also continues to be one of the largest sources of IMGs for Australia.

Countries with centrally managed economies (eg China and Russia) were not included due to the significantly different approach to healthcare, while Asian countries were not included due to their high concentration of urban populations and government policies towards healthcare in non-urban areas which differ significantly from Australia and so were less relevant to Australia's context.

6.2 International country comparison summary

6.2.1 The general practice workforce challenge is worsening in most Western countries.

With GP numbers not keeping up with population growth, burden of disease, and expectations of access, there is universally increased workload and reports of the workforce experiencing burnout. In Canada, where GPs can work in a variety of settings, up to 30% are working outside of primary care.[39] The workforce in regional and rural areas is ageing and nearing retirement with smaller cohorts available to take over, worsening the gap between rural and metro services levels.

Another major challenge for most nations is remuneration for GPs in comparison with other medical specialties, which is considerably lower in most surveyed countries (a trend we see consistently across the OECD).[40] While the UK has similar remuneration between medical specialists and GPs, their low pay across all medical professions is causing many UK doctors to migrate to higher paying countries - with Australia being one of the most popular.[41] The exception is Denmark, where GPs are remunerated, on average, higher than other hospital-specialists and consequently the general practice workforce is projected to meet population growth needs.

6.2.2 Scope of practice is a key strategy employed internationally to deliver adequate primary care

Increasing the scope of practice and the introduction of new professions who share duties with doctors has been one of the most common reforms for governments particularly in the UK and Canada. While not reviewed here, the US model of physician's assistant is well entrenched with the qualification increasingly offered at a postgraduate master's degree.

The UK has seen a rise in the number of physician associates with expanded roles in both community general practice and hospitals (with recent concerns reported by the media); likewise, Canada has a high reliance on nurse practitioners and physician assistants.[42]

France has seen an increase in the use of medical assistants, who primarily support GPs in administrative/care coordinator roles in practices. Activity-based funding models have thus far created a barrier for GPs to employ advanced nurses in practices.

6.2.3 Distribution is a challenge for all countries, regardless of geography

Australia and Canada face major challenges with the provision of healthcare and workforce distribution in large geographically rural and remote regions. Similar problems, to a lesser extent, were found in all surveyed countries – with an oversupply of health professionals in metro areas and maldistribution in areas of low population density, even when adjacent to metro areas.

Financial incentives for medical students and GPs/registrars are the only strategy which has consistently, and at-scale shown success for short-term retention. Longer-term retention is an almost universal challenge, and focus is shifting everywhere to strengthening pipelines, expanding selection strategies and targeted management of education and training pathways.

6.2.4 Short-term reliance on IMG workforce

Unlike Australia, which has a broad distribution strategy for IMGs (working anywhere in MM2-7), there is a more localised or targeted approach in other countries – placing IMG GPs in very specific areas of workforce need. Canada, for example, recruits IMGs at a provincial not national level, which allows for placement into specific areas of workforce need.

Across most OECD countries, there has been growth in the skilled migration of IMGs since 2010 and continued reliance on IMGs is incorporated into national medical workforce strategies. Remuneration, training and immigration processes influence the rates of IMGs as a global cohort of skilled migrants.

Few countries are as reliant on IMGs as Australia (in 2023 IMGs make up 32.2% of the overall medical workforce) with some countries beginning to articulate long-term strategies to reduce reliance and expand the domestic trained medical workforce.[43]

6.2.5 There is an appetite for reform

To develop the pipeline of locally trained GPs and reduce reliance on the migration of internationally recruited doctors, countries are developing strategies for the short and long term.

The UK has developed the NHS long-term workforce strategy, which has set the goal of decreasing the IMG workforce from 25% to 9% over the next 15 years. Key features of the plan include doubling the number of domestic medical school places, and the possible introduction of four year undergraduate medical degree and medical apprenticeships.[44] Like the UK, France is aiming to increase the number of medical interns completing general practice rotations.[45,46]

Both New Zealand and France are also increasing the number of medical school places. In France medical places increased between 2016 and 2020 from 7987 to 10,675 and are expected to rise a further 20% by 2025, while a third medical school is due to commence in New Zealand by 2027.[47,48]

Like Australia, Canada continues to develop strategies around increasing the IMG workforce primarily in areas of workforce need (regional, rural and remote).

7. Cross-cutting themes

7.1 Underrepresented cohorts

General practitioners in Australia deliver healthcare to priority populations which have unique challenges and opportunities. These groups include:

- Aboriginal and/or Torres Strait Islander peoples
- Residents in rural, regional and remote locations
- Refugees and asylum seekers
- Socio-economically disadvantaged individuals and people experiencing homelessness
- Older adults (particularly those living in residential aged care)
- People with disabilities

All of these underrepresented groups are included in the Cross-Cutting Themes research paper that sits behind this strategy. For brevity, only summary issues for Aboriginal and Torres Strait Islander peoples and rural and remote communities will be included here.

7.1.1 Aboriginal and Torres Strait Islander peoples

The RACGP national workforce strategy takes a similar approach to the National Medical Workforce Strategy in identifying cross-cutting themes. It is important that any workforce strategy enhance equitable access to GPs and include strategies for growing the Aboriginal and Torres Strait Islander medical workforce and for improving cultural safety in the healthcare system – for patients and Aboriginal and Torres Strait Islander GPs.

7.1.2 Access to general practitioners

Aboriginal and Torres Strait Islander people are more likely to live in urban and regional areas compared with more remote areas. However, the proportion of the total First Nations population increases with remoteness from 1.9% in *Major cities*, to 32% in *Remote and very remote* areas based on estimated Indigenous population projections for 2021.[49]

The Australian Institute of Health and Wellbeing's (AIHW) most recent Index of Access Relative to Need (ARN Index) has shown that nationwide, 17% of Aboriginal and Torres Strait Islander people currently have relatively poor physical access to a GP, compared with 5% of non-Indigenous Australians. This limited access increases with remoteness.

7.1.3 Access to culturally safe primary healthcare supported by skilled general practitioners

The RACGP recognises the important role of GPs in providing culturally safe healthcare in a range of primary healthcare settings and understands that for Aboriginal and Torres Strait Islander patients, connection to culture is protective of health. The RACGP recognises that the social and historical context of colonisation, systemic racism and intergenerational trauma increase the burden of disease and makes it imperative that Aboriginal and Torres Strait Islander people can receive culturally safe, accessible and responsive healthcare that is free of racism – wherever they seek care.

GPs serving Aboriginal and Torres Strait Islander patients often encounter higher burdens of disease and poorer health outcomes. These include higher rates of chronic diseases such as diabetes, cardiovascular disease, and mental health conditions. Aboriginal and Torres Strait Islander people are over-represented in communities in poverty.

7.1.4 Aboriginal Community Controlled Health Organisations (ACCHOs)

The RACGP acknowledges the strengths and successes of ACCHOs, many of which were established in response to experiences of racism in mainstream health services and an unmet need for culturally safe and accessible primary health care.[50]

The sector has contributed to significant health improvements for Aboriginal people. Outcomes have been especially evident in the areas of child and maternal health, detection and management of chronic disease, sexual health and mental health, and social and emotional wellbeing.[51]

ACCHOs are uniquely positioned to provide high-quality health and preventive care to their community.[52] Consultations can often take longer, with more patients who experience multi-morbidities and who may consult multiple health professionals at each visit.[53]

The complexity, skill and time required to deliver these services is not always recognised or supported through the current Medicare Benefits Schedule (MBS) structure or rebate values.

7.1.5 Rural and remote communities

Around 7 million people, or 28% of the Australian population,[54] live in rural and remote areas, where healthcare access is significantly more limited compared to urban areas. These regions face chronic shortages of healthcare professionals, including GPs.

Consumers living in rural and remote communities represent a complex healthcare demographic with higher rates of mortality and morbidity, poorer health outcomes, lower household income, and limited access to healthcare services. Historical disadvantages due to geographic isolation and a lack of flexible and responsive policy have contributed to the health inequities rural and remote consumers face.

Addressing the shortage of GPs in rural areas is essential. With only 66.2 GPs per 100,000 people in very remote areas compared to 122.7 in major cities, enhancing access to primary care is vital. Improved primary care access will alleviate the burden on hospital systems and enhance overall health outcomes. Efforts to increase Medicare utilisation in rural areas and reduce wait times for GP appointments are already underway, aiming to match the care accessibility found in metropolitan regions.

As of 2023, the distribution of Australians by MMM was:

- 72% in MM1 (metro)
- 26% in MM2-5 (regional centres and rural towns)
- 2% in MM6-7 (remote communities)

Over one-third of students (34%) enrolling in medicine in 2023 were from a rural background (defined as residence anywhere in the MM2-7 for 5+ years continuously or 10 years cumulatively) and this number is set to increase in the next decade.[55]

Data show that people living in rural and remote areas have higher rates of hospitalisations, deaths and injury and also have poorer access to, and use of, primary health care services, than people living in major cities'. People living in rural and remote Australia experience higher rates of poverty than those who live in metropolitan areas, and experience the challenges of geographic distance and workforce shortages, alongside limited infrastructure and resource availability.[56]

The maldistribution of the general practice workforce exacerbates healthcare disparities. Rural areas have fewer GPs per capita compared to urban centres which impacts on the availability and quality of care. GPs in these areas often work extended hours and cover a broader range of medical issues due to the lack of non-GP specialists.

7.1.6 A diverse general practice workforce

The RACGP is committed to growing a diverse general practice workforce. There are 137 Aboriginal and/or Torres Strait Islander Fellows of the RACGP including 20 new Fellows for 2023 (the largest cohort of new Fellows we have recorded). In 2024 the RACGP had a total of 63 Aboriginal and/or Torres Strait Islander GPs in training. We aim to have parity with the population percentage (3%). We are currently at 1.69% so more work needs to be done in encouraging our prevocational doctors and medical students to consider GP as a specialty training program.

7.1.7 Medical school admissions seek to become more inclusive.

Aboriginal and Torres Strait Islander students: Enrolments in medicine of First Nations students increased from 1.25% of the domestic student cohort in 2010 (163 students) to 2.02% in 2017 (291 students) to 3.13% in 2024 (491 students). Whilst enrolments are approaching population parity for Indigenous Australians – and are higher than average enrolments across university programs – there is still more work to do, particularly in supporting these students to progress to graduation (First Nations graduates represented 2.3% of the domestic student cohort in 2024).[57] First Nations students on average are more likely to be female (56% in 2024).

Lower SES and rural: Over one-third of students (34%) enrolling in medicine in 2023 were from a rural background, (defined as anywhere in the MM2-7) and this number is set to increase in the next decade. An increasing proportion of students from lower SES backgrounds are also commencing medicine.

Students with a disability: In 2021, MDANZ released a principles-based guide to support and guide schools' work on building and enhancing an inclusive approach to prospective and current students with a disability. A proportion of students in every medical school (e.g., up to 5% of each year cohort at Monash University) is enrolled in a disability support unit and the large majority of these successfully graduate. Ensuring medicine is a profession open to all is an important change the sector has been working to bring about and needs to be progressed further.

7.1.8 Pre-Vocational Initiatives at scale

The Commonwealth has long recognised the need for programs that encourage doctors to leave hospital settings for experiences in community-based practice, ideally leading to a subsequent decision to embark on GP training. In the past, programs have included the More Doctors for Rural Australia Program (MDRAP), the John Flynn Prevocational Doctor Program (JFPDP), and more recently the Pre-Fellowship Program (PFP). In addition, the Commonwealth funds over 200 clinical rotations in general practice for junior and other pre-vocational doctors to increase exposure to general practice and has committed to double this number to 400 funded rotations per annum from 2026 onwards.

The RACGP seeks to collaborate with all pre-vocational training programs to ensure a quality experience in general practice that will increase applicant rates for GP training. There are indications the Commonwealth is seeking to streamline the pre-vocational training space. The RACGP is keen to support the review of program effectiveness and program efficiency and consideration of how to optimise pre-vocational pathways into GP Training.

From the perspective of GPs, addressing the healthcare needs of vulnerable populations in Australia requires a multifaceted approach that includes improving access to culturally safe care, providing incentives for GPs to work in underserved areas, and implementing supportive policies and programs. By focusing on these areas, GPs can work towards ensuring equitable health outcomes for all their patients while managing the unique challenges of serving vulnerable communities.

Appendices

Appendix A – Data sources

- Selection Assessment Management Systems (SAMS) for applications to acceptances for AGPT
- Training Management System (TMS) for AGPT
- Excel spreadsheets for FSP and Pep Special
- DoHDA HeaDSUPP for national and regional data
- DoHDA Scenario Modelling tools (from August 2024)
- OECD for global health workforce data
- RACGP Evaluation team for qualitative data
- Workforce Planning and Prioritisation Reports for state/territory supply and demand analysis
- Published reports and research (eg Deloitte, AMA, MDANZ etc)
- Cubiko (analytics platform seeking agreement with RACGP)

Appendix B – Glossary of terms

- **ACCHOs (Aboriginal Community Controlled Health Organisations)**: Community-based organisations that deliver culturally appropriate and comprehensive primary health care services to Aboriginal and Torres Strait Islander communities.
- **ACRRM (Australian College of Rural and Remote Medicine)**: A professional body that provides training, education, and advocacy for medical practitioners working in rural and remote areas of Australia.
- **AIDA (The Australian Indigenous Doctors' Association)**: Peak professional body representing Aboriginal and Torres Strait Islander medical students and doctors in Australia.
- **AGPT (Australian General Practice Training)**: A government-funded program that provides vocational training to doctors to become GPs, including placements in various practice settings across Australia.
- **AHPRA (Australian Health Practitioner Regulation Agency)**: The agency responsible for the regulation of health practitioners in Australia, ensuring that only qualified health practitioners are registered and practice within the required standards.
- **Department of Health, Disability and Ageing**: The Australian government department responsible for national health and aged care policies, programs, and services.
- **DPA (Distribution Priority Area) and DWS (District of Workforce Shortage)**: Classification systems used to identify areas in Australia with a shortage of health professionals, particularly GPs, where recruitment incentives are often provided.
- **FSP (Fellowship Support Program)**: A program designed to support doctors in rural and remote areas to achieve Fellowship, ensuring they meet the standards required for unsupervised practice.
- **GPRA (General Practice Registrars Australia)**: An organization that supports GP registrars, the doctors who are training to become general practitioners, through advocacy, education, and professional development.

- **GPSA (General Practice Supervisors Australia)**: An organisation representing GP supervisors who provide training and mentoring to GP registrars.
- **IGPTN (The Indigenous General Practice Trainee Network)**: An Aboriginal and Torres Strait Islander not-for-profit organisation dedicated to achieving training and workforce equity for Indigenous General Practitioners (GPs) in Australia.
- **International Medical Schools**: Medical schools located outside of Australia where students can obtain medical degrees that may be recognised in Australia, subject to accreditation and registration processes.
- **MBS (Medicare Benefits Schedule)**: A listing of the Medicare services subsidised by the Australian government, including consultations, procedures, and diagnostic tests.
- **Medical Universities**: Institutions that provide medical education and training to students who will become doctors, including undergraduate and postgraduate medical courses.
- **PEP (Practice Experience Pathway) Specialist**: A pathway for doctors to achieve Fellowship in general practice, focusing on those who have extensive practice experience but may not have formal training.
- **Primary Health Networks (PHNs)**: Independent organisations funded by the Australian government to coordinate primary health care services in specific geographical areas.
- **RACGP (Royal Australian College of General Practitioners)**: The professional body for general practitioners (GPs) in Australia, responsible for setting and maintaining standards of general practice.
- **RFDS (Royal Flying Doctor Service)**: A not-for-profit organisation that provides emergency and primary health care services to people living in rural, remote, and regional areas of Australia.
- **RVTS (Remote Vocational Training Scheme)**: A program that provides GP training specifically tailored for doctors in remote areas, combining distance education with practical placements.
- **RWA (Rural Workforce Agencies)**: Agencies that focus on recruiting and supporting health professionals in rural and remote areas to ensure access to health care in these communities.
- **SIMG (Specialist International Medical Graduates) Fast Track**: A pathway for international medical graduates who are specialists in their home countries to quickly achieve recognition and registration in Australia.
- **State Health**: Refers to the various state and territory health departments in Australia, which are responsible for delivering public health services within their jurisdictions.
- **WPPOs (Workforce Planning and Prioritisation Organisations)**: Entities involved in the strategic planning of the GP health workforce across different regions in Australia.

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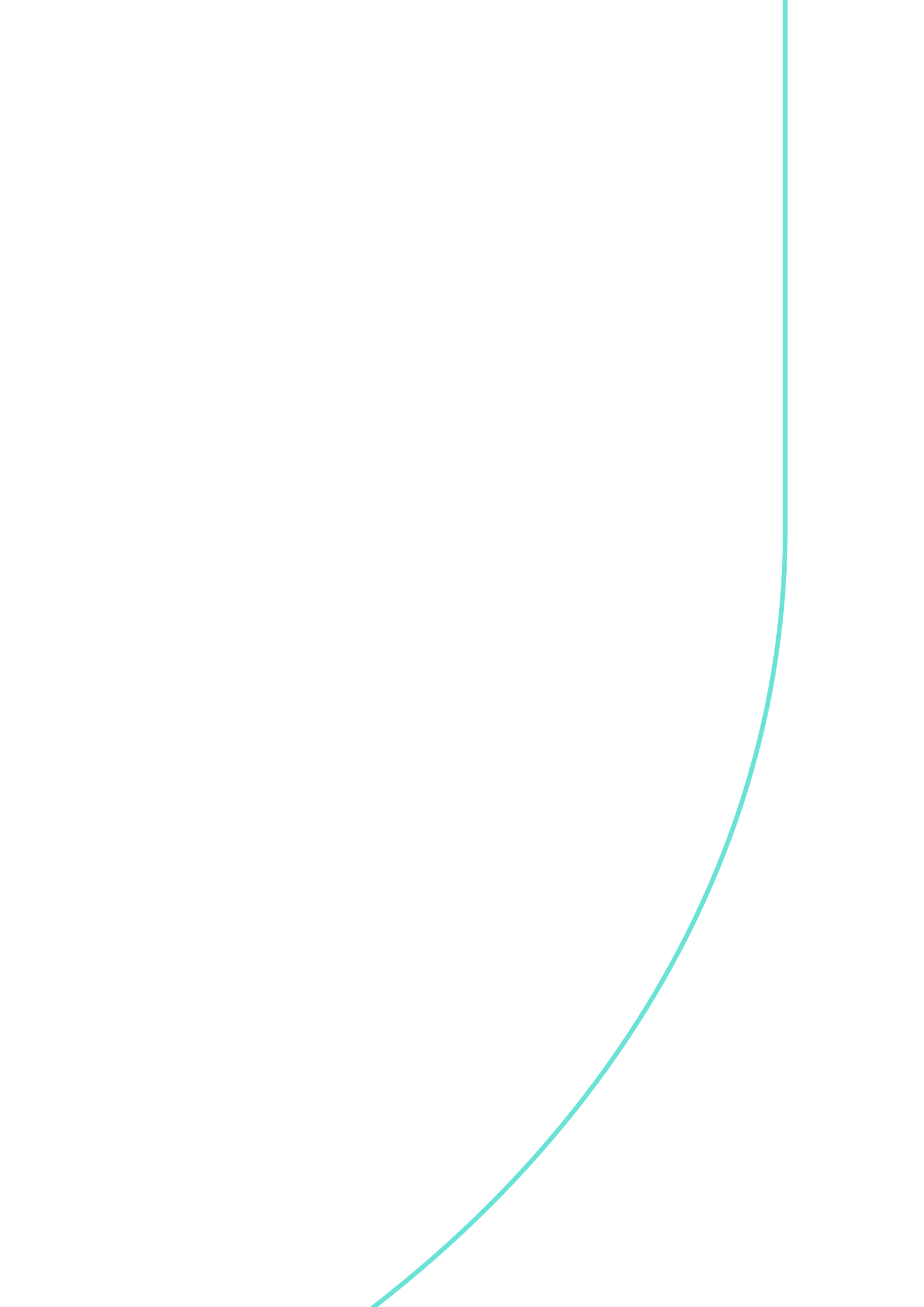

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