

GENERAL PRACTICE  
HEALTH  
— OF THE —  
NATION

2020



A unique insight into the state of Australian general practice

## **General Practice: Health of the Nation 2020**

### **Recommended citation**

The Royal Australian College of General Practitioners. General Practice: Health of the Nation 2020. East Melbourne, Vic: RACGP, 2020.

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ABN: 34 000 223 807  
ISBN: 978-0-86906-583-9

First published September 2017, this edition published November 2020

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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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**RACGP**

Royal Australian College of General Practitioners



## Acknowledgements

This report comprises information drawn from a variety of sources, including publicly available data from the Department of Health's (DoH's) Medicare statistics, the Australian Institute of Health and Welfare (AIHW), the Australian Bureau of Statistics (ABS) and the Productivity Commission.

This report used data from the MABEL (Medicine in Australia: Balancing Employment and Life) longitudinal survey of doctors conducted by the University of Melbourne and Monash University (the MABEL research team). Funding for MABEL has been provided by the National Health and Medical Research Council (2007 to 2016: 454799 and 1019605); the Australian Department of Health and Ageing (2008); Health Workforce Australia (2013); and, in 2017, the University of Melbourne, Medibank Better Health Foundation, the NSW Ministry of Health, and the Victorian Department of Health and Human Services.

The MABEL study was approved by the University of Melbourne, Faculty of Business and Economics Human Ethics Advisory Group (Ref. 0709559) and the Monash University Standing Committee on Ethics in Research Involving Humans (Ref. CF07/1102 – 2007000291). The MABEL research team bears no responsibility for how the data has been analysed, used or summarised in this report.

## The RACGP

The Royal Australian College of General Practitioners (RACGP) is Australia's largest professional general practice organisation, representing 90% of the general practice profession.

The RACGP is responsible for defining the nature of the general practice discipline, setting the standards and curriculum for education and training, maintaining the standards for high-quality clinical practice, and supporting general practitioners (GPs) in their pursuit of excellence in patient care and community service.

## Thanks

The RACGP thanks the general practice community for its ongoing passion, support and dedication to the health of the nation. Thanks also to the many RACGP Fellows who responded to the Health of the Nation survey.

Many GPs have provided input, ideas and feedback during the development of the 2020 Health of the Nation report. The RACGP thanks members of the RACGP Expert Committee – Funding and Health System Reform for their contribution.

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# Message from the Acting President

The last 12 months have tested Australia's healthcare system like no other time in living memory.

Bushfires swept through vast swathes of our country, claiming lives and destroying homes and businesses. Smoke blanketed our towns and cities and left people with respiratory conditions gasping for air.

Then came a global pandemic. Although Australia has managed to avoid the worst of what some other countries have experienced, COVID-19 has killed hundreds of people, devastated livelihoods and tested our resolve as individuals and as a nation.

The *General Practice: Health of the Nation 2020* report reveals what many of us already knew: GPs are essential when crisis strikes.

Our GPs have done an outstanding job helping their communities heal. Over many months, GPs have stepped up to help in the regions hit hardest by the bushfires, helping people experiencing injuries and trauma and coordinating local health responses. And they will carry on supporting their communities as the bushfire recovery process continues. The RACGP continues to advocate for involvement in emergency response planning to ensure the voice of general practice is heard loud and clear.

General practices across Australia adapted quickly to expand or implement telehealth services. Consultations via phone and video technology have been crucial in helping patients access care from the safety of their home during the COVID-19 pandemic. Telehealth has also likely contributed to the very low rate of infection among general practice staff.

The response to the pandemic from GPs in the Aboriginal and Torres Strait Islander health sector has been particularly successful. Decisive action to protect remote Aboriginal communities, including culturally appropriate public health messages from Aboriginal-led health services, has undoubtedly saved lives.

Even with the recent decision to prioritise visas for international medical graduates and overseas-trained doctors, the temporary closure of Australia's borders during the pandemic, combined with



movement restrictions, has affected rural general practice. Almost half the rural GP workforce consists of doctors from overseas. However, the RACGP is making solid progress towards addressing shortages, including a 40% increase in junior doctors choosing the rural generalist pathway when applying for Australian General Practice Training.

Looking ahead, many challenges remain.

GPs will almost certainly see an increase in patients presenting with mental health issues following the pandemic. As the first port of call for those with mental health concerns, GPs stand at the ready.

We're also deeply concerned about the possible downstream effects of people delaying or avoiding seeking care during the pandemic. This report shows a significant decrease in the number of GPs reporting musculoskeletal, circulatory, and endocrine and metabolic issues as the most common presentations.

On top of that is the emerging evidence of the long-term impacts of the virus itself on patient wellbeing. GPs can expect to see more physical, cognitive and psychological issues from COVID-19-positive patients in the months and years to come.

Clearly, many patients will need ongoing support from their GPs. However, in the midst of these challenges, I also see opportunity – opportunity to change how primary care is delivered to improve health outcomes in a more cost-effective way. This year has highlighted how essential GPs are when health crises strike – but we must not revert to the status quo when the grip of the pandemic eases.

## The solutions are right in front of us.

The RACGP's *Vision for general practice and a sustainable healthcare system* outlines a model of care that addresses many of the nation's healthcare challenges. Those challenges are only set to grow in the wake of the pandemic, so we don't have a moment to lose.

Continuity of care is vital to improving patient health outcomes and reducing hospitalisations. Medical experts and policymakers have long called for a voluntary patient-enrolment model to help coordinate access to multidisciplinary care. Such a model would support GPs and practice teams to better manage chronic disease and mental health issues.

The extension of Medicare subsidies for telehealth services to 31 March 2021 is welcome, but a longer-term plan is needed. There's no turning back – patients and GPs have seen how valuable these services are. If Medicare subsidies were available for longer mental health consultations, patients would be better supported to talk to their GP about what they're experiencing.

We must learn from what we've experienced in 2020 and work constructively with all levels of government to achieve lasting primary care reforms that will benefit generations to come.

GPs are among the heroes of the bushfires and pandemic. They've demonstrated a resilience, adaptability, positivity and empathy that's nothing short of inspiring.

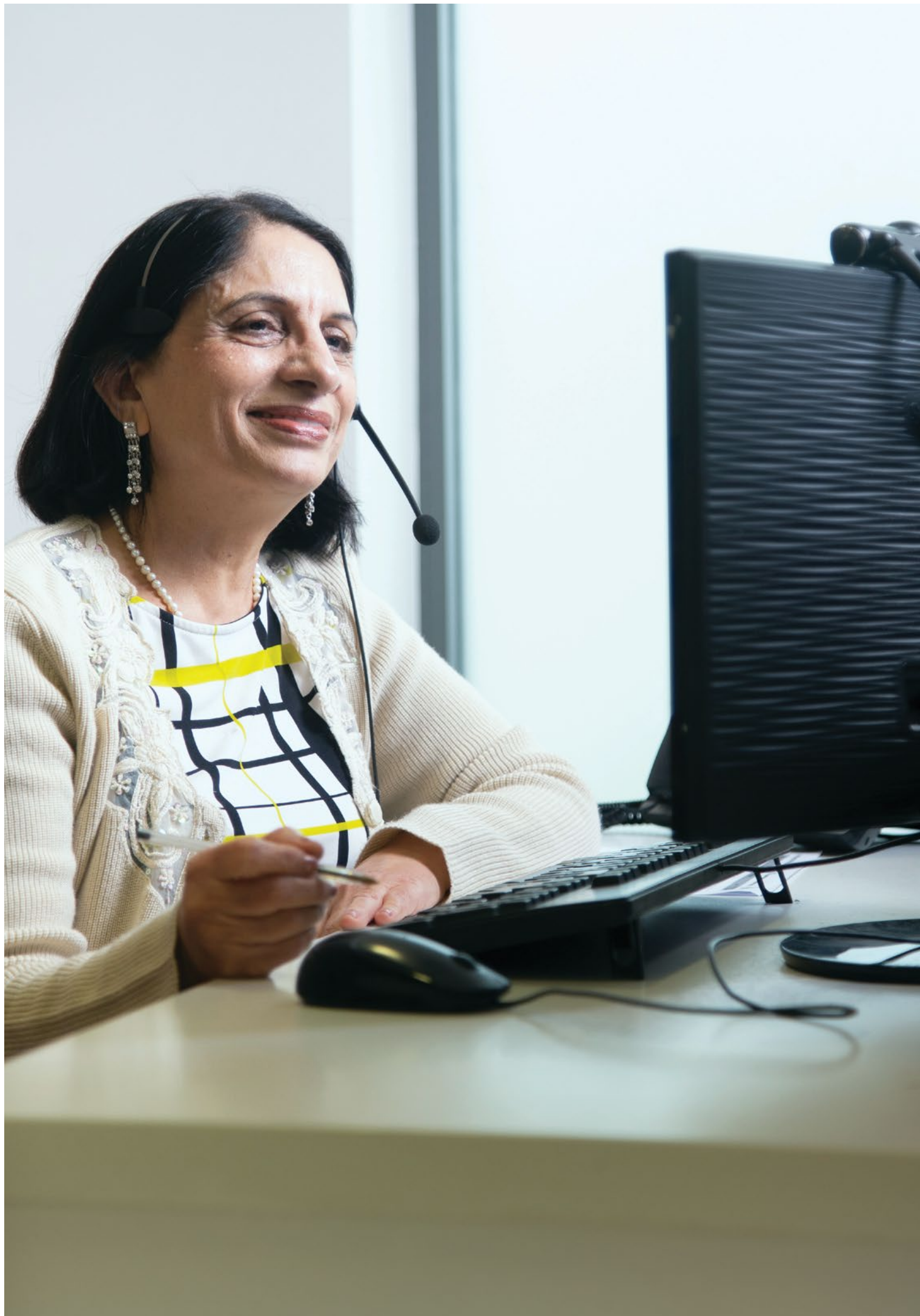
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### Associate Professor Ayman Shenouda

Acting President, RACGP  
November 2020

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# Introduction

A thriving, accessible and high-quality general practice sector is vital to the health of Australia. General practitioners (GPs) are the first point of contact for most Australians seeking healthcare, with almost 90% of the population seeing a GP at least once each year.<sup>1</sup>

The Royal Australian College of General Practitioners (RACGP) is the country's largest professional general practice organisation, representing more than 41,000 members, including more than 24,000 Fellows, who treat more than 22 million patients<sup>1</sup> across Australia every year.

The annual *General Practice: Health of the Nation* report collates data from various sources to provide a unique overview of the general practice sector.

The report draws on specifically commissioned research spanning four years, involving RACGP Fellows from all parts of Australia. The online survey was undertaken by EY Sweeney during May 2020. Demographics of the 1782 respondents from the 2020 RACGP Health of the Nation survey was as follows:

- 62% female, 38% male\*
- 8% <35 years, 26% 35–44 years, 33% 45–54 years, 24% 55–64 years, 9% ≥65 years
- 9% Western Australia, 10% Northern Territory/South Australia, 22% Queensland, 29% New South Wales/Australian Capital Territory, 30% Victoria/Tasmania, 1% overseas
- 73% in major cities, 19% inner-regional, 7% outer-regional, 2% remote and very remote.<sup>†</sup>

The report also draws on information from the MABEL (Medicine in Australia: Balancing Employment and Life) survey, and a range of government and other stakeholder publications.

The *General Practice: Health of the Nation* report focuses on a range of topic areas, including:

- the health of the profession
- patient access to general practice
- the varied and important services that GPs provide to communities
- challenges facing GPs and general practices.

Each year, RACGP members select a topic of focus for the report. In 2020, the report focuses on the unique environment created by the SARS-CoV-2 (COVID-19) pandemic and the 2019–20 summer bushfires. The challenge of adapting processes and responding to crises is reflected in the survey findings throughout the report.

As the fourth edition of *General Practice: Health of the Nation*, this report provides opportunity to track changes over the short and medium term, and forecasts possible longer-term changes and their implications.

Previous editions of the report are available online:

- [General Practice: Health of the Nation 2017](#)
- [General Practice: Health of the Nation 2018](#)
- [General Practice: Health of the Nation 2019](#)

Where this symbol is shown throughout the report, commentary is provided to outline the context of the data findings in more detail.

\*All RACGP Fellows were invited to participate in the survey. To minimise the impact of non-response, reminders were sent throughout the fieldwork period. However, there was a higher proportion of female respondents than the population of RACGP Fellows (50%), suggesting some response bias is present in the final sample.

<sup>†</sup>Some respondents' postcodes used to determine rurality fall into more than one Accessibility and Remoteness Index of Australia (ARIA) code, hence regions sum to more than 100%.



## CHAPTER 1

# Current and emerging issues

As the most regularly accessed health professionals in Australia, GPs are in an unparalleled position to provide insight into emerging health conditions, and to highlight issues that require an urgent response from government.

During 2020, GPs are the frontline in the battle against COVID-19, and have taken on significant responsibility to ensure the safety and wellbeing of all Australians.

GPs were also there to support communities affected by the 2019–20 summer bushfires, and will continue to provide this support as the effects are felt over the coming months and years.

## 1.1 Common health presentations in general practice

The physical health impact of the 2019–20 bushfires and the COVID-19 pandemic on the community is immediately apparent in the survey results from GPs.

Psychological issues, including depression, anxiety and sleep disturbance, remain the most commonly seen presentations in general practice, with 64% of GPs reporting it in their three most common reasons for patient presentations (Figure 1).

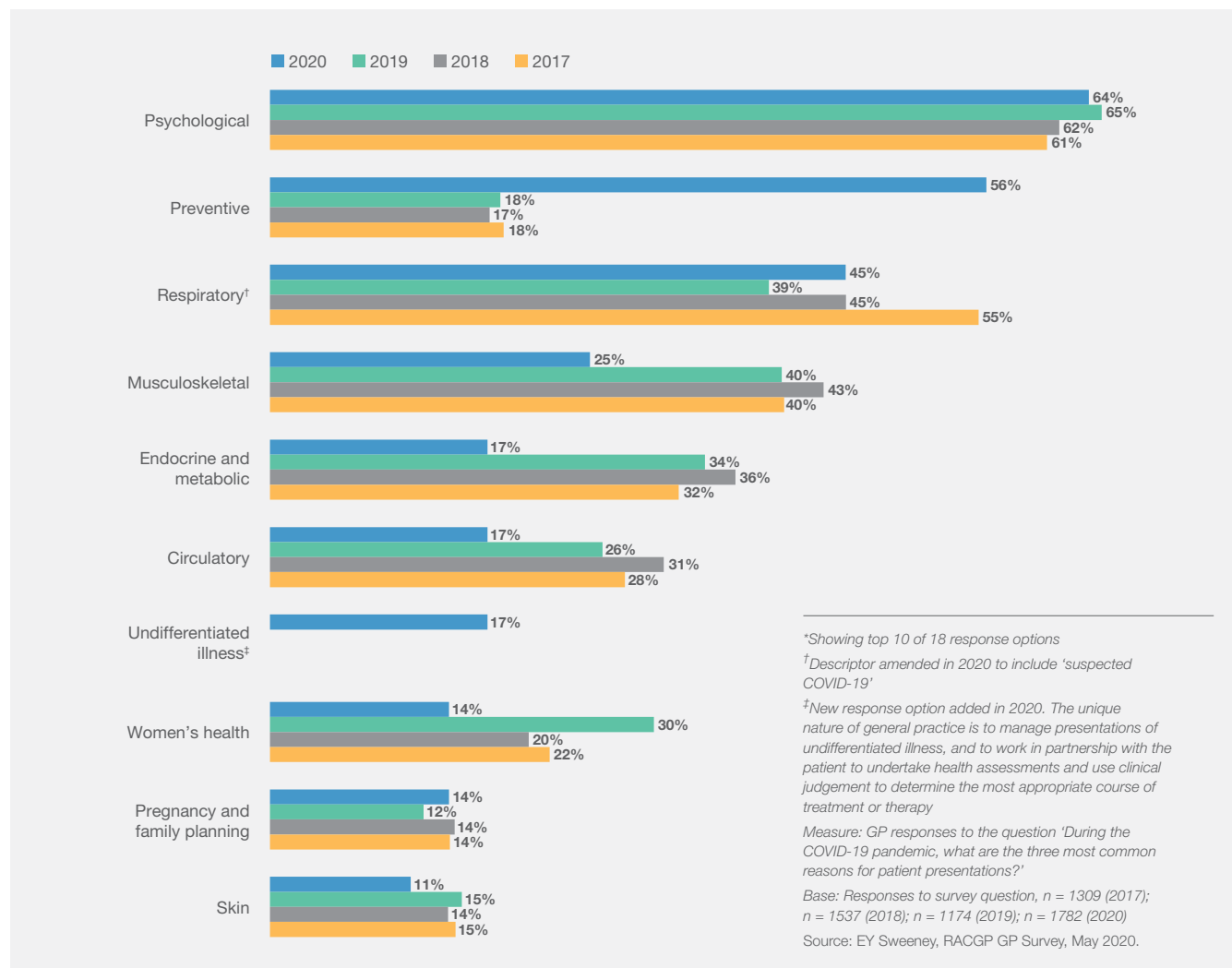
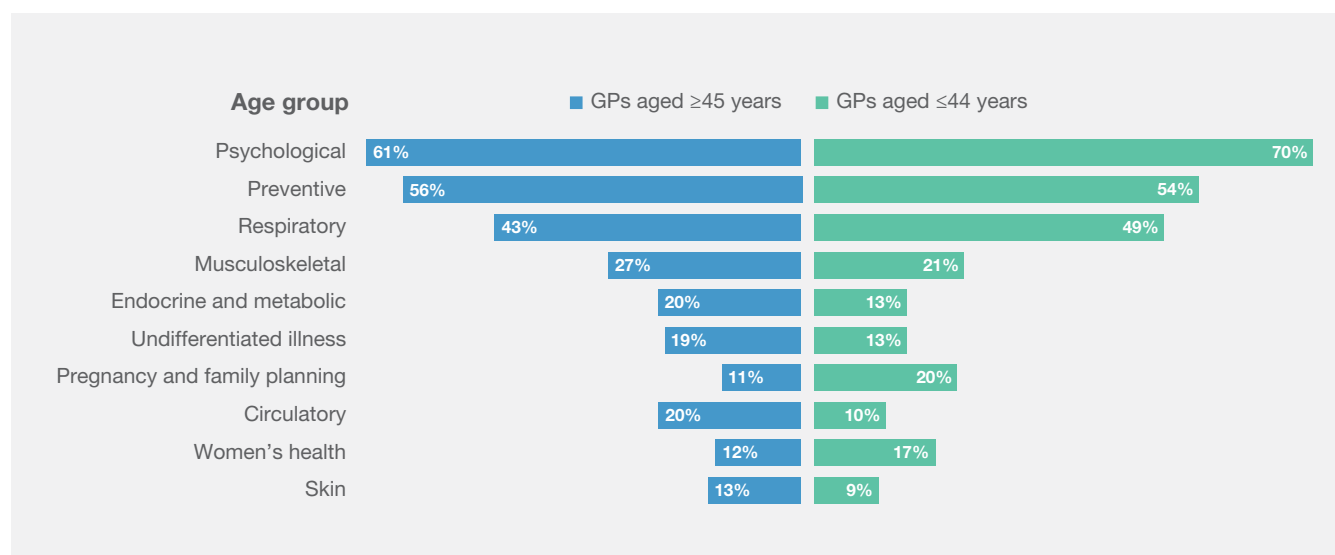
However, 2020 sees a significant shift in the second most commonly reported presentation, with preventive healthcare increasing to 56% (from 18% in 2019)<sup>2</sup> (Figure 1). This is due to the greater number of flu vaccinations provided in 2020 compared to other years. The Australian Government secured 18 million doses of the flu vaccination in 2020, significantly more than in 2019, and encouraged all Australians to

get vaccinated early to avoid extra stress on the health system during the COVID-19 pandemic.<sup>3</sup>

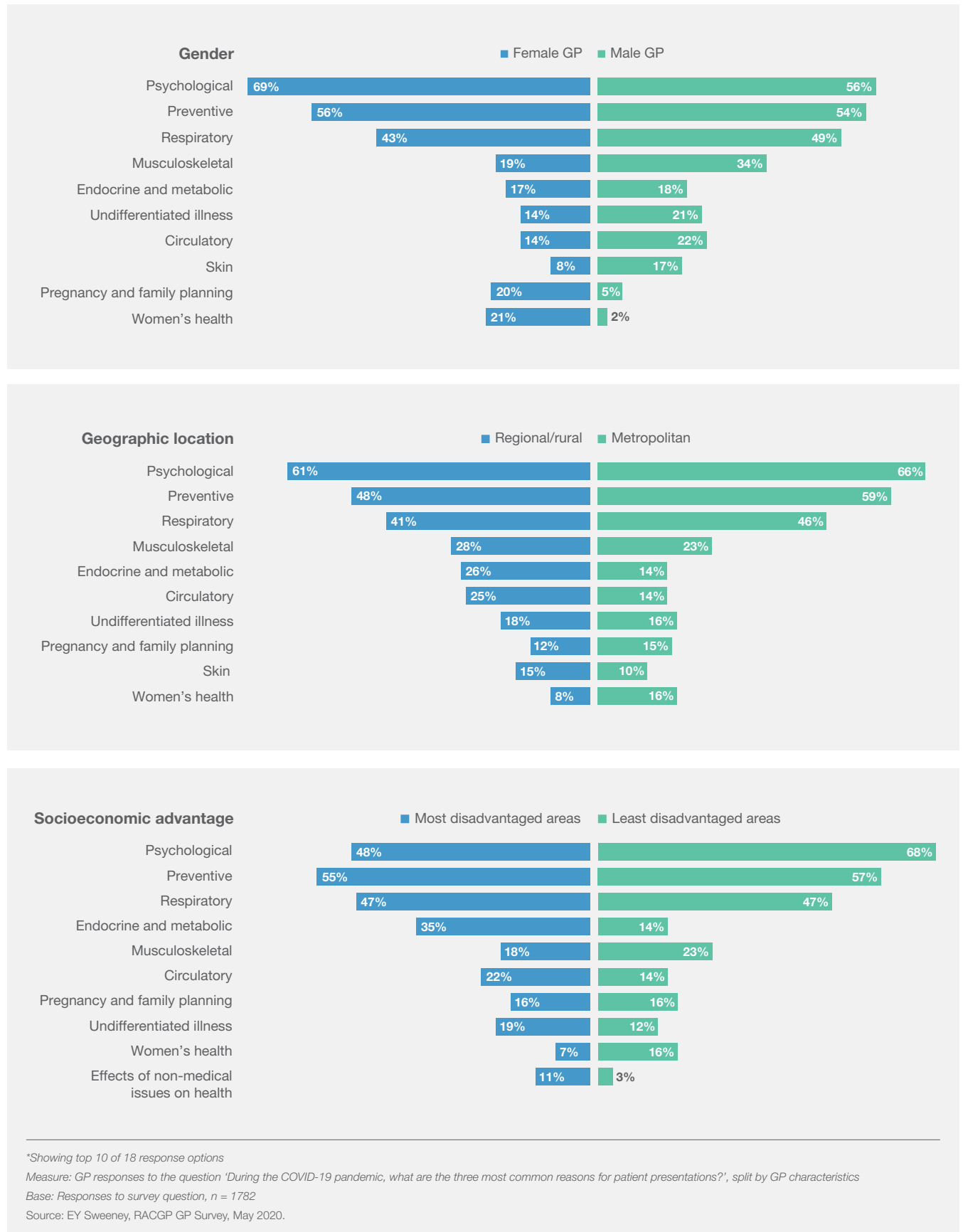
The preventive healthcare category includes health screening as well as vaccination. While there was an increase in vaccination, it is likely health screening decreased as patients avoided presenting for usual care. There was a corresponding decrease in other health presentations, including musculoskeletal (from 40% to 25%), circulatory (from 26% to 17%) and endocrine and metabolic (from 34% to 17%) (Figure 1).<sup>2</sup> This change in patient presentations is concerning, as the longer term impacts of patients delaying health screening and chronic disease care could be significant. Refer to [section 1.4.2](#) for further discussion of this topic.

There was an increase in respiratory presentations, including cases of suspected COVID-19 (Figure 1).<sup>\*</sup> This may also reflect increased presentations related to smoke inhalation as a result of the 2019–20 bushfires. Exposure to bushfire smoke can have significant short- and long-term health impacts, especially for the most vulnerable members of the community. This puts increasing pressure on general practices with more attendances. A national survey found more than half of Australians were affected in some way by the 2019–20 bushfires, with an estimated 5.1 million people experiencing adverse health impacts from smoke inhalation alone.<sup>4</sup>

<sup>\*</sup>The higher rate of respiratory presentations in 2017 is attributable to the timing of the survey, which occurred in July (rather than May) and so coincided with the flu season.

**Figure 1.** COVID-19 changed the patient presentations seen in general practice\***Figure 2.** Commonly managed health issues vary according to a practitioner's personal characteristics\*



**Figure 2 (continued).** Commonly managed health issues vary according to a practitioner's personal characteristics\*


As seen in previous years, women's health issues and pregnancy and family planning presentations are more likely to be reported by younger GPs, female GPs and metropolitan GPs (Figure 2).


Psychological presentations are less commonly reported by GPs in areas of socioeconomic disadvantage and regional/rural areas in 2020. This may reflect the increased presentations for physical (such as endocrine and metabolic) health conditions, rather than a direct decrease in presentations for mental health (Figure 2).

Younger GPs and female GPs are more likely to report that psychological issues are the most common reason for patient presentations (Figure 2).

The RACGP survey also found that GPs located in areas of differing socioeconomic advantage<sup>†</sup> reported some variance in common patient presentations. Areas of lower socioeconomic advantage see more patients with endocrine and metabolic issues as well as the effects of non-medical issues on health (such as domestic violence, housing, income and racism). GPs in the most advantaged areas are more likely to see psychological issues and women's health presentations (Figure 2).

GPs working in Aboriginal Medical Services more commonly report seeing patients about the effects of non-medical issues on health (18%) than GPs working in all types of practices (5%).<sup>5</sup> GPs working in Aboriginal Medical Services are also more likely to be located in areas of socioeconomic disadvantage, with 50% of respondents located in SEIFA 1–3, compared to 16% of all GPs in SEIFA 1–3.<sup>†,5</sup>

As with other findings, the lower reported rates of psychological presentations in areas of socioeconomic disadvantage may reflect the need to prioritise concurrent physical health issues (endocrine and metabolic, circulatory) rather than actual lower rates of mental health presentations. 

 It is well known that social and economic disadvantage increases the risk of mental health issues and their adverse consequences. Poorer communities are more frequently exposed to risk factors for mental health, such as violence, crime, homelessness and unemployment.<sup>6</sup>

The findings may relate to a range of issues which make it more difficult for patients located in areas of socioeconomic disadvantage to seek help, including lower levels of mental health literacy. A lack of mental health literacy may mean patients are unable to recognise or explain their health problems, or know where to seek appropriate support.<sup>7,8</sup>

GPs want to help their patients; the third most commonly cited challenge for GPs is ensuring high-quality care is accessible for patients from disadvantaged backgrounds (refer to section 5.1).

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## GPs working in Aboriginal Medical Services more commonly report seeing patients about the effects of non-medical issues on health

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<sup>†</sup>According to the Australian Bureau of Statistics' Socio-Economic Indexes for Areas (SEIFA) ranking 1 (most disadvantaged) versus 10 (least disadvantaged).

## 1.2 Mental health impact of national disasters and emergencies

General practice is the frontline for mental health services, as with physical health services.

GPs are essential in supporting individuals and communities before, during and in the aftermath of natural disasters and emergencies, such as the 2019–20 Australian bushfires and the COVID-19 pandemic.

In times of natural disaster and emergencies, the mental health impact on people and communities is significant. RACGP member feedback highlights that a higher percentage of patients experience mental health issues following disasters, which is often raised in consultations where mental health is not the primary presenting problem.

The mental health impact on communities is often protracted over time – in the context of COVID-19, this has been referred to as a ‘fourth wave’ comprising trauma, mental illness, post-traumatic stress, economic injury, burnout and more.<sup>9</sup>

One study found that five years after the 2009 Black Saturday fires in Victoria, 22% of people in high-impact communities were still reporting symptoms of mental health disorders at approximately twice the rate evident in low-impact communities.<sup>10</sup>

Modelling suggests that Australia could see a 13.7% increase in suicide deaths over the next five years, due to high rates of unemployment and reduced community connectedness. The modelling also highlights the likelihood of increased mental health-related emergency department (ED) presentations and self-harm hospitalisations during that time period.<sup>11</sup>

**🗨 Doubling the current growth rate in community mental health services capacity is forecast to prevent 15,955 mental health-related ED presentations, 1127 self-harm hospitalisations and 136 suicide deaths over the period 2020–25.<sup>11</sup>**

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**GPs are essential** in supporting individuals and communities before, during and in the aftermath of natural disasters and emergencies

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### 1.2.1 Mental health impact on patients

For the fourth year running, psychological issues are reported as the most common presentation in general practice (Figure 1).

The mental health of young Australians in particular has been impacted by COVID-19. Between February 2017 and April 2020, the proportion of people aged 18–34 experiencing severe psychological distress has increased much more than for older participants (Figure 3).

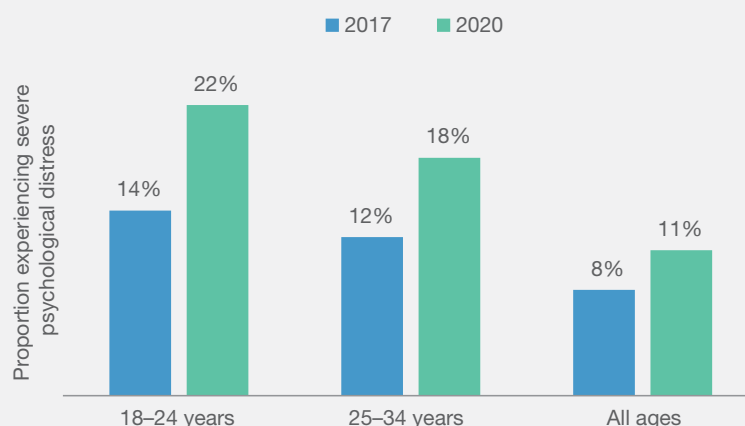
The impact of COVID-19 on mental health disproportionately affects younger Australians, as well as females.<sup>12</sup> Between 3 April and 3 May 2020, during the Australia-wide lockdown, the psychological impact of the pandemic was reported as moderate to severe in 35% of females compared to 19% of males for depression symptoms, and in 21% of females compared to 9% of males for anxiety symptoms.<sup>13</sup>

Prior to the COVID-19 pandemic, suicide rates among Aboriginal and Torres Strait Islander peoples were double those of other Australians, due to a history of intergenerational trauma, economic inequity and inadequate access to culturally appropriate health services. The pandemic is therefore likely to disproportionately affect the mental wellbeing of this group.<sup>9</sup>

It is vitally important that general practices and Aboriginal Community Controlled Health Services (ACCHSs) are adequately resourced to continue to provide timely, accessible and culturally appropriate mental health services. Primary healthcare teams are, and always will be, the most appropriate first point of contact to diagnose and treat symptoms early. They provide expert mental health care, and help patients manage any co-existing physical health problems.

ACCHSs are the preferred facilitators of suicide prevention activity to their communities, working in partnership with community members.<sup>14</sup>

**Figure 3.** The proportion of young Australians experiencing poor mental health has increased



Measure: Participant responses to the question 'How often in the last four weeks have you felt: 'nervous'; 'hopeless'; 'restless or fidgety'; 'so depressed that nothing could cheer you up'; 'that everything was an effort'; or 'worthless'

Base: Total respondents, n = 1745

Data sources: Life in Australia™ February 2017 and ANU poll April 2020, in: Biddle N, Edwards B, Gray M, Sollis K. Initial impacts of COVID-19 on mental health in Australia. Canberra: ANU Centre for Social Research and Methods, Australian National University, 2020.



### 1.2.2 Mental health impact on GPs

The emotional and psychological impacts of disasters on healthcare workers is known to change with time, as emerging events elicit different responses and coping mechanisms.<sup>15</sup>

In May 2020, one in two GPs (52%) reported at least one negative impact to their wellbeing during the COVID-19 pandemic. The most commonly reported impact was to work–life balance (33%), although more than one in four (27%) reported a deterioration in their mental health state (Figure 4).

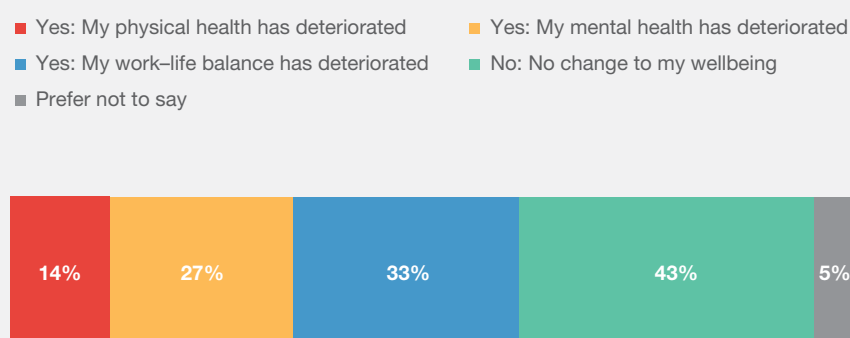
GPs aged <45 years are more likely to report a deterioration in their mental health than GPs aged ≥45 years (33% versus 23%). Female GPs are more likely to report a deterioration in their work–life balance than male GPs (35% versus 29%).<sup>5</sup>

One in three GPs rank their own wellbeing as one of the top three challenges that impacts their ability to provide care to patients during the COVID-19 pandemic (Figure 8, [section 1.4.2](#)).

# 52%

of GPs reported at least one negative impact to their wellbeing during the COVID-19 pandemic<sup>5</sup>

**Figure 4.** Impact of COVID-19 on GPs' wellbeing\*



\*Due to rounding, figures do not add up to 100%

Measure: GP responses to the question 'Have you experienced any negative impact on your own wellbeing as a result of COVID-19?' (select all that apply)

Base: Responses to survey question, n = 1782

Source: EY Sweeney, RACGP GP Survey, May 2020.

### 1.3 Issues requiring policy action

For the fourth year, Medicare Benefits Schedule (MBS) patient rebates are the most commonly identified priority area, with over 40% of GPs placing this in their top three priorities for policy action. Mental health remains the second most commonly identified area GPs want to see prioritised by the Australian Government (Figure 5). The need to better fund primary healthcare services is strongly reflected in responses, with 'Medicare rebates', and 'Creating new funding models for primary healthcare' being the most commonly identified 'number one' priority identified by GPs (Figure 5).

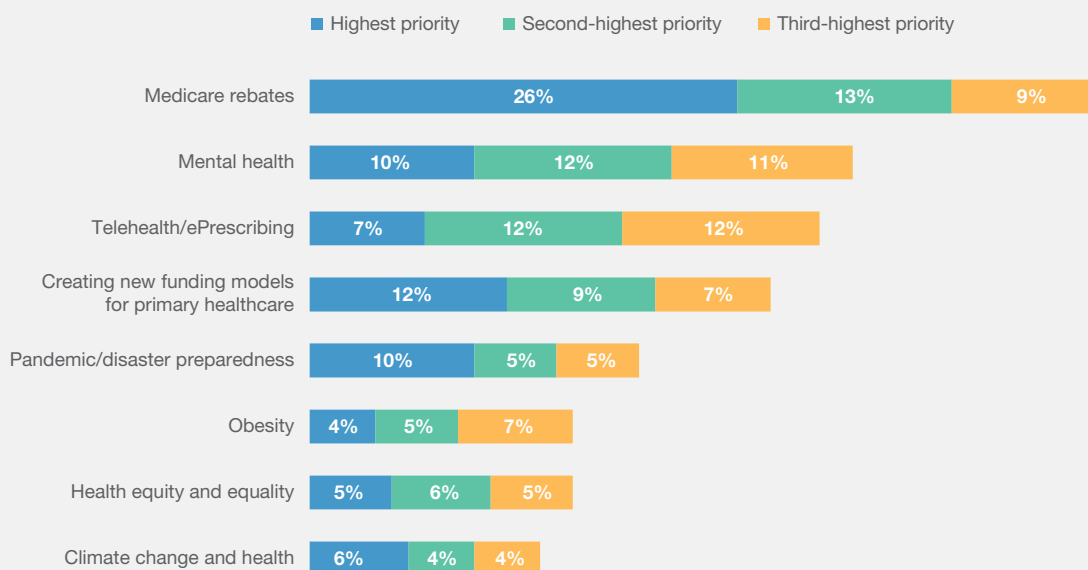
The impact of COVID-19 on general practice is seen with the appearance of telehealth and electronic prescribing (ePrescribing)<sup>‡</sup> as the third-ranked priority policy issue (Figure 5).

Other current events are reflected in the identified priorities, including 'Pandemic and disaster preparedness', and 'Climate change and health' (Figure 5). In 2020, these issues increased in concern to GPs, more than aged care or rural health services, which were identified as higher priorities in previous years.

GPs working in Aboriginal Medical Services were particularly concerned about social and cultural determinants of health and health equity and equality, with 33% and 31% respectively including these issues in their top two policy concerns. Aboriginal and Torres Strait Islander Health rounded out the top three (31%) policy concerns for these GPs.<sup>5</sup>

<sup>‡</sup>The introduction of ePrescribing was fast-tracked in 2020 to support remote delivery of healthcare to patients.

**Figure 5.** GPs want the Australian Government to prioritise primary care funding, mental health and telehealth\*



\*Showing the top eight out of 27 response options. Where data labels are not included, data represents less than 5%

Measure: GP responses to the question 'From the list below, please rank the three top priority health policy issues that you think the federal government should focus on.'

Base: Responses to survey question, n = 1782

Source: EY Sweeney, RACGP GP Survey, May 2020.

## 1.4 An issue in focus: Pandemic response

■ The Australian governments' combined response to the COVID-19 pandemic has yielded mostly positive results to date. Australia performed well in comparison to other similar countries around the world, successfully limiting the spread of COVID-19 and flattening the infection curve early in the pandemic. A combination of early case identification, physical distancing, public health measures and a reduction in international travel slowed the spread of the disease in Australia.<sup>16</sup>

GPs rapidly shifted care away from face-to-face visits and embraced telehealth, demonstrating the adaptability of general practice in the face of challenging situations. Telehealth helped to ensure the safety of patients and general practice staff and undoubtedly saved many lives. Australia's confirmed deaths due to COVID-19 is just 35 per million population, compared to other developed countries with rates of 100–600 per million population, or higher.<sup>§,17</sup>

While the governments' actions allowed time for health services to prepare and build capacity, later outbreaks in Victoria and the aged care sector revealed faults and limitations in the response.

The Royal Commission into Aged Care Quality and Safety hearing was told on 10 August 2020 that Australia's coronavirus aged care death rate is among the highest in the world, with 68% of COVID-related deaths in Australia occurring in nursing homes.<sup>18</sup>

The response to COVID-19 in the Aboriginal and Torres Strait Islander health sector was successful. More than four in 10 Aboriginal and Torres Strait Islander people have at least one chronic health condition which poses a significant health problem.<sup>19</sup> High rates of chronic health issues are a risk factor for COVID-19 mortality.<sup>20</sup> Aboriginal and Torres Strait Islander people are also 16 times more likely to be living in an overcrowded house than non-Indigenous Australians,<sup>21</sup> making physical distancing measures difficult to implement.

Decisive action was taken to reduce the impact of COVID-19 on remote Aboriginal communities, including community closures and designated biosecurity (travel restricted) areas across Australia. Aboriginal-led health services ensured that public health messages were communicated to communities in their local languages and in a culturally appropriate way. These actions resulted in this part of the population avoiding significant impact of COVID-19, with only 148 confirmed cases.<sup>†</sup> Only one case among Aboriginal and Torres Strait Islander people was notified from remote or very remote areas of Australia.<sup>1,22</sup>

These outcomes contrast with Indigenous communities in other countries; for example, the Navajo nation had the highest infection rate per capita in the United States at 2304.41 cases of COVID-19 per 100,000 people in June 2020.<sup>23</sup>

§Figures correct at 12 October 2020

†Figures correct at 27 September 2020

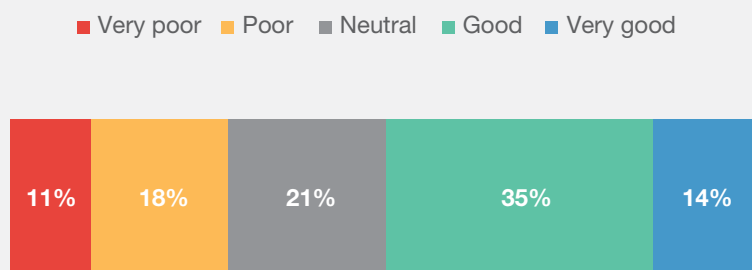
### 1.4.1 GP views of government responses

Survey responses showed a range of opinions among GPs about the Australian governments' responses to the pandemic. Many GPs are supportive of the federal government's response, with one in two ranking the response as 'good' or 'very good' for ensuring the safety of GPs and general practice teams (Figure 6).

Free text responses highlight that GPs are grateful to have the option to bill a Medicare item for phone and video consultations, work which had previously been unpaid, and that the increased bulk-billing incentive had been instrumental in allowing them to continue to provide care to patients during the pandemic.<sup>24</sup> In the midst of a pandemic, the need for telehealth was recognised quickly, and the government provided funding to support this model of care.

**In the midst of a pandemic,** the need for telehealth was recognised quickly, and the government provided funding to support this model of care

**Figure 6.** GPs view the federal government's COVID-19 response favourably for ensuring the safety of general practice teams\*



\*Due to rounding, figures do not add up to 100%

Measure: GP responses to the question 'How would you rate the federal government's pandemic response for ensuring the safety of GPs and general practice teams?'

Base: Responses to survey question, n = 1782

Source: EY Sweeney, RACGP GP Survey, May 2020.



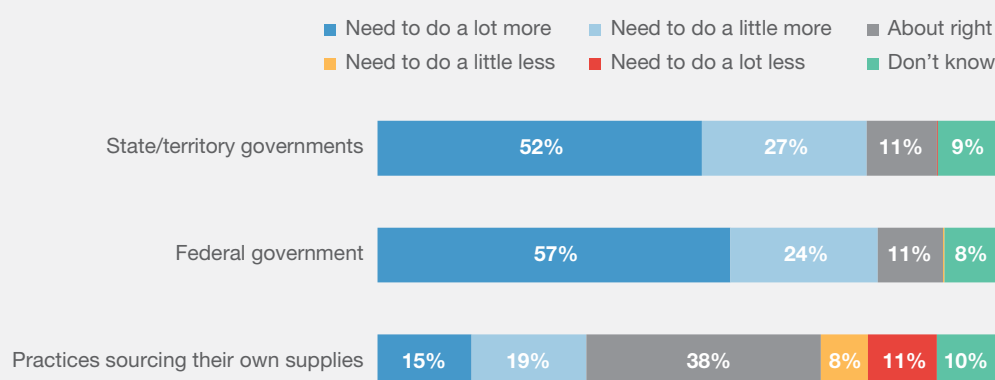
However, the pandemic has had a significant impact on the viability of general practices and the ability of GPs to provide holistic care to their patients. GPs report that more could have been done – both in the early stages of the pandemic and as it progressed – to involve GPs in pandemic planning and to support GPs in their role as frontline healthcare workers.

One of the greatest challenges facing general practice during the pandemic is access to appropriate personal protective equipment (PPE) (Figure 8).

Eight out of 10 GPs thought both the federal and state governments needed to do more to provide practices with PPE (Figure 7).

One of the greatest challenges GPs report during the pandemic is **access to PPE**

**Figure 7.** GPs want government help to source personal protective equipment during the pandemic\*



\*Due to rounding, figures do not add up to 100%

Measure: GP responses to the question 'Below is a list of groups who can be seen to be responsible for providing practices with personal protective equipment (PPE) during a public health emergency. For each group please indicate how you feel they are currently acting in ensuring PPE is available to practices.'

Base: Responses to survey question, n = 1782

Source: EY Sweeney, RACGP GP Survey, May 2020.

### 1.4.2 Challenges faced by GPs during the pandemic

COVID-19 created many challenges for GPs and the delivery of general practice services, from changes in patient presentation patterns; impacts on GPs' personal wellbeing; financial, employment and business impacts; to the need to rapidly adapt to new models of care. These matters are discussed throughout the report.

#### Inability to provide usual care to patients

The most cited challenge for GPs during the COVID-19 pandemic is their inability to provide usual care to patients, with one in two (52%) indicating this as one of their top three challenges (Figure 8). This is likely due to a combination of the challenges inherent in a non-face-to-face model of care (discussed further in [section 2.3](#)), combined with the decreased number of patients presenting for

usual care when they were being encouraged to isolate at home (Figure 9).

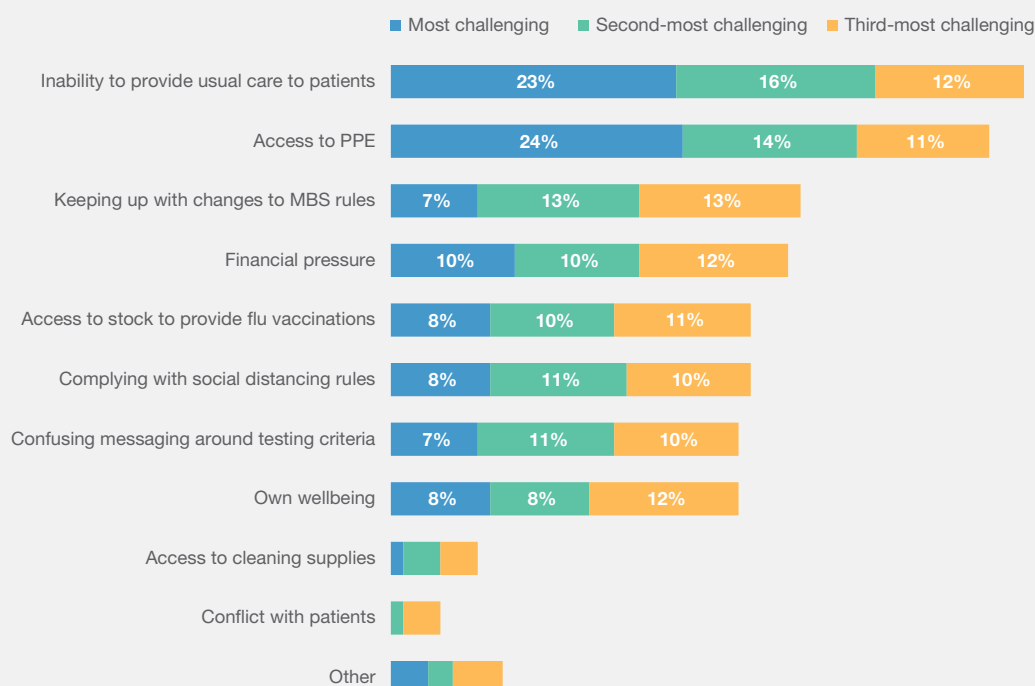
In 2019–20, 87.4% of Australians visited a GP – the lowest rate since 2014–15.<sup>1</sup>

GPs who work in Aboriginal Medical Services are more likely to cite inability to provide usual care to patients as one of their top three challenges (67%).<sup>5</sup>

Total MBS claims for chronic disease management items, such as care plans, fell dramatically at the start of the pandemic, despite the creation of telehealth equivalents (refer to [section 2.3](#) for further discussion).

GP chronic disease management items (provided both face-to-face and via telehealth) claimed in April 2020 fell by 15% from the previous month, and by 4% from the same period in 2019 (Figure 9).

**Figure 8.** An inability to provide usual care, and access to personal protective equipment, are the top challenges for GPs during COVID-19\*



\*Where data labels are not included, data represents less than 5%

Measure: GP responses to the question 'What challenges are you experiencing which impact your ability to provide care to patients as a result of COVID-19?'

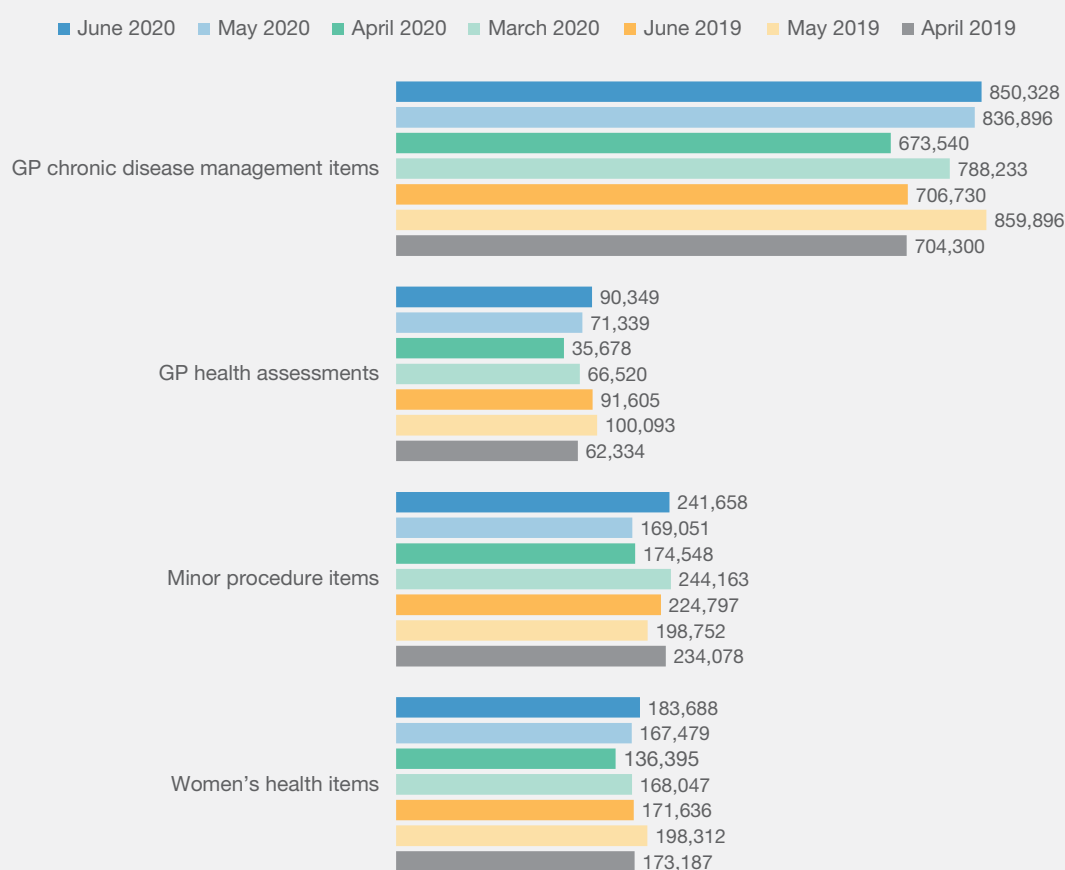
Base: Responses to survey question, n = 1782

Source: EY Sweeney, RACGP GP Survey, May 2020.

Consultation types that did not have telehealth equivalents saw the most dramatic decreases at the start of the pandemic. Claims for GP health assessments in April fell by 46% from the previous month, and by 43% compared to the same period in 2019. Minor procedure items fell by 29% from the previous month, and by 25% compared to the same period in 2019 (Figure 9).

The picture began to normalise from May 2020. Chronic disease management items, women's health, and health assessments all saw increases, although the number of presentations across all categories remained lower than in the same month in 2019. Minor procedure items saw the smallest recovery in number of presentations (Figure 9).

**Figure 9.** MBS data shows the impact of the pandemic on GPs' ability to provide usual care



Measure: GP chronic disease management items (MBS items 721, 723, 732, 729, 731, along with their COVID-19 telephone and video equivalents)


GP health assessment items (MBS items 701, 703, 705, 707, 715 and 699)

Minor procedure items (MBS items 30071, 30072, 30192, 30196, 30202, 30064, 30061, 30219, 41500, 30026, 30032, 30029, 30035, 47904, 47915, 47916, 32147, 32072 and 30003)

Women's health items (MBS items 73806, 16500, 16591, 14206, 30062 and 35503)

Billed in April 2019, May 2019, June 2019, March 2020, April 2020, May 2020, June 2020

Data source: Services Australia. MBS item statistics reports. Available at [http://medicarestatistics.humanservices.gov.au/statistics/mbs\\_item.jsp](http://medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp) [Accessed 15 August 2020].

More than one in two patients surveyed by the Continuity of Care Collaboration reported that they had delayed or avoided a medical appointment in the three months leading up to May 2020.<sup>25</sup> Reasons for avoiding regular health checks included concerns about taking public transport to the practice, difficulty using telehealth, and concerns they might be breaking lockdown rules.<sup>25</sup> Patients also reported that they were worried about their own safety (90%), ie through coming into contact with people with COVID-19 when visiting their doctor, and that they thought health services might be too busy to see them for routine care (36%).<sup>25</sup> 

### Access to personal protective equipment

The second most commonly cited challenge, by 48% of GPs, is difficulty accessing adequate PPE including masks, gloves, eye protection and gowns (Figure 8).

Healthcare workers rely on PPE to protect themselves and their patients from being infected and infecting others. Supply chain disruptions caused by increased global demand for PPE, and some instances of panic buying or misuse, meant GPs were not always able to obtain adequate supplies of PPE through normal distribution channels. Prices surged to privately purchase PPE, causing increased financial pressure on practices.<sup>26</sup> Although masks were distributed to practices through Primary Health Networks, supplies were initially sporadic, and gowns and other PPE were not supplied.

One study indicated that 30% of healthcare workers resorted to using non-traditional or non-vetted forms of PPE, and 70% of healthcare workers needed to ration their use of PPE.<sup>27</sup>


In Victoria during the month of August, an average number of 33.7 new cases among healthcare workers were diagnosed each day. At least 69% of all healthcare workers who were infected with COVID-19 acquired it in the workplace, including hospitals, aged care services, and general practice.<sup>28</sup>

### Other challenges

By the end of July, there had been seven waves of Medicare reform related to telehealth item numbers. One in three GPs report that constantly changing messaging around new Medicare telehealth item number usage (33%), and COVID-19 testing criteria (29%), were significant stressors at the start of the pandemic. Financial pressure, complying with social distancing rules, and own wellbeing are ranked similarly highly as challenges which impact on GPs' ability to provide care (Figure 8).

GPs who work in Aboriginal Medical Services are more likely to cite difficulty complying with social distancing rules as one of their top three challenges (43%) compared to GPs working in other locations (29%).<sup>5</sup>

GPs also report that obtaining enough stock to supply flu vaccinations for their patients was a significant challenge, despite advice issued to the public that it was imperative to get vaccinated earlier this year. In a poll of over 1000 RACGP members in late April 2020, 54% reported they were unable to access enough stock to provide influenza vaccinations to their patients.<sup>29</sup>

 It is not yet known what long-term impacts COVID-19, or the temporary decrease in patients presenting for usual care, will have on the health of the population.

It is more important than ever that GPs are able to provide continuity of care for patients with chronic diseases. Cardiac disease, diabetes and chronic respiratory conditions are the most common comorbid conditions among hospitalised COVID-19 cases.<sup>22</sup> Of hospitalised COVID-19 cases in Australia, 55% reported one or more comorbid conditions.<sup>22</sup> Having one or more comorbid conditions was found to be significantly associated with increased odds of hospitalisation and death among COVID-19 cases aged ≥50.<sup>20</sup>

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It is more important than ever that GPs are able to provide continuity of care for patients with **chronic diseases**

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## CHAPTER 2


# General practice access

## 2.1 Patient access to, and experience of, general practice

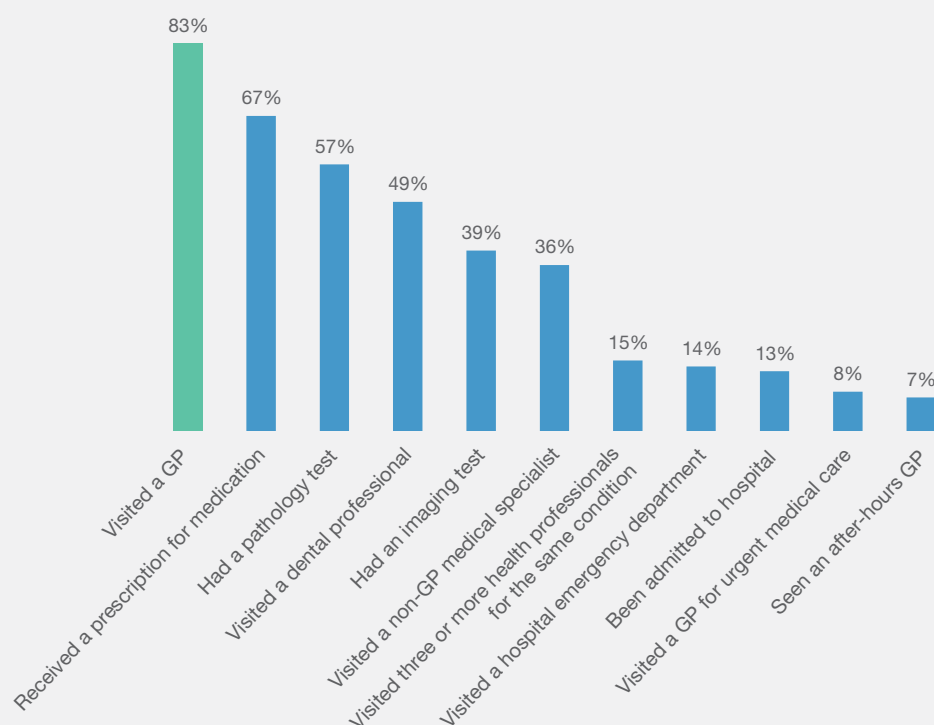
There are 8147 general practices in Australia, 84% of which are accredited.<sup>30</sup>

Australians access general practice more than any other part of the health system, with almost 90% of the population visiting their GP at least once each year.<sup>1</sup>

Patients report they visit their GP more than they receive prescriptions, have pathology or imaging tests, or see other specialists (Figure 10). 

 Each visit to a GP directly impacts on a patient's health and wellbeing. There is no such thing as a low-value GP presentation. A visit to a GP provides an opportunity for the GP to build the patient-doctor therapeutic relationship and offer health education, screening and advice.

**Figure 10.** Patients see their GP more than any other health professional



Measure: Patient responses to the question 'Since <month> last year, have you [insert category]?'

Base: Total survey responses, n = 28,719

Data source: Australian Bureau of Statistics. Patient experiences in Australia: Summary of findings, 2018–19. Cat. no. 4839.0. Canberra: ABS, 2019.

In 2018–19, less than 1% of patients reported they needed to, but did not, see a GP at all in the previous 12 months, supporting the idea that general practice is very accessible to patients.<sup>31</sup>

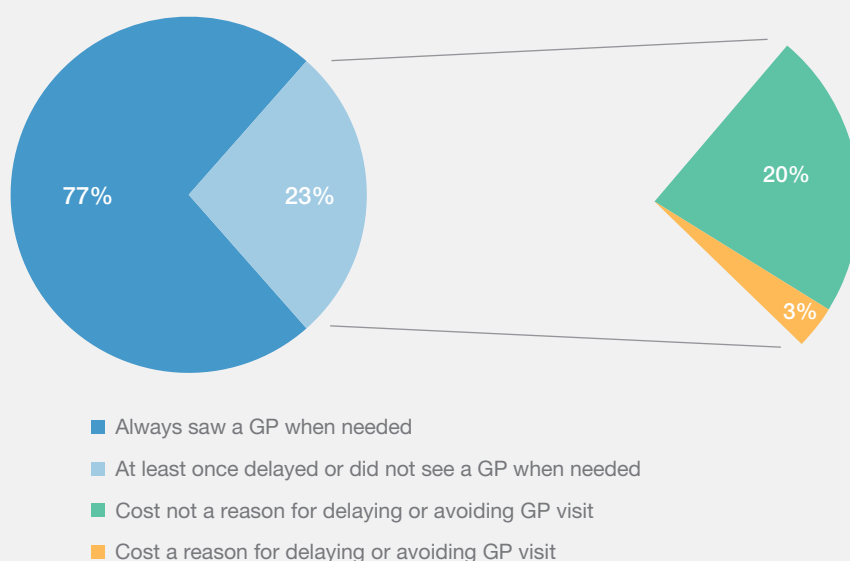
Less than 23% of people reported that they had at least once delayed or avoided seeing a GP when needed – the lowest rate in six years. The most common reasons for delaying or not booking an appointment with a GP when needed are non-cost related, such as the patient being too busy or the preferred GP being unavailable (Figure 11).

GPs responding to the MABEL survey indicated that the median wait time to see a GP at their practice is less than 24 hours, although this increased to two days where the patient specified one preferred GP.<sup>32</sup>

Only 3% of patients cite cost as a reason to delay seeing their GP (Figure 11). By comparison, almost 7% of patients report they delayed or did not get prescribed medication due to cost.<sup>31</sup>

Less than 1% of patients reported they needed to, but did not, **see a GP**<sup>31</sup>

**Figure 11.** Cost is rarely a reason patients delay seeing their GP



Measure: Patient responses to the question 'Thinking about when you needed to see a GP but didn't, what was the main reason you did not go?'

Base: Total survey responses, n = 28,719

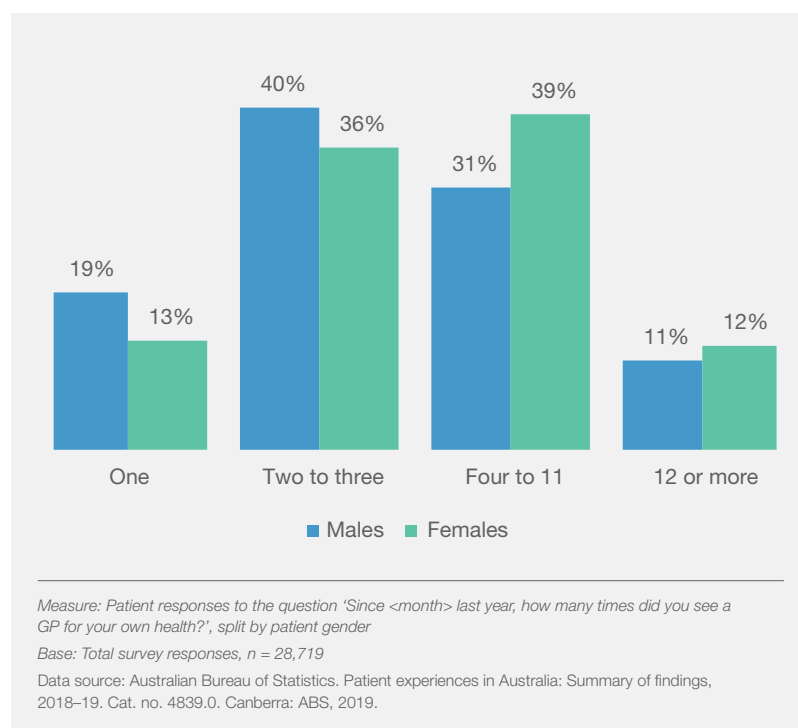
Data source: Australian Bureau of Statistics. Patient experiences in Australia: Summary of findings, 2018–19. Cat. no. 4839.0. Canberra: ABS, 2019.

Almost half of Australians who needed to see a GP report that they visited a GP four or more times during the year (Figure 12). This rate has remained steady over the past four years.<sup>31</sup>

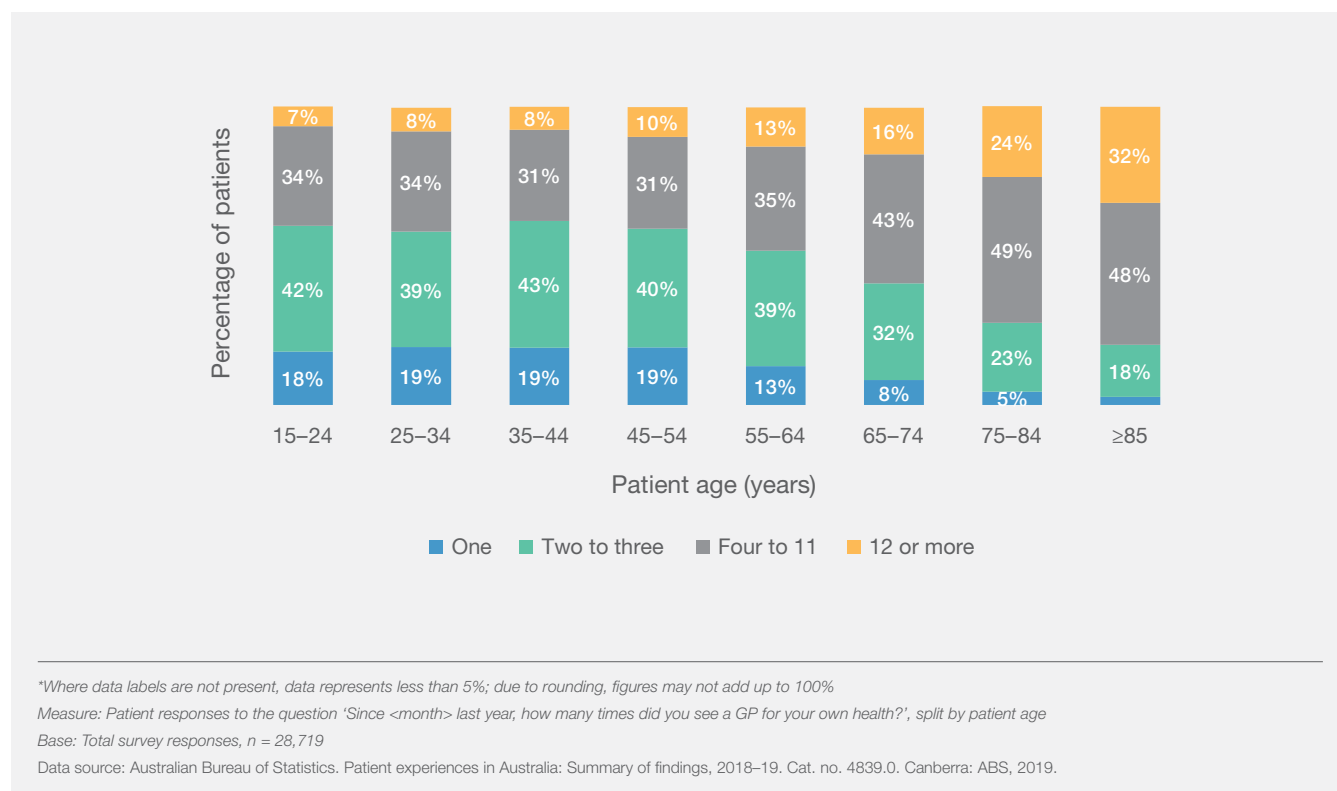
Patient age and gender have an effect on frequency of presentations, with females seeing their GP more often than males, and older people visiting their GP more regularly than younger people.

Of patients who visited a GP, one in two females (52%) visited their GP four or more times in 2018–19, compared to two in five (41%) of males. Fifty-eight per cent of people aged ≥55 visited their GP four or more times in 2018–19, compared to 40% of people between 15 and 54 years of age (Figure 12, Figure 13).

**Figure 12.** Most patients visit their GP multiple times during the year



**Figure 13.** Older patients visit their GP more frequently than younger patients\*

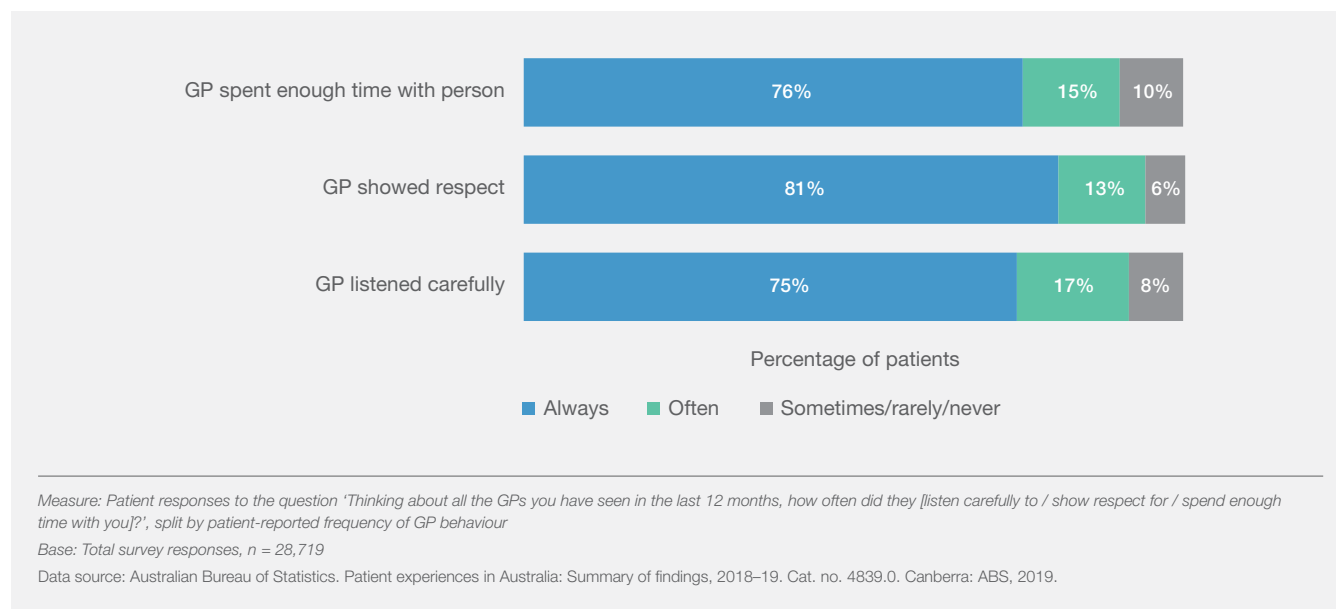


Patients consistently report very positive experiences with their GP. Nine in 10 patients report their GP always or often spends enough time with them. Almost 95% of patients report that their GP always or often shows respect, and more than 90% report that their GP listens carefully (Figure 14).

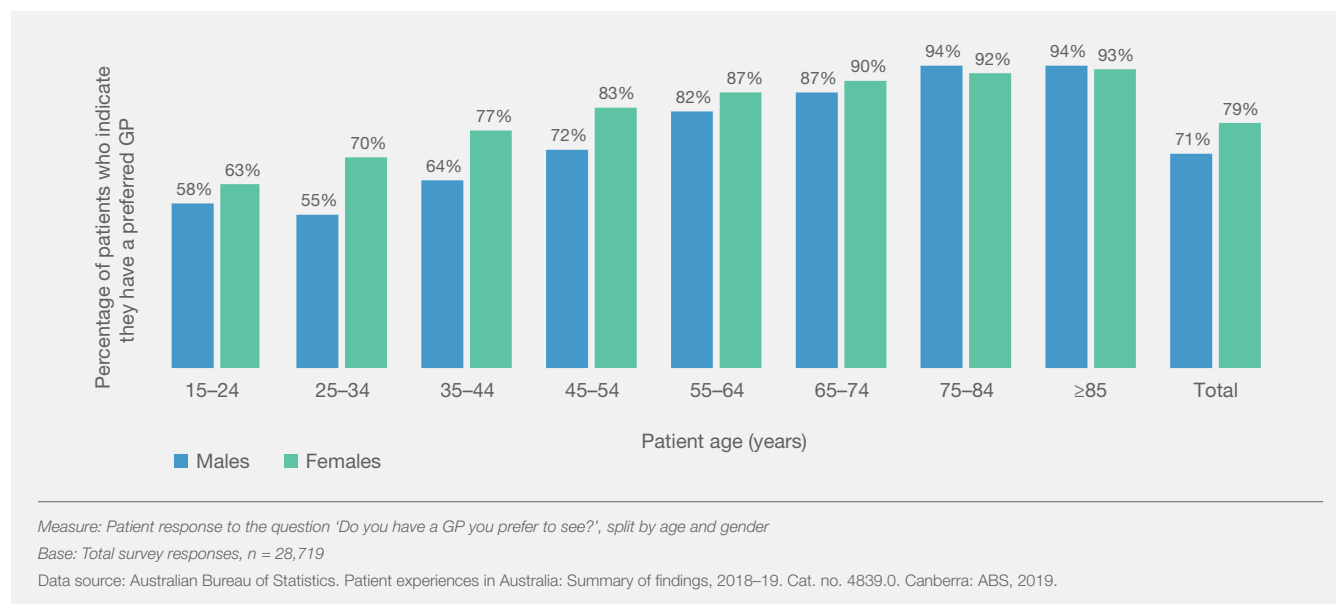
Older patients are more likely to report a positive experience with their GP than younger patients.<sup>31</sup>

In 2018–19, the number of people who reported that they had a preferred GP declined by 1.8% from the previous year, to 75.5%. As with previous years, younger patients and male patients are less likely to report that they have a preferred GP (Figure 15).

**Figure 14.** Patients have positive experiences when they see their GP



**Figure 15.** Older people and females are more likely to have a preferred GP



## 2.2 GP workforce

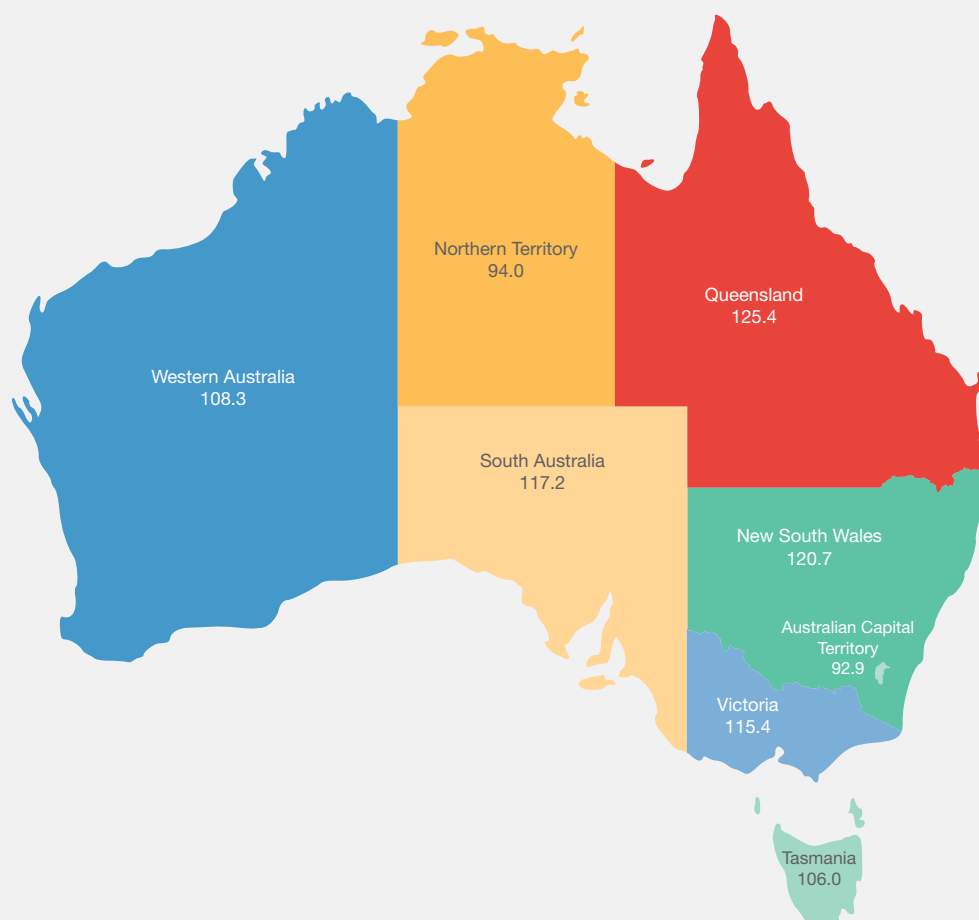
### 2.2.1 Location

GPs are the most accessible medical professionals in Australia, and provide the backbone of primary healthcare. There are more full-time equivalent (FTE) GPs in all remoteness areas than any other primary healthcare professional, with the exception of Aboriginal and Torres Strait Islander health workers in very remote areas, and registered nurses.<sup>33,34</sup>

Nationally, the average number of FTE GPs per 100,000 population is 117.7.<sup>34</sup> Figure 16 shows that many states have less than this national average number of GPs, with the ACT and the Northern Territory having the lowest number (Figure 16).

Nationally, the number of FTE GPs per 100,000 population has increased by 4% since 2017. However, Tasmania and the Northern Territory have seen much lower rates of increase, and the number of FTE GPs per 100,000 for the Tasmanian population has declined by 0.4% since 2018.<sup>34</sup>

**Figure 16.** The GP-to-patient ratio is lowest in the ACT, Northern Territory, Tasmania and Western Australia



Measure: Full-time equivalent (FTE) GPs per 100,000 population, by state/territory, 2019

Base: Total number of GPs in 2019 (head count),  $n = 37,472$

Data source: Department of Health. GP workforce statistics – 2014 to 2019. Canberra: DoH, 2020.

Please note that this data cannot be compared to the data included in the 2019 *General Practice: Health of the Nation* report, due to changes in the way the Department of Health reports GP workforce data.

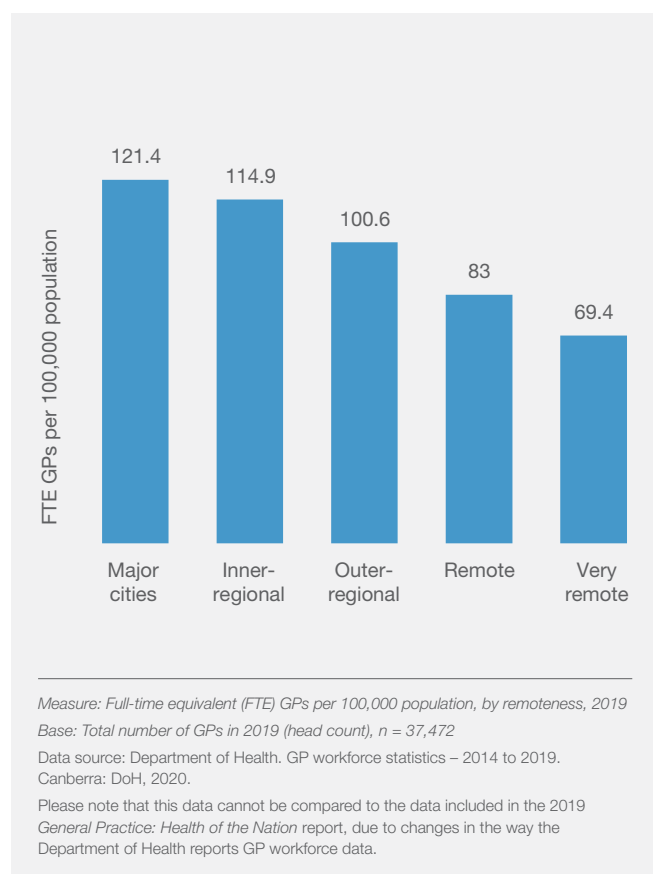
The concentration of GPs working in major cities is higher than the national average, whereas regional, rural and remote areas all have below average numbers (Figure 17).

Over the past five years, the proportion of the GP workforce choosing to work in rural and remote areas has not changed significantly. Since 2014, the proportion of GPs working in major cities has increased by 1.3%, to 74.5% in 2019. The proportion of GPs working in remote and very remote areas has declined by 0.1% over the same period.<sup>34</sup>

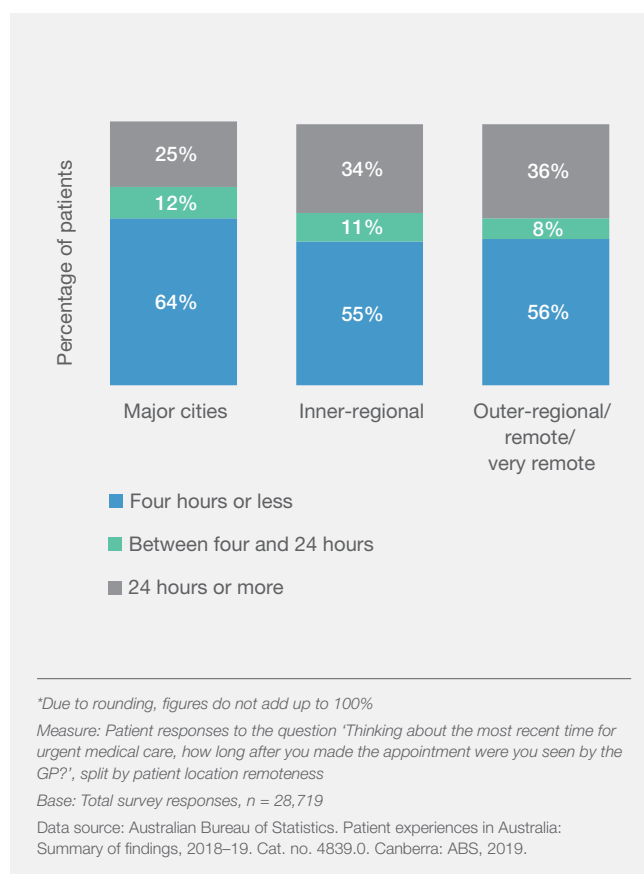
Patient experience data shows that there are longer waits to see a GP for patients outside major cities. While patients in major cities report that in 75% of cases they were able to see a GP within 24 hours for their most recent need for urgent care, this figure drops to 64% for patients in outer-regional, remote and very remote areas (Figure 18).

A small proportion of patients (1.2%) in outer-regional, remote and very remote areas report that they needed to but did not see a GP at all during the previous 12 months. This is a higher rate than reported by patients in major cities (0.6%).<sup>31</sup> Compared to the previous year, each region saw slight increases in reported wait times for a patient's most recent urgent care episode.<sup>31</sup>

**Figure 17.** There are fewer GPs in remote locations than in major cities of Australia



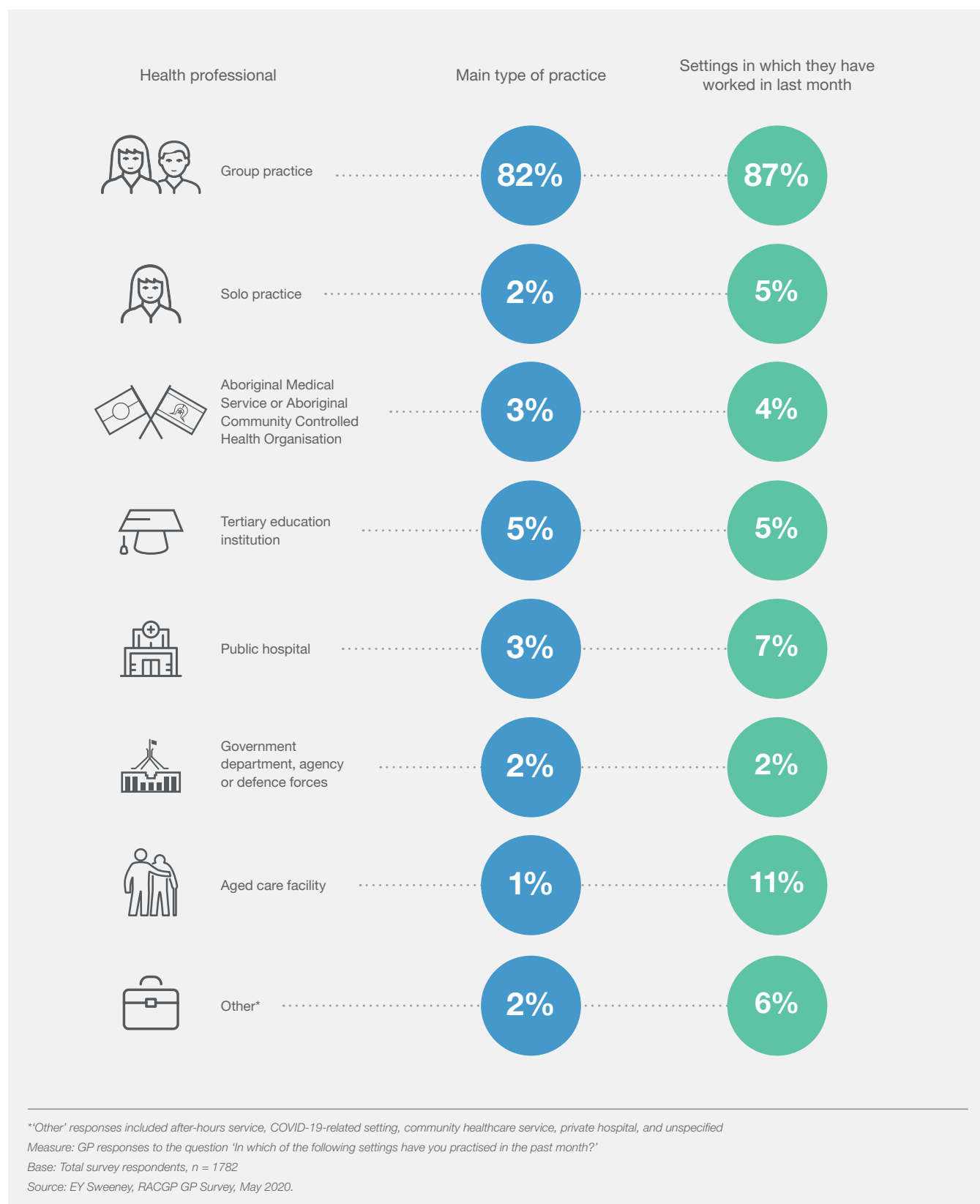
**Figure 18.** Patients in outer-regional, remote and very remote areas report longer waits to see a GP\*





## 2.2.2 Place of work

**Figure 19.** GPs work predominantly in group practices



### 2.2.3 Demographics

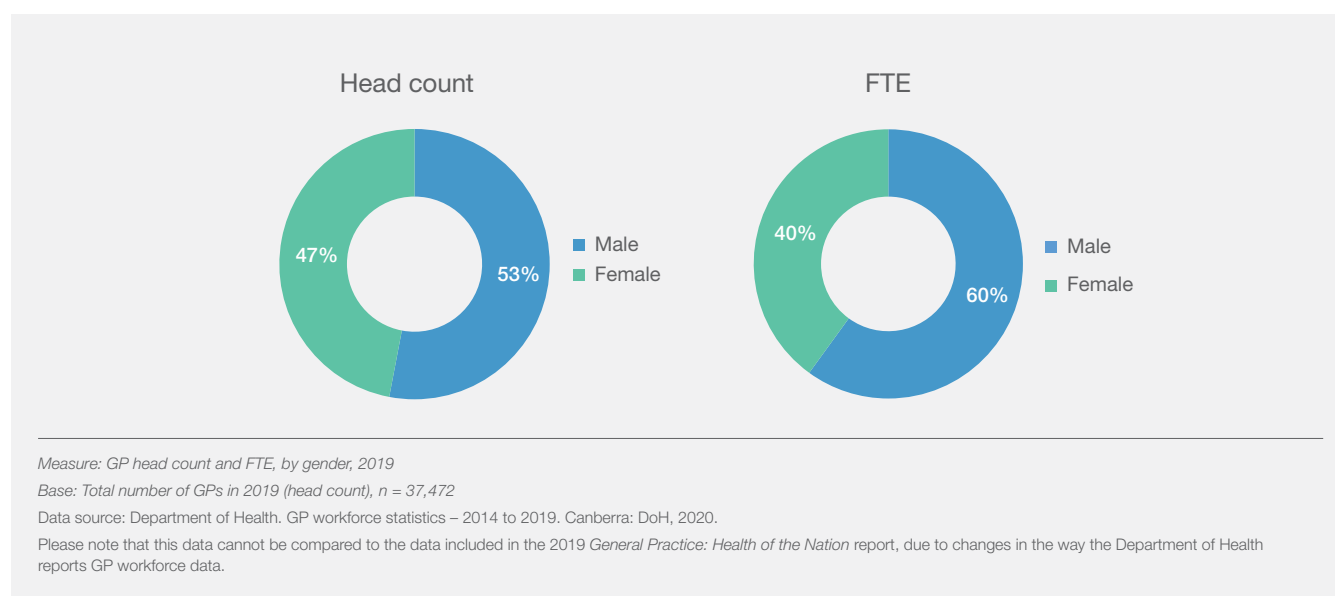
#### Gender

There are more male GPs than female GPs (Figure 20). The proportion of the GP workforce that is female is slowly increasing, and has grown by 4% since 2014.<sup>34</sup>

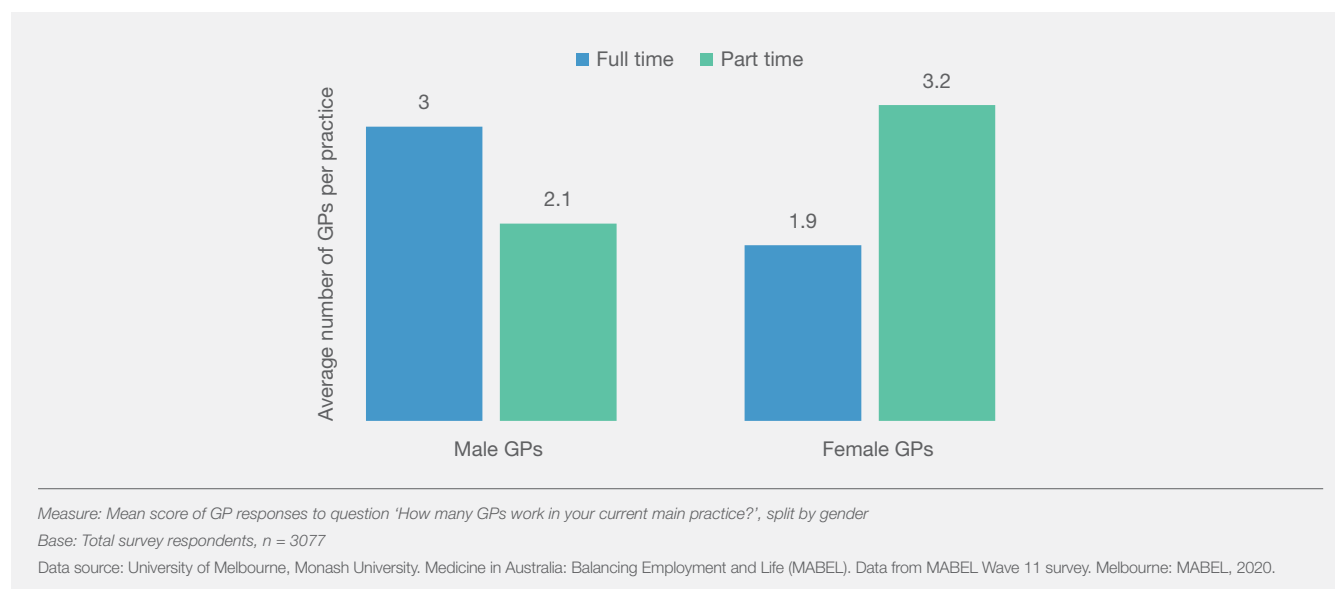
As in previous years, female GPs are more likely to work part time than their male colleagues (Figure 21).

Both male and female GPs report lower overall hours of work compared to the previous year (median of 37 hours, compared to 38 hours in 2017).<sup>32</sup> Further, the mean consultation length for female GPs is 2.2 minutes longer than the mean consultation length for male GPs.<sup>32</sup> This combination of factors could mean a larger head count of GPs will be needed in future to provide the same level of patient access.

**Figure 20.** There are more male GPs than female GPs in the workforce



**Figure 21.** Female GPs are more likely to work part time



## Age

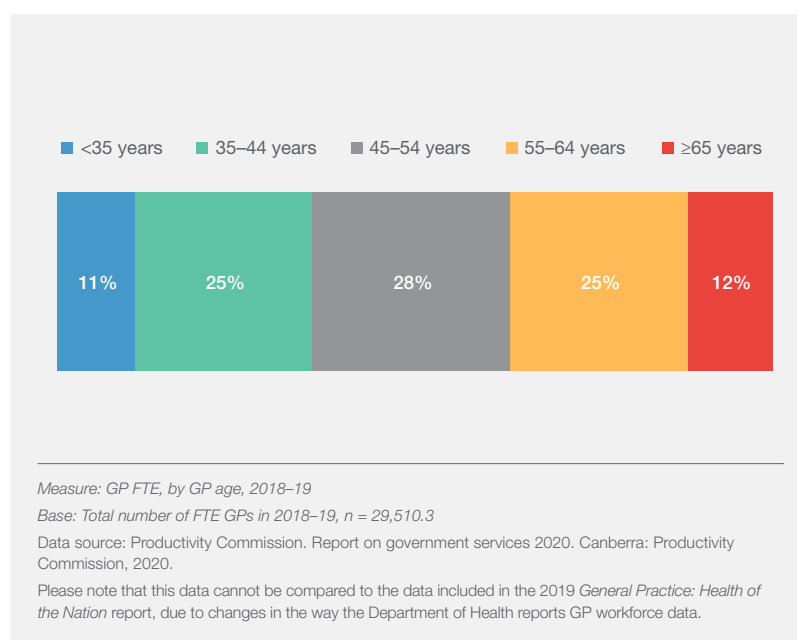
While the GP workforce is distributed across age groups, over one-third (37%) of GPs are aged  $\geq 55$  years (Figure 22).

## Country of basic qualification

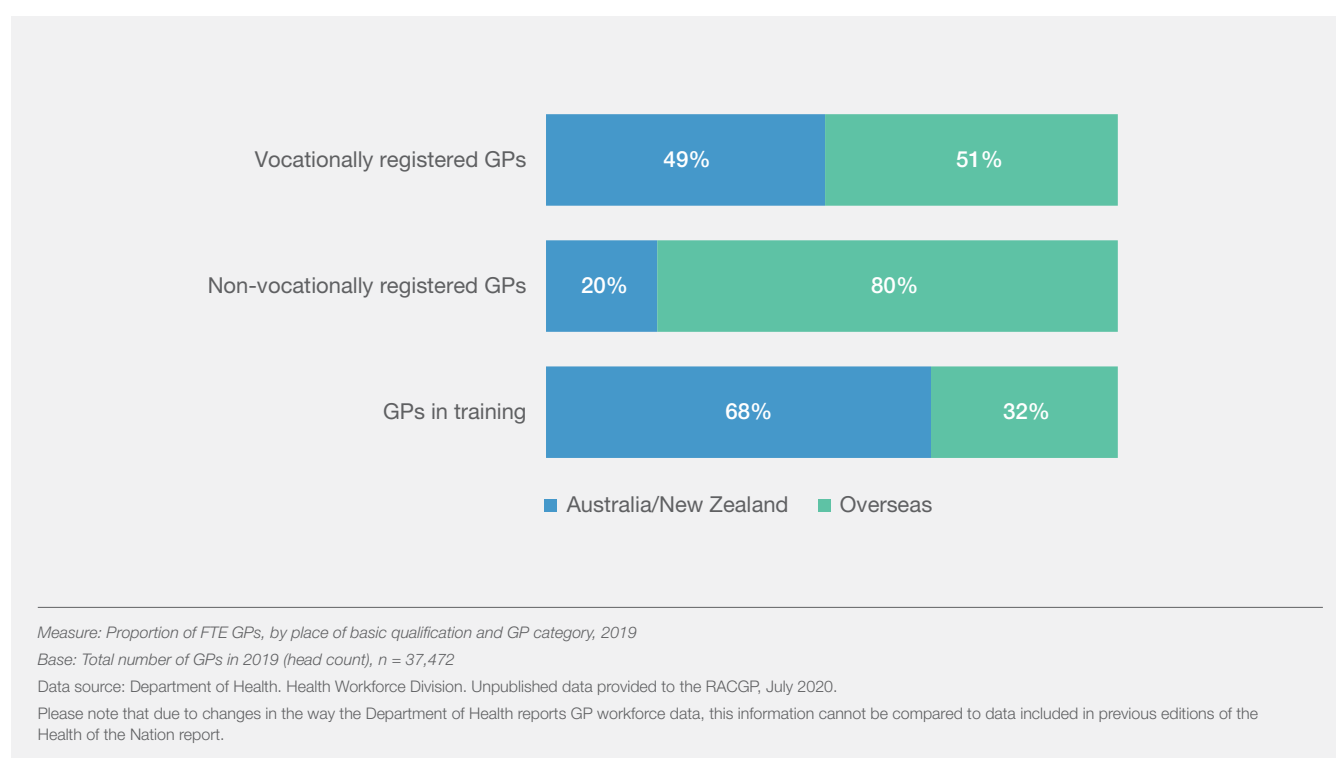
In 2019, 52% of the FTE GP workforce had obtained their basic qualification in a country other than Australia or New Zealand (Figure 23). This proportion increased from 40% of full-time service equivalent GPs in 2009–10, and 32% in 2004–05.<sup>35</sup>

The majority of vocationally registered and non-vocationally registered GPs in Australia obtained their basic qualifications overseas (Figure 23).

**Figure 22.** GPs are distributed across age groups



**Figure 23.** A higher proportion of GPs attained their basic qualification overseas than in Australia or New Zealand



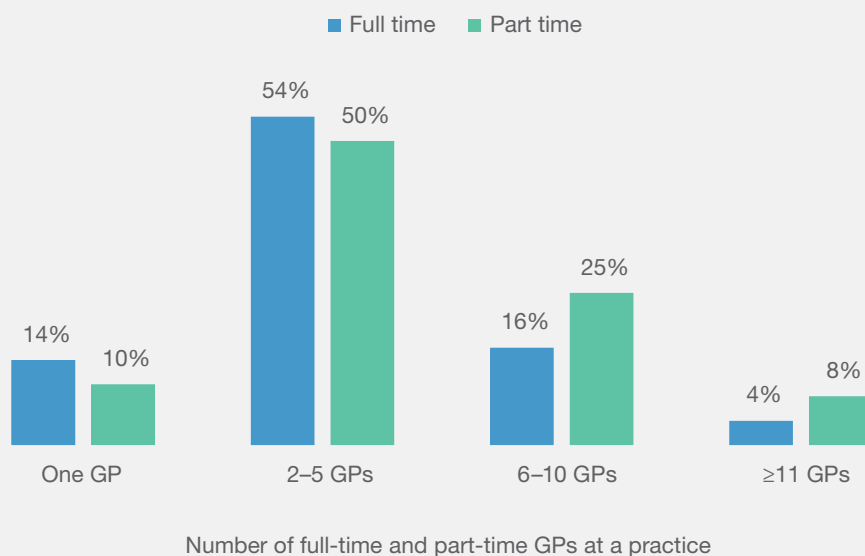
### 2.2.4 General practice teams

General practices and their teams provide more than 160 million services each year.<sup>1</sup> In addition to GPs, practices may employ any number of other healthcare professionals to ensure that patients have access to comprehensive healthcare, coordinated by the general practice team. 📄

📄 Primary care has been at the forefront of Australia's response to the COVID-19 pandemic, providing usual care as well as responding to the emergency situation. General practices remain open for business for the duration of the pandemic, with almost 97% reporting that they continue to offer patients face-to-face consultations.<sup>24</sup> This is in contrast to other services in the community that closed early in the pandemic, such as hospital outpatient clinics.

General practices and their teams provide more than **160 million services** each year<sup>1</sup>

**Figure 24.** The number of GPs at each practice varies\*

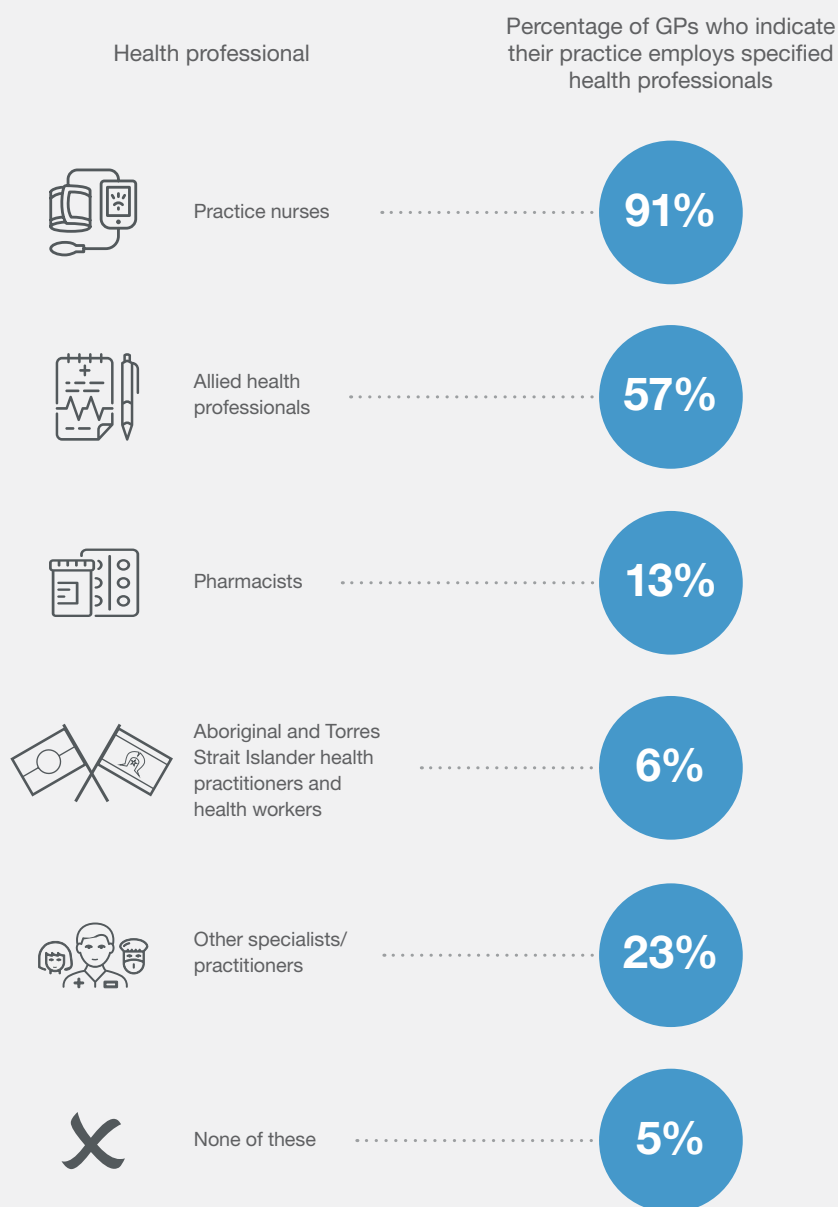


\*12% of respondents worked in a practice with no full-time GPs, and 8% of respondents worked in a practice with no part-time GPs.

Measure: GP responses to the question 'Including yourself, typically how many individual GPs work in a full-time or part-time capacity at your main practice?'

Base: Responses to survey question, n = 1782

Source: EY Sweeney, RACGP GP Survey, May 2020.

**Figure 25.** Patients can access a range of other services when they visit their GP

Measure: GP responses to the question 'What other individual health workers or professionals are employed by or work in your main practice?'

Base: Responses to survey question, n = 1782

Source: EY Sweeney, RACGP GP Survey, May 2020.

Members of a general practice team report that they experienced the effects of COVID-19 in different ways.

All staff are faced with concerns for their own safety, as well as the safety of their loved ones, which they balanced with the need to do their job and provide care to patients.

Practice owners and practice managers take on significant responsibility to ensure that safe processes and procedures are in place to protect their staff. Early in the pandemic, constantly changing guidelines around appropriate use of PPE, new Medicare item numbers, COVID-19 testing criteria and social distancing were all added stressors for an already difficult time.

The role of receptionists changed due to the pandemic. Receptionists rely on practice owners and practice managers to assist them to implement safe practices in the workplace. Many receptionists effectively provide health and safety advice to patients and the community, including quasi-triage and referrals to appropriate services. Member feedback has highlighted that receptionists face significant concerns about contracting COVID-19 due to their close proximity to unwell patients in clinic waiting rooms.

In a poll of more than 1000 primary care nurses about the impact of COVID-19 on their employment, almost one-third said their paid hours had been reduced, and 7% had lost their jobs.<sup>36</sup>

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**General practice staff faced concerns for their own safety, and the safety of their loved ones, but continued to provide care to patients**

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### 2.2.5 Aboriginal and Torres Strait Islander primary healthcare

Organisations providing Aboriginal and Torres Strait Islander primary health services employ about 4500 FTE health staff, nearly half (47%) of whom identify as Aboriginal and/or Torres Strait Islander.<sup>38</sup>

Nurses and midwives are the most common type of health worker, followed by Aboriginal and/or Torres Strait Islander health workers and practitioners, and GPs (Figure 26).

These services had contact with 483,000 clients to provide 3.6 million episodes of care in 2017–18.<sup>39</sup> This increased to almost 500,000 clients and 3.7 million episodes of care in 2018–19.<sup>38</sup>

In 2018 there were 74 Aboriginal and Torres Strait Islander GPs registered and employed, an increase from 50 in 2015.<sup>37</sup>

Nearly 11,000 members have joined the RACGP Aboriginal and Torres Strait Islander Health (the Faculty) – demonstrating active interest and engagement. In 2020, the RACGP is celebrating the 10-year anniversary of the foundation of the Faculty. The Faculty supports the general practice workforce and works to improve Aboriginal and Torres Strait Islander health outcomes in the areas of education and training, innovation and policy, advocacy and collegiality.

**Figure 26.** GPs are an important part of Aboriginal and Torres Strait Islander primary health services



Measure: Number of FTE health workers employed by Aboriginal and Torres Strait Islander primary health services in 2018–19

Data source: Australian Institute of Health and Welfare. Indigenous primary health care: Results from the OSR and nKPI collections. Cat. no. IHW 227. Canberra: AIHW, 2020.

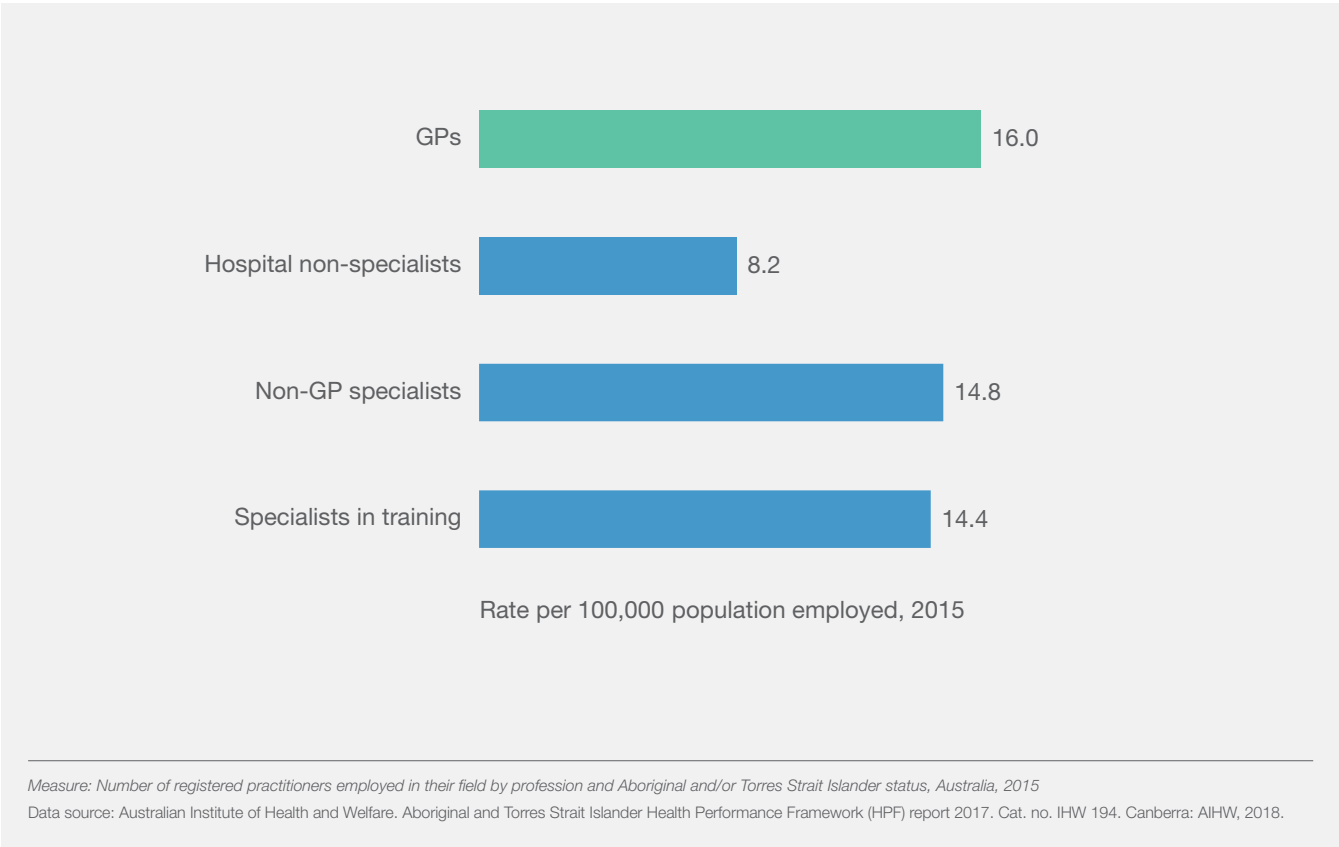
While there are more Aboriginal and Torres Strait Islander GPs than other medical specialists, Aboriginal and Torres Strait Islander people remain significantly under-represented in the health workforce (Figure 27). This potentially contributes to reduced access to health services for the broader Aboriginal and Torres Strait Islander population.

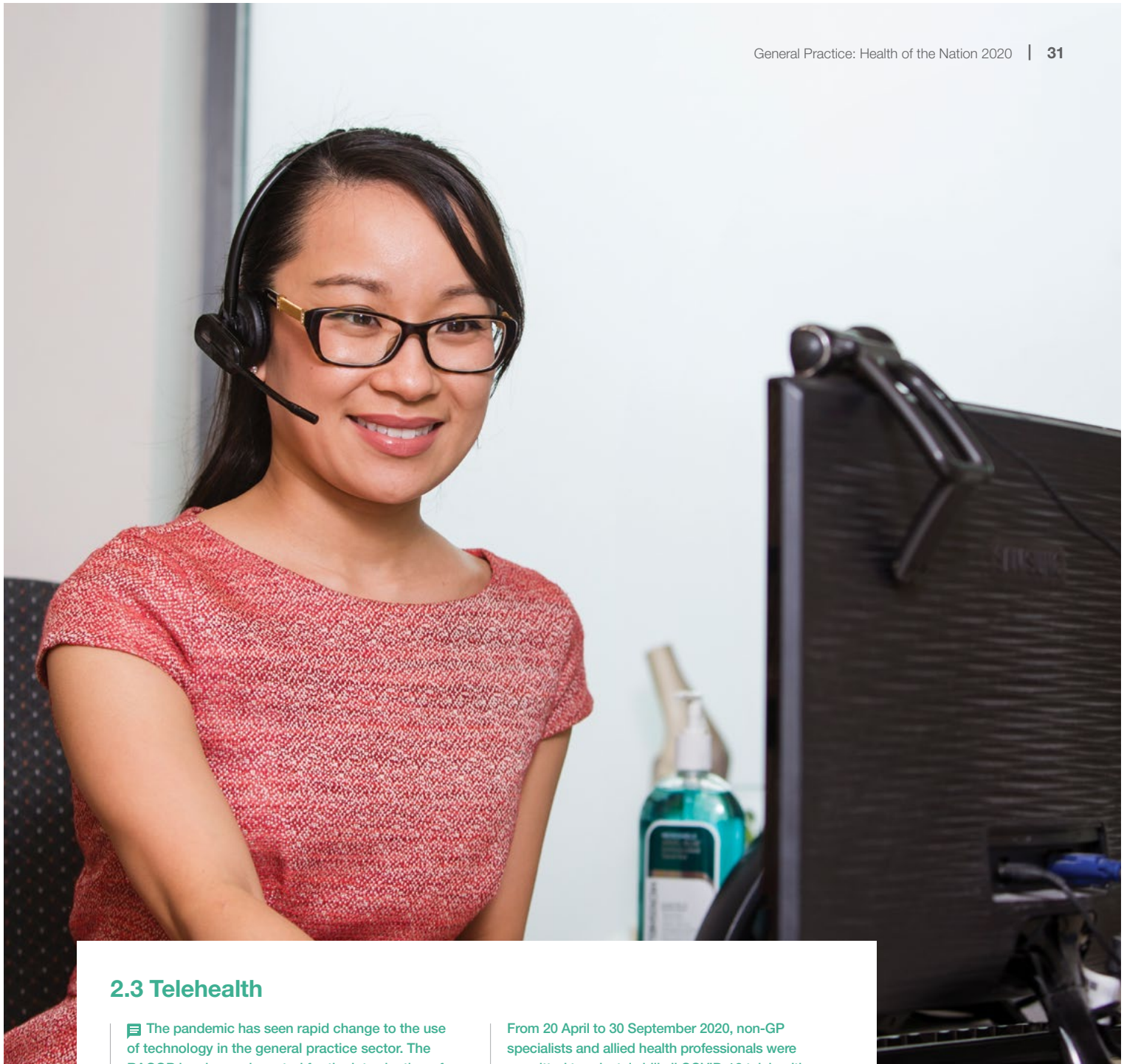
The future Aboriginal and Torres Strait Islander general practice workforce is discussed in [section 6.5](#).

Almost one in five Australian General Practice Training (AGPT) Program registrars report they were currently training or had already completed a training post in an Aboriginal Medical Service or Aboriginal Community Controlled Health Service. Aboriginal and Torres Strait Islander health is the second most common area in which registrars undertake extended skills, advanced rural skills or advanced specialised training.<sup>40</sup>

**Aboriginal and Torres Strait Islander** people are under-represented in the health workforce

**Figure 27.** More Aboriginal and Torres Strait Islander medical graduates choose general practice than other specialties





## 2.3 Telehealth

■ The pandemic has seen rapid change to the use of technology in the general practice sector. The RACGP has long advocated for the introduction of telehealth (phone and video) consultation items to complement face-to-face care in general practice.

From 13 March 2020, Medicare Benefits Schedule (MBS) telehealth items were made available to support GPs and other doctors, nurses, midwives and allied health professionals to provide services by phone or video to all Australians. On average, more than 1.1 million GP telehealth services were provided each week in April 2020, declining to one million per week the following month, and fewer than one million per week in June.<sup>41</sup>

From 20 April to 30 September 2020, non-GP specialists and allied health professionals were permitted to privately bill all COVID-19 telehealth consultations, however bulk-billing requirements remained in place for GPs seeing vulnerable patients.

By allowing communication and collaboration remotely and at a distance, telehealth was key to the prompt adoption of COVID-19 suppression strategies. In addition to allowing business to be conducted as usual, telehealth ensures people can access care in a way that reduces their potential exposure to infection, while maintaining continuity of care. It also mitigates the infection risk for key healthcare workers who are at the frontline of the pandemic.

### 2.3.1 Technology use in general practice

GPs have embraced change and rapidly adapted their models of care to ensure the safety of patients, ongoing accessibility of quality general practice care, and safety of practice staff.

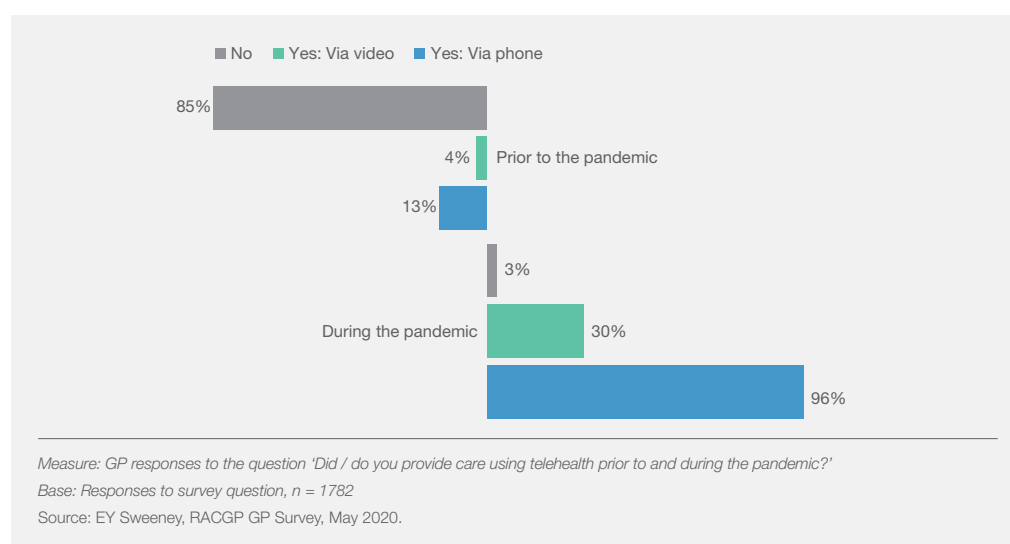
Overall use of telehealth has increased significantly as a result of the pandemic, with 97% of respondents providing care via either phone (96%) or video (30%), compared to just 15% prior to the pandemic (Figure 28).<sup>5</sup>

While 97% of GPs report they are using telehealth,<sup>5</sup> about 65% of GP consults in April and May 2020 were provided face to face.<sup>41</sup> Telehealth is complementing face-to-face care, with GPs deciding how best to meet their patients' needs.

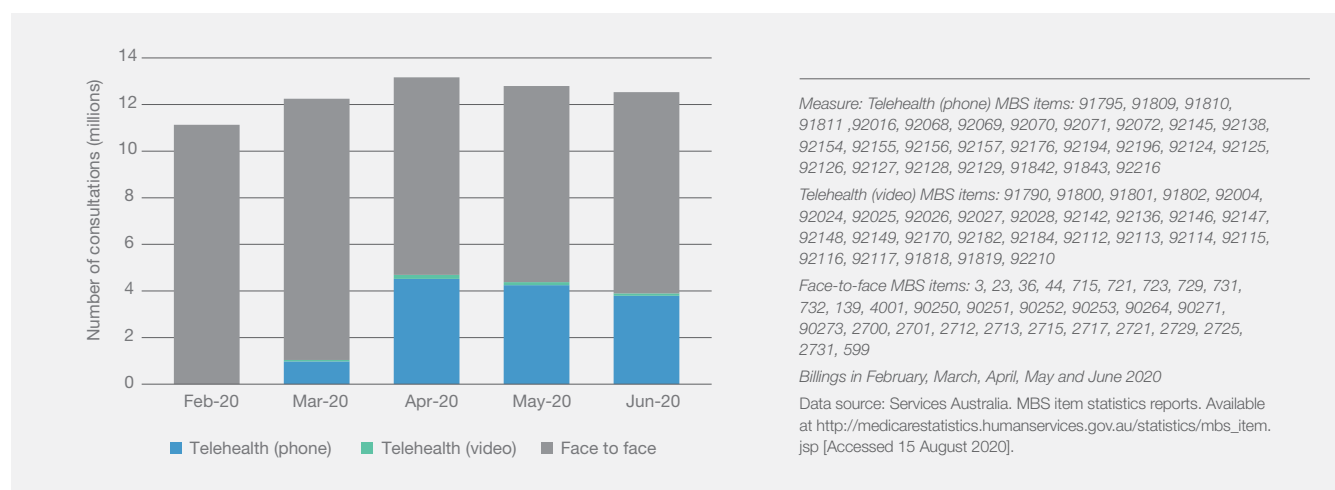
Prior to the pandemic, more GPs aged  $\geq 45$  years were using telehealth (17%) than those aged  $< 45$  years (11%).<sup>5</sup> Ease of adopting telehealth was mixed. Of those GPs using telehealth for the first time, four in ten (40%) found it 'easy' or 'very easy', but three in ten (30%) found adapting to telehealth 'difficult' or 'very difficult'.<sup>5</sup>

While 30% of GPs report using video to provide telehealth in April,<sup>5</sup> only a small percentage (4%) of telehealth attendances were billed as video health items in April.<sup>41</sup> Many GPs had difficulty providing care via video due to equipment shortages, internet issues, or patient-end issues. However, the fact that 30% attempted at least once to use video shows a willingness among GPs to incorporate new ways of consulting into their practice.

**Figure 28.** Use of telehealth has increased significantly since the start of the pandemic



**Figure 29.** Two-thirds of GP consultations between April and June 2020 were face to face



### 2.3.2 GP and patient attitudes toward telehealth

More than two in three (67%) GPs report a positive change in attitude toward using telehealth as the result of the pandemic – only 10% felt more negative (Figure 30). GPs practising in a group practice are more positive toward using telehealth than GPs practising in a solo practice (69% versus 52%).<sup>5</sup>

GPs cite many reasons for feeling more positive towards using telehealth. The most common reason is that MBS items now support use of telehealth. GPs also report that their patients like the convenience of telehealth, telehealth supports GP safety in the workplace, and patient access to care has been improved (Figure 31).

Free text responses from GPs highlight some other benefits of telehealth, including:

- the ability to see their patients more regularly, or in a more timely manner, rather than patients saving up all their concerns over a period of time, to discuss in one longer consult
- an increased feeling of safety, security and familiarity for patients, and building a closer relationship with them, by consulting with them in their own home – this was particularly raised as a benefit for mental health consultations and counselling.<sup>24</sup>

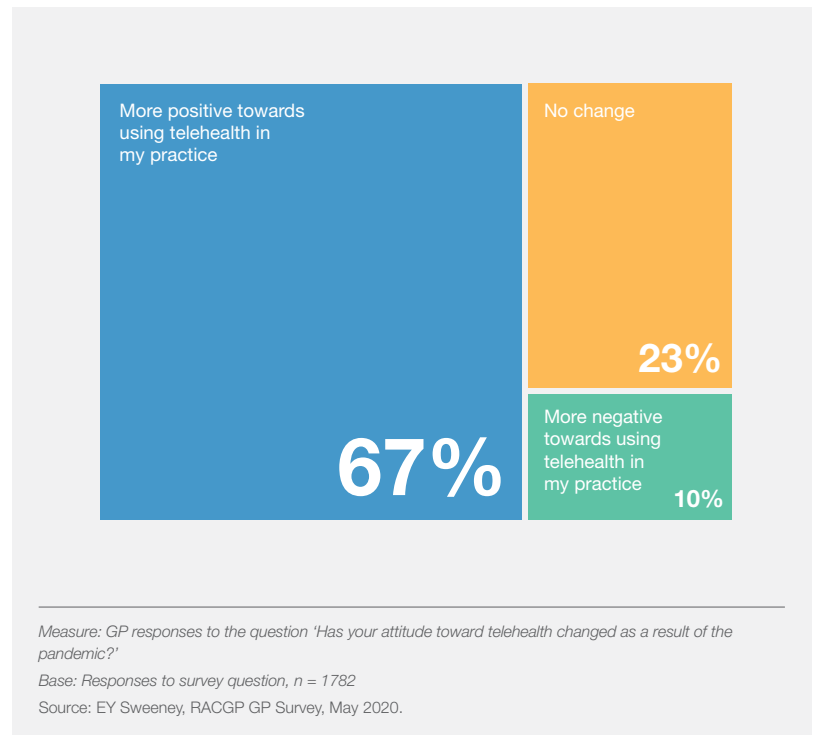
Patients, too, report positive experiences of telehealth, with two in three of those surveyed reporting that they would be open to continuing to use telehealth after the pandemic.<sup>42</sup> Patients report multiple reasons in favour of using telehealth, including:

- convenience, eg easier appointment times and no travel
- improved accessibility
- personal safety by avoiding time in the waiting room with other sick people.<sup>43</sup>

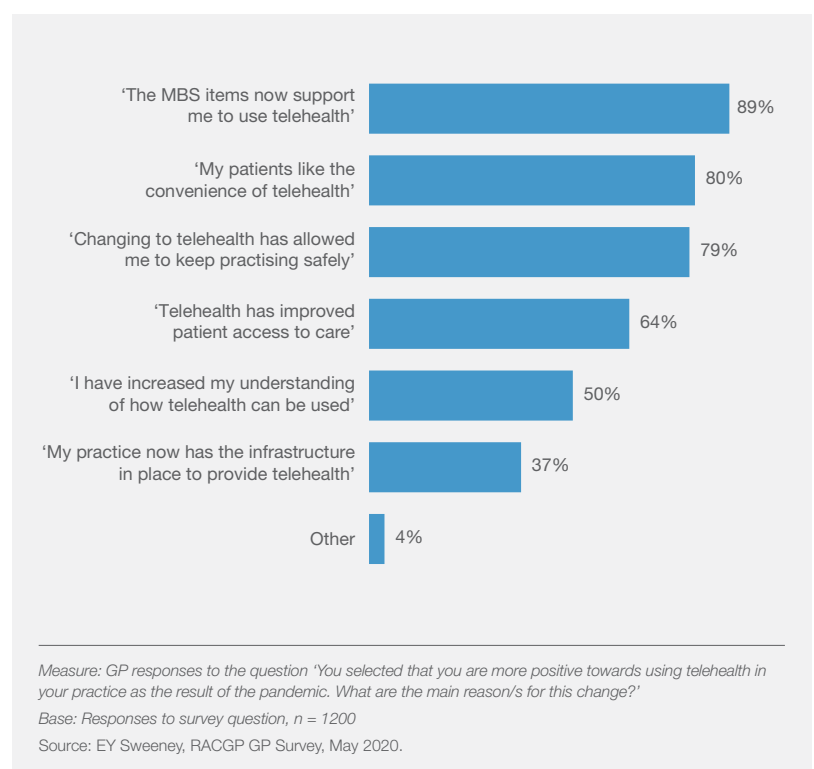
Of those few GPs who feel more negative towards telehealth, the majority (95%) indicate that the reason they feel this way is that telehealth has limitations to care provision.<sup>5</sup> This supports the RACGP's position that telehealth should always complement, rather than replace, face-to-face consultations. This is reflected in Figure 32.

One in five of those who felt more negative toward telehealth cited technical limitations as a reason.<sup>5</sup>

**Figure 30.** Most GPs feel more positive about using telehealth than they did before the pandemic



**Figure 31.** MBS support to provide telehealth is the main contributing factor to GPs' positive attitude toward telehealth



### 2.3.3 The future of telehealth in general practice

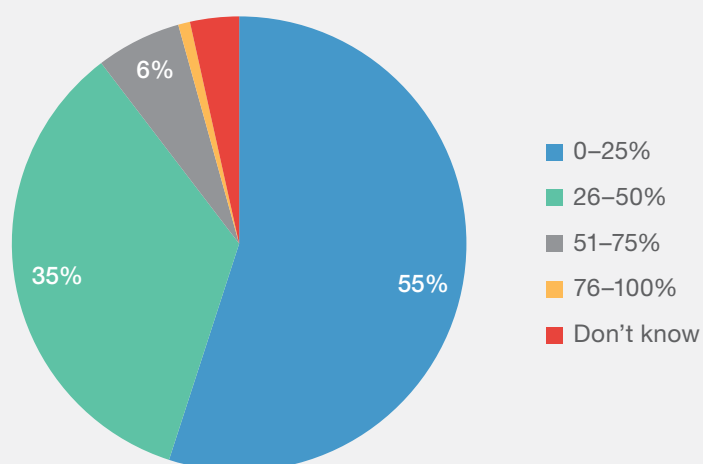
Seven in ten GPs think that continuing telehealth after the pandemic would support patient access to high-quality care in general practice.<sup>24</sup> Free text responses highlight that telehealth should only be available for patients already known to the practice, and for specific types of consults such as routine repeat scripts, discussing uncomplicated test results, some counselling, or doing referrals after recently seeing the patient.<sup>24</sup> However, a strong theme emerged that it is essential to see patients face to face to provide high-quality care, conduct examinations and provide ad hoc preventive interventions.<sup>24</sup>

When asked how much of routine care could be provided by telehealth in non-pandemic circumstances, most GPs (55%) suggested it would be appropriate for up to 25% of their consultations. A further 35% of respondents thought between 26% and 50% of consultations could be managed by telehealth in non-pandemic circumstances (Figure 32). This may reflect estimates that approximately 25% of the work GPs do is for care coordination and administration, which has historically not attracted remuneration through a patient rebate (Figure 44). Telehealth rebates can support many of these care coordination activities.

GPs value face-to-face consultations and the personalised care that can be provided to their patients in a standard consultation. The introduction of telehealth has been vital to support the necessary non-face-to-face activities and interactions between GP and patient, but both patients and GPs recognise that there are limitations to the telehealth mode of care delivery.

In the future, patients should expect that some of their care will involve a phone or video call with their usual GP, and at other times they'll see their GP in person.

**Figure 32.** Most GPs think up to 25% of their patient consultations can be via telehealth post-pandemic\*



\*Data less than 5% is not labelled.

Measure: GP responses to the question 'Looking forward, post-pandemic, what proportion of consultations do you think could be handled via telehealth?'

Base: Responses to survey question, n = 1782

Source: EY Sweeney, RACGP GP Survey, May 2020.



## CHAPTER 3

## Funding Australian general practice care

■ The COVID-19 pandemic has exposed limitations of the Medicare fee-for-service model and the need for change in funding models. General practices are private businesses operating with small profit margins. Many suffered severely with the drop in patient consultations early in the pandemic, having to reduce staff to survive (refer to [section 5.1.2](#)).

Reports from successive governments have called for reform in the ways primary healthcare is funded, to improve the long-term sustainability and agility of the sector. From the 2009 National Health and Hospitals Reform Commission, to the 2015 Primary Healthcare Advisory Group, medical experts and policymakers have called for voluntary patient enrolment with a 'healthcare

home' to coordinate access to multidisciplinary care. Experts recommend a range of funding models (not all supported by the RACGP) comprising mixed fee-for-service, grants to support multidisciplinary clinical services and care coordination, outcome payments to reward good performance, and episodic or bundled payments.<sup>44,45</sup>

The pandemic is an opportunity for innovation, and is a prompt for long-overdue health funding reform. The RACGP's [Vision for general practice and a sustainable healthcare system](#) outlines the urgent need to restructure the healthcare system into one that provides the right care for patients at the right time and in the right place, and that is sustainably funded into the future.



### 3.1 Government contribution to patient services

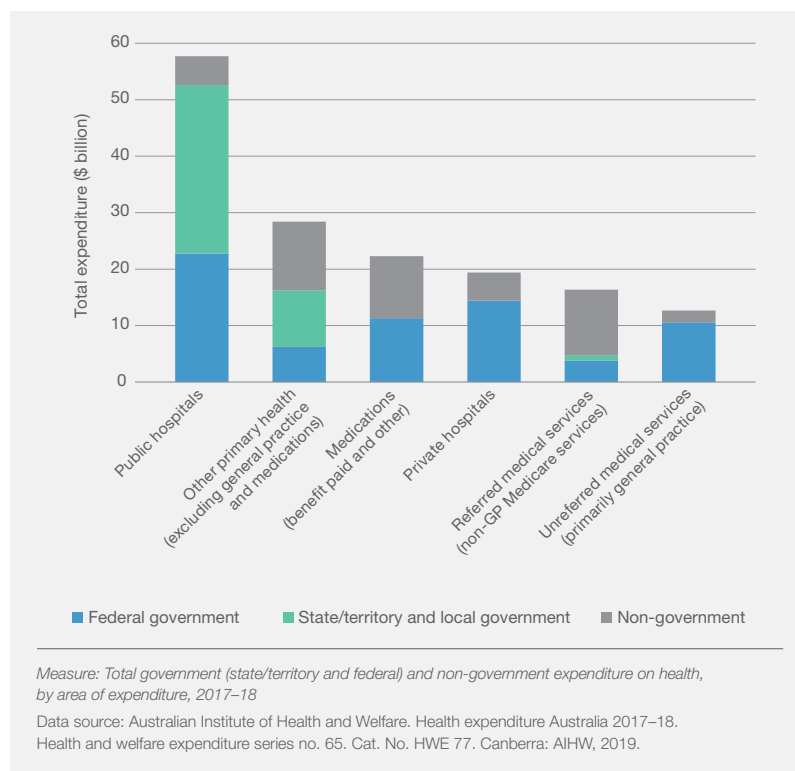
Despite the vast majority of patient care being provided in the general practice sector, most government expenditure on health continues to be dedicated to the hospital system (Figure 33). The percentage of total government health expenditure on hospitals continues to increase each year, while the percentage spent on primary care has gradually declined (Figure 34).

Australian government expenditure on health as a share of gross domestic product (GDP) is lower than other developed countries with primary care focused systems.<sup>46</sup>

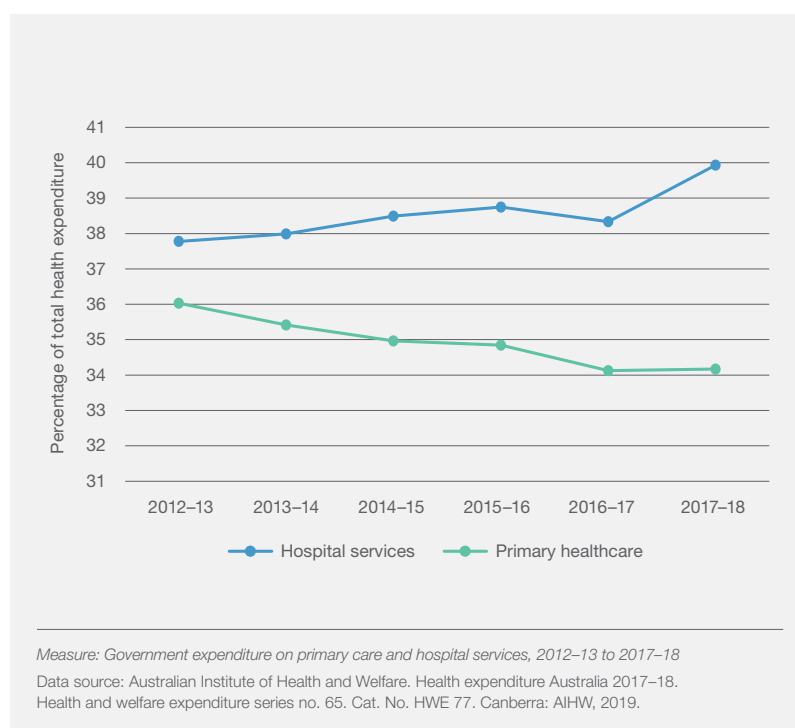
Total government (state/territory and federal) expenditure on general practice services is around 7.5% of health expenditure.<sup>\*,47</sup>

Expenditure per person on general practice was \$391 in 2018–19, a decrease in real terms from \$395 per person in 2017–18.<sup>30</sup>

**Figure 33.** Government expenditure on general practice services is overshadowed by spending on all other areas of the health system



**Figure 34.** The proportion of government health expenditure directed to primary care is declining



Government funding for general practice has fallen from **\$395** to **\$391** per person since 2017–18<sup>30</sup>

\*Calculated using 2017–18 dollars for total expenditure on general practice, against 2017–18 total expenditure on health.

## 3.2 General practice billing

### 3.2.1 Bulk billing

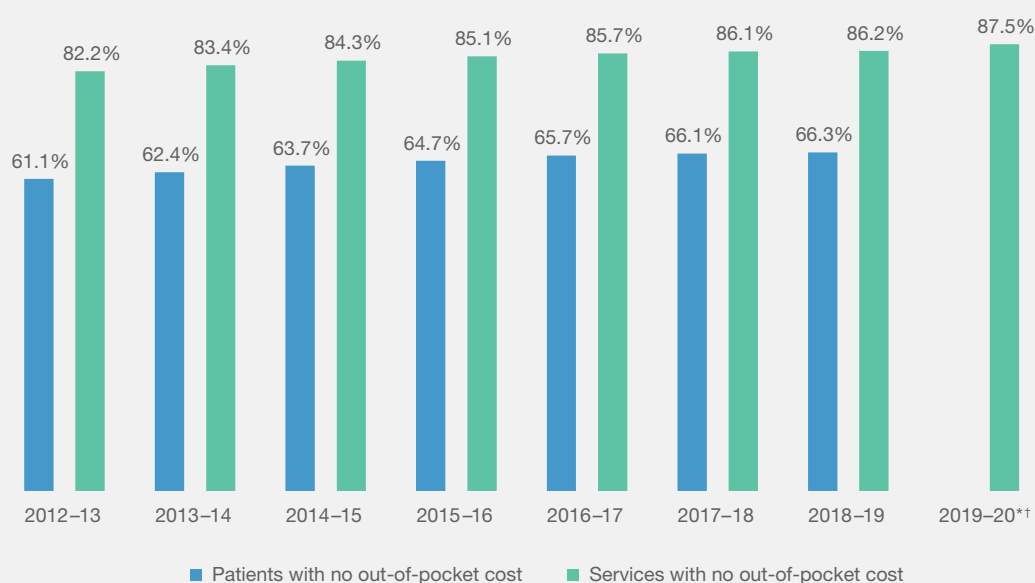
Almost nine in 10 (87.5%) of all general practice services were provided with no out-of-pocket cost to patients (ie were bulk billed) in 2019–20.<sup>1</sup> The bulk-billing rate was higher for new telehealth items introduced in response to COVID-19 – 99.1% of telephone consultations and 97.5% of video consultations in general practices were bulk billed.<sup>1</sup>

While these figures provide an indication of total bulk-billed services in Australia over this period, they do not represent the number of patients who are bulk billed for all of their general practice care.

Patients may receive a number of services during a single visit to a GP, with some of these services bulk billed and others privately billed. Therefore, the proportion of patients bulk billed (and who therefore face no out-of-pocket costs for general practice care) is lower.

In 2018–19, while 86% of GP services were bulk billed, nationally only 66% of patients had all of their GP services bulk billed (Figure 35).

**Figure 35.** Bulk billing is not as common as Medicare statistics indicate



\*2019–20 service data includes new telehealth items introduced March 2020


†2019–20 patient data was not available at time of print

Measure: Percentage of bulk-billed services and bulk-billed patients in category 'Broad type of services: Total non-referred attendances (excluding practice nurse items)', Australia wide  
Base: Population-level data


Data sources: Department of Health. Documents prepared in response to correspondence from Senator O'Neill dated 4 October 2019. Available at [www.aph.gov.au/Parliamentary\\_Business/Senate\\_estimates/ca/2019-20\\_Supplementary\\_Budget\\_estimates/health](http://www.aph.gov.au/Parliamentary_Business/Senate_estimates/ca/2019-20_Supplementary_Budget_estimates/health) [Accessed 15 August 2020].

Department of Health. Annual Medicare statistics: Financial year 1984–85 to 2019–20. Canberra: DoH, 2020.

The proportion of patients who face no out-of-pocket costs varies between the states and territories. In 2018–19, the Northern Territory had the highest proportion of patients with all GP services bulk billed, at 76%. NSW was the next highest, at 72%. The ACT and Tasmania had the lowest proportions, at 39% and 49% respectively.<sup>48</sup>

The number of services and patients bulk billed has increased over time. However, each year the rate of increase slows further (Figure 36). 

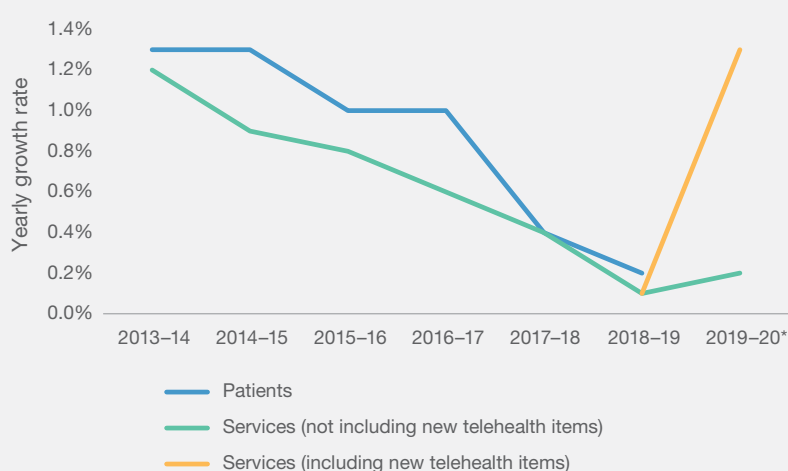
While nationally, the proportion of patients who have all their GP services bulk billed continues to increase, in several states the rate is in decline. The proportion of Tasmanian patients bulk billed for all GP services has steadily declined from 52% in 2014–15, to 49% in 2018–19. NSW and Queensland have seen slight decreases since 2017–18.<sup>48</sup>

 Prior to the pandemic, the RACGP predicted the increase in bulk billing would halt or reverse from 2020, meaning that in the future, more patients would face an out-of-pocket cost to see their GP.

The COVID-19 pandemic and the mandate to bulk bill most GP telehealth consultations affected this trend, and future data analysis on this topic will need to account for the effects of the pandemic environment on general practice billing.

Due to general practice viability issues (discussed in section 5.1.2), the RACGP expects the bulk-billing rate will decrease in the coming years.

**Figure 36.** Growth in national bulk-billing rates has been escalated by the pandemic



Measure: Growth in percentage of bulk-billed services in category 'Broad type of services: Total non-referred attendances (Excl practice nurse items)', Australia wide


Base: Population-level data


Data sources: Department of Health. Annual Medicare statistics – Financial year 1984–85 to 2018–19. Canberra: DoH, 2019.

Department of Health. Documents prepared in response to correspondence from Senator O'Neill dated 4 October 2019. Available at [www.aph.gov.au/Parliamentary\\_Business/Senate\\_estimates/ca/2019-20\\_Supplementary\\_Budget\\_estimates/health](http://www.aph.gov.au/Parliamentary_Business/Senate_estimates/ca/2019-20_Supplementary_Budget_estimates/health) [Accessed 15 August 2020].

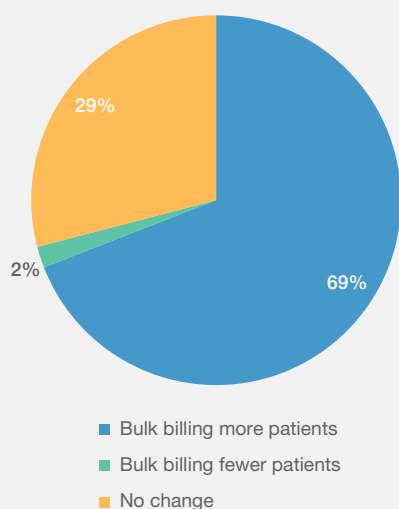
Four in 10 GPs report that they bulk bill at least 75% of their patients.<sup>5</sup> This number has fallen by 11% on the previous year.<sup>2</sup> However, more than two in three GPs report they were bulk billing more patients as a result of the COVID-19 crisis (Figure 37).

When the COVID-19 MBS telehealth items were introduced in March 2020, it was compulsory for doctors to bulk bill all patients. GPs were required to continue bulk billing the majority of patients for several months after non-GP specialists and allied health professionals were permitted to bill privately.

The financial impact of this impost is further discussed in [section 5.1.2](#). 

 Just as GPs were there to support their communities during the 2019–20 summer bushfires – and will continue to do so during the recovery – general practices remained open and accessible to their patients during the COVID-19 pandemic and lockdown. There was a significant shift toward bulk billing more patients due to the mandated bulk billing of telehealth items (Figure 37). The change in patient load and billing methods had a significant deleterious effect on general practice sustainability.<sup>49</sup>

**Figure 37.** GPs were bulk billing more patients as a result of the pandemic



Measure: GP responses to the question 'Have your bulk-billing practices changed compared to before the pandemic?'

Base: Responses to survey question, n = 1782


Source: EY Sweeney, RACGP GP Survey, May 2020.


**Four in 10 GPs** report that they bulk bill at least 75% of their patients<sup>5</sup>

### 3.2.2 Out-of-pocket costs

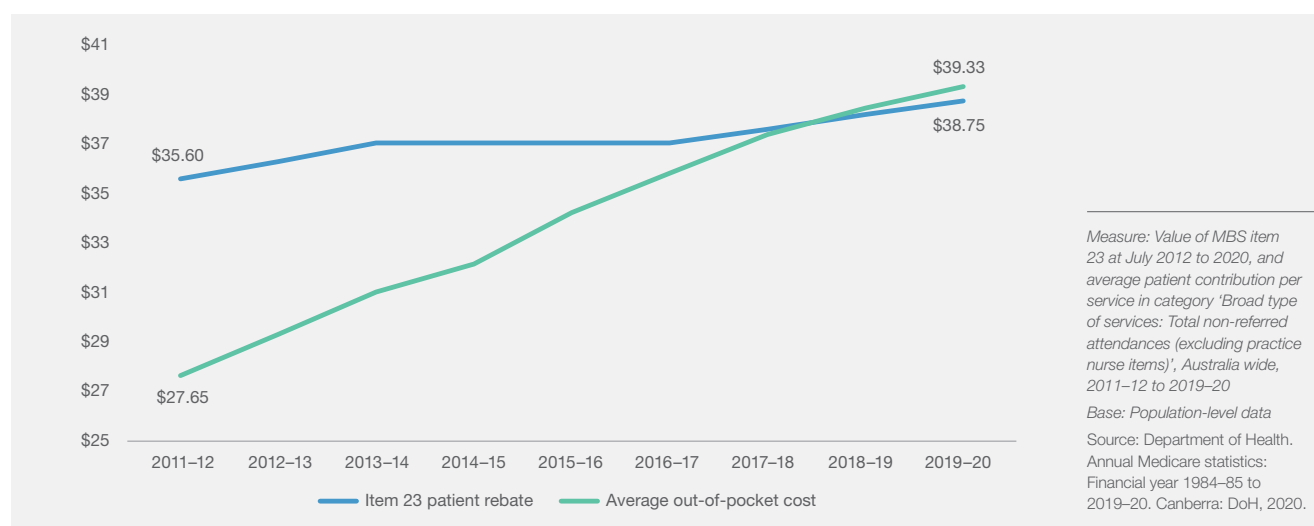
Patient out-of-pocket contributions continue to increase each year. The average patient co-payment, or out-of-pocket cost, to visit a GP in 2019–20 was \$39.33.<sup>1</sup> In 2018–19, for the first time, the average patient out-of-pocket cost was higher than the Medicare rebate for the most commonly used general practice item (standard GP consultation less than 20 minutes – item 23). In 2019–20, this trend has continued, and the gap between the patient rebate for item 23 and the average out-of-pocket cost has more than doubled from \$0.26 to \$0.58 (Figure 38).

Out-of-pocket costs vary across Australia, with patients in the Northern Territory and ACT experiencing higher out-of-pocket costs than in other jurisdictions. Remote and very remote areas also show higher patient out-of-pocket costs.<sup>1</sup>

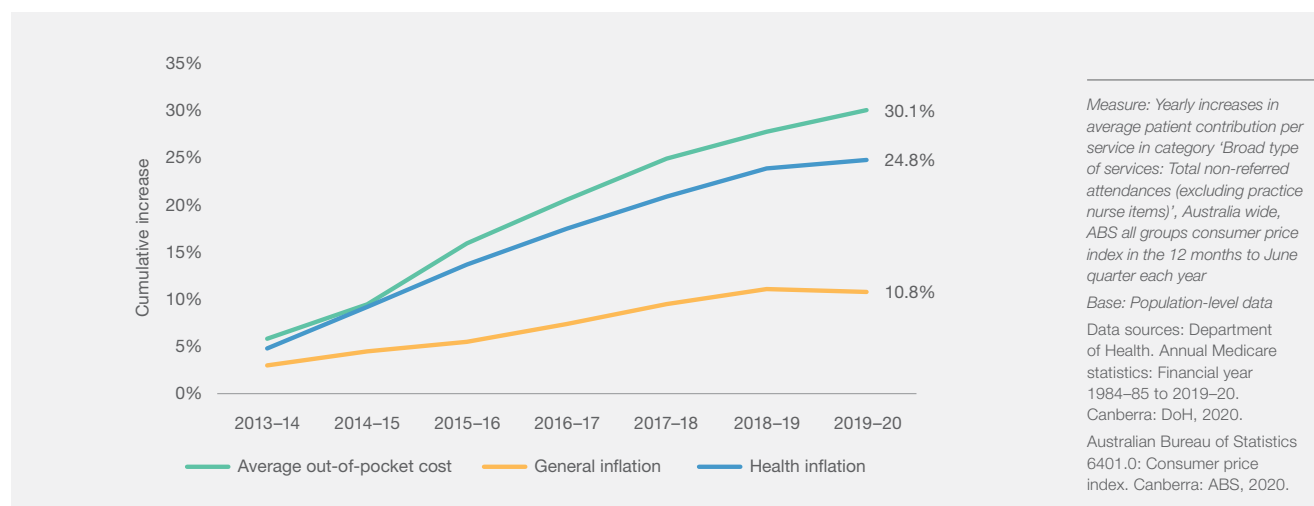
Average out-of-pocket costs increased by 2.26% between 2018–19 and 2019–20,<sup>1</sup> whereas the consumer price index (CPI) fell by 0.3% over the same period (Figure 39). 

 Patient rebates were 'frozen' (ie did not receive an annual indexation increase from the government) between 2013 and 2017. The effect of this freeze is reflected in Figure 39. While the patient rebate did not increase during those years, inflation continued to affect general practice operating costs. As such, in order for practices to remain viable, patient out-of-pocket costs increased.

**Figure 38.** Growth in patient out-of-pocket costs are out-pacing the patient rebate



**Figure 39.** Increases in patient out-of-pocket costs since 2013 are triple general inflation rates





## CHAPTER 4

# Job satisfaction and work–life balance

## 4.1 GP job satisfaction

Nine out of 10 GPs report that they are satisfied, or very satisfied, with their work overall. This figure has remained consistently high over time (Figure 40).

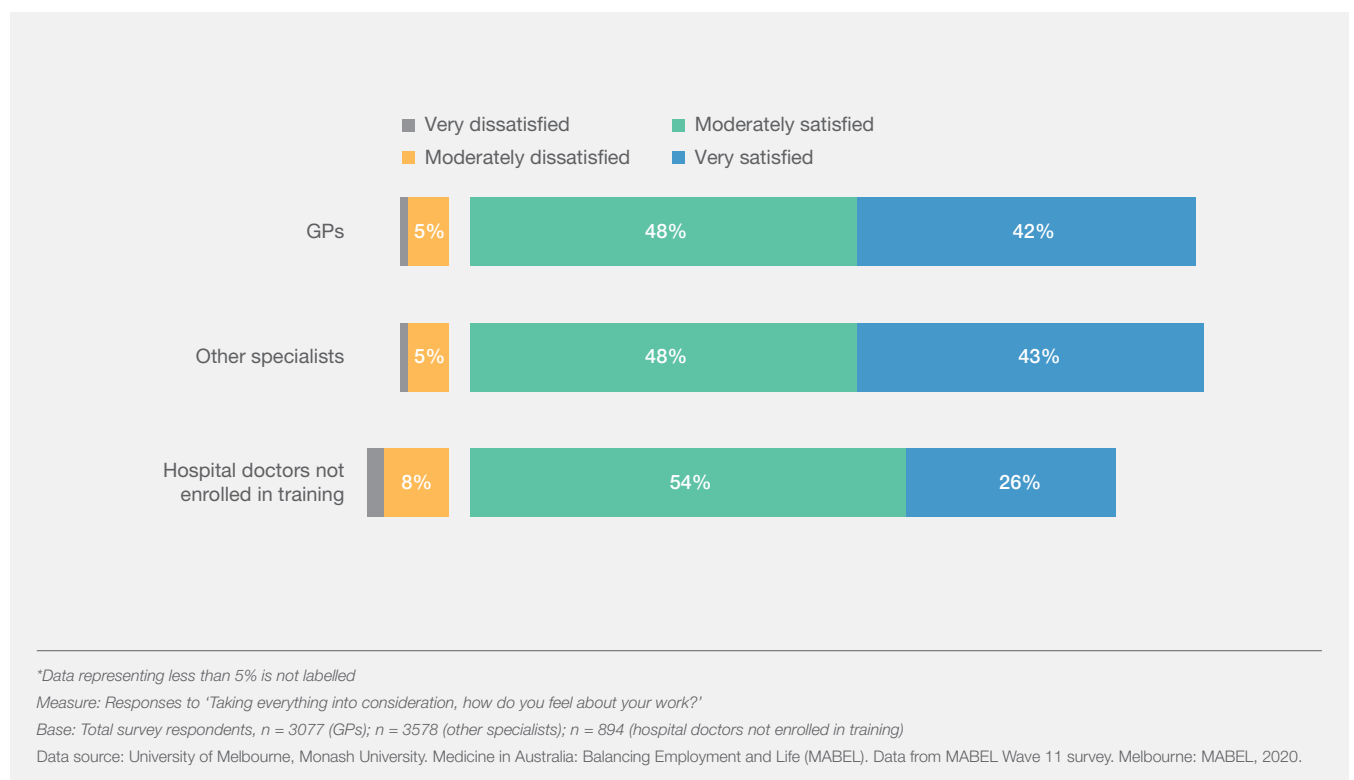
The areas in which GPs report the highest rates of satisfaction include freedom to choose their own method of working and physical working conditions (92% each), opportunities to use their abilities (91%), and the amount of variety in their work (93%) (Figure 41, Figure 42, Figure 43).<sup>32</sup> GPs are least satisfied with their remuneration and the recognition they get for good work (Figure 50).<sup>32</sup>

A career in general practice can be very fulfilling and opens up a life of endless possibilities. GPs report that they thrive on the varied and interesting clinical challenges that each patient presents, and the opportunity to build trusted, ongoing patient relationships, making a real difference to their patients' lives.

As the first point of contact for most Australians seeking healthcare, GPs have an opportunity to take a holistic approach to patient health, and can work in partnership with patients and colleagues from other specialties.

GPs can choose where and how often they work, and workplaces are supportive and collegial. There is scope for GPs to pursue their own specific clinical interests, and further develop skills in areas such as obstetrics and gynaecology, refugee health or even aerospace medicine.

**Figure 40.** GPs are satisfied with their work overall\*

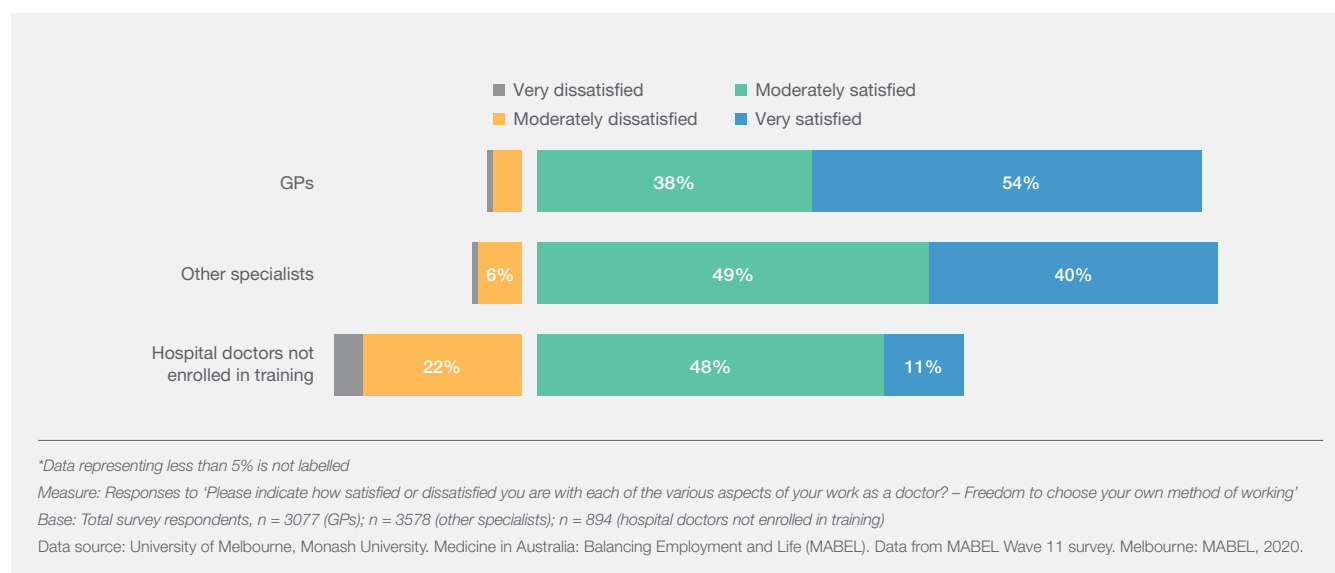


GPs report high levels of satisfaction with the freedom they have to choose their own method of working. When contrasted with other medical specialists and hospital-based doctors not enrolled in training, GPs are far more satisfied than their counterparts (Figure 41).

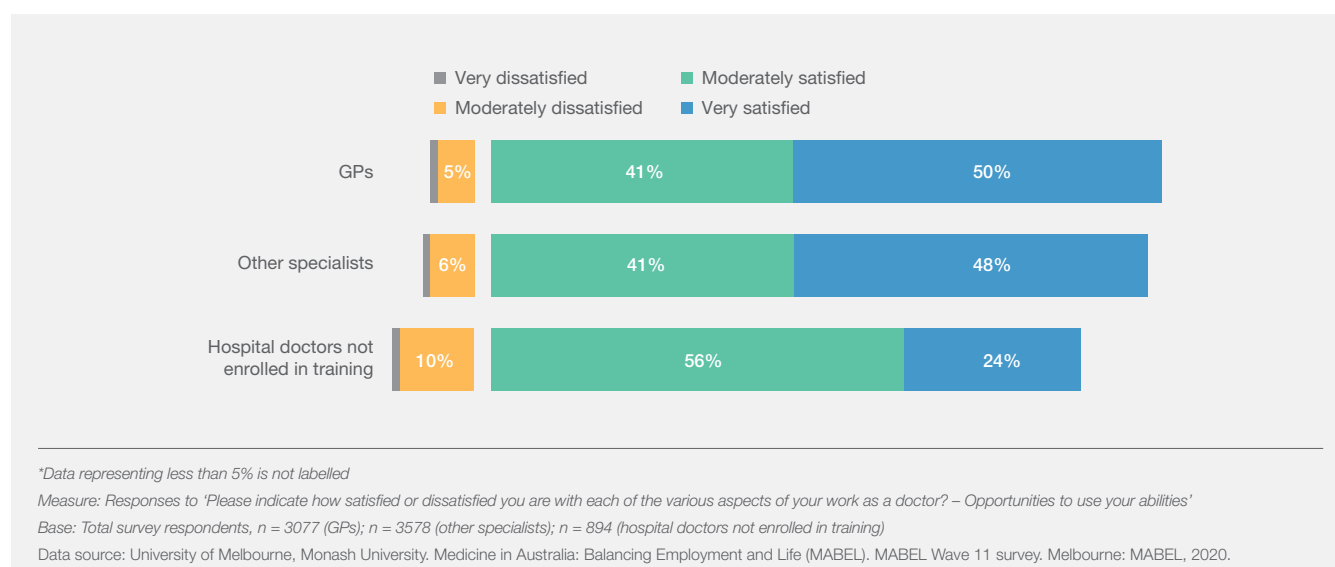
Ninety-two per cent of GPs report that they are satisfied or very satisfied with their physical working conditions, compared to 86% of other specialists, and 78% of hospital-based doctors not enrolled in training.<sup>32</sup>

Ninety-one per cent of GPs report that they are satisfied or very satisfied with the opportunities to use their abilities in their work, compared to 89% of other specialists, and 80% of hospital-based doctors not enrolled in training (Figure 42).

**Figure 41.** GPs are very satisfied with the autonomy of their work\*



**Figure 42.** GPs are very satisfied with the opportunities to use their abilities in their work\*



## 4.2 Work variety

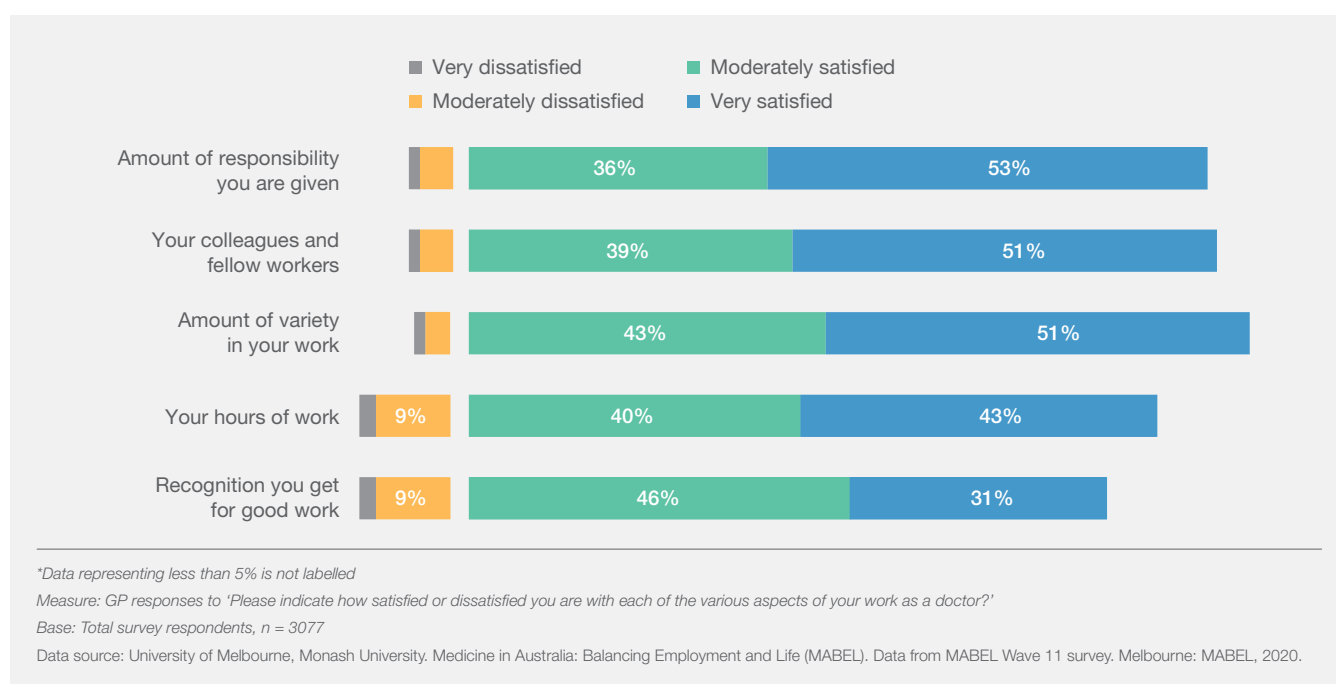
Ninety-four per cent of GPs are satisfied or very satisfied with the variety of their work (Figure 43).

Fifty-one per cent of GPs are very satisfied with the amount of variety in their work, compared to only 32% of hospital doctors not enrolled in training, and 50% of non-GP specialists.<sup>32</sup>

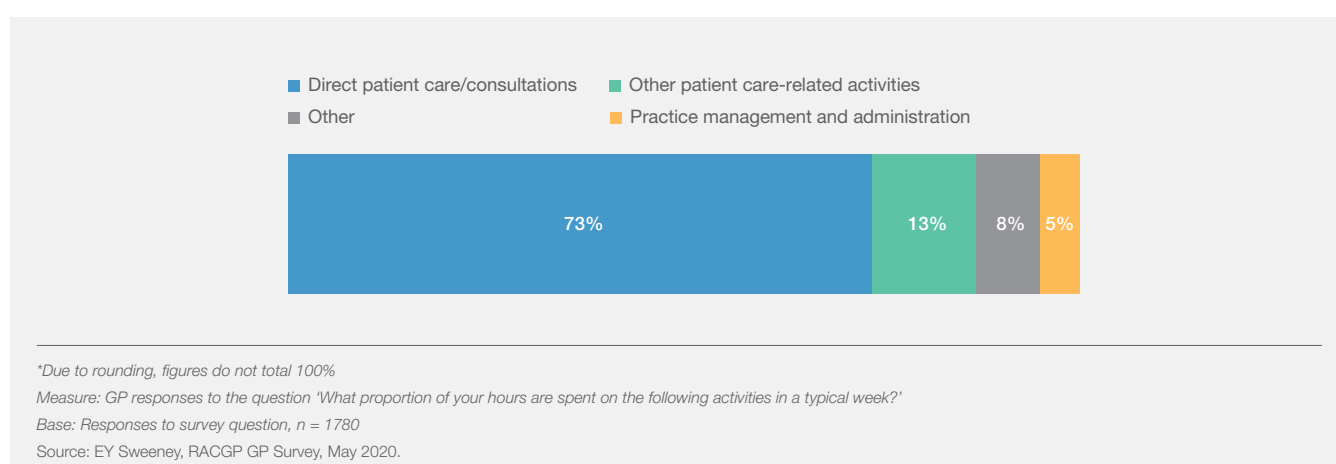
# 94%

of GPs are satisfied or very satisfied with the variety of their work<sup>32</sup>

**Figure 43.** GPs are satisfied with the variety in their work\*



**Figure 44.** GPs spend most of their time on direct patient care activities\*



GPs report they spend 73% of their work week on direct patient care and patient consultations. However, more than a quarter of their work week is spent on other activities, such as care coordination activities including following up test results, reviewing or writing letters, administration, and teaching and learning (Figure 44). These activities are largely unfunded by Medicare. This is particularly concerning as almost nine in 10 GPs are paid as a proportion of Medicare billings (Figure 52).

The impact of these hours spent on care coordination activities is being felt. Three in four GPs perceive the time they spend on care coordination activities has significantly or slightly increased over the past 10 years (Figure 45).

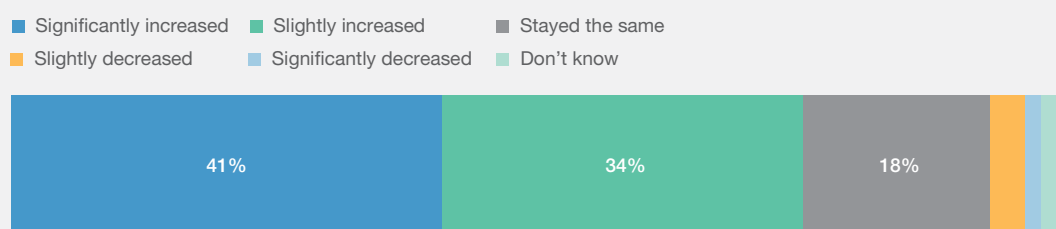
GPs who own a practice are more likely to report an increase in the time spent on patient coordination (85%) than those who do not own a practice (71%).<sup>5</sup>

The relationship between the proportion of time spent on tasks, and hours worked, is similar to previous years. Those working more than 60 hours per week on average report that they spend less time directly with patients (65%) and more time on practice management and admin tasks (11%) than those working between 20 and 60 hours.<sup>5</sup>

GPs report they are spending more time coordinating their patients' care than in the past, using the skills unique to general practice. This may be linked to the increasing prevalence of chronic and complex conditions in Australia, which require more complex care involving more services.<sup>45</sup>

GPs assisting to coordinate care means patients are receiving higher quality, less fragmented and better targeted care than ever before. Access to well-coordinated and high-quality healthcare is crucial to enhancing patients' understanding, control and self-management of their illnesses. Better coordinated care will equal better long-term health outcomes for the Australian population.<sup>45</sup>

**Figure 45.** GPs report that the time spent in care coordination activities has increased over the past 10 years\*



\*Data representing less than 5% is not labelled

Measure: GP responses to the question 'How has the proportion of time you spend on care coordination activities (patient follow up, case conferences, letters related to patient care) changed over the past 10 years?'

Base: Responses to survey question, n = 1782

Source: EY Sweeney, RACGP GP Survey, May 2020.

### 4.3 Hours of work

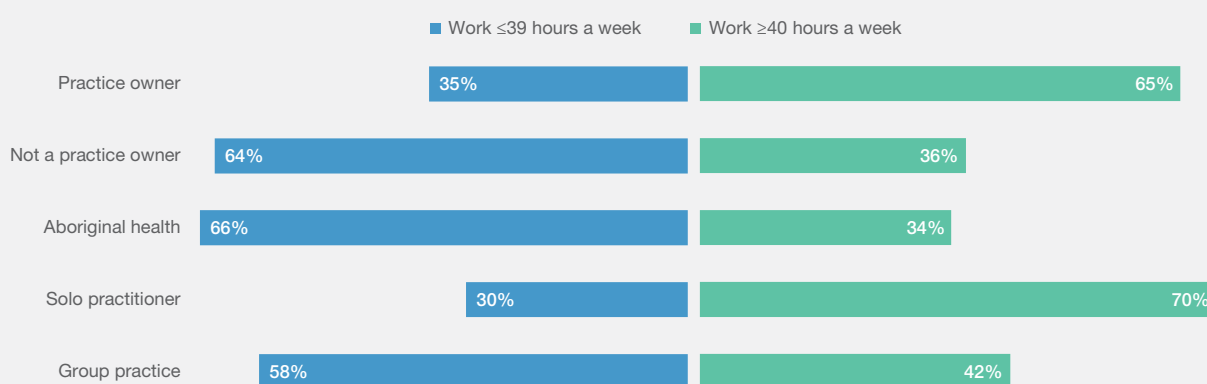
Four out of five GPs are satisfied or very satisfied with the hours they work (Figure 43).

GPs who are part or majority owners of a general practice report they work longer hours than GPs who are not practice owners. GPs who work in a solo practice also report working longer hours in a typical week (Figure 46).

GPs on average see  
**102 patients** each week<sup>32</sup>

GPs on average spend  
**16 minutes** with each patient<sup>32</sup>

**Figure 46.** Practice owners and GPs working in solo practices are the most likely to work ≥40 hours per week



Measure: GP responses to the question 'Approximately, how many hours do you spend at work during a typical week? Include all the hours of work you do as a doctor at all your places of work, including home visits', split by GP main place of work, and by those who report they are a part or majority owner of a general practice.

Base: Responses to survey question, n = 1782

Source: EY Sweeney, RACGP GP Survey, May 2020.

As discussed in [section 2.2.3](#), GPs are reducing their work hours, with the proportion reporting that they work <39 hours in a typical week increasing by 3% from 2019.<sup>2</sup> Younger GPs are also more likely to work ≤39 hours than GPs aged ≥45 years (Figure 47).

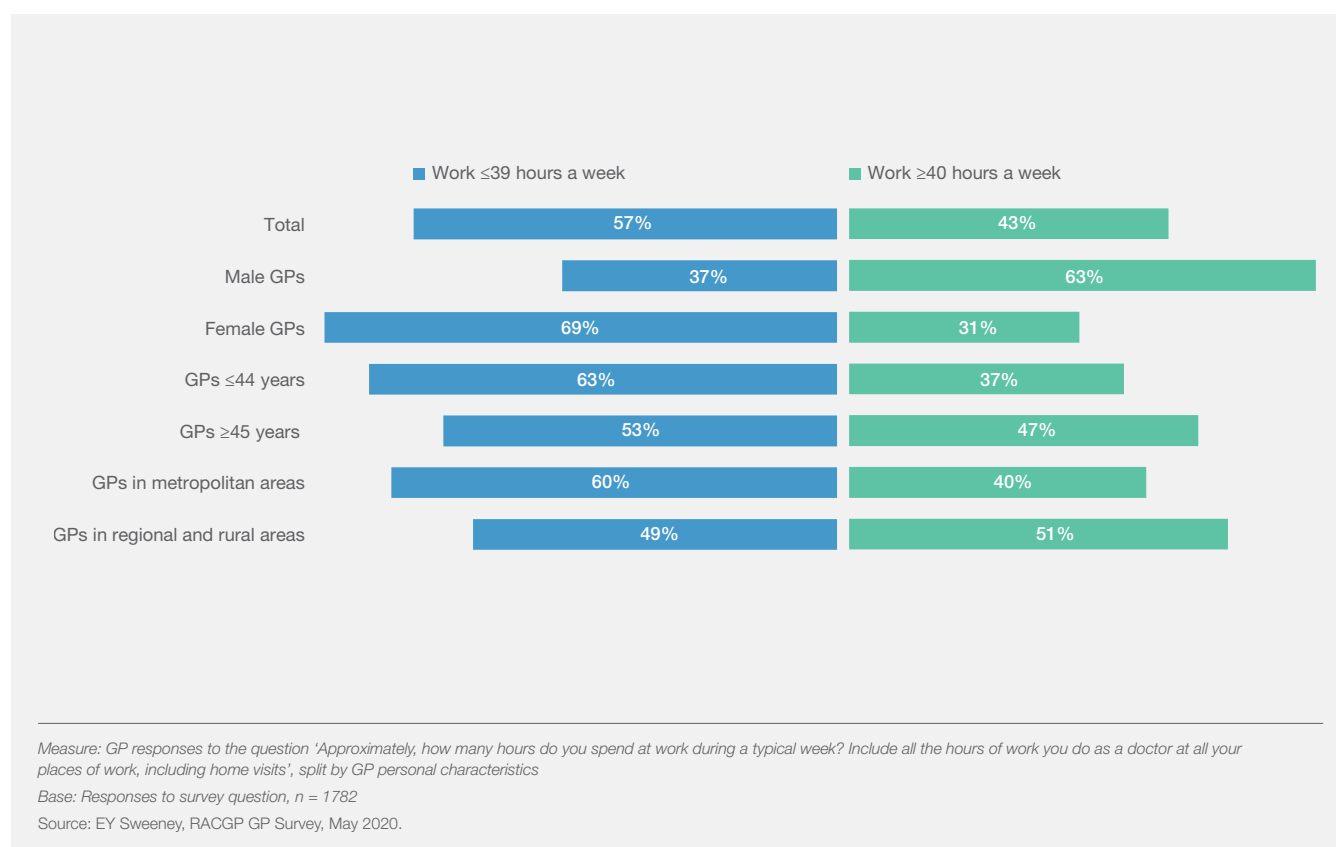
More than half (52%) of registrars surveyed in the 2019 AGPT National Registrar Survey report that they intend to work part time after they complete their training.<sup>40</sup>

GPs in rural areas continue to work longer hours than their colleagues in metropolitan areas (Figure 47).

In general, regional/rural GPs are less likely to report they have a manageable workload (43%) than GPs in metropolitan areas (53%).<sup>5</sup> For further discussion on the business challenges faced by rural GPs, refer to [section 5.1.2](#).

**More than half** of registrars intend to work part time after they finish training<sup>40</sup>

**Figure 47.** Male GPs and GPs located in regional and rural areas are the most likely to report working ≥40 hours per week

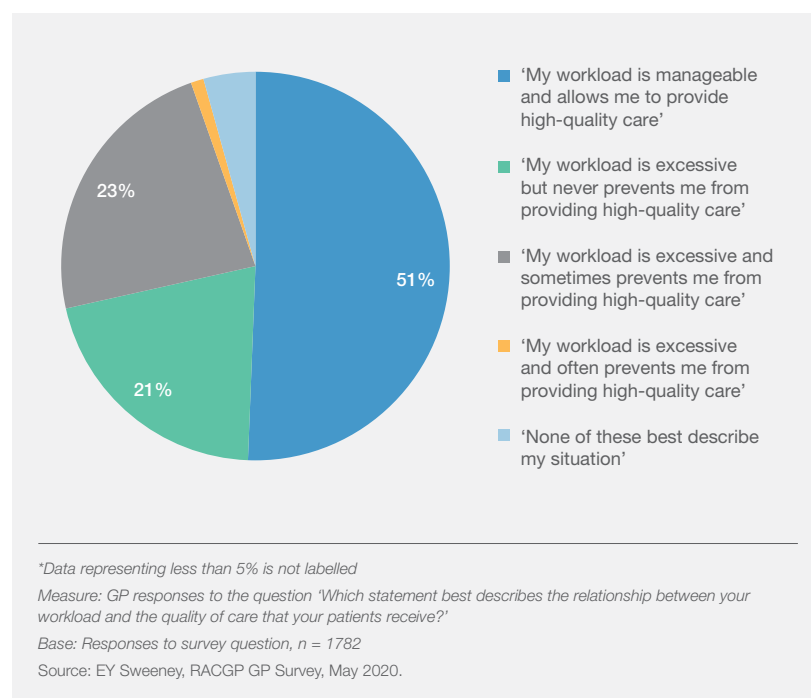


More than seven in ten GPs report their workload does not impact on their ability to provide high-quality patient care. More than one in two GPs report their workload is manageable, which is unchanged from 2019.<sup>2</sup> In line with this, a similar proportion of GPs report having an excessive workload that sometimes prevents them from providing high-quality care (23%), in comparison to 2019 (24%) (Figure 48).<sup>2</sup>

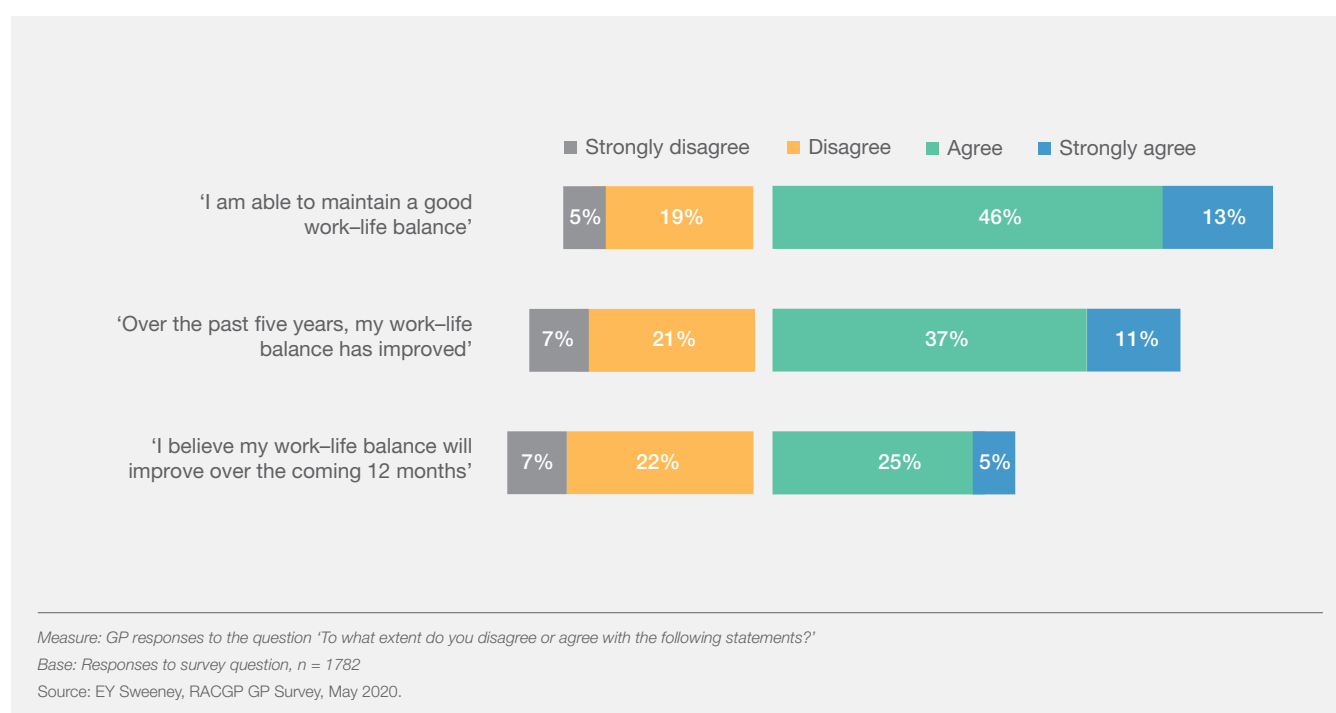
GPs are able to maintain a good work–life balance, and many perceive this balance has improved over the past five years (Figure 49). This may be linked to the increase in the proportion of GPs choosing to work part time.<sup>5</sup>

However, work–life balance is the most commonly reported challenge for GPs, with 47% including this in their top three challenges.<sup>5</sup>

**Figure 48.** The majority of GPs can provide high-quality care regardless of their workload\*




**Figure 49.** GPs are able to maintain a good work–life balance






## 4.4 Remuneration

Remuneration remains the area of greatest dissatisfaction among GPs, with 45% reporting 'maintaining income' as one of their top challenges as a GP in 2020.<sup>5</sup>

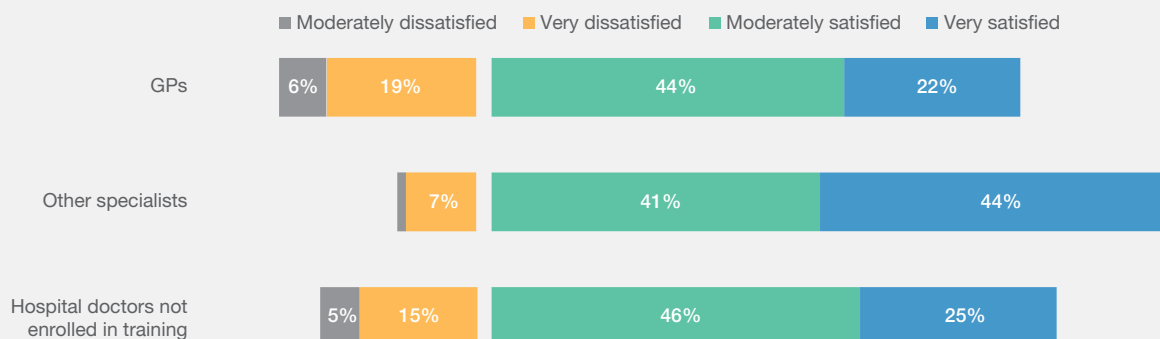
One in four GPs (25%) are dissatisfied or very dissatisfied with their remuneration, compared to 8% of other medical specialists and 20% of hospital doctors not enrolled in training (Figure 50). 

 GPs, like all medical specialists, can set their consultation fees to reflect the cost of providing high-quality medical care. There are a range of factors which inform a GP's decisions about the fees they charge for their care, including their practice's billing policies, their patient cohort and social demographic, the GP's level of clinical and business experience, and community expectations about the cost of GP care.

# 40%

of GPs report maintaining income as one of their top challenges<sup>5</sup>

**Figure 50.** GPs are less satisfied with their remuneration than other medical professionals\*



\*Data representing less than 5% is not labelled


Measure: Responses to 'Please indicate how satisfied or dissatisfied you are with each of the various aspects of your work as a doctor?'


Base: Total survey respondents, n = 3077 (GPs); n = 3578 (other specialists); n = 894 (hospital doctors not enrolled in training)

Data source: University of Melbourne, Monash University. Medicine in Australia: Balancing Employment and Life (MABEL). Data from MABEL Wave 11 survey. Melbourne: MABEL, 2020.

Some GPs, particularly in remote areas (43%), report that they are very satisfied with their remuneration.<sup>32</sup> GPs in inner-regional areas are the next mostly likely (27%), followed by outer-regional (25%) and major cities (20%).<sup>32</sup> This may be due to variation in cost of living across locations, as well as patient mix, and higher incentives available in rural and remote areas.

One-third (31%) of GPs working as locums report being very satisfied with their remuneration, with salaried employees the next most satisfied (27%).<sup>32</sup> GPs who are a principal partner of their practice, or an associate, are the least likely to report they are very satisfied with their remuneration, at 20% and 18% respectively.<sup>32</sup>

GPs who report that a majority of their patients have complex health and social problems are less likely to report high rates of satisfaction with their remuneration.<sup>32</sup> 

 This relationship may be reflective of the falling rebate value for longer standard consultations (for example MBS items 36 and 44).

The Medicare rebate that patients receive is far lower (per minute) if they spend more time with their GP – as would be needed to discuss complex health and social care needs (Figure 51).

GPs treating patients with more complex health and social problems also spend more unpaid time undertaking care coordination activities.

Considerable unfunded time may be spent seeking links with other local agencies, and information to assist social prescribing, to improve the social support for their patients. This is reflected in findings that awareness of community supports available to patients is the fourth most

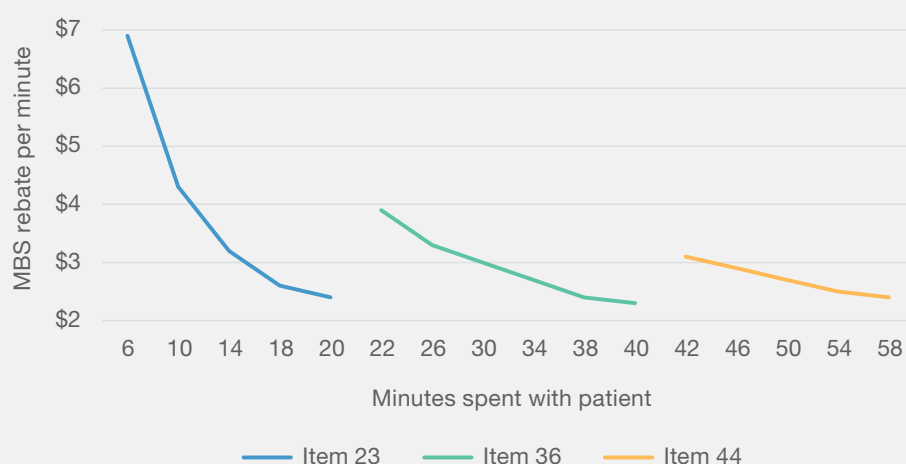
commonly cited challenge for GPs (refer to section 5.1).

Studies have shown a link between patient complexity and GP burnout. Rates of burnout can be almost twice as high among GPs caring for the highest number of patients with multimorbidity, compared with those caring for the lowest number.<sup>50</sup>

It is important that GPs are able to maintain a mix of patients and presentations to support their own wellbeing and ongoing sustainability of their practices. Recent moves to redirect 'straightforward' healthcare services, such as immunisations, minor procedures, and repeat prescribing, to other health professionals has implications for patient safety and continuity of care, as well as GP wellbeing.

It is important that GPs are able to maintain a mix of patients and presentations

**Figure 51.** The patient rebate per minute is far lower for longer consultations



Measure: MBS item values, divided by duration of consultation (minutes)

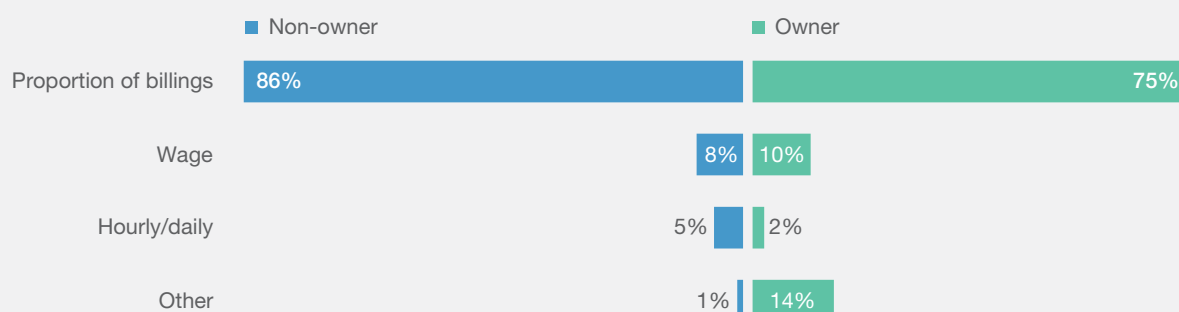
Data source: Department of Health. MBS online: 1 May 2020 Medicare Benefits Schedule. Canberra: DoH, 2019.

Eighty-four per cent of GPs report they are paid by a proportion of their patient billings, while 9% are paid an annual salary or wage.<sup>5</sup>

GPs aged <45 years (88%) and metropolitan GPs (88%) are more likely to be paid by a proportion of billings than those aged ≥45 years (82%) and regional/rural GPs (76%).<sup>5</sup>

GPs who are practice owners are less likely to be remunerated through a proportion of billings than non-owners (Figure 52). One in four GPs who are practice owners report they are remunerated via other means, including wages, a fixed hourly or daily rate, proportion of business profit, income after expenses, or partnership distribution.<sup>5</sup>

**Figure 52.** The majority of GPs are remunerated by proportion of their billings



Measure: GP responses to the question 'Which statement best describes how you are remunerated at your main practice?', split by GP practice ownership status

Base: Responses to survey question, n = 1782

Source: EY Sweeney, RACGP GP Survey, May 2020.

## CHAPTER 5

# The business and economics of general practice

General practice is a key part of the healthcare sector; it is worth over \$13 billion in 'value add' to the Australian economy, and employs more than 100,000 people.<sup>51</sup>

## 5.1 Business and income challenges

The most commonly reported challenges for GP practice owners have remained the same as in previous years. GPs who are practice owners are more concerned with maintaining practice accreditation and electronic systems, maintaining income and their work-life balance, and staffing issues, than non-practice owner GPs (Figure 53).

General practice is worth over \$13 billion in 'value add' to the Australian economy<sup>51</sup>

\$13b

**Figure 53.** Practice owners report different challenges to non-practice owner GPs\*

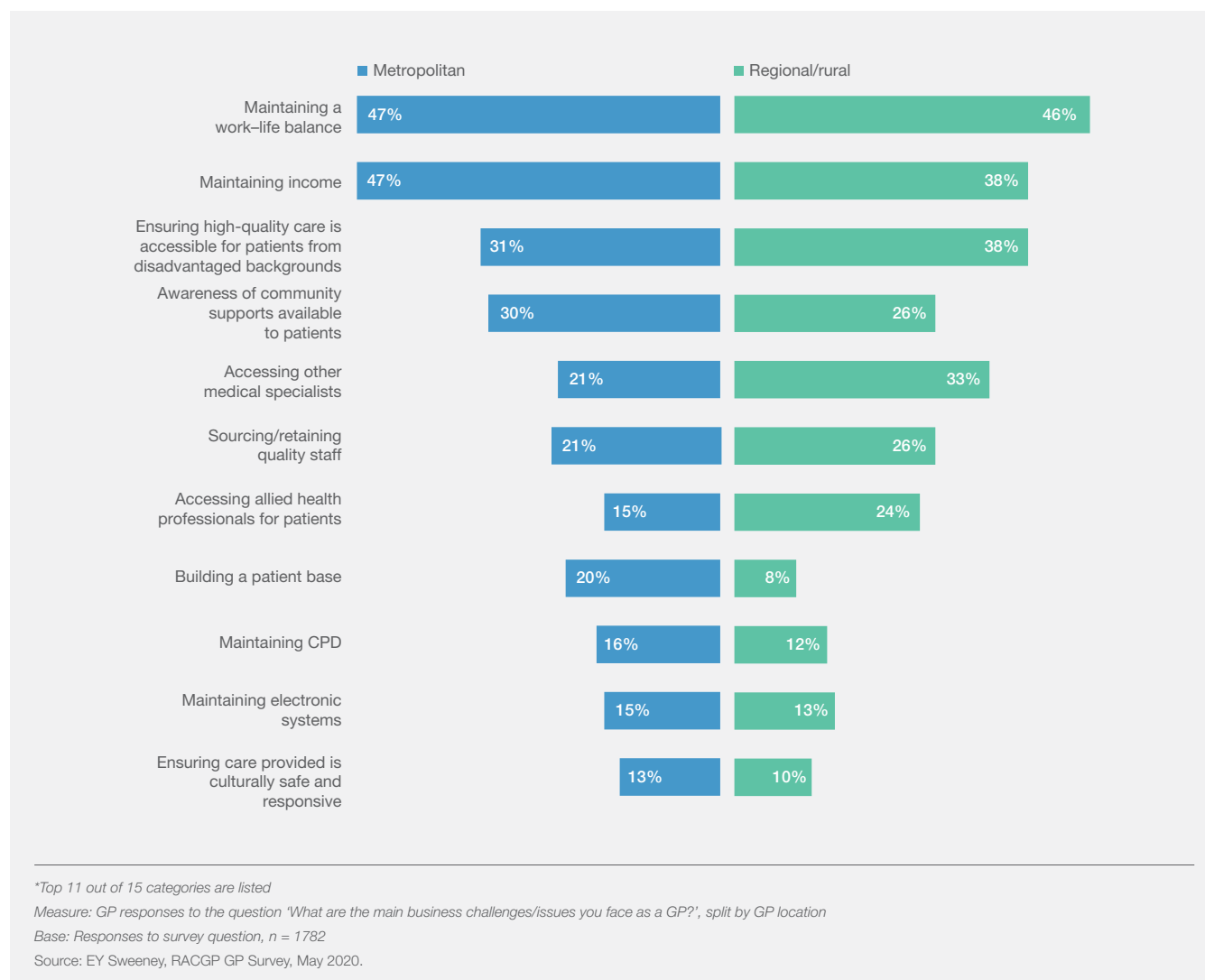


GPs in regional, rural and remote areas report different challenges to GPs located in Australia's cities.

Accessing other medical specialists, networking with other GPs, and accessing allied health professionals, is more challenging for GPs in regional and rural areas. GPs located in cities report more difficulty building a patient base than their colleagues outside cities.

Likely related to greater competition, and fewer government incentives, GPs in metropolitan areas report greater challenges maintaining income as well (Figure 54).

**Figure 54.** GPs in rural areas report different challenges to GPs in metropolitan areas\*



### 5.1.2 Business and financial challenges relating to COVID-19

Seven in ten GPs report that their income or revenue in April/May 2020 was lower than it was in the same period in 2019. For one in four GPs, their income was much lower (Figure 55). The effect is seen more strongly among metropolitan GPs, with 74% reporting lower incomes, compared to 61% among regional and rural GPs.<sup>5</sup>

With social distancing and vulnerable patients being asked to stay at home, general practice has been challenged to innovate in order to continue to meet patient needs.

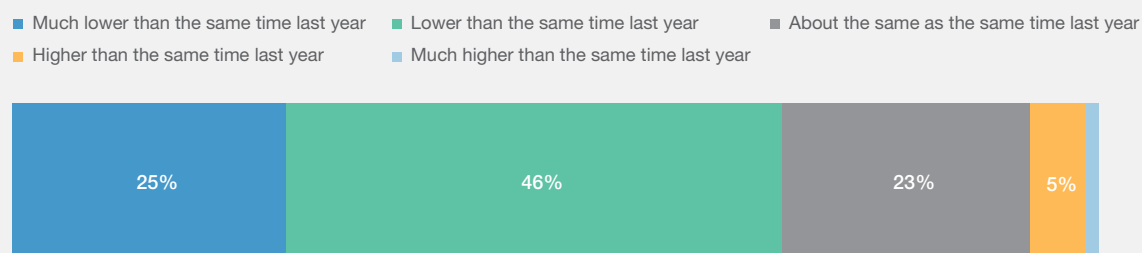
Unlike large state-funded acute care services, primary and community healthcare is largely provided by small businesses. This makes the sustainability of general practice highly sensitive to changes in funding, service

demand and business structures. It is estimated that general practice profit margins have decreased by 7.3% over the past five years.<sup>52</sup>

GPs, and their teams, have been faced with a lack of job security at a time when the Australian community needs them the most to both manage the health issues of the pandemic and support ongoing management of chronic conditions.

GPs, and their teams, have been faced with a lack of job security at a time when the Australian community **needs them the most**

**Figure 55.** GP income has been negatively affected by the pandemic\*



\*Data representing less than 5% is not labelled

Measure: GP responses to the question 'How would you compare your income/revenue now to the same time last year?'


Base: Responses to survey question, n = 1782

Source: EY Sweeney, RACGP GP Survey, May 2020.

An RACGP poll of 980 GPs produced further insight; 85% of respondents indicated they had seen a decrease in revenue compared to the same time period in 2019.<sup>24</sup> Of these, two in five GPs (43%) saw a decrease of between 10% and 30%, and one in three GPs (32%) saw a decrease of more than 30%.<sup>24</sup>

Many GPs indicated in free text responses that this decrease in income had been temporarily offset by a large number of presentations due to the start of the flu season, but also that many GPs were working longer hours to maintain the same income.<sup>24</sup>

When asked what they think are the main contributing factors for the reduction in income or revenue, 83% of GPs cite that fewer patients are presenting for usual care (Figure 56). This reflects the findings reported in [section 1.1](#) that fewer patients have been presenting for chronic conditions such as circulatory, endocrine and metabolic disorders. It is also a recurring theme reflecting the challenges GPs report which impact on their ability to provide patient care during the pandemic, and Medicare billings data (discussed in [section 1.4.2](#)).

Seven in ten GPs report the requirement to bulk bill a large proportion of their patients was also a contributing factor (Figure 56). As discussed in [section 2.3](#), for several months it was required by legislation that GPs bulk bill telehealth consultations provided to Commonwealth concession card holders, children <16 years old and patients who are more vulnerable to COVID-19. 

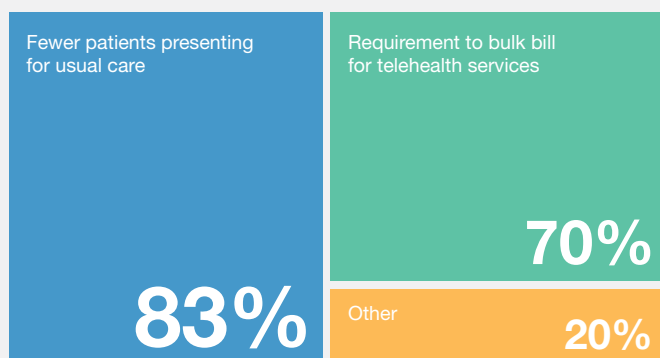
Fifty per cent of GPs reported that the removal of the mandatory bulk-billing requirements for telehealth would improve the viability and sustainability of their practice.<sup>24</sup> Free text responses highlight that GPs are happy to support their patients by bulk billing during a time when many are experiencing financial difficulties, but that longer-term practice sustainability cannot be supported without either increased rebates or charging fees to more patients.<sup>24</sup>

GPs strongly advocated that they should be able to use their own professional judgement and knowledge of each individual patient's circumstances to decide when to bulk bill for telehealth. GPs also note that the systems are not in place to effectively and efficiently process payments for telehealth services.<sup>24</sup>

Other reasons cited for reduced income or revenue included reduced rental income; reduced work hours; changed employment or personal circumstances; more time spent on administrative tasks; and increased expenses in response to the demands of COVID-19, such as needing to pay practice staff for longer hours, cleaning expenses and sourcing PPE.<sup>5</sup>

 The financial viability of practices is under threat because from March to September 2020, GPs were unable to charge a co-payment for a large percentage of patient telehealth consultations. The financial viability of many practices across Australia had already been impacted as a result of Australia's recent devastating bushfire season. These are practices that stepped up to assist their communities in a time of severe adversity. It is important these practices are able to continue to support their communities in the months and years ahead, as the bushfire recovery process and the effects of the pandemic continue.

**Figure 56.** The most commonly cited reason for reduced income was fewer patients presenting for usual care



Measure: GP responses to the question 'What do you think are the main contributing factor/s? (for reduced income compared to the previous year)'

Base: Responses to survey question, n = 1263

Source: EY Sweeney, RACGP GP Survey, May 2020.



Six in ten (57%) GP owners are concerned about the viability of their practice.<sup>5</sup> GP owners in major cities are more concerned about the short-term viability of their practices than GP owners in regional Australia (Figure 57) although, overall, GP owners are more concerned with viability in the longer term (37%) than in the shorter term (20%).<sup>5</sup>

More than two out of three GP owners attribute their concerns about practice viability primarily to the effects of the COVID-19 pandemic.<sup>5</sup>

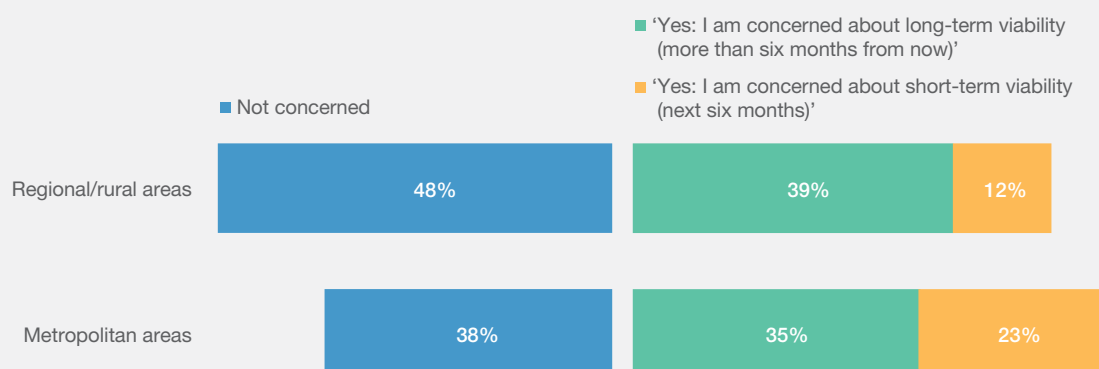
As a result of this concern, two in five (43%) reduced their workforce, most commonly by reducing staff hours (31%) but also by laying off practice staff (13%).<sup>5</sup>

GPs in rural areas face unique challenges, which are reflected in survey findings. GPs working in regional/rural areas (38%) are more likely to report a deterioration to work–life balance due to COVID-19 than their metropolitan counterparts (31%) (Figure 4).<sup>5</sup>

🗨️ GPs in rural areas are less likely to have other specialist colleagues to support them locally, meaning they are more likely to be directly testing patients for COVID-19. At the start of the pandemic, there were few respiratory clinics in rural and regional areas.

Further to this, COVID-19 travel restrictions impacted on the ability for locums or fly-in fly-out doctors to reach the clinics where they usually practise. This put additional pressure on services within those communities.

**Figure 57.** GP owners are concerned about the viability of their practices



Measure: GP responses to the question 'Are you concerned about the viability of your practice?'

Base: Responses to survey question, n = 428

Source: EY Sweeney, RACGP GP Survey, May 2020.

5.2 Practice ownership

General practices in Australia can be owned by anyone. While almost three in four GPs report that their main practice is majority owned by a GP, there are many other ownership models represented, including shareholders (publicly listed companies), cooperatives, mutuals, not-for-profits and university or government-owned agencies (Figure 58).

📖 This year's survey sought to collect information on the links between practices, and the consolidation of practices into larger groups which share administrative functions. These networked practices are either GP owned, or public company/ shareholder owned – more commonly called ‘corporate’ practices. The models of care patients experience vary across all types of general practice and the RACGP will continue to explore these models and changes over future editions of the Health of the Nation report.

25% of survey respondents were **practice owners**<sup>5</sup>

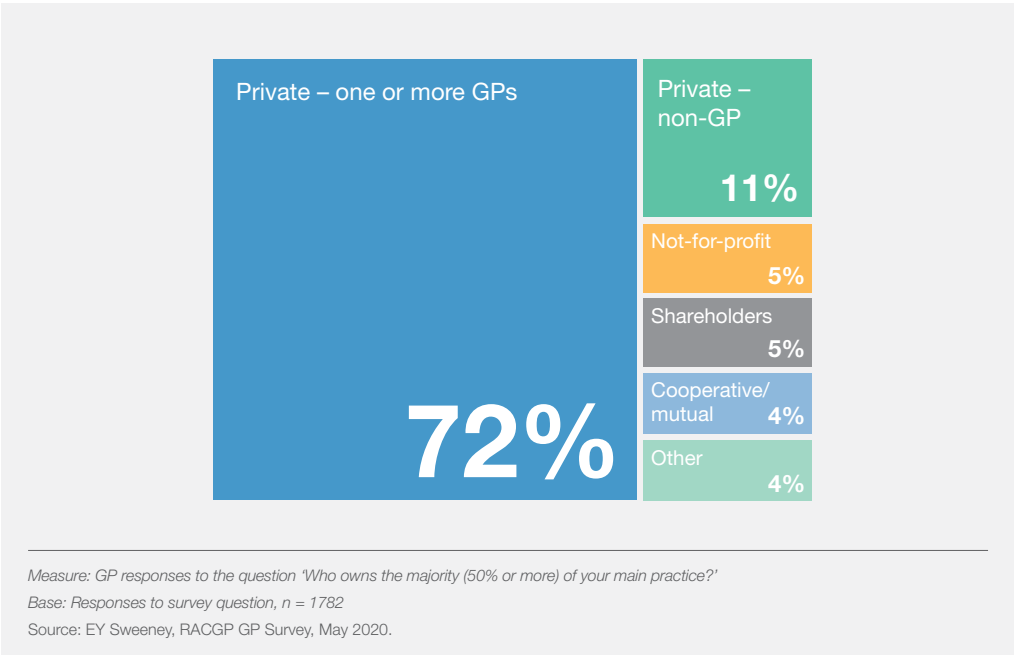
46% of practice owners were **female**<sup>5</sup>

54% of practice owners were **male**<sup>5</sup>

83% of practice owners were **aged ≥45 years**<sup>5</sup>

17% of practice owners were **aged ≤44 years**<sup>5</sup>

Figure 58. Many general practices are owned by GPs



One in three GPs (28%) report their main practice is networked with other practices – sharing human resources, payroll, marketing or clinical governance arrangements.<sup>5</sup>

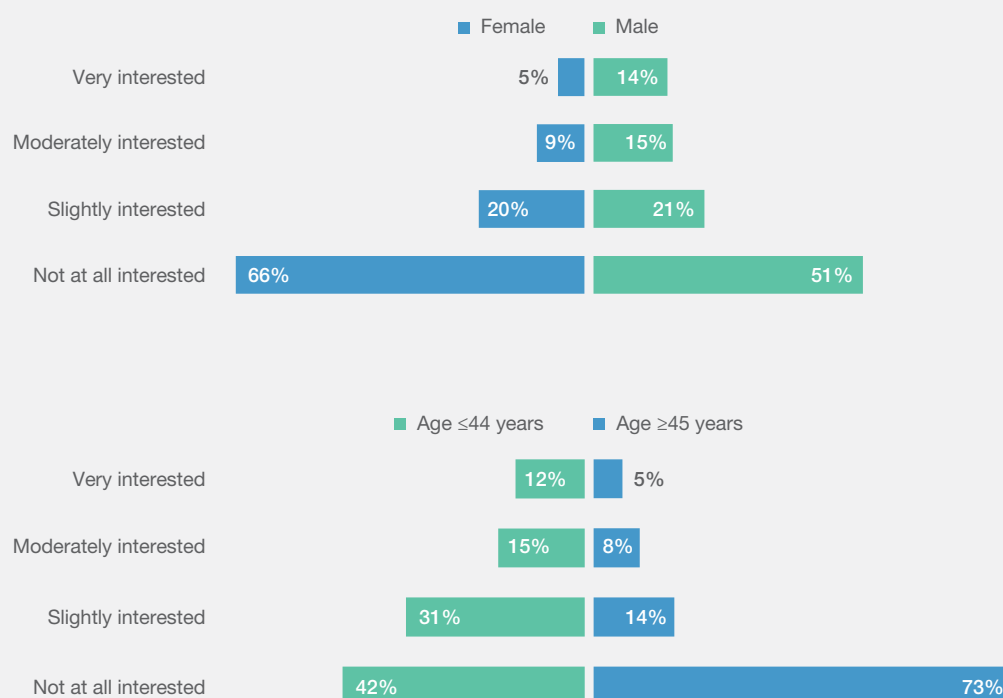
One in four GPs (25%) report they own at least part of a general practice, and 15% report they are a majority owner of a general practice.<sup>5</sup>

Almost two in three (61%) GPs who do not own a practice report that they have no interest in becoming a practice owner in the future.<sup>5</sup> This figure has increased from 58% in 2019<sup>2</sup> and 51% in 2017.<sup>53</sup>

Younger GPs and male GPs are the most likely to indicate an interest in becoming a practice owner (Figure 59).

Twice as many male (22%) as female (11%) registrars express an interest in becoming a practice owner within the next five years.<sup>40</sup>

**Figure 59.** Interest in practice ownership varies between age and gender divides



Measure: GP responses to the question 'How interested are you in owning your own practice in the future?', split by GP personal characteristics

Base: Responses to survey question, n = 1345

Source: EY Sweeney, RACGP GP Survey, May 2020.




## CHAPTER 6

# The future of the general practice workforce

## 6.1 Graduates entering pre-Fellowship general practice training

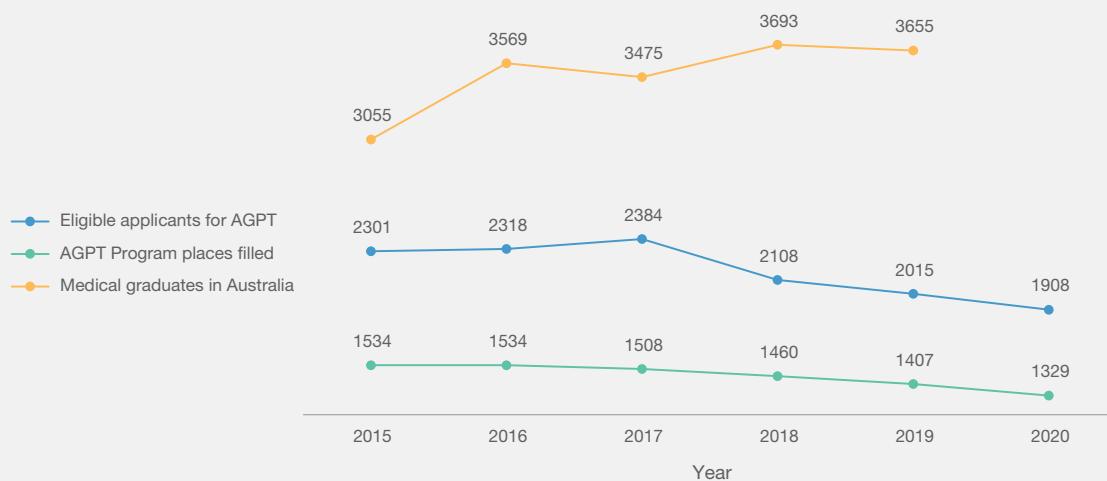
As discussed in [section 2.2.3](#), the RACGP has identified that changes in work patterns could mean a larger head count of GPs will be needed in the future to provide the same level of patient access. However, the level of interest among medical graduates in entering general practice training appears to be waning. In 2018, 15.4% of final year medical students listed general practice as their preferred specialty, the lowest percentage since 2012.<sup>54</sup> The number of eligible applications for the Australian General Practice Training (AGPT) Program has declined by 17% since 2015, while the number of Australian medical graduates has increased by 20% over the same period (Figure 60). 

 There is anecdotal evidence that medical graduates may be delaying entering vocational training, which may contribute to the apparent decline in the number of graduates applying for general practice training.

It should be noted that there are several pathways to obtaining Fellowship of the RACGP (FRACGP). In 2019, 676 GPs in training obtained FRACGP through non-AGPT training pathways.

As part of the Australian Government's transition to RACGP-led training from January 2022, the RACGP has had the opportunity to lead and align recruitment efforts of individual training partners. The first time the RACGP did this was for the 2021 intake, and the impact of this change on AGPT recruitment will be considered in future program intakes.

**Figure 60.** The number of medical graduates interested in the AGPT Program is in decline



Measure: number of graduates/applicants/trainees, by year

Data sources: Department of Health. Health Workforce Division. Unpublished data provided to the RACGP July 2020.

Medical Deans Australia and New Zealand. Student statistics tables 2015–2018; and Medical Deans Australia and New Zealand. Student statistics report 2019–20. Sydney, MedicalDeans, 2020.

The top three responses why AGPT Program registrars decided to become GP specialists were the hours and working conditions for the specialty (80%), the diversity of patients and medical presentations (65%), and the ability to build long-term relationships with patients (57%) (Figure 61).

65%

of AGPT Program registrars chose general practice due to the diversity of patients and medical presentations

**Figure 61.** Top reasons AGPT registrars chose general practice training



Measure: Responses to question, 'Why did you decide to become a specialist GP?' (select all that apply), top 11 of 18 response options.

Base: Total survey respondents, n = 1460

Data source: Radloff A, Clarke L, Matthews D. Australian General Practice Training Program: National report on the 2019 National Registrar Survey. Australian Council for Educational Research, 2019. Available at <https://health.gov.au/resources/publications/agpt-program-national-report-on-the-2019-registrar-satisfaction-survey> [Accessed 15 August 2020].



## 6.2 The experience of GPs in training

Only 14% of GPs in training report they are concerned about whether they will be able to secure employment on completion of the training program, compared to one in four non-GP specialists, and one in three interns (Figure 62).

GPs in training with the RACGP's Fellowship Pathways are satisfied with their training. Eighty-four per cent would recommend their training position to other doctors, and eight in 10 would recommend their workplace as a place to train.<sup>55</sup>

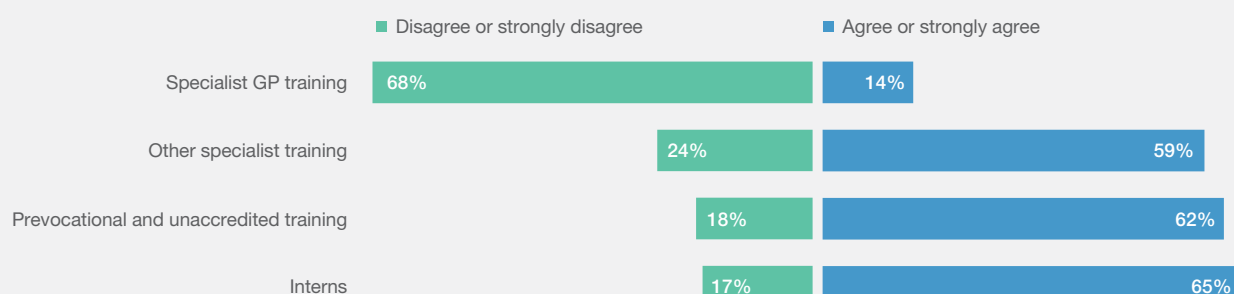
When compared to their peers, GPs in training feel well supported in their workplace. They are also less likely to experience workplace conflict, feelings of being unappreciated and difficulty accessing senior clinicians, and are not as adversely affected by requirements to work overtime as their peers in other specialty training pathways (Figure 63).

However, GPs in training do report a greater impact from dealing with patient expectations than their peers report (Figure 63).

# 84%

of GPs in training would recommend their training position to other doctors<sup>55</sup>

**Figure 62.** Most GPs in training are confident they will find employment on completion of training\*



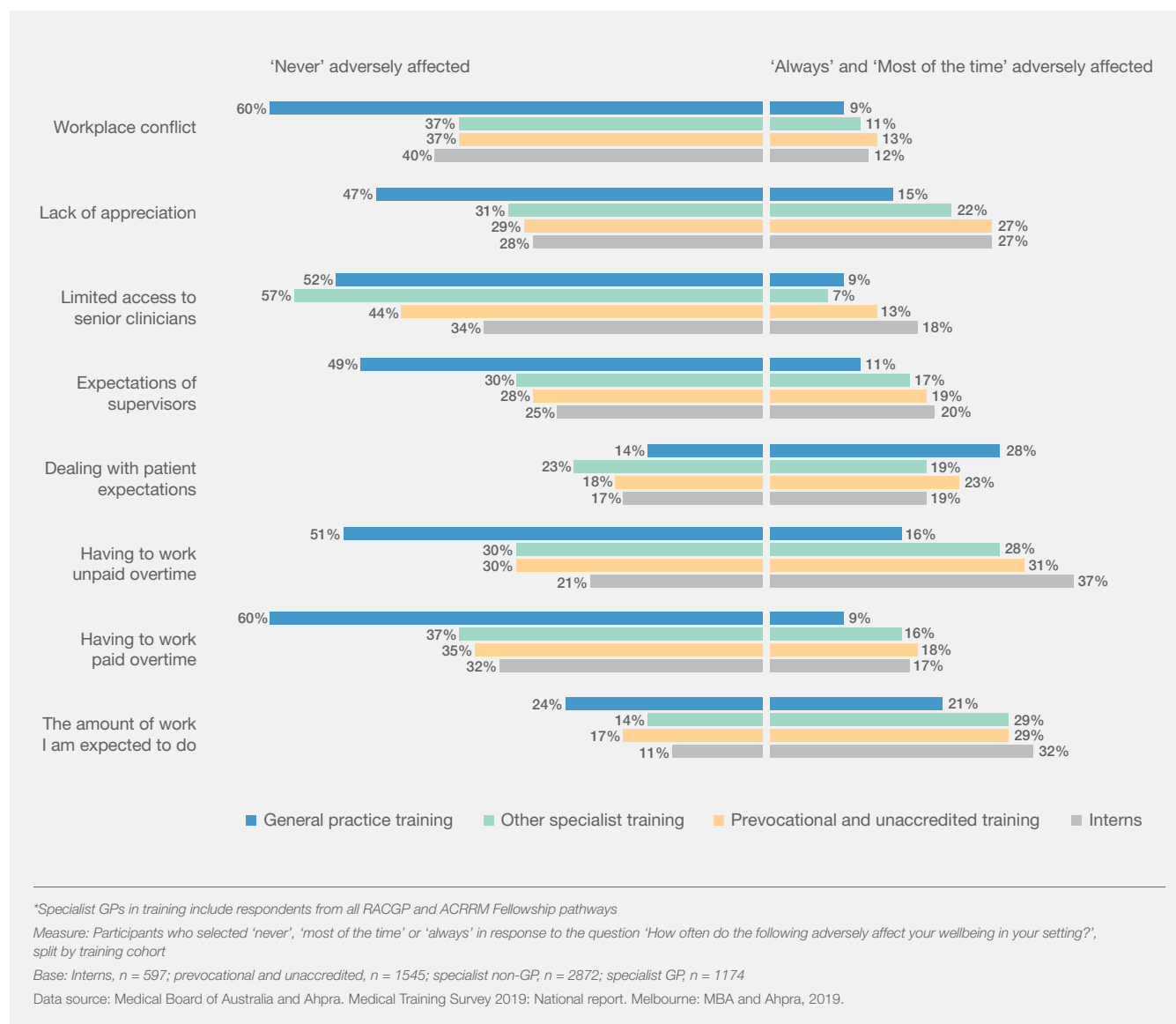
\*Specialist GPs in training include respondents from all RACGP and ACRRM Fellowship pathways

Measure: Participants who selected 'agree' or 'strongly agree' in response to question, 'Thinking about your future career, to what extent do you agree or disagree with the following statements? I am concerned about whether I will be able to secure employment on completion of training/the pathway', split by training cohort

Base: Interns, n = 587; prevocational and unaccredited, n = 1511; specialist non-GP, n = 2840; specialist GP, n = 1153

Data source: Medical Board of Australia and Ahpra. Medical Training Survey 2019: National report. Melbourne: MBA and Ahpra, 2019.



**Figure 63.** GPs in training report limited adverse effects from commonly raised training concerns\*

Prior to commencement of RACGP-led training, GPs in training have varied views on their interactions with their colleges, although the majority report they are able to discuss the training program with other doctors (71%), and the requirements of their training program are clearly communicated (72%).<sup>56</sup>

The RACGP and the Australian College of Rural and Remote Medicine (ACRRM) are in the process of resuming responsibility of the AGPT Program, which has been administered by the Department of Health via Regional Training Organisations and the Remote Vocational Training Scheme since 2001. The transition period will continue until January 2022.

The RACGP National Faculty for GPs in Training was established in 2019 to strengthen the voice of GPs in training around Australia, and to ensure that GPs in training can be involved in the decisions and policies that affect them. The faculty is governed by a Council made up of GPs in training and new Fellows, representing a diversity of trainee groups.

### 6.3 The impact of COVID-19 on GPs in training

GPs in training are experiencing unique challenges during the COVID-19 pandemic. In addition to uncertainty around employment, training and exams, they manage the professional and personal challenges of being a frontline healthcare worker in difficult times. GPs in training are adaptable learners, as demonstrated by their uptake of telehealth and non-face-to-face teaching modalities.

In mid-April 2020, almost one in three GPs in training reported they had needed to take leave due to self-isolation or illness. Some reported that they were able to work from home during isolation; however, many others needed to use their personal or annual leave allowances. For 6%, this leave was unpaid.<sup>57</sup>

Three in four GPs in training reported a decrease in their patient load since the COVID-19 pandemic, and for half of these this was a significant decrease (Figure 64).

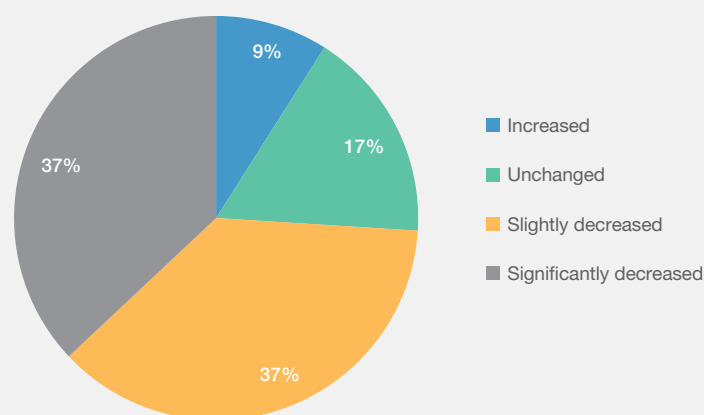
As discussed in [section 2.3](#), the pandemic has dramatically increased the uptake of telehealth in general practice. This is true for GPs in training as well, with 97% reporting they had used telehealth to deliver care, either from home or from their place of work.<sup>57</sup>

As discussed in [Chapter 3](#), a number of practices had to reduce staff hours in order to remain viable during the pandemic. This challenge impacted GPs in training, with 13% reporting their hours had been reduced, and a further 5% reporting that their employer was considering reducing their hours.<sup>57</sup>

Free text responses to the survey demonstrated that GPs in training were concerned about the disruption COVID-19 has caused to their training and employment, and the potential effects on their career and training progression.<sup>57</sup>

A range of policy changes were made to provide GPs in training with more support and flexibility during their training time.

**Figure 64.** Three in four GPs in training reported a reduced patient load since the start of the pandemic



Measure: Responses to survey questions regarding changes to patient load since the start of the COVID-19 pandemic (including both face-to-face and telehealth)

Base: Total survey respondents, n = 1081

Data source: General Practice Registrars Australia. Impacts of COVID-19 on GP trainee employment survey: Summary report. Melbourne: GPRA, 2020.

## 6.4 RACGP support for rural general practice training

GPs are an integral part of rural communities, and the skills they practise depend on the context in which they work and the specific needs of their community.

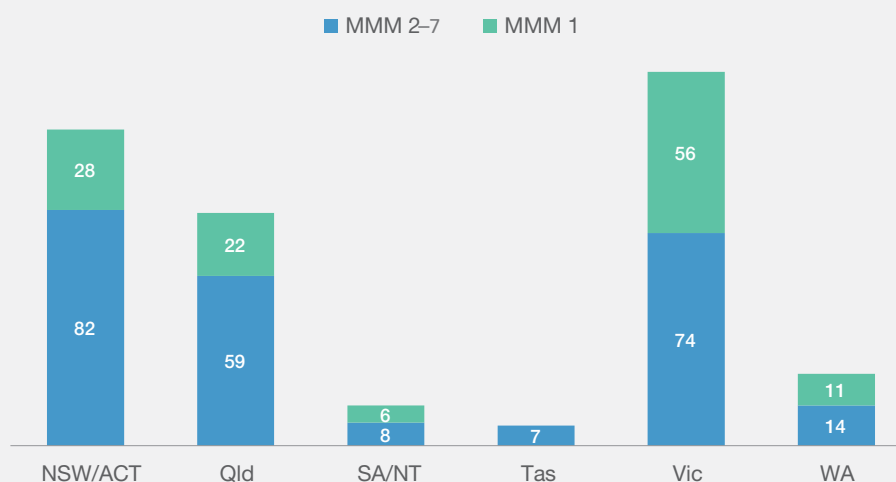
Applications for the RACGP's 2021 AGPT Program showed a 40% increase in junior doctors, compared to applications for 2020 training, indicating an interest in rural generalism.

The Fellowship in Advanced Rural General Practice (FARGP) is delivered by RACGP Rural, and recognises the additional skills and training GPs need for rural practice to meet community needs. With over 677 graduates to date and 111 new enrolments over the last year,<sup>58</sup> the FARGP qualification is awarded in addition to FRACGP and has pathways for GPs in training and practising GPs. 📄

Almost half (40%) of the rural workforce is made up of international medical graduates and overseas-trained doctors.<sup>35</sup> Commencing in 2019, the RACGP's Practice Experience Program (PEP) is a self-directed education program to support non-vocationally registered (non-VR) doctors on their journey to FRACGP. The PEP is partially funded under the Australian Government's Stronger Rural Health Strategy for doctors based in rural areas (Modified Monash Model [MMM] areas 2–7), with some exceptions approved by the government. In July 2020, there were 367 active participants in the PEP.<sup>58</sup>

📄 The RACGP supports the implementation of a national rural generalist pathway and has been working with stakeholders to develop strategies to attract and retain rural and remote doctors, including the development of the RACGP's own rural generalist Fellowship. Candidates training toward FARGP will be offered the opportunity to transition to the RACGP's rural generalist Fellowship when it is launched.

**Figure 65.** The majority of PEP participants are located in regional and rural areas

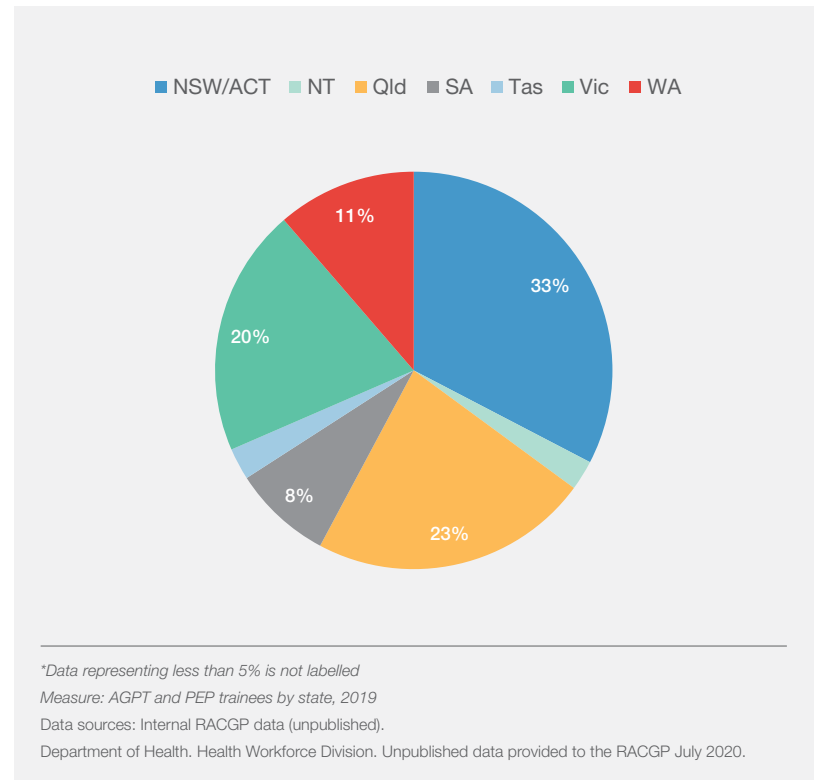


Measure: Number of active PEP participants, by primary practice location – State and rurality (Modified Monash Model), as at 31 July 2020  
Source: Internal RACGP data (unpublished).

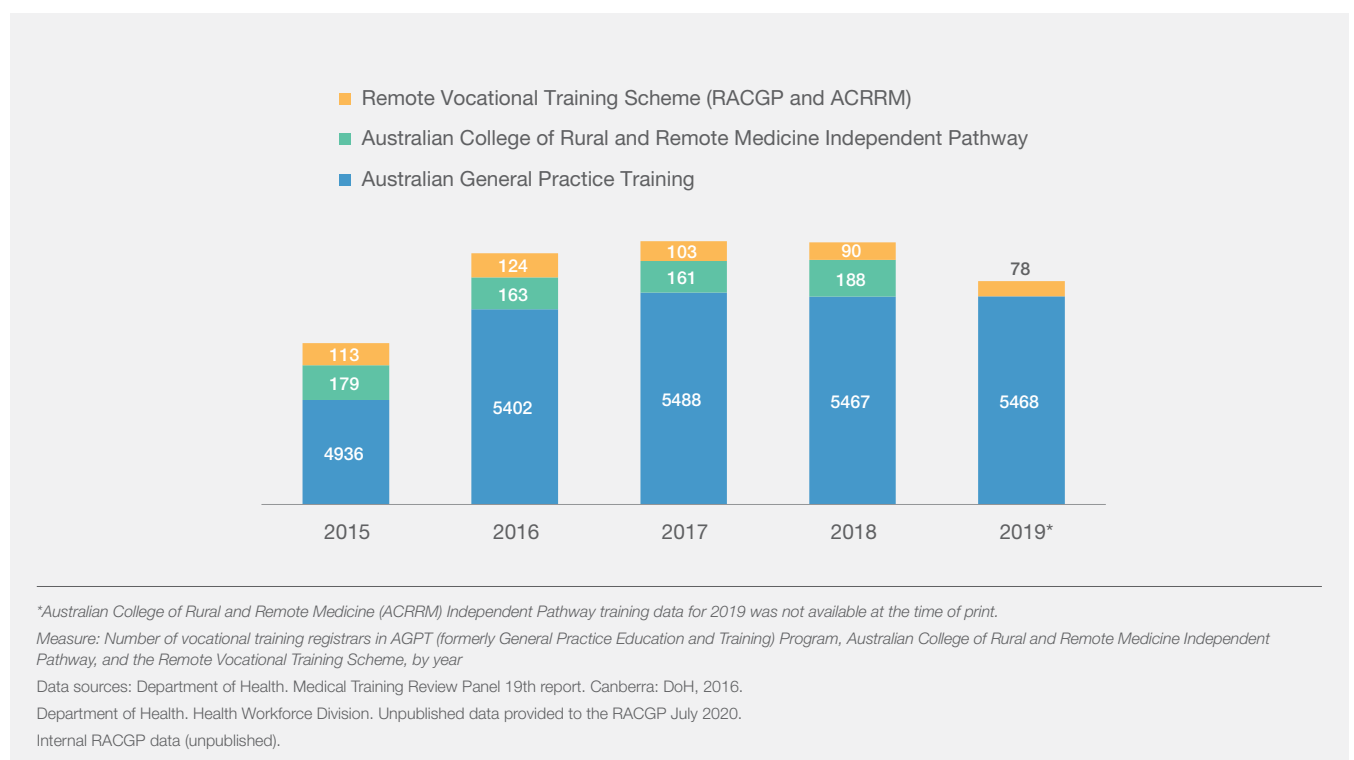
## 6.5 GPs in training demographics

AGPT Program and PEP participants are training in every Australian state and territory (Figure 66). There were more than 5500 GPs in pre-Fellowship training in 2019 (Figure 67).

**Figure 66.** Distribution of AGPT and PEP trainees\*



**Figure 67.** Number of pre-Fellowship trainees



As with previous years, there are more female AGPT trainees (61%) than male trainees (39%).<sup>59</sup> The number of registrars achieving FRACGP is increasing each year, and there are consistently more female general practice registrars attaining FRACGP than their male counterparts (Figure 68).

In 2019, 46 Aboriginal and Torres Strait Islander doctors graduated from medical programs in Australia. In Australian medical schools in 2020, there were 404 Aboriginal and Torres Strait Islander students, representing

2.7% of total domestic students. This has increased from 265 in 2014 (1.8% of total domestic students). In 2020, 121 Aboriginal and Torres Strait Islander students started studying medicine, which is a 55% increase over the past three years.<sup>60</sup>

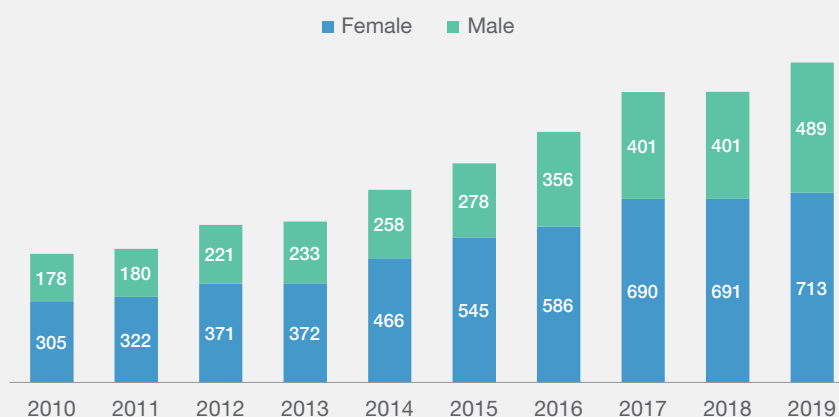
As discussed in [section 2.2.5](#), general practice is the preferred specialty for Aboriginal and Torres Strait Islander medical graduates. In 2019, there were 69 Aboriginal and Torres Strait Islander people in the AGPT Program.<sup>59</sup>

Given the growth in Aboriginal and Torres Strait Islander medical students, the RACGP hopes to see the number of Aboriginal and Torres Strait Islander GPs in training increase within the next five years. Growing the Aboriginal and Torres Strait Islander GP workforce is fundamental in closing the gap in life expectancy and health outcomes.

## Aboriginal and Torres Strait Islander people in the Australian General Practice Training Program<sup>59</sup>

48 females  
21 males

**Figure 68.** AGPT Program trainees gaining Fellowship are more frequently female



Measure: Number of trainees obtaining FRACGP, by year and registrar gender  
Source: Internal RACGP data (unpublished).

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