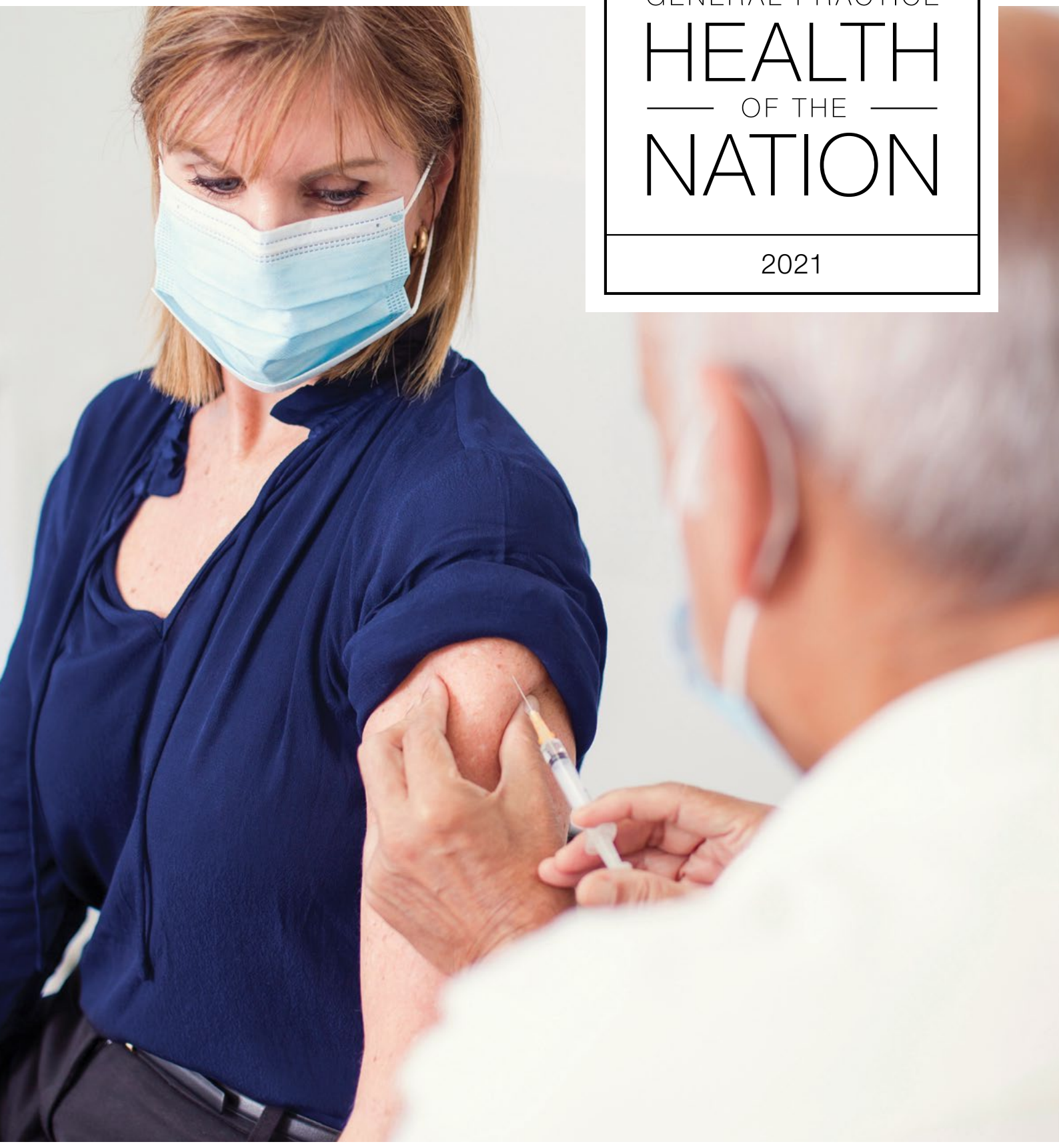
GENERAL PRACTICE HEALTH OF THE NATION

2021



RACGP

Royal Australian College *of* General Practitioners

A unique insight into the state of Australian general practice

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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GENERAL PRACTICE HEALTH OF THE NATION

2021

The *General Practice: Health of the Nation* report gives a unique overview of Australian general practice. This year's report reflects the experience of more than 1300 RACGP Fellows from across Australia, and incorporates information from the Australian Bureau of Statistics (ABS), Medicare, the Australian Institute of Health and Welfare (AIHW) and various government publications.

The report provides information at a specific point in time and identifies longer-term trends across the general practice sector.

The 2021 Health of the Nation report also highlights a number of critical issues affecting GPs and their patients, including:

- treatment of multimorbidities in general practice
- the increasing mental health burden on general practice
- restrictions to GP involvement in aged care
- barriers to the use of video telehealth services
- the COVID-19 vaccine rollout.

RACGP
Royal Australian College *of* General Practitioners

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Message from the President

This last year has again shown how resourceful, determined and capable general practices are in times of crisis

The COVID-19 pandemic lingers and many communities, including my own in Melbourne, have been plunged into lockdown again and again.

The vaccine rollout has encountered many challenges, yet our GPs, practice managers, nurses, receptionists and administrative staff have not only persevered, but performed tremendously. Practices have delivered more than 12 million COVID-19 vaccine doses (more than half the national total), and by the time you read this it will be many more.

The *General Practice: Health of the Nation 2021* report underscores that GPs are more important than ever, and we need greater support to help communities manage the fallout from the pandemic.

General practice is a ready-made mass-vaccination service

Our survey found that almost three out of five GPs reported 'managing patient expectations about vaccinations' as one of the most challenging issues arising from the pandemic. Multiple changes to vaccine eligibility requirements left many people confused and overwhelmed and, unfortunately, some of these patients took their frustrations out on general practice staff.

Differing eligibility requirements across jurisdictions added to the strain. Government can alleviate this additional pressure by ensuring practices are kept in the loop on public health decisions. General practice must be involved in public health decisions, including changes to the vaccine rollout.

This rollout will no doubt have more twists and turns ahead, and it is vital that GPs are properly consulted to ensure we can best perform our critical role as the backbone of the vaccine rollout.

We must look ahead and be clear-eyed about the future of our profession

Not enough junior doctors are choosing a career in general practice. It is that simple.

The general practice workforce is ageing – the proportion of GPs over the age of 65 increased from 11.6% in 2015 to 13.3% in 2019.

At the same time, not enough medical graduates want to be GPs. The proportion of final-year students listing general practice as their first preference specialty has fallen to just 15.2% – the lowest since 2012.

International medical graduates will continue to play a crucial role in bolstering the general practice workforce, but we must also grow our locally trained workforce. We also need more GPs to practise outside major cities. The RACGP is Australia's largest representative body of rural GPs, so that will always be a high priority.

I believe that by highlighting how diverse and rewarding this career path can be, we can encourage more doctors to opt for general practice. But it is also important to address what is holding more doctors back from a career as a GP. Piece-by-piece repair is not sufficient – genuine reform in the sector is required.

A great place to start would be putting general practice on a more sustainable, long-term financial footing. At a time when we are needed by our communities more than ever, the share of total government healthcare spend for primary care is in decline. Funding for GPs and general practice services is less than 8% of total health expenditure, yet we provide more than twice the number of episodes of care a year than hospitals, and all at one-sixth of the cost.

As we revealed last year, economic analysis by PricewaterhouseCoopers estimates that implementing the RACGP's *Vision for general practice and a sustainable healthcare system* and boosting primary care funding could provide benefits of $5.6 billion over the next five years.

This issue is front of mind for many of our members. This year's survey found that 26% of respondents ranked Medicare rebates as their highest priority. More than half of GPs surveyed said they would recommend general practice as a career to their junior colleagues, but 48% indicated they are less likely to do so now compared to a decade ago. Those who would not recommend general practice as a career have concerns around their remuneration, recognition and Medicare billing requirements.

So, if the Federal Government is serious about boosting the general practice workforce of the future so all patients can continue to access high-quality primary care regardless of where they live, it is vital this is reflected in long-term funding arrangements. The task of attracting more junior doctors to general practice would be made that much easier and the savings for the entire health system would be immense.

We need to set a target and stick with it. Anything less could be detrimental to the entire health system and, indeed, the health of the nation.

Managing the fallout from the pandemic in the years ahead will be crucial

Ask any GP and they will likely report more and more patients presenting with mental health concerns. This is part of a longer-term trend. For the fifth consecutive year, psychological conditions, including sleep disturbance and depression, were the most reported reasons for patient presentations. Over 70% of GPs selected 'psychological' in their top three reasons for patient presentations, a number that has risen steadily from 61% in 2017.

As the first port of call for many patients with mental health issues, GPs play a vital ongoing role over many months or even years. Four out of five GPs report they have patients with mental health conditions that are mostly managed within general practice. This aligns with data showing that GPs provide the majority of Medicare-subsidised mental health services.

The scale of the task has only grown over the last 12 months. To help these patients, we need new Medicare items for longer mental health consultations so we can really get to the bottom of what is going on.

The true measure of any society is how it treats its most vulnerable

The last year has seen an increased focus on aged care, a shift that could not have come soon enough. GPs play a vital and often unrecognised role in caring for older people in residential aged care facilities and in the community. People aged 65 and over account for 16% of the Australian population but represent nearly 30% of all general practice consultations.

Ensuring adequate access to primary care can make an enormous difference. We know people with dementia entering the aged care system are less likely to experience an increase in prescriptions for medications like antipsychotics if they retain a relationship with their usual GP.

When asked what would make them more likely to work in aged care, two-thirds of GP respondents said better remuneration via Medicare items, while more than half selected fewer administrative burdens and more clinical staff in aged care settings as key drivers. Helping GPs get on with the job of helping older people in aged care is essential.

It is also important to remember that GPs are the only medical practitioners that specialise in managing patients with multiple health conditions. Almost three-quarters of GPs surveyed reported that most of their patients have multiple medical conditions.

This challenge looms large on the horizon for general practice. To better help patients with multiple conditions who are at heightened risk of ending up in hospital, we must change how we structure general practice funding. As things currently stand, Medicare discourages GPs from treating more than one condition in the same consultation. It is vital that we remove this barrier and incentivise longer consultations to support comprehensive care by GPs.

The solutions are in plain sight – we just need the political will

The RACGP will continue fighting for practices and their patients across Australia.

Only when the fundamental role of general practice is properly recognised and greater support and resources are given to our hardworking GPs can government honestly say it is committed to improving the health of the nation.

To all practices, I say keep up the great work. Your communities need you now more than ever before.

Dr Karen Price
RACGP President
17 September 2021

Introduction

GPs are the backbone of Australian healthcare, with almost 85% of the population seeing a GP at least once each year.[1] A thriving, accessible and high-quality general practice sector is vital to the health of the nation.

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

As Australia's largest professional general practice organisation, the RACGP represents more than 43,000 members, including more than 24,000 Fellows who have completed specialist training (or its equivalent). These are the frontline GPs who treat almost 22 million patients[1] across the country every year.

Our annual *General Practice: Health of the Nation* report helps shine a light on Australian general practice. It examines the main reasons people see their GP, as well as how they interact with the primary health system. It also points to the main challenges GPs face and what must be addressed to ensure Australians can access the care they need, when they need it.

The report collates data from various sources – including publicly available data from the Department of Health, Medicare, the Australian Institute of Health and Welfare (AIHW), the Australian Bureau of Statistics (ABS) and the Productivity Commission – to provide a unique overview of the general practice sector. It also draws directly on GPs' own thoughts via the 2021 Health of the Nation survey, specifically commissioned research spanning five years that has involved RACGP Fellows from all parts of Australia.

The online survey was undertaken by EY Sweeney during April and May 2021. The 1386 survey respondents covered a wide range of demographics:

- 59% female, 40% male*
- 8% <35 years, 26% 35–44 years, 31% 45–54 years, 24% 55–64 years, 11% ≥65 years
- 12% Western Australia, 10% Northern Territory/South Australia, 23% Queensland, 28% New South Wales/Australian Capital Territory, 27% Victoria/Tasmania, <1% overseas
- 70% in major cities, 20% inner-regional, 8% outer-regional, 2% remote and very remote

The *General Practice: Health of the Nation* report focuses on a range of general practice 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 practices.

RACGP members select a specific topic of focus for the report each year. In 2021, that focus is multimorbidity in general practice. The ongoing challenge of adapting processes and responding to the COVID-19 pandemic is also reflected in survey findings throughout the report.

As the fifth 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 can be viewed online:

- *General Practice: Health of the Nation 2017*
- *General Practice: Health of the Nation 2018*
- *General Practice: Health of the Nation 2019*
- *General Practice: Health of the Nation 2020*

* All RACGP Fellows were invited to participate in the survey. To minimise the impact of non-response, reminders were sent throughout the fieldwork period. The survey sample was representative in terms of GP age and practice location, but had a greater proportion of female respondents than the overall RACGP Fellow cohort.

1. Department of Health. Annual Medicare statistics: Financial year 1984–85 to 2020–21. Canberra: DoH, 2021.

Chapter 1: Current and emerging issues

1.1 Common health presentations in general practice

As in previous years, RACGP Fellows participating in the 2021 Health of the Nation survey were asked to nominate the three most common presentations they see.

Psychological conditions (including sleep disturbance and depression) were the most commonly reported reasons for patient presentations for the fifth consecutive year, and the overall number of GPs who selected mental health in their top three reasons for patient presentations has risen steadily since the survey was first launched, from 61% in 2017 to over 70% in 2021. This increase is statistically and clinically significant and reflects findings from multiple sources that mental health presentations in general practice are increasing (Figure 1, Figure 3).

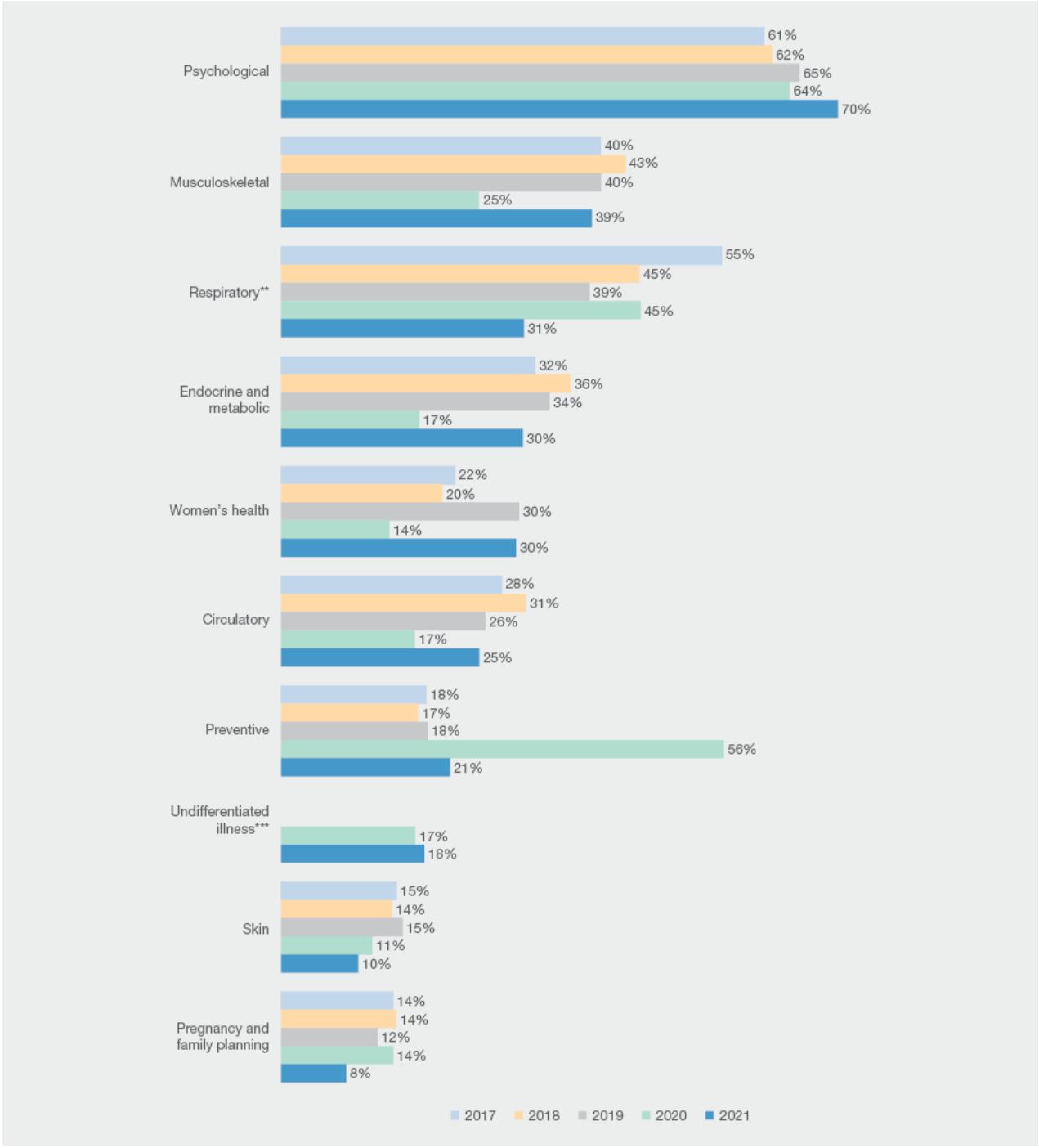
General practices and their teams provide more than 170 million services each year.[1] Many consultations involve discussion of several problems covering multiple disease domains. Understanding and measuring what happens in a general practice consultation can be difficult, as publicly available data extracted from medical records are limited. Self-reported aggregate survey data can provide some guidance to policymakers on the types of presentations GPs most often see.

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

The 2020 survey showed a large spike in preventive care (particularly immunisation) during the early days of the COVID-19 pandemic and a drop in management of physical health conditions. The 2021 survey results, however, showed a return to previous rates of care for musculoskeletal, endocrine and metabolic, women's health, and circulatory presentations[2] (Figure 1).

Musculoskeletal conditions (back or neck pain, arthritis) have returned to the second-most commonly reported reason for patient presentation (according to 39% of GPs). Respiratory presentations (cough, asthma, sinusitis and suspected COVID-19) remain the third-most commonly reported reason by GPs (31% of GPs), falling from 45% at the start of the COVID-19 pandemic. Preventive care (immunisation, diet) has returned to similar rates reported in pre-COVID years (21% of GPs) (Figure 1).

Figure 1. Mental health is the most commonly reported reason for patient presentations in general practice



*Showing top 10 of 18 response options.
**Descriptor amended in 2020 to include 'suspected COVID-19'.
***New response options added in 2020. Caution should be used on the magnitude of differences from 2019 and 2020, as two new codes – 'undifferentiated illness' and 'effects of non-medical issues' – were added in 2020. Note: 'Men's health' code label changed in 2019 (from male genital system); 'Women's health' code label changed in 2019 (from female genital system).
Measure: GP responses to the question, 'What are the three most common reasons for patient presentations?'
Base: Total survey respondents, n = 1309 (2017); n = 1537 (2018); n = 1174 (2019); n = 1782 (2020); n = 1386 (2021).
Source: EY Sweeney, RACGP GP Fellow Survey, May 2021.

Figure 2 shows variation in reported health presentations according to the GP's age, gender and practice location. GPs aged 44 years and younger are more likely to report a higher proportion of patients presenting for psychological, respiratory, women's health, and pregnancy and family planning reasons, whereas GPs aged 45 years and older are more likely to report musculoskeletal, endocrine and metabolic, and circulatory issues as reasons for patient presentations (Figure 2).

Female GPs are more likely to report psychological, women's health, and pregnancy and family planning as reasons for patient presentations, whereas male GPs are more likely to report musculoskeletal, respiratory, circulatory and skin presentations (Figure 2).

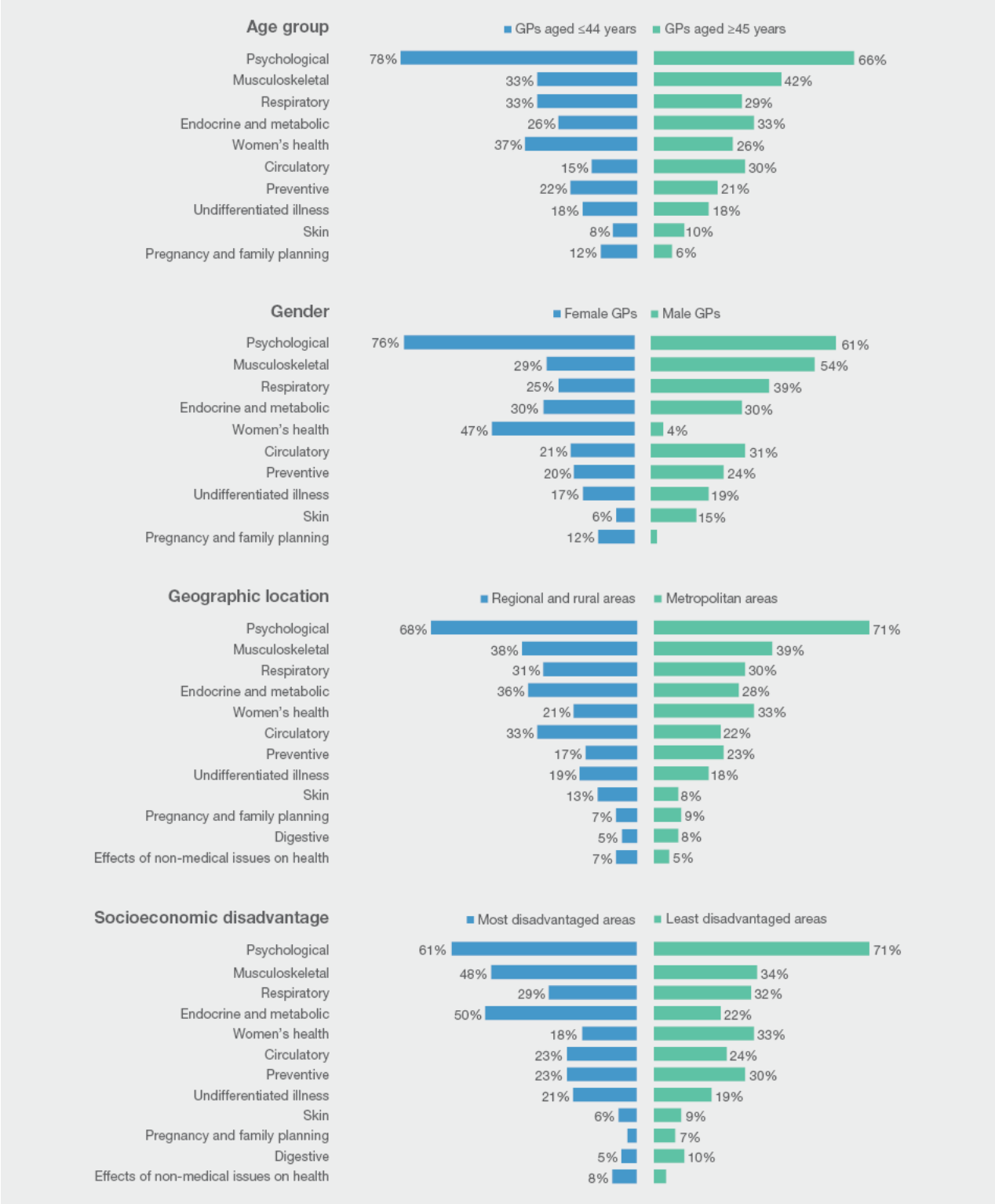
GPs in rural and regional areas[†] more commonly see endocrine and metabolic, circulatory and skin issues compared to their colleagues in metropolitan areas. GPs in areas of greatest socioeconomic disadvantage[‡] reported seeing a higher proportion of musculoskeletal, endocrine and metabolic issues, as well as the effects of non-medical issues on health (such as domestic violence, inadequate housing) (Figure 2).

These gender- and age-related differences in presentations, along with the differences related to practice location, have been consistently reported through the five years of the Health of the Nation survey.[3]

GPs working in Aboriginal medical services (AMSs) are more likely to report endocrine and metabolic issues (66%) and the effects of non-medical issues on health (38%), and are less likely to report psychological (53%), musculoskeletal (25%), women's health (9%), and preventive care (9%) than GPs working in all practice types.[3] GPs in AMSs are more likely to work in areas of socioeconomic disadvantage.[3]

As with previous years, the 2021 findings may reflect an overall higher disease burden in areas of socioeconomic disadvantage and a need to prioritise acute physical health issues. Lower rates of health literacy among patients in these areas may also affect when and how they seek help.[2]

Figure 2. Commonly managed health issues vary according to a practitioner's personal characteristics



Showing top 10–12 of 18 response options.
Measure: GP responses to the question, 'What are the three most common reasons for patient presentations?', split by GP characteristics.
Base: Total survey respondents, n = 1386.
Source: EY Sweeney, RACGP GP Fellow Survey, May 2021.

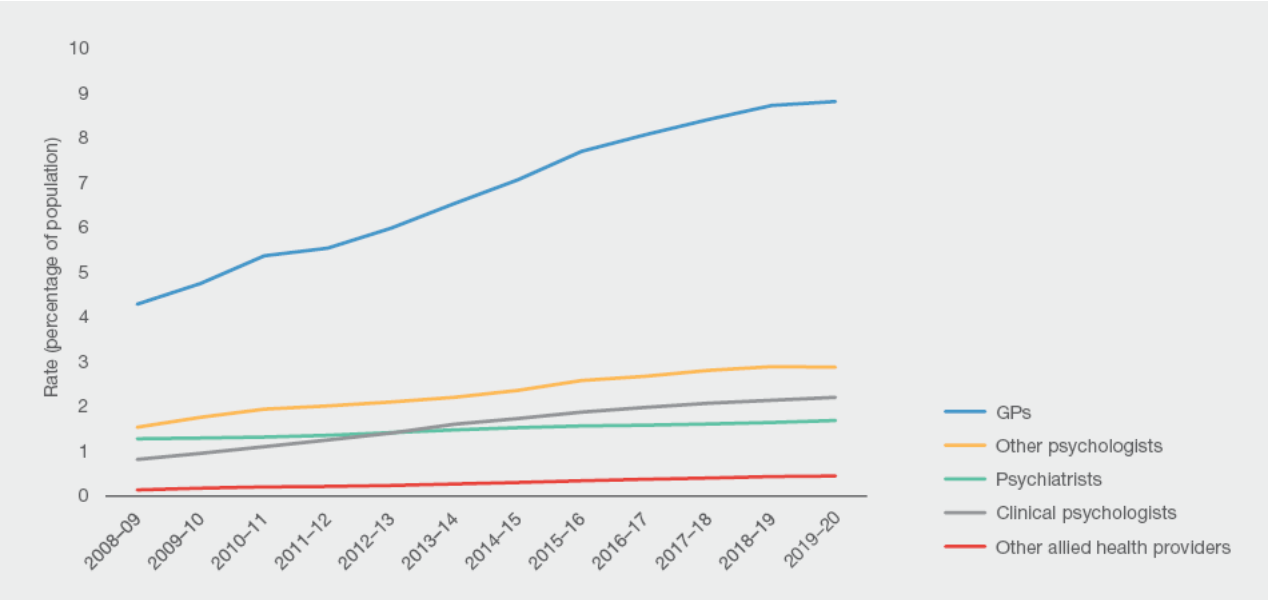
In addition to an increase in psychological presentations, more patients are accessing mental health Medicare Benefits Schedule (MBS) items.

This trend of increasing use of mental health services has been exacerbated by the COVID-19 pandemic.[5]

It is important to note that these figures are likely an under-representation of the true magnitude of mental health presentations to GPs, as the longer consultations required for these presentations are often billed as a general consultation rather than under a specific mental health MBS item number.

> ‘ More than 10% of the population received specific MBS-supported mental health care in 2019–20, almost doubling the rate from the previous 10 years.[4]
> The majority of these services (82%) were provided by a GP (Figure 3).’

Figure 3. GPs provide the majority of MBS-subsidised mental health services, and attendances are rapidly increasing



Source: Australian Institute of Health and Welfare 2021. Mental health services in Australia. Canberra: AIHW. Viewed 27 May 2021

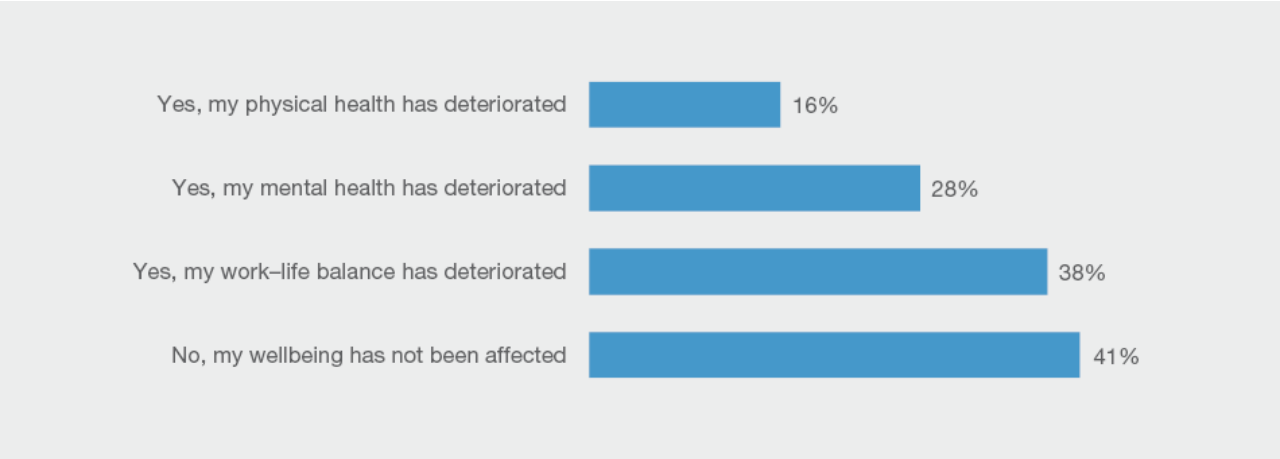
In addition, it is important to recognise that GPs have also been affected by COVID-19, with more than half (53%) reporting at least one negative impact to their wellbeing because of the pandemic (Figure 4). These rates have remained steady since the 2020 survey and suggest ongoing effects on GPs and their practices.

Increased reporting of a deterioration in work–life balance, from 33% in 2020 to 38% in 2021,[3] may be due to the increased burden of providing COVID-19 vaccines and related counselling in 2021.

Male GPs are more likely to report no change to their wellbeing as a result of COVID-19 (50%) compared to female GPs (35%).[3] This is consistent with GP survey findings in 2020,[6] and aligns with findings from surveys of the wider population, with women often disproportionately affected by unpaid caregiving duties.[7]

GPs in rural and regional areas are more likely to report a deterioration in their work–life balance (44%) compared to GPs in metropolitan areas (37%). GPs in Victoria are the most likely to report a negative effect to their wellbeing (58%), with more reporting effects on their work–life balance (44%) and physical health (20%) compared to GPs in other states.[3] This likely reflects the impact of Victoria’s prolonged COVID-19 lockdown in 2020.

Figure 4. One in two GPs reported the COVID-19 pandemic had a negative effect on their wellbeing



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: Total survey responses, n = 1386.
Source: EY Sweeney, RACGP GP Fellow Survey, May 2021.

During the COVID-19 pandemic, GPs' need to manage more stringent infection-control measures and concerns for their own wellbeing, as well as those of their patients, has affected them and their practice staff. GPs also reported increased stress from constantly changing clinical advice, Medicare rule changes, financial and business pressures, and managing a larger volume of patient enquiries. See Figure 7 for more information.

† According to the Australian Bureau of Statistics remoteness areas.
‡ According to the Australian Bureau of Statistics' Socio-Economic Indexes for Areas ranking 1 (most disadvantaged) versus 10 (least disadvantaged).

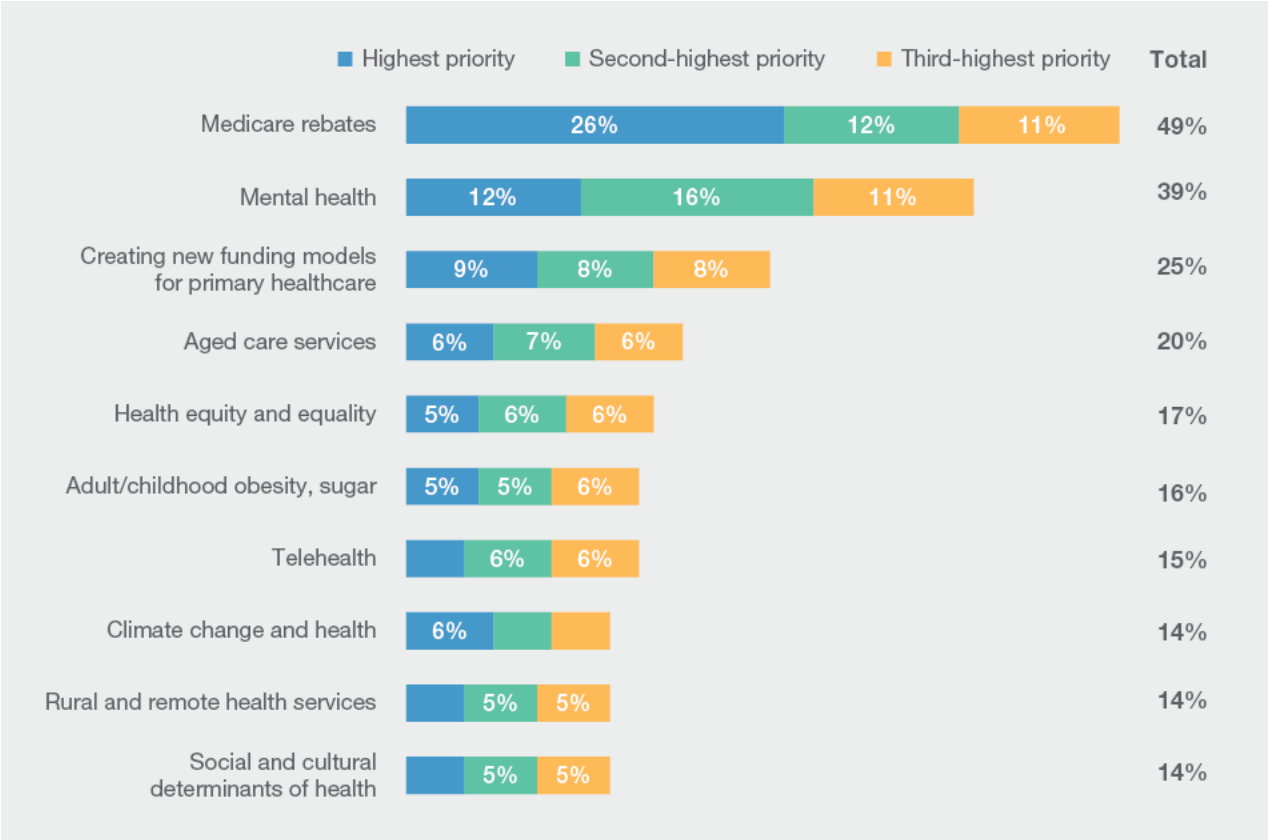
1. Department of Health. Annual Medicare statistics: Financial year 1984–85 to 2020–21. Canberra: DoH, 2021.
2. RACGP. General Practice: Health of the Nation 2020. East Melbourne: RACGP, 2020.
3. EY Sweeney. RACGP GP Fellow Survey. Melbourne: EY Sweeney, 2021.
4. Australian Institute of Health and Welfare. Mental health services in Australia. Canberra: AIHW, 2021.
5. Black Dog Institute. Mental health ramifications of COVID-19: The Australian context. Sydney: Black Dog Institute, 2020.
6. RACGP. General Practice: Health of the Nation 2020. East Melbourne: RACGP, 2020.
7. Hammarberg K, Tran T, Kirkman M, et al. Sex and age differences in clinically significant symptoms of depression and anxiety among people in Australia in the first month of COVID-19 restrictions: A national survey. BMJ Open 2020;10(11):e042696.

1.2 Issues that require policy action

As was found in previous Health of the Nation surveys, funding issues remain the most important health policy area for GPs, with 26% ranking Medicare rebates as their highest priority and 9% naming the creation of new funding models for primary care as their highest priority (Figure 5).

Mental health has been highly ranked as a priority for government action each year since 2018, reflecting the most common presentations GPs see in their practice. These issues have been consistently raised as among the most important health policy areas for GPs since 2018.

Figure 5. GPs want the government to prioritise Medicare rebates, mental health and creating new funding models for primary care



*Showing the top 10 out of 23 response options.
Data of less than 5% not labelled.
Measure: GP responses to the question, 'From the [randomised] 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 = 1386.
Source: EY Sweeney, RACGP GP Fellow Survey, May 2021.

Aged care services are the fourth-highest priority policy area among surveyed GPs, reflecting current events such as the COVID-19 pandemic and the Royal Commission into Aged Care Quality and Safety.

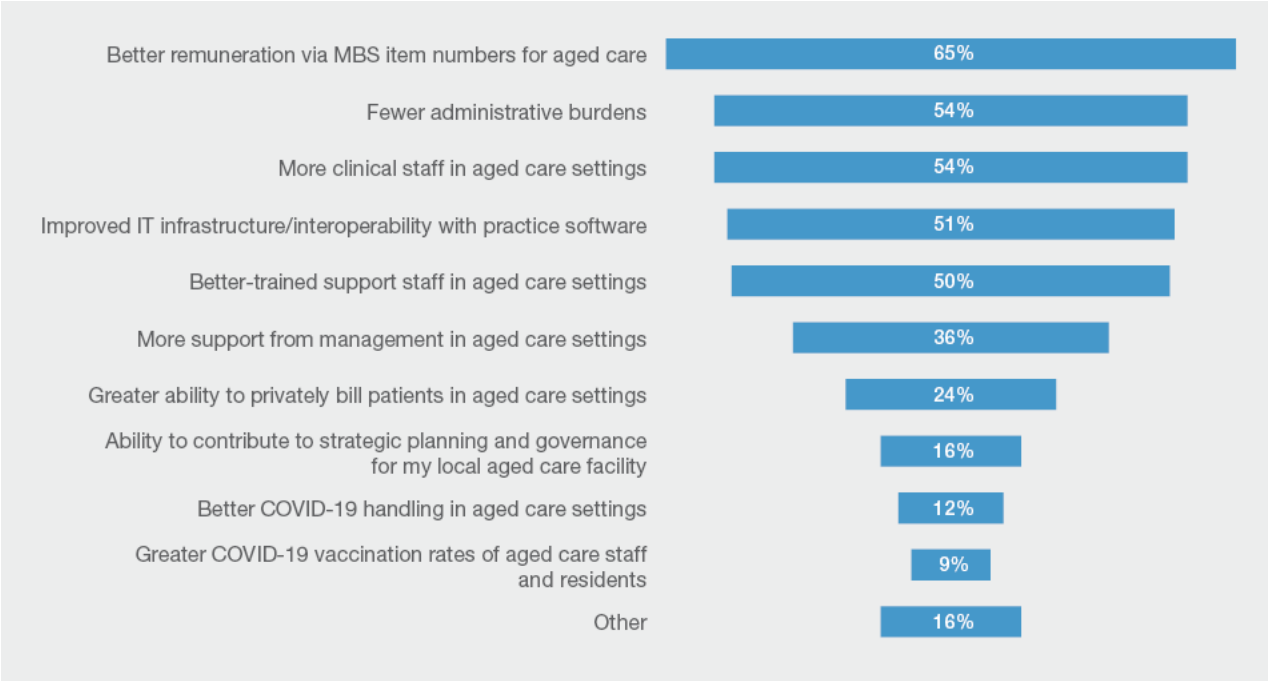
When asked what would make them more likely to work in aged care, two-thirds of GPs indicated better remuneration via MBS items and more than half named fewer administrative burdens, more clinical staff in aged care settings (such as nurses, general practice registrars or allied health) and improved IT infrastructure (including interoperability with practice software) as key drivers (Figure 6).

GPs have the training and experience to provide high-quality aged care in community settings and residential aged care facilities (RACFs). Although people aged over 65 years represent only 16% of the Australian population, they represent nearly 30% of all general practice consultations.[8]

It is vitally important that GPs are supported to provide aged care services. Studies have revealed that people with dementia entering the aged care system are less likely to experience an increase in medication prescription (including antipsychotics, benzodiazepines and antidepressants) if they retain a relationship with their usual GP.[9]

However, there are significant barriers that prevent GPs from operating effectively in RACFs.

Figure 6. Two-thirds of GPs indicate better MBS rebates in aged care are needed



Other responses in free text included nothing/no interest in aged care/no time, improved aged care standards, a more supportive work environment, politics, better access to facility, less on-call time.
Measure: GP responses to the question, 'What would make you more likely to want to work in aged care [select all that apply]?'
Base: Survey respondents who had not worked in aged care in the past month, n = 1028.
Source: EY Sweeney, RACGP GP Fellow Survey, May 2021.

8. Australian Institute of Health and Welfare. Health of older people. Canberra: AIHW, 2020.
9. Welberry HJ, Jorm LR, Schaffer AL, et al. Psychotropic medicine prescribing and polypharmacy for people with dementia entering residential aged care: The influence of changing general practitioners. Med J Aust 2021; 215(3):130–36. doi:10.5694/mja2.51153.

1.3 COVID-19 and general practice

Since the start of the pandemic in March 2020, concerns have been raised about COVID-19's impact on patients, GPs, practice staff and practice viability.[10] This continues to be reflected in the 2021 survey, with particular challenges related to Australia's vaccine rollout. Almost three in five GPs (59%) reported that managing patient expectations about vaccinations is one of the most challenging issues arising from the COVID-19 pandemic. The second-most reported challenge is finding a financially viable way to provide COVID-19 vaccinations (37%), with another 33% reporting financial pressures (Figure 7).

The third-most challenging issue for GPs is that patients are not coming into the practice during the pandemic. Almost one in three GPs reported difficulty accessing adequate supplies of a COVID-19 vaccine and difficulty providing face-to-face services, such as complying with social distancing, ensuring adequate staffing and accessing PPE (Figure 7).

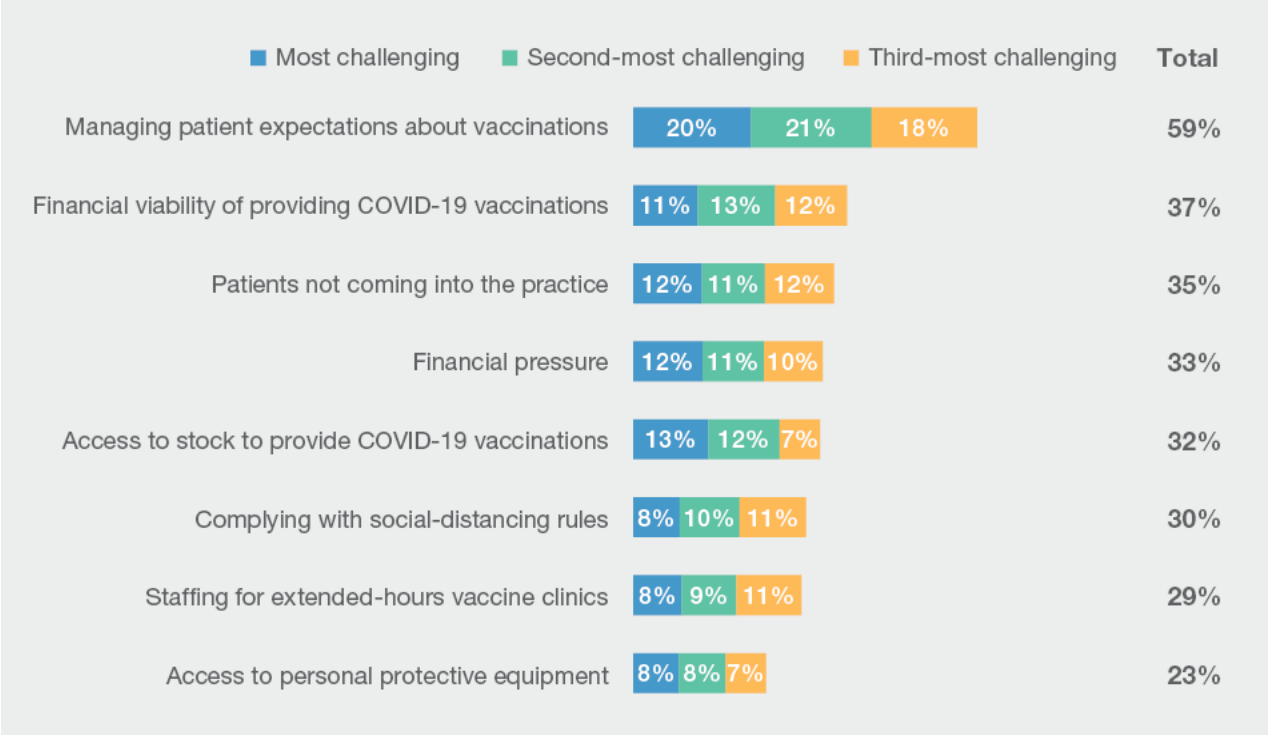
One in seven respondents (15%) reported a challenge under 'other' in a free-text box. Among those specifying an 'other' response, these included increased workload (14%), dealing with potentially COVID-19-positive patients (13%), patients' stress levels (9%), vaccine hesitancy (8%), vaccine rollout issues (7%), access to stock to provide flu vaccinations (7%), and staff stress levels (6%).[3]

COVID-19 vaccination services involve considerable additional costs and administrative requirements, such as developing and updating consent forms and online booking systems, training staff, paying additional wages (often at after-hours rates), reporting adverse events following immunisation, and providing the necessary infrastructure, cleaning supplies and personal protective equipment (PPE) at reasonable prices to support safe immunisation services on a large scale.

In March 2021, new MBS items were introduced to enable GPs and other medical practitioners to assess patients for their suitability to receive a COVID-19 vaccine. These new items were based on a Level A attendance item and were required to be bulk billed.

Patients are turning to GPs as their trusted health professionals for advice on vaccines, including possible side effects. The announcement of recommended age restrictions for the use of the AstraZeneca vaccine resulted in a noticeable increase in vaccine hesitancy early in 2021. It takes considerable time to discuss these concerns and provide patients with full vaccine counselling.

Figure 7. The most commonly reported challenge arising from COVID-19 is managing patient expectations about vaccinations



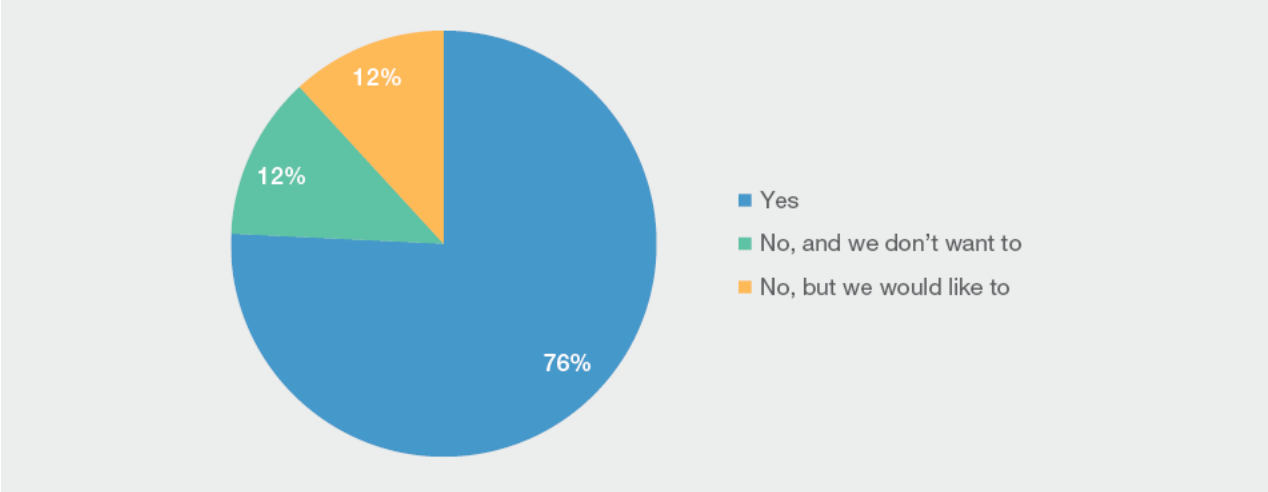
Measure: GP responses to the question, 'What challenges are you experiencing which impact your ability to provide care to patients as a result of COVID-19?'
Base: Responses to survey question, n = 1386.
Source: EY Sweeney, RACGP GP Fellow Survey, May 2021.

'Despite concerns about the financial viability of providing COVID-19 vaccinations, as well as difficulty accessing doses, almost nine out of 10 GPs reported that their practice is administering these vaccinations or is willing to provide this service (Figure 8).'

Practice teams are again demonstrating that they are prepared to put the wellbeing of their patients first, regardless of financial and logistical barriers.

GPs working at group practices are the most likely to be providing COVID-19 vaccinations (81%), whereas solo GPs (41%) and GPs working in public or private hospitals (43%) are the least likely.[3]

Figure 8. The majority of general practices are providing COVID-19 vaccinations

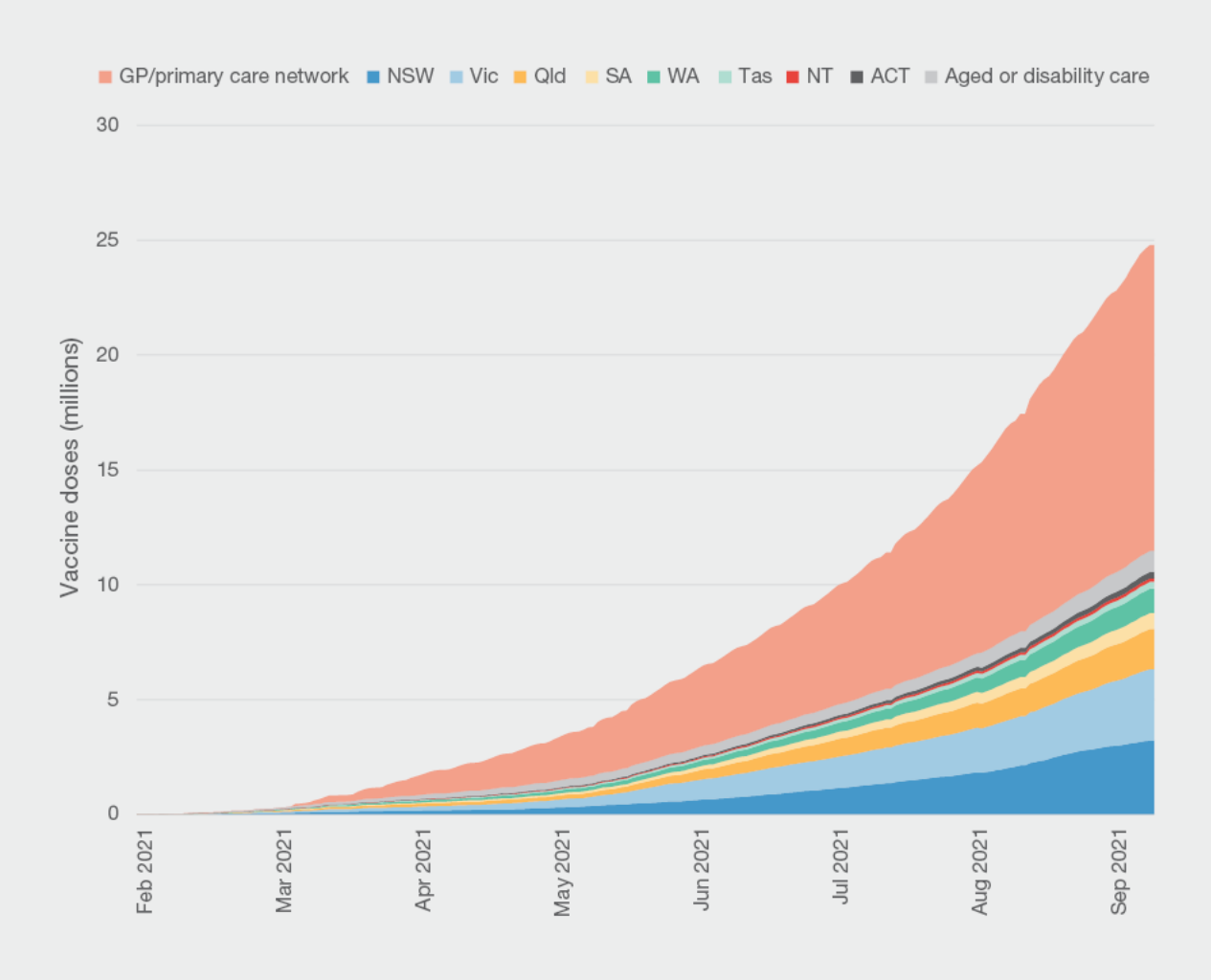


Measure: GP responses to the question, 'Is your main practice providing COVID-19 vaccinations?'
Base: Responses to survey question, n = 1386.
Source: EY Sweeney, RACGP GP Fellow Survey, May 2021.

Data show that GPs are at the forefront of the COVID-19 vaccine rollout, with more than half of all vaccines across the country administered in general practice during the first seven months of the rollout (from February 2021). This is despite being restricted from joining the rollout until four weeks after the first doses were available through state-run clinics and ongoing difficulty receiving supply of adequate doses (Figure 9).

In June 2021, approximately 10% of general practice activity in NSW and Victoria was directed at providing COVID-19 vaccinations, a figure that is likely to increase as more doses become available.[11]

Figure 9. General practices are leading the COVID-19 vaccine rollout



Measure: COVID-19 vaccine cumulative doses by administration channel – state-run vaccination hubs, aged care, disability care and general practices.
Source: www.covid19data.com.au/vaccines [Accessed 21 September 2021].

3. EY Sweeney. RACGP GP Fellow Survey. Melbourne: EY Sweeney, 2021.
10. Kippen R, O'Sullivan B, Hickson H, et al. A national survey of COVID-19 challenges, responses and effects in Australian general practice. Aust J Gen Pract 2020;49(11). doi:10.31128/AJGP-06-20-5465.
11. Pearce C, MA, Gardner K, Supple J. COVID-19 and Australian general practice: The impact of vaccination programs. Melbourne: Outcome Health, 2021 [Accessed 10 September 2021].

1.4 An issue in focus: Multimorbidity in general practice patients

GPs are the only medical practitioners that specialise in managing multimorbidity across the full patient spectrum, from paediatrics to aged care. This unique case load requires broad-ranging knowledge and a whole-of-person approach to providing care. We know multimorbidity is increasing, and the complexity of care required is increasing with it.

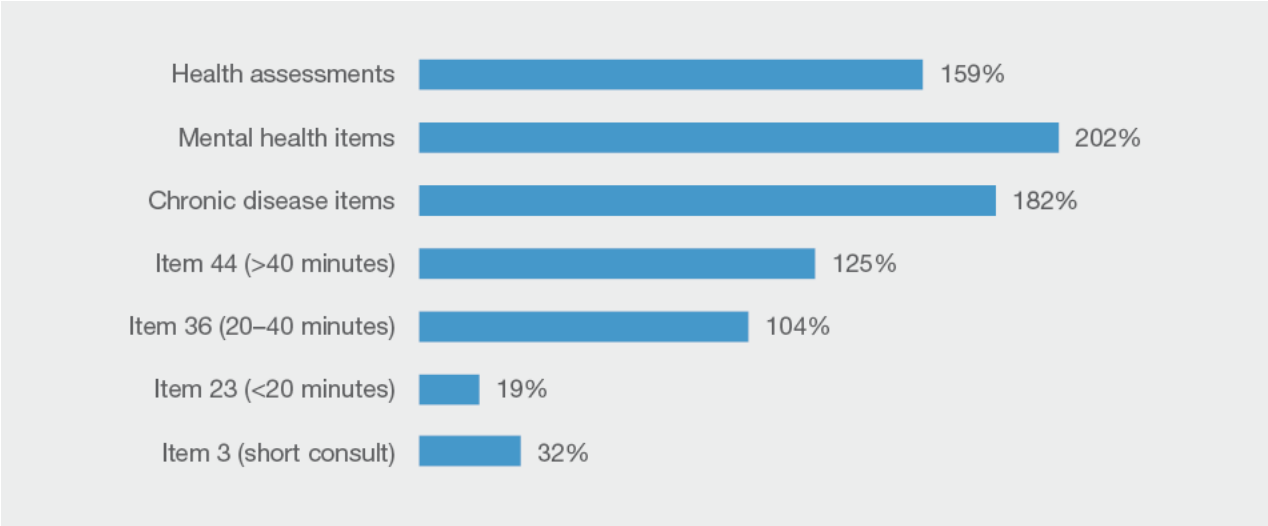
This burden of complexity is in part reflected in the increasing use of MBS item numbers for longer consultations, mental health items and items relating to more complex care. GPs are spending more time with their patients as the complexity of their health conditions increases.

Between 2010–19, billing of long (20–40 minutes) and prolonged (longer than 40 minutes) consultations increased by 104% and 125%, respectively. At the same time, use of MBS items for patients with chronic disease increased by 182% and specific mental health items increased by 202%. In comparison, consultations of under 20 minutes and short consultations increased by only 32% and 19%, respectively, over the same period (Figure 10).

Patients with multimorbidity need to access more health services more often, and they want this care to be well coordinated across the system.[13] General practice is well placed to coordinate care across sectors, providing continuity of care as guided by an ongoing relationship with the patient. However, GPs' ability to deliver this care effectively is challenged by the limitations of funding models, inadequate guidelines and fragmented healthcare systems built around single-disease states.[14] Limited time and resources for dealing with increased patient complexity can contribute to low morale and burnout among GPs.[15]

The COVID-19 pandemic has demonstrated how important an integrated and well-supported primary care sector is in managing threats to population health. Long-term reform across Australia's healthcare system, with greater focus on primary care and preventive health, is vital.[16]

Figure 10. Medicare item statistics show increased use of longer and more complex item numbers

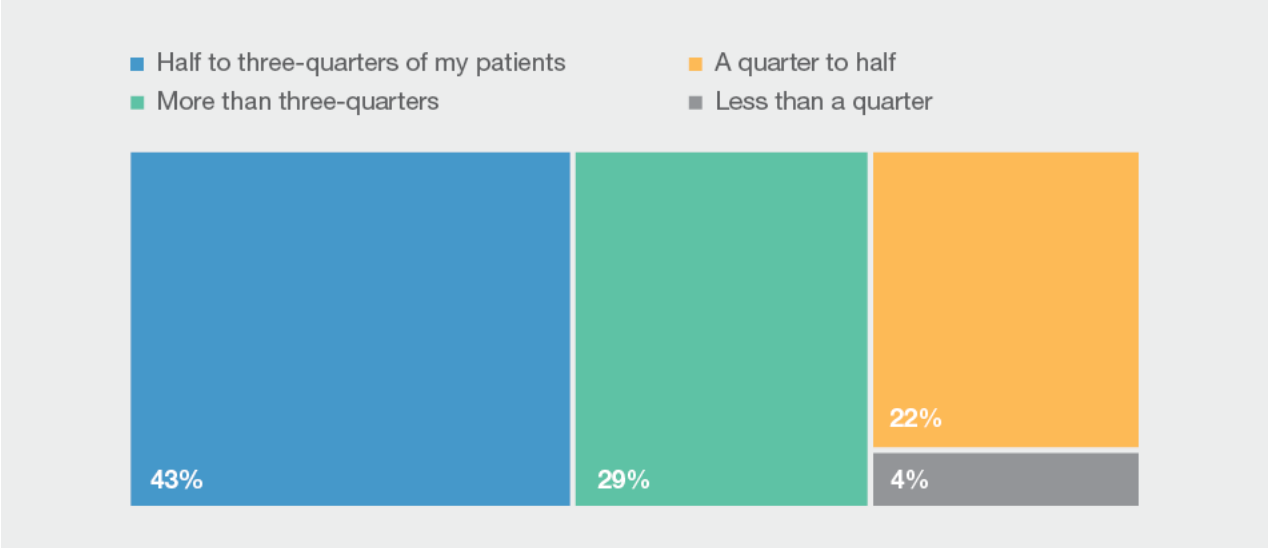


Measure: Percentage increase in billing between January 2010 and December 2019 for Standard Consults: 3,23,36,44 CDM: 721,723,729,732 Mental Health: 2700,2701,2715,2717,2712,2713 Health Assessments:701,703,705,707,715.
Source: Services Australia Medicare Item Reports.

Nearly three in four GPs reported that more than half of their patients have multimorbidity, with 29% saying more than 75% of their patients fall into that category (Figure 11).

More GPs in rural and regional areas (79%) reported that the majority of their patients have multimorbidity than their colleagues in metropolitan areas (69%).[3]

Figure 11. Most GPs reported that more than half of their patients have more than one chronic condition



Measure: GP responses to the question, 'What proportion of your patients would you describe as having more than one chronic health condition (physical and/or mental)?'
Base: Responses to survey question, n = 1386.
Source: EY Sweeney, RACGP GP Fellow Survey, May 2021.

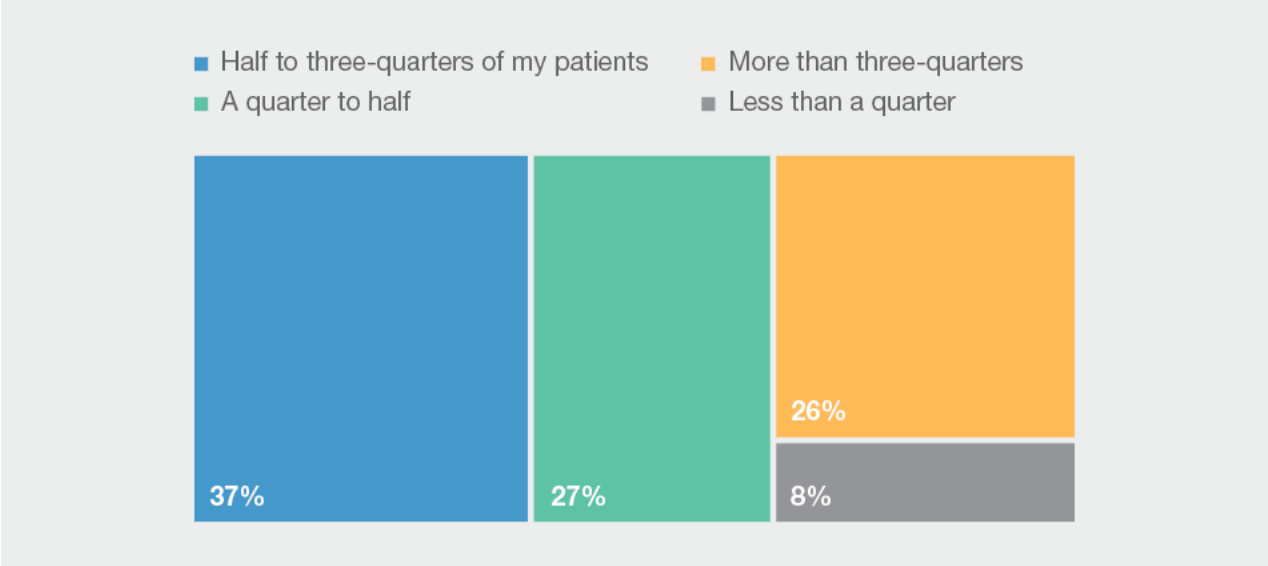
Almost two-thirds of GPs (63%) reported that most of their patients have physical and mental health conditions that they treat concurrently (Figure 12).

There is some variation between genders, with 70% of female GPs reporting that a majority of their patients have both physical and mental health conditions, compared to 51% of male GPs.[3]

This mirrors the higher proportion of female GPs reporting psychological issues as the most common reason for patient presentations (Figure 2).

The prevalence of physical health conditions, including cardiovascular disease, diabetes, hypertension, dyslipidaemia, obesity and smoking, is higher among patients with long-term mental illness.[17] However, the funding system is not structured to support care for multiple conditions, with patients ineligible for Medicare rebates for both mental health and physical health on the same day. GPs provide comprehensive, holistic, patient-centred care with an understanding of the interplay between biopsychosocial contributors to health. GPs believe that to treat physical ailments separately to mental wellbeing is not person-centred care and is not reflective of health needs.

Figure 12. The majority of patients have physical and mental health conditions that are treated concurrently



Measure: GP responses to the question, 'What proportion of your patients would you describe as having physical and mental health conditions which you treat concurrently?'
Base: Responses to survey question, n = 1386.
Source: EY Sweeney, RACGP GP Fellow Survey, May 2021.

Four out of five GPs (81%) reported having patients with mental health conditions that are mostly managed within general practice. Only one in five refer patients with mental health conditions on to another medical specialist who manages their condition/s.[3] This aligns with data showing that GPs provide the majority of Medicare-subsidised mental health services in Australia (Figure 3).

3. EY Sweeney. RACGP GP Fellow Survey. Melbourne: EY Sweeney, 2021.
12. Academy of Medical Sciences. Multimorbidity: A priority for global health research. London: The Academy of Medical Sciences, 2018.
13. Mason B, Nanton V, Epiphaniou E, et al. 'My body's falling apart.' Understanding the experiences of patients with advanced multimorbidity to improve care: Serial interviews with patients and carers. BMJ Support Palliat Care 2016;6(1):60–5.
14. Damarell, RA Morgan DD, Tieman JJ. General practitioner strategies for managing patients with multimorbidity: A systematic review and thematic synthesis of qualitative research. BMC Fam Pract 2020;21(1):131. doi:10.1186/s12875-020-01197-8.
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16. Wright M, Versteeg R, Hall J. General practice's early response to the COVID-19 pandemic. Australian health review. Aust Health Rev 2020;44(5):733–36. doi:10.1071/AH20157.
17. NPS MedicineWise. General practice insights report July 2018–June 2019. Sydney: NPS MedicineWise, 2020.

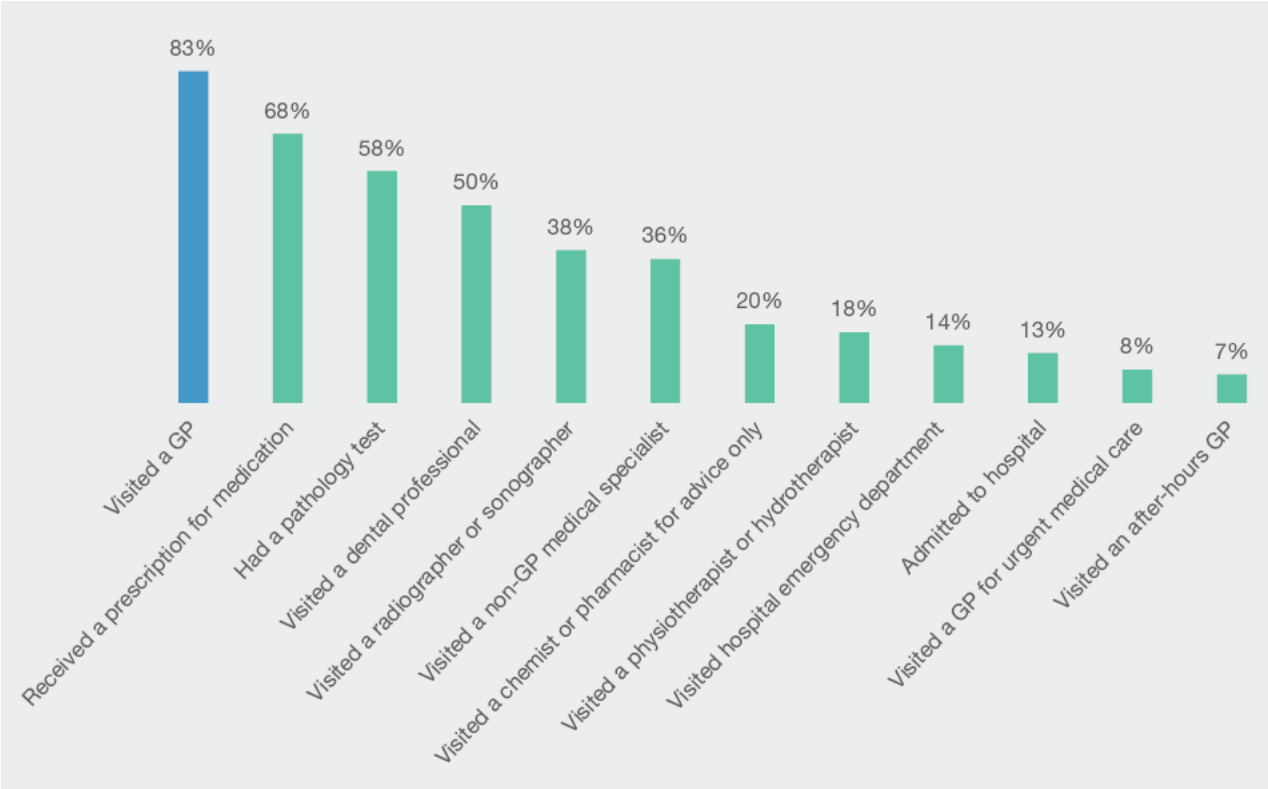
Chapter 2: General practice access

2.1 Patient access to, and experience of, general practice

General practice is Australia's healthcare frontline, with almost 85% of the population visiting their GP at least once each year.[1]

Patients reported they visit their GP more than any other health professional – more than they visit a pharmacist, physiotherapist or dental professional or see other specialists (Figure 13).

Figure 13. Patients reported they see their GP more than any other health professional



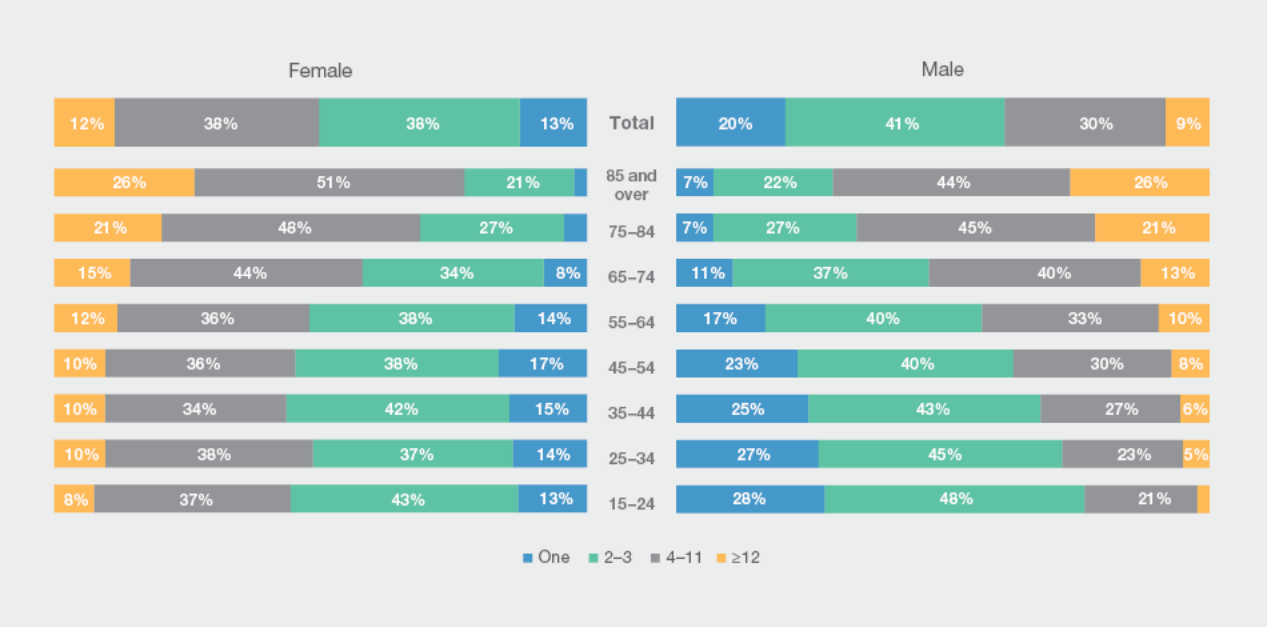
Measure: Patient responses to the question, 'In the last 12 months, have you [insert category]?'
Base: Total survey responses, n = 29,793.
Data source: Australian Bureau of Statistics. Patient experiences in Australia: Summary of findings, 2019–20. Cat. no. 4839.0. Canberra: ABS, 2020.

General practice remains highly accessible, with less than 1% of patients reporting they needed to, but did not, see a GP at all in the previous 12 months.[18]

Nearly half (45%) of Australians who needed to see a GP reported that they visited one four or more times during the year.[18] Patient age and gender influence frequency of presentations, with females seeing their GP more often than males and older people visiting their GP more regularly than younger people (Figure 14).

> ' Almost nine in 10 (87%) GPs indicated their practice has same-day appointments set aside for urgent presentations.[3]'

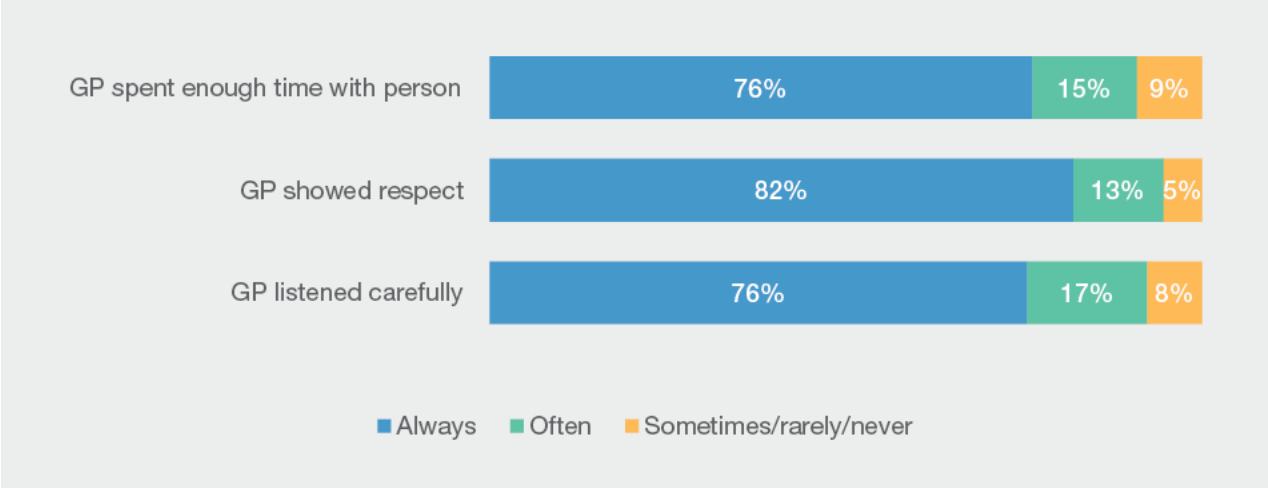
Figure 14. Age and gender have an effect on how often patients visit their GP



Data of less than 5% not labelled.
Measure: Patient responses to the question, 'Since <month> last year, how many times did you see a GP for your own health?', split by patient gender and patient age.
Base: Total survey responses, n = 29,793.
Data source: Australian Bureau of Statistics. Patient experiences in Australia: Summary of findings, 2019–20. Cat. no. 4839.0. Canberra: ABS, 2020.

Patients consistently reported very positive experiences with their GP. More than nine in 10 said their GP listens carefully, 95% said their GP always or often shows respect, and more than 90% reported their GP always or often spends enough time with them (Figure 15).

Figure 15. Patients reported positive experiences with their GP



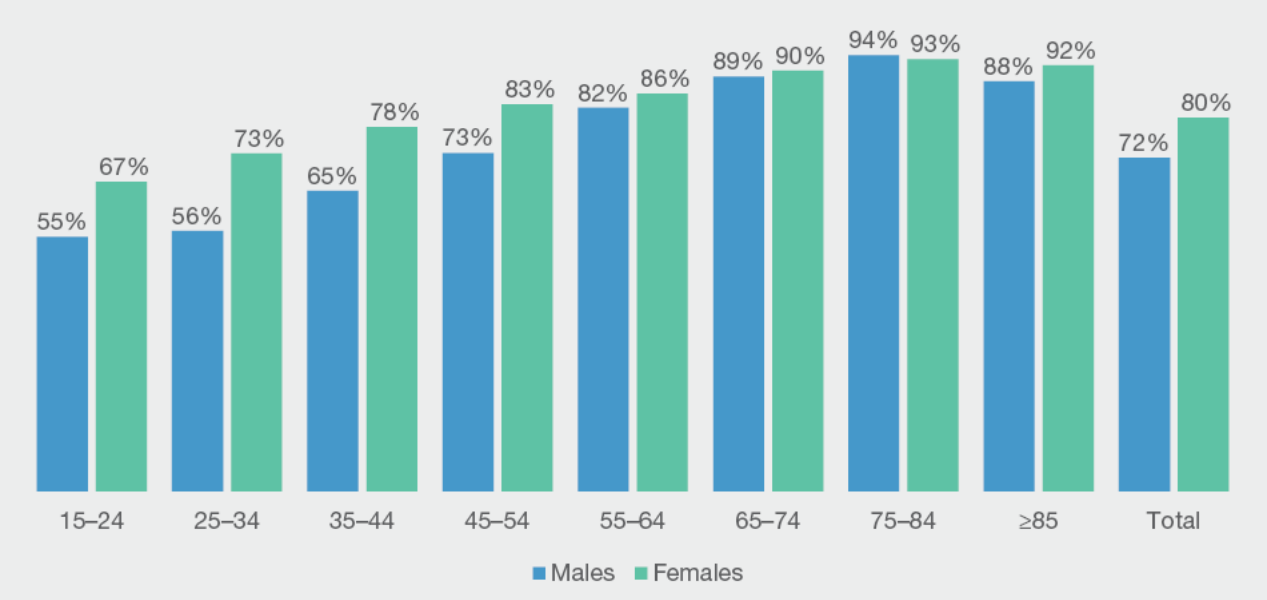
Measure: Patient responses to the question, 'Thinking about all the GPs you have seen in the last 12 months, how often did they [listen carefully to/show respect for/spend enough time with you]?', split by patient-reported frequency of GP behaviour.
Base: Total survey responses, n = 29,793.
Data source: Australian Bureau of Statistics. Patient experiences in Australia: Summary of findings, 2019–20. Cat. no. 4839.0. Canberra: ABS, 2020.

Older patients are more likely to report a positive experience with their GP than younger patients and are also more likely to have a preferred GP (Figure 16).

The number of people who reported they had a preferred GP rose to 76.3% in 2019–20, an increase of 0.8% from the previous year. The largest increase was seen in the 15–24-year-old female cohort of respondents.[18]

Having a preferred GP that a patient sees regularly is essential for high-quality care. This continuity of care has been linked to improved patient–provider relationships, better uptake of preventive care, increased access to care, and reduced healthcare use and costs.[19] The benefits of continuity of care in general practice are clear, with studies showing association with fewer hospital admissions,[20] saving the health system money and signalling that a person's health condition is being well managed. Seeing a different GP every time care is required has been linked to a higher risk of mortality.[19]

Figure 16. Older patients and female patients are more likely to have a preferred GP



Measure: Patients that responded 'yes' to the question, 'Do you have a GP you prefer to see?', split by age and gender.
Base: Total survey responses, n = 29,793.
Source: Australian Bureau of Statistics. Patient experiences in Australia: Summary of findings, 2019–20. Cat. no. 4839.0. Canberra: ABS, 2020.

2.1.2 Experience of Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people face considerable health inequities driven by factors such as socioeconomic determinants of health, resulting in gaps in life expectancy between Aboriginal and Torres Strait Islander people and non-Indigenous Australians. Improving patient experiences of health services, as well as increasing ease of access to those services, will contribute to better health outcomes.[21]

Primary healthcare for Aboriginal and Torres Strait Islander people is delivered by a range of providers, including mainstream organisations (such as general practices) and Indigenous-specific organisations.

Almost nine in 10 (86%) Aboriginal and Torres Strait Islander people reported seeing a GP or other medical specialist in the last 12 months.[22] The rate of general practice MBS items claimed by Aboriginal and Torres Strait Islander people increased by 42% between 2003–04 and 2017–18 and has been slightly higher than the rate for non-Indigenous Australians since 2010–11.

Aboriginal and Torres Strait Islander people use GP services at rates that are slightly higher than non-Indigenous Australians (1.2 times) but do not reflect the higher level of need among Aboriginal and Torres Strait Islander people.[23]

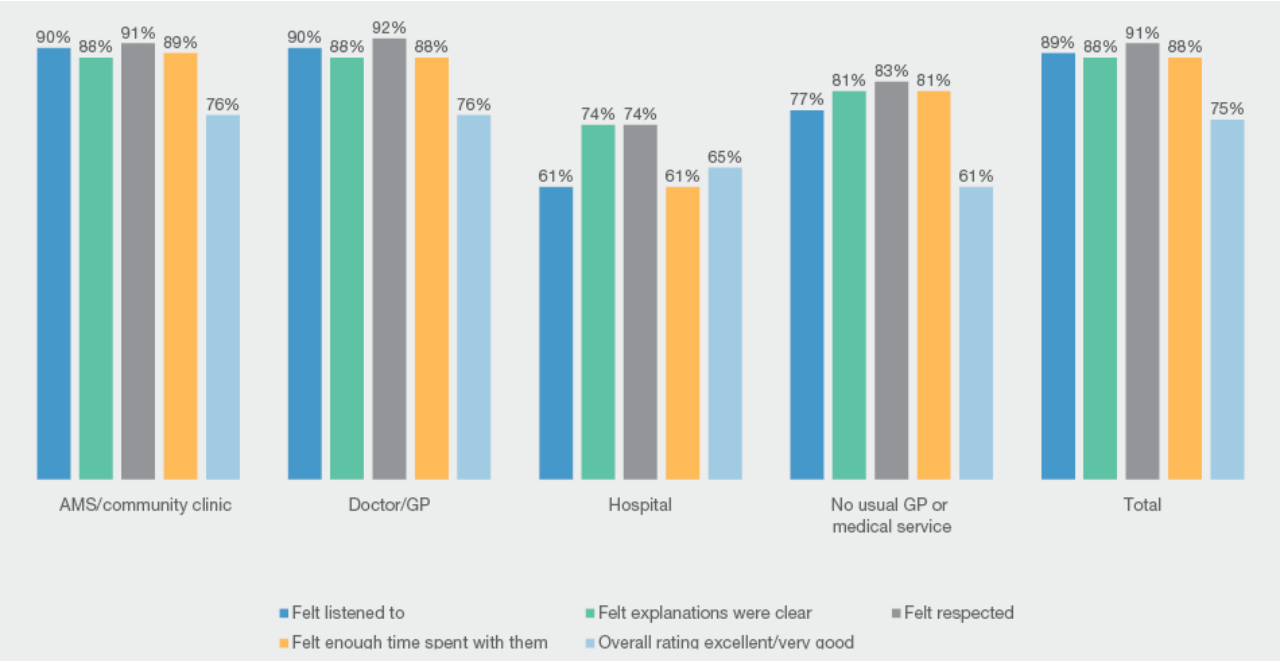
More than one in 10 (13%) Aboriginal and Torres Strait Islander people said they had needed to see a GP but had not done so on at least one occasion in the last 12 months. The proportion of people who did not see a GP when needed is higher for those living in non-remote areas (14%) than in remote areas (8%). The most common reasons for not going are being too busy (33%) and deciding to not seek care (28%).[22]

More than nine out of 10 (92%) Aboriginal and Torres Strait Islander people reported they have a usual place to go for health services and advice. Of these, 34% usually go to an Aboriginal medical service (AMS) or community clinic and 54% go to a GP or other doctor.[22] Almost seven in 10 (68%) people living in remote areas reported they usually see a GP who is part of an AMS or community clinic, compared with almost three in 10 (29%) in non-remote areas.[22]

When asked about their preferred source of medical help, almost half (48%) of Aboriginal and Torres Strait Islander people reported they prefer to go to an AMS or a community clinic, 43% prefer a doctor or GP (other than at an AMS, community clinic or hospital), 7% prefer a hospital and 3% prefer other healthcare (including a traditional healer or Ngangkari).[22]

Aboriginal and Torres Strait Islander people reported more positive experiences of their care at AMSs, community clinics and with their GP than with use of hospital services (Figure 17).

Figure 17. Aboriginal and Torres Strait Islander people with a regular GP or AMS reported greater satisfaction levels



Measure: Survey participants that responded 'always' or 'usually' to question, 'In the last 12 months, how often did your GP/doctor etc listen to you, explain things in a way that you could understand, show respect for what you had to say, spend enough time with you?' And survey participants that responded 'excellent' or 'very good' to the question, 'Overall, how good was the healthcare you got from GPs and other health services in the last 12 months?' cross referenced to usual source of healthcare or advice.
Base: Total survey respondents, n = 10,579.
Source: AIHW and ABS analysis of National Aboriginal and Torres Strait Islander Health Survey 2018–19.

1. Department of Health. Annual Medicare statistics: Financial year 1984–85 to 2020–21. Canberra: DoH, 2021.
3. EY Sweeney. RACGP GP Fellow Survey. Melbourne: EY Sweeney, 2021.
18. Australian Bureau of Statistics. Patient Experiences in Australia: Summary of Findings, 2019–20. Canberra: ABS, 2020.
19. Maarsingh OR, Henry Y, van de Ven PM, et al. Continuity of care in primary care and association with survival in older people: A 17-year prospective cohort study. Br J Gen Pract 2016;66(649):e531–9. doi:10.3399/bjgp16X686101.
20. Barker I, Steventon A, Deeny S. Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: Cross sectional study of routinely collected, person level data. BMJ 2017;356. doi:10.1136/bmj.j84.
21. Jones B, Heslop D, Harrison R. Seldom heard voices: A meta-narrative systematic review of Aboriginal and Torres Strait Islander peoples healthcare experiences. Int J Equity Health 2020;19(222). doi:10.1186/s12939-020-01334-w.
22. Australian Bureau of Statistics. National Aboriginal and Torres Strait Islander Health Survey, 2018–19. Canberra: ABS, 2019.
23. Australian Institute of Health and Welfare. Aboriginal and Torres Strait Islander Health Performance Framework 2020 summary report. Canberra: AIHW, 2020.

2.2 GP workforce

2.2.1 Distribution

GPs are the only category of doctor in Australia that has seen faster growth in numbers in major metropolitan areas than in regional, rural and remote areas. The number of doctors working outside major cities has grown by 4.8% since 2013, compared to 3.9% in major cities. For GPs, growth outside major cities has been 3.4% per year since 2013, compared to 3.9% within major cities.[24]

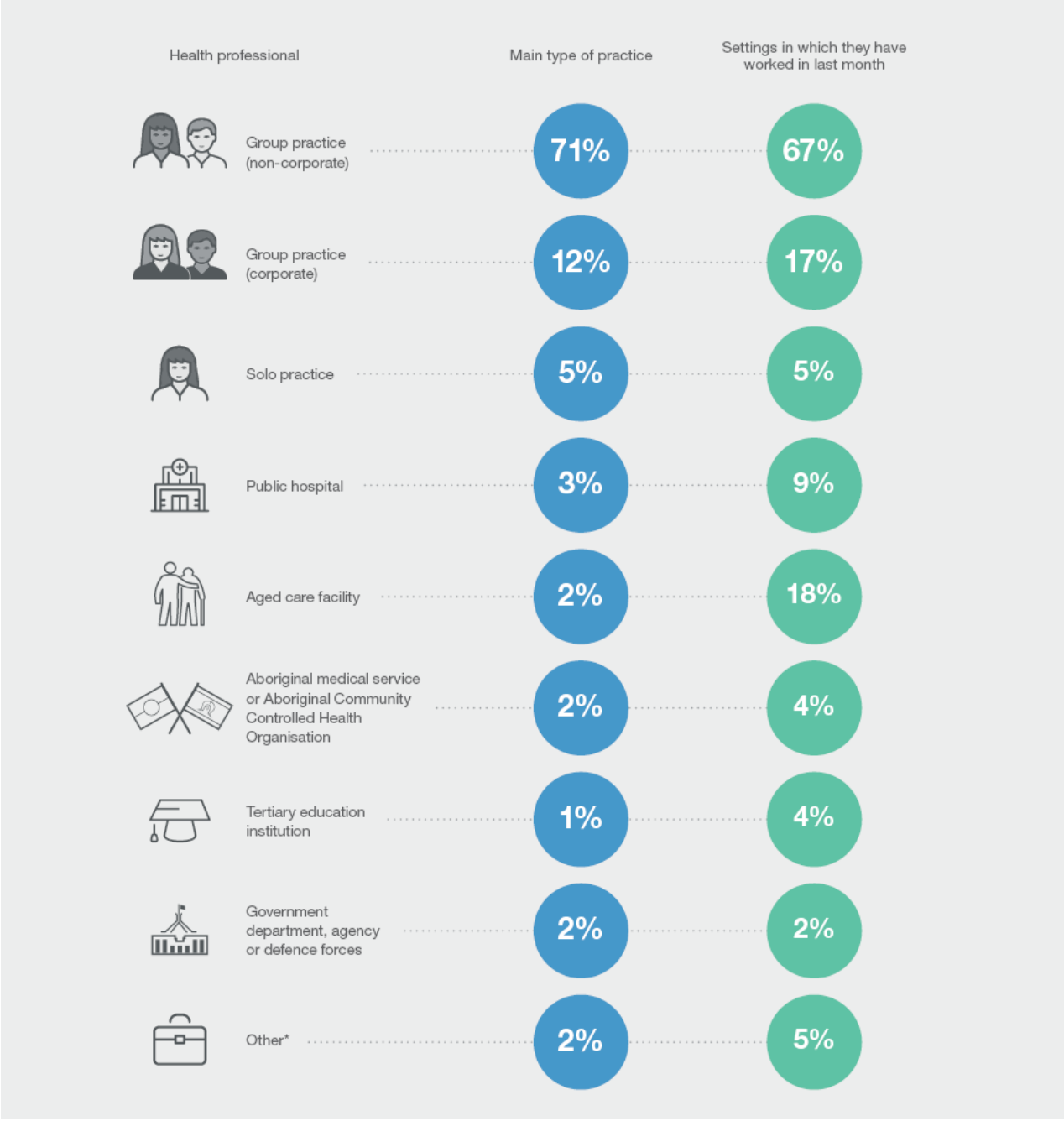
There is strong interest in rural health among Australian GPs. RACGP Rural has more than 20,000 members, 9500 of whom live and work in rural and remote Australia. Almost three in five (59%) GPs in training reported an interest in rural practice, compared to two in five (40%) of other specialists in training.[25]

One in four (25%) Australian General Practice Training (AGPT) Program participants surveyed said they would like to work in a rural or remote location in the future, with 17% saying they would like to work as a rural generalist in five years' time.[26]

2.2.2 Work setting

More than four in five (83%) GPs reported working mainly in group practices, with just 5% working in solo practice. These figures have remained stable over the last five years.[3]

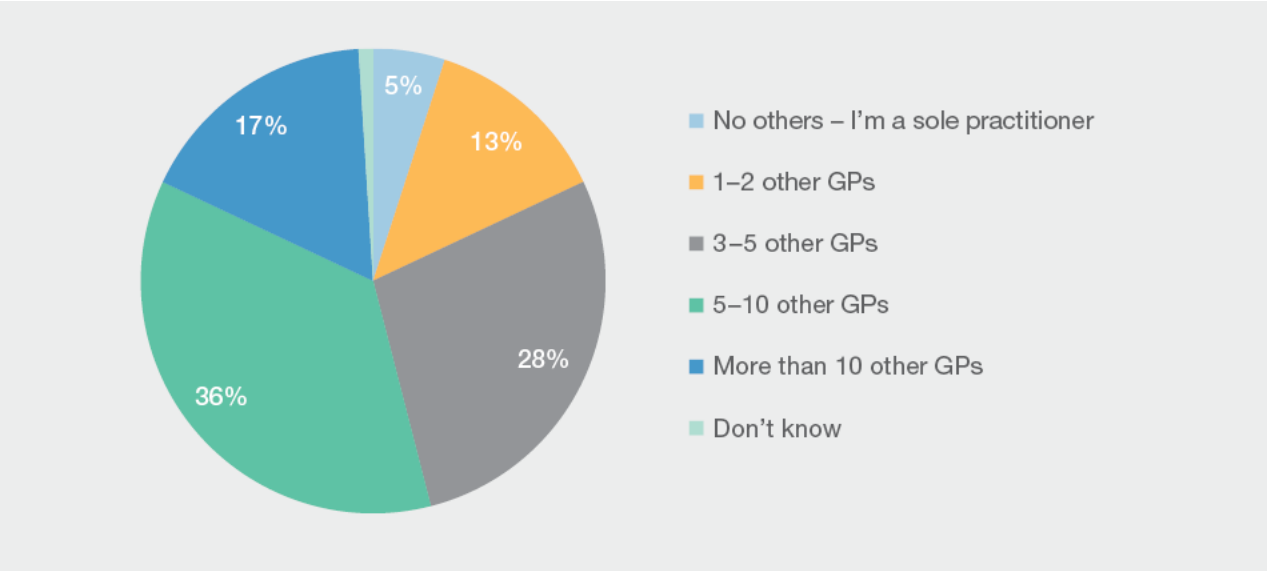
Figure 18. GPs work in a variety of settings



*'Other' responses included private hospital, community healthcare, COVID-19-related setting, headspace, non-government organisation (NGO), family planning clinic, Royal Flying Doctor Services, regional training provider, services for asylum seekers/refugees, telehealth, cancer clinic/services, justice/correctional health, after-hours and medical deputising services, consulting, medical defence organisations (MDO), research, sexual health clinic.
Measure: GP responses to the questions, 'Which setting is your main practice, where you spend the most time?' and 'In which of the following settings have you practised in the past month?'
Base: Total survey respondents, n = 1386.
Source: EY Sweeney, RACGP GP Fellow Survey, May 2021.

Fewer than one in five GPs reported working in an aged care facility in the preceding month, and 56% of those GPs who had not worked in an aged care setting in the past month indicated they were somewhat or very unlikely to work in aged care in the future. Fewer than one in five (19%) reported they were somewhat or very likely to work in aged care in the future, and one in four were unsure.[3] Section 1.2 Issues requiring policy action discusses drivers for GP participation in aged care settings in more detail.

Figure 19. The number of GPs at each practice varies



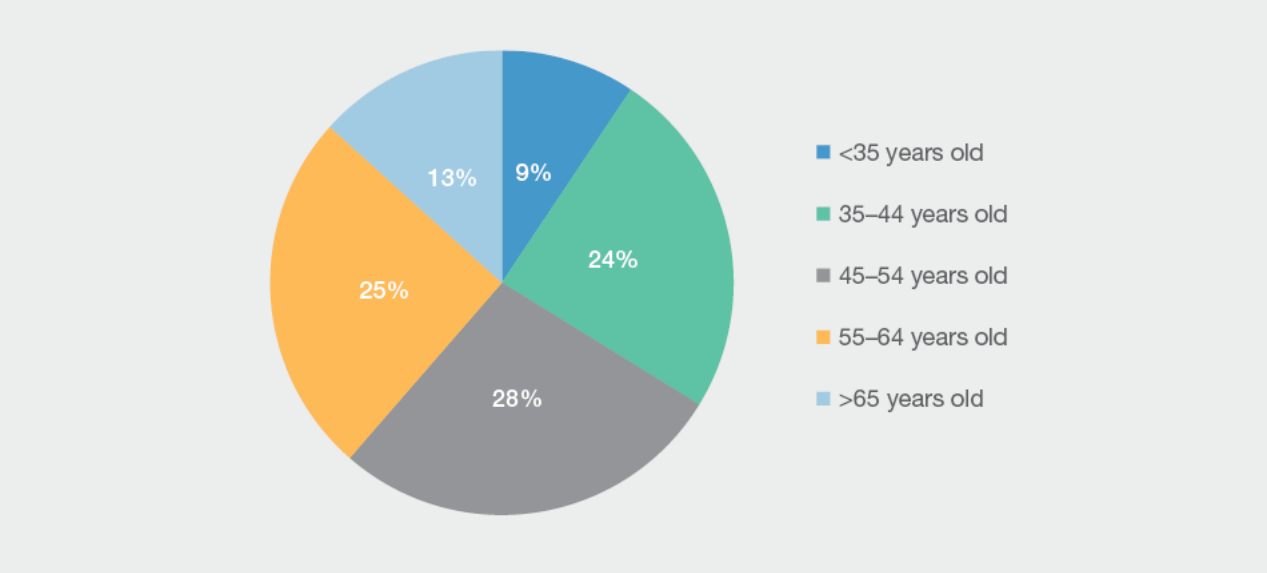
Data of less than 5% not labelled.
Please note this data cannot be directly compared to previous editions of the report due to differences in the question and response options in the RACGP member census.
Measure: RACGP member response to the question, 'Approximately how many other GPs do you work with at the location you currently work or spend the most time working?'
Base: Survey responses, n = 2078.
Source: RACGP member census, February 2021.

2.2.3 Demographics

Age

The GP workforce is ageing, with the proportion of GPs over the age of 65 increasing each year, from 11.6% in 2015 to 13.3% in 2019.[27]

Figure 20. Distribution of the GP workforce by age

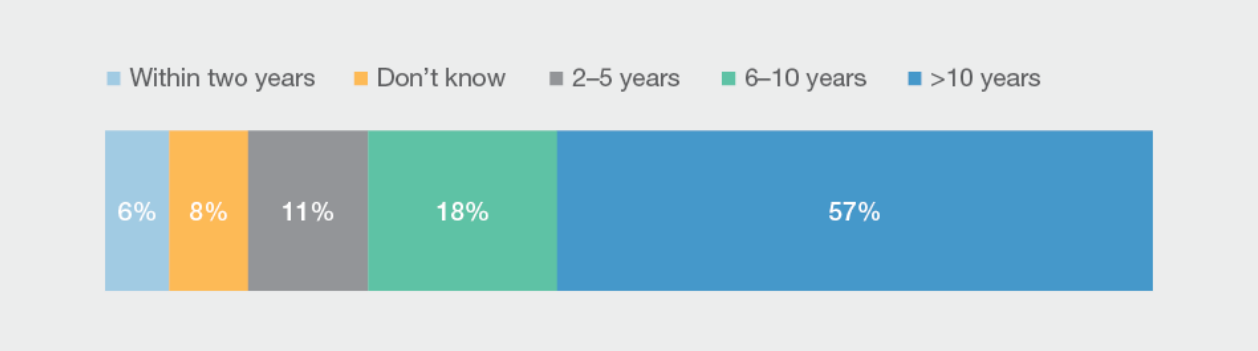


Measure: GP full-time equivalent (FTE), by GP age, 2019–20.
Base: Total number of FTE GPs in 2019–20, n = 29 853.8.
Data source: Productivity Commission. Report on government services 2021. Canberra: Productivity Commission, 2021.

Retirement intention

Almost one in five (18%) GPs surveyed said they intend to retire within the next five years, an increase from 14% in 2017. The proportion of survey respondents who stated they will not retire within the next 10 years has fallen from 64% in 2017 to 57% in 2021.[3] This could be related to a higher proportion of survey respondents aged over 45 years in 2021 (66%) compared to 2017 (60%).[3]

Figure 21. Almost one in five GPs intends to retire within the next five years



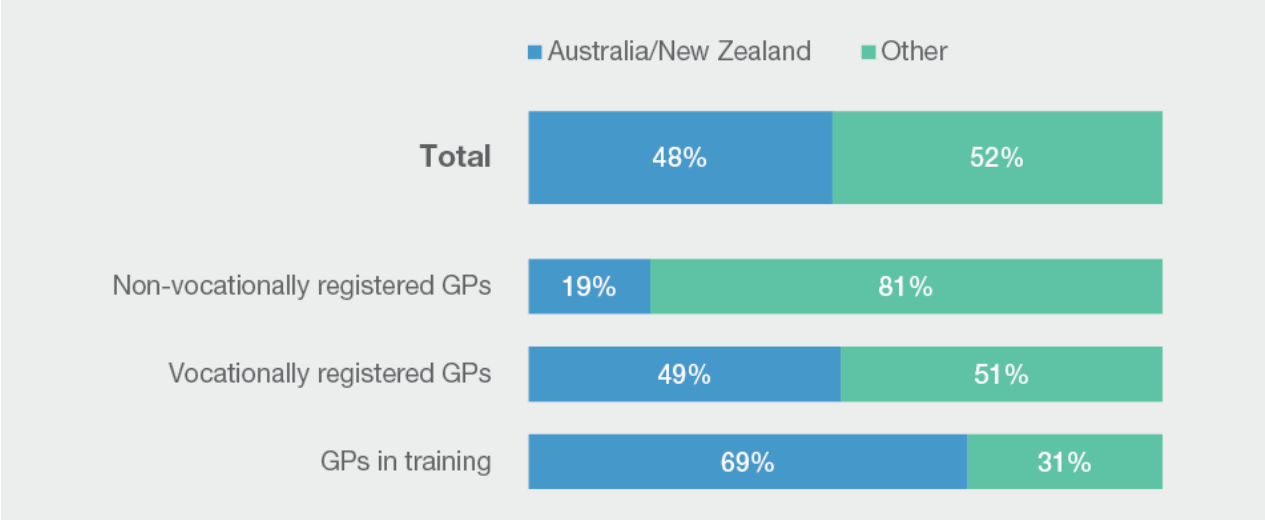
Measure: GP responses to the question, 'When do you intend to retire from practising medicine?'
Base: Total survey respondents, n = 1386.
Source: EY Sweeney, RACGP GP Fellow Survey, May 2021.

Country of initial qualification

In regional, rural and remote areas, international medical graduates (IMGs) can be a flexible and mobile solution for temporary or ongoing medical workforce shortages. Until 2019, the number of GPs who are IMGs was increasing more quickly than the number of locally trained GPs. However, this growth slowed when the 2020 border closures caused by the COVID-19 pandemic reduced overall immigration into Australia by around 90%, although medical practitioners remain on the Priority Migration Skilled Occupation List.[24]

The percentage of GPs who are IMGs is reported to have grown from 43.1% in 2013 to 44.8% in 2019.[24] In 2020, the proportion of vocationally registered GPs who attained their medical degree overseas was 51% (Figure 22).

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



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

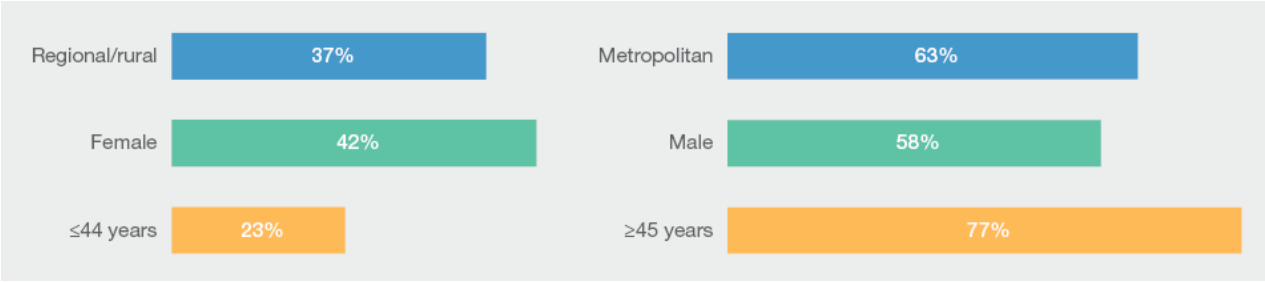
2.2.4 Practice owners

Almost one in four (23%) GPs reported that they own all or part of a practice.[3]

Almost two-thirds (63%) of these practice owners are in metropolitan areas, more than half (58%) are male and almost four out of five (77%) are aged 45 or older (Figure 23). These proportions have not changed significantly over the five years of the Health of the Nation survey.

Of AGPT Program participants surveyed, 14% said they would like to own their own practice and 18% would like to purchase or buy into an existing practice in the future.[26]

Figure 23. Practice ownership varies according to rurality, gender and location



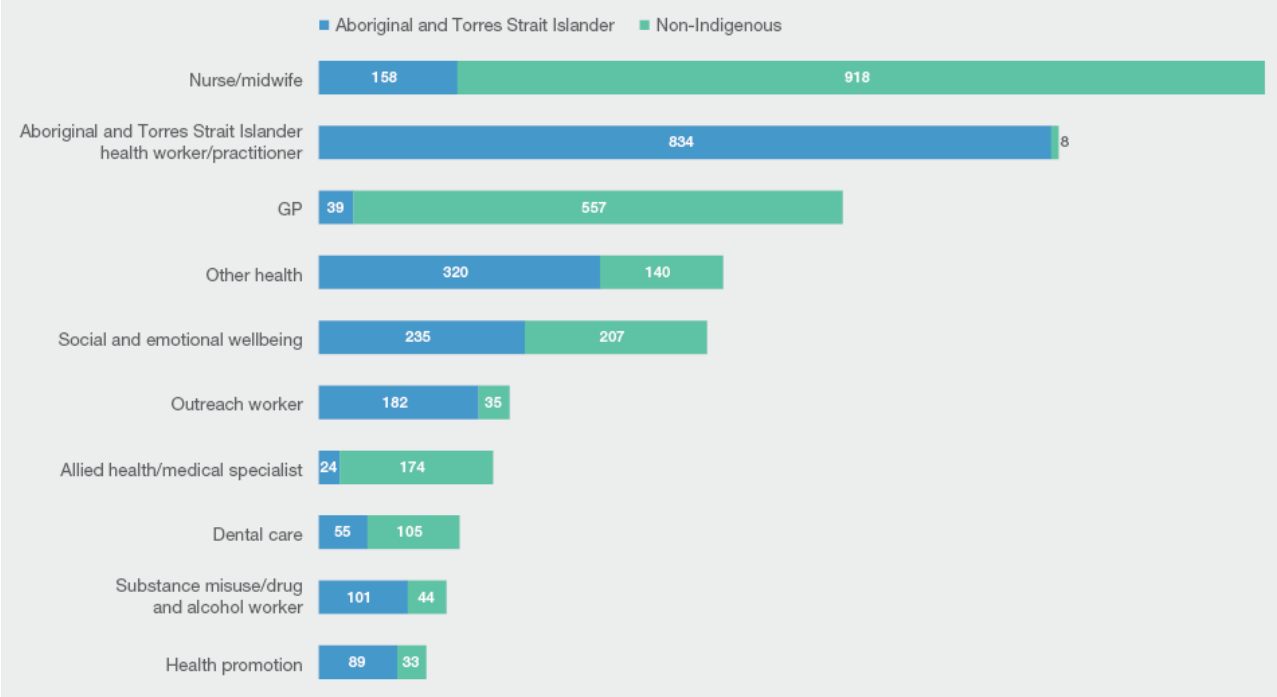
Measure: GPs who reported they own all or part of a practice, split by rurality, gender and age.
Base: n = 167.
Source: EY Sweeney, RACGP GP Fellow Survey, May 2021.

2.2.5 Aboriginal and Torres Strait Islander people in the health workforce

Organisations providing Aboriginal and Torres Strait Islander primary healthcare services employ about 4300 full-time equivalent (FTE) health staff, nearly half (48%) of whom identify as Aboriginal and/or Torres Strait Islander.[28]

Nurses and midwives are the most common type of healthcare worker in these facilities, followed by Aboriginal and/or Torres Strait Islander healthcare workers and practitioners and GPs (Figure 24). The number of FTE GPs employed in Aboriginal and Torres Strait Islander primary healthcare services increased from 568 in 2018–19 to 596 in 2019–20.[28]

Figure 24. GPs are an important part of Aboriginal and Torres Strait Islander primary health services



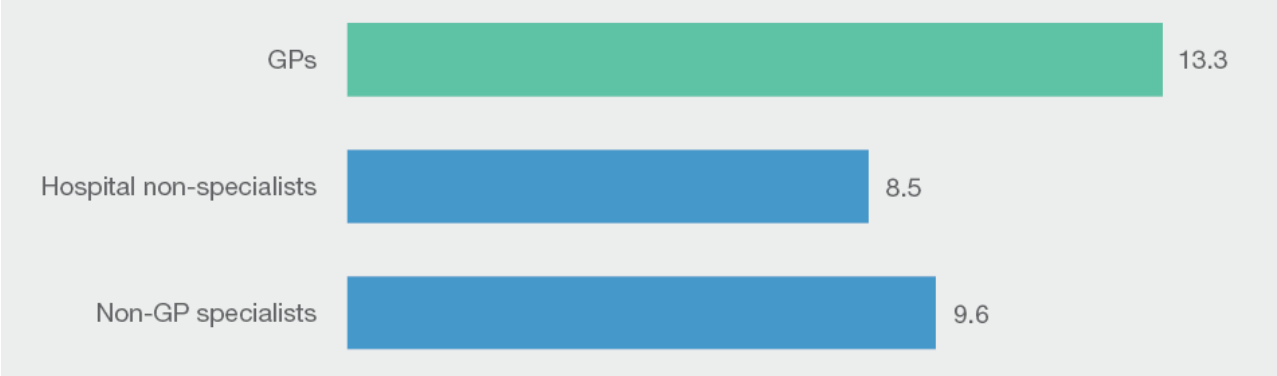
Measure: Number of FTE healthcare workers employed by Aboriginal and Torres Strait Islander primary health services in 2019–20, according to Aboriginal and Torres Strait Islander status.
Source: Australian Institute of Health and Welfare 2021. Aboriginal and Torres Strait Islander specific primary health care: results from the nKPI and OSR collections. Cat. no. IHW 227. Canberra: AIHW.

In 2019–20, Aboriginal and Torres Strait Islander primary healthcare services saw around 469,000 patients and provided 3.5 million episodes of care. This has decreased from 500,000 patients and 3.7 million episodes of care in the previous year.[28] This decrease likely reflects the impacts of the COVID-19 pandemic, such as restrictions on travel, reluctance to travel and barriers to using telehealth.

The rate of Aboriginal and Torres Strait Islander medical practitioners has increased from 1.7 per 10,000 Aboriginal and Torres Strait Islander people in 1996 to 5.3 per 10,000 in 2016.[23] General practice is the most common specialty of choice for Aboriginal and Torres Strait Islander medical graduates (Figure 25). Of RACGP members, 86 Fellows, 63 GPs in training and 170 other types of members identify as Aboriginal and/or Torres Strait Islander in 2020–21.

More than half (56%) of GPs in training surveyed agreed or strongly agreed with the statement, 'I have an interest in Aboriginal and Torres Strait Islander health/healthcare', compared to 44% of trainees in other specialties.[25] In 2017, the majority of employed Aboriginal and Torres Strait Islander medical practitioners (62%) were aged under 44 (62%).[23]

Figure 25. General practice is the most common career for Aboriginal and Torres Strait Islander medical graduates



Measure: Rate per 100,000 of registered practitioners employed in their field by profession and Aboriginal and/or Torres Strait Islander status, Australia, 2017.
Source: Australian Institute of Health and Welfare. Aboriginal and Torres Strait Islander Health Performance Framework report 2020. Canberra: AIHW, 2020.

More than 10% of AGPT Program participants reported they were in an Aboriginal health training post in the first semester of 2020. A further 11.6% reported they had already completed training in an Aboriginal health post.[26]

Almost one-third (28%) of AGPT Program participants surveyed reported they are considering training in an Aboriginal health post in future, and 16% said they would like to work as a GP in Aboriginal health in future.[26]

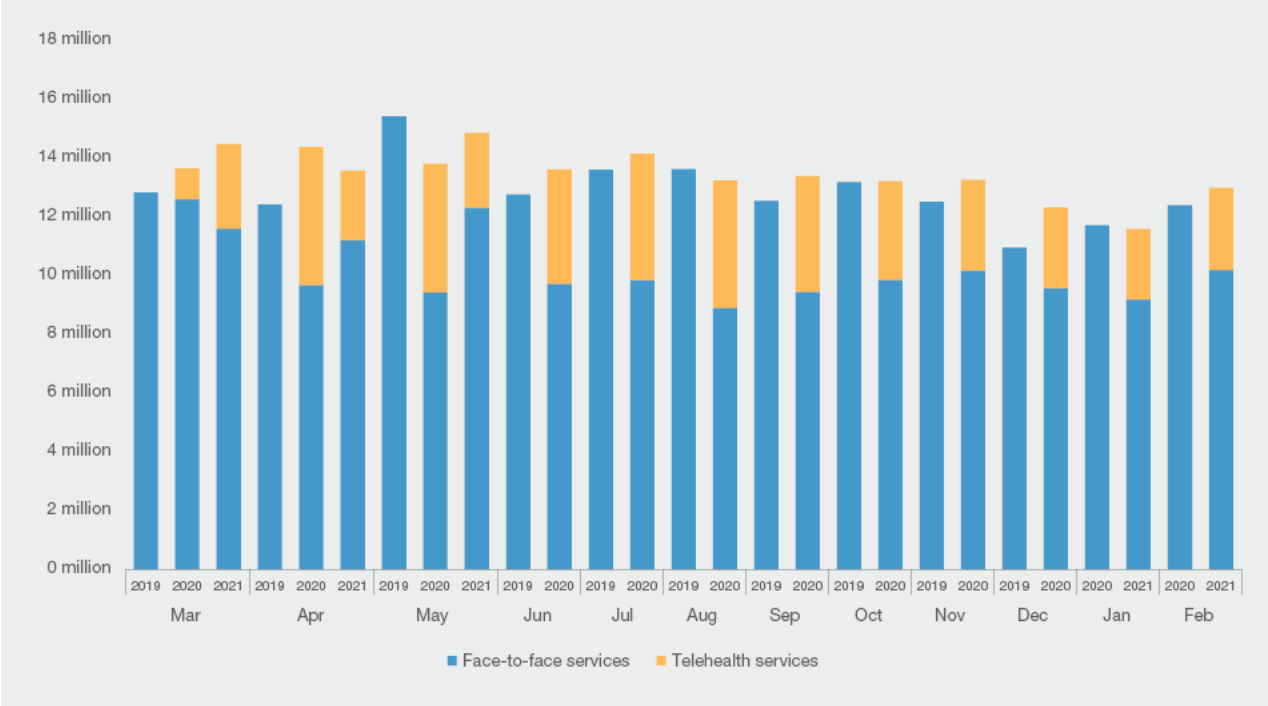
3. EY Sweeney. RACGP GP Fellow Survey. Melbourne: EY Sweeney, 2021.
23. Australian Institute of Health and Welfare. Aboriginal and Torres Strait Islander Health Performance Framework 2020 summary report. Canberra: AIHW, 2020.
24. Scott A. The evolution of the medical workforce. Melbourne: The Melbourne Institute, 2021.
25. Australian Health Practitioner Regulation Agency, Medical Board of Australia. Medical Training Survey 2020. Melbourne: AHPRA, 2021.
26. Taylor R, Clarke L, Radloff A. Australian General Practice Training Program: National Report on the 2020 National Registrar Survey. Melbourne: Australian Council for Educational Research, 2021.
27. Productivity Commission. Report on Government Services. Canberra: Productivity Commission, 2021.
28. Australian Institute of Health and Welfare. Aboriginal and Torres Strait Islander specific primary health care: Results from the nKPI and OSR collections. Canberra: AIHW, 2021.

2.3 Telehealth

General Practice: Health of the Nation 2020 highlighted that the introduction of MBS-supported telehealth in general practice was a welcome innovation amid the COVID-19 pandemic. Patients and GPs alike reported high rates of satisfaction with telehealth. Telehealth (via phone and video) has complemented face-to-face services as clinically appropriate, improving patient access to healthcare and ensuring general practice is supported to provide modernised care.

Figure 26 illustrates the first 15 months of MBS-supported telehealth in general practice compared to the previous year's activity, underlining GPs' ability to adapt to new technology.

Figure 26. The first 15 months of MBS-supported telehealth via phone in general practice



Measure: Number of services March 2019 to May 2021.
Telehealth (phone): Standard consultations: 91790,91800,91801,91802,91795,91809,91810,91811 Mental Health: 92112,92113,92114,92115,92116,92117, 92124,92125,92126,92127,92128,92129 CDM: 92024,92025,92026,92028,92068,92069,92070,92072 After Hours: 92210,92216 RACF Mental Health: 93404,93405,93406,93407,93422,93408,93409,93410,93411,93423.

Face-to-face items: Standard consultations: 3,23,36,44,4,24,37,47,90020, 90035,90043,90051 CDM: 721,723,729,732 Mental Health: 2700,2701,2715,2717,2712,2713 Health assessments:701,703,705,707,715,699 After hours: 5003,5023,5043,5063,5000,5020,5040,5060,5010,5028,5049,5067,585,594,599.
Source: Services Australia MBS item number reports.

Although phone consultations have been widely embraced, video has not been widely adopted in general practice. In April 2020, 1.3% of all GP attendances used video, falling to 0.29% by May 2021. By comparison, phone consultations represented 17.1% of all GP attendances in May 2021, a decline from around one-third of all GP consultations in April 2020.[29]

In June 2020, 55% of GPs reported having used video technology at least once in their practice,[30] an increase from 30% in April 2020, indicating a willingness to attempt to use new technology.[6] However, there are several reasons GPs have not commenced or continued using video technology.

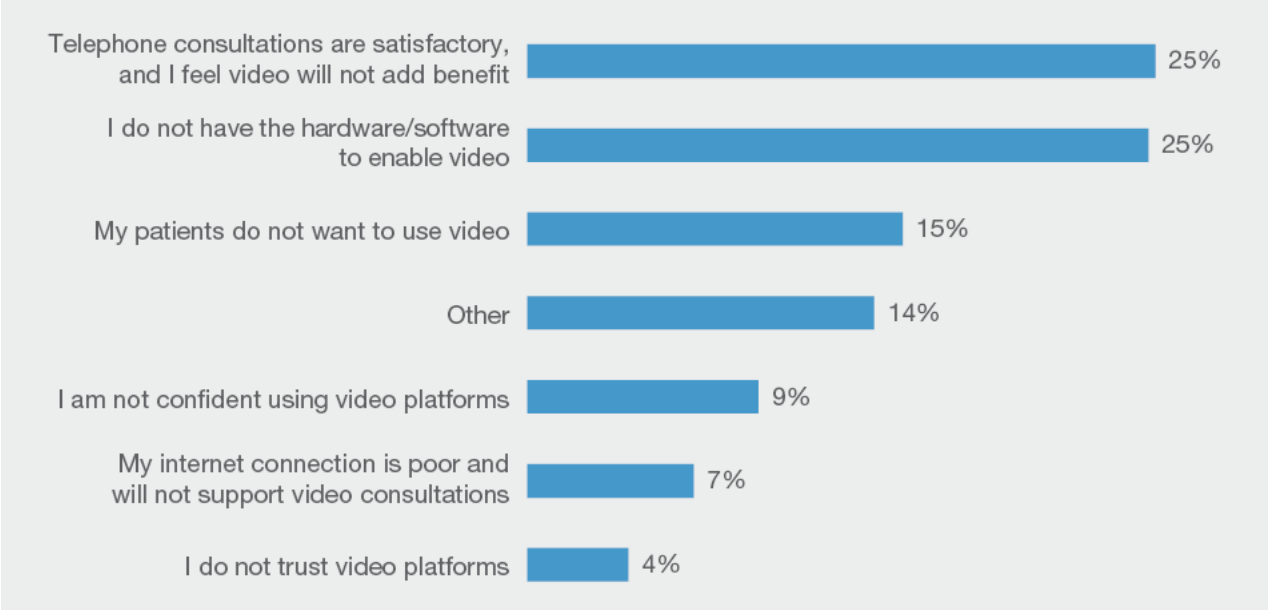
Of those who had never attempted to use video, the most common reasons were lack of technology, no perceived benefit compared to phone consultations and patients not wanting to use video (Figure 27).

Free-text responses in the survey included concern about older patients' ability to use video technology, the high costs involved with acquiring the necessary technology, inadequate internet connections, the amount of time required to help patients understand video technology and privacy concerns regarding the use of video on personal devices/accounts. GPs practising in lower socioeconomic areas also had concerns about patient access to technology.[30]

The most common devices GPs use to provide video consultations are their personal device (smartphone or tablet) (35%), the practice's computer (29%) or their personal computer (23%).[30] This reflects the lack of infrastructure within practices and highlights the need for greater government support to facilitate video telehealth before it can be widely used in general practice. More than half (53%) of surveyed GPs said they have invested more than initially budgeted in technology to meet demand for telehealth consultations.[31]

When asked if they would be willing to use video if their concerns were addressed, 66% of GPs said they would.[30]

Figure 27. One in four GPs reported they do not have the technical capability to provide video consultations



Measure: GP responses to the question, 'Please outline the reason/s you have not undertaken telehealth consultations using video (select all that apply).'
Base: GPs who had indicated they had never attempted using video technology in their practice, n = 342.
Source: RACGP Telehealth survey, June 2020.

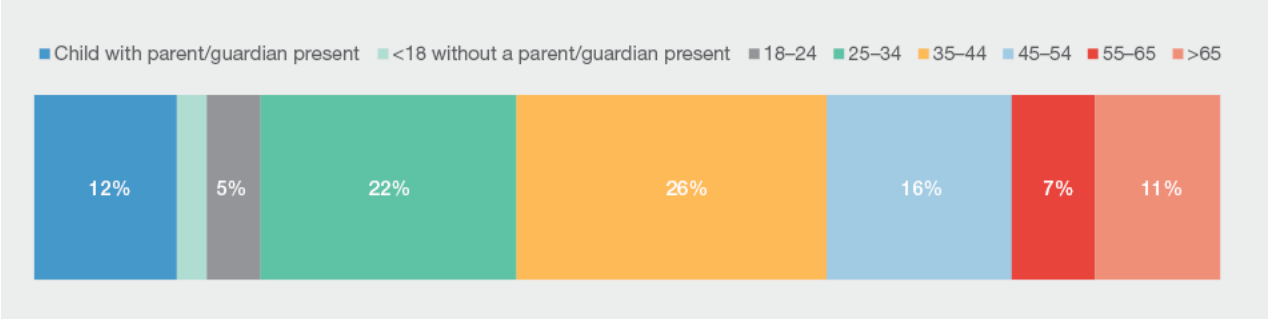
A similar perception of video consultations among staff and patients is reflected in other healthcare settings.

Phone is seen as an easy and accessible platform for communicating, with most survey respondents indicating no added benefit to using a video function. In some cases, patients did not have the equipment to support video consultations, or staff and patients reverted to a phone call after experiencing connection problems in an attempted video consultation. Staff reported that patients needed considerable support setting up their devices and connecting to video appointments.[32]

Medicare data show that patients in lower socioeconomic areas are less likely to use telehealth, particularly via video. Older patients are also less likely to use telehealth, with those aged 70 and older showing the lowest uptake of video consultations in general practice.[33]

GPs reported that almost half (48%) of video consultations were provided to adults aged 25–44 (Figure 28).

Figure 28. Adults aged 25–44 are most likely to use video consultations



Data of less than 5% not labelled.
Measure: GP responses to the question, 'Of the telehealth consultations conducted using video, what is the most common age group of patients?'
Base: n = 199.
Source: RACGP Telehealth survey, June 2020.

6. RACGP. General Practice: Health of the Nation 2020. East Melbourne: RACGP, 2020.
29. Services Australia. Medicare Item Number Reports. 2021.
30. RACGP. Telehealth survey. 2020. Unpublished data.
31. Commonwealth Bank of Australia. CommBank GP Insights Report: Opportunities and challenges amid the pandemic recovery. Sydney: CommBank, 2021.
32. Smithson R, Roche E, Wicker C. Virtual models of chronic disease management: Lessons from the experiences of virtual care during the COVID-19 response. Aust Health Rev 2021;45(3):311–16. doi:10.1071/AH20190.
33. Hardie RA, Sezgin G, Dai Z, et al. Socioeconomic and demographic comparisons in the uptake of telehealth services during COVID-19. Sydney: Macquarie University, 2021.

Chapter 3: Funding Australian general practice care

3.1 Government contribution to patient services

Funding for primary care as a proportion of total government healthcare spend is in decline (Figure 30), and funding for GPs and general practice services is less than 8% of total health expenditure in Australia. Chronic disease expenditure in Australia is heavily weighted towards tertiary healthcare, with 61% of spending going to public and private hospitals compared to 8% to general practices.[34] This limits the ability of GPs to provide preventive care for patients with chronic diseases and ignores the overwhelming evidence of the health benefits and economic savings that could be achieved by investing more in primary healthcare.[35]

The 158 million services GPs provided in 2018–19[1] represent only 7.4%[§] of total government health spend, with the investment in general practice health services totalling $9.85 billion.[36,37] The same year saw 11.5 million hospitalisations, 8.4 million emergency department presentations and 39 million non-admitted service events – totalling around 59 million services[38] that cost federal, state and territory governments $61.8 billion.[37]

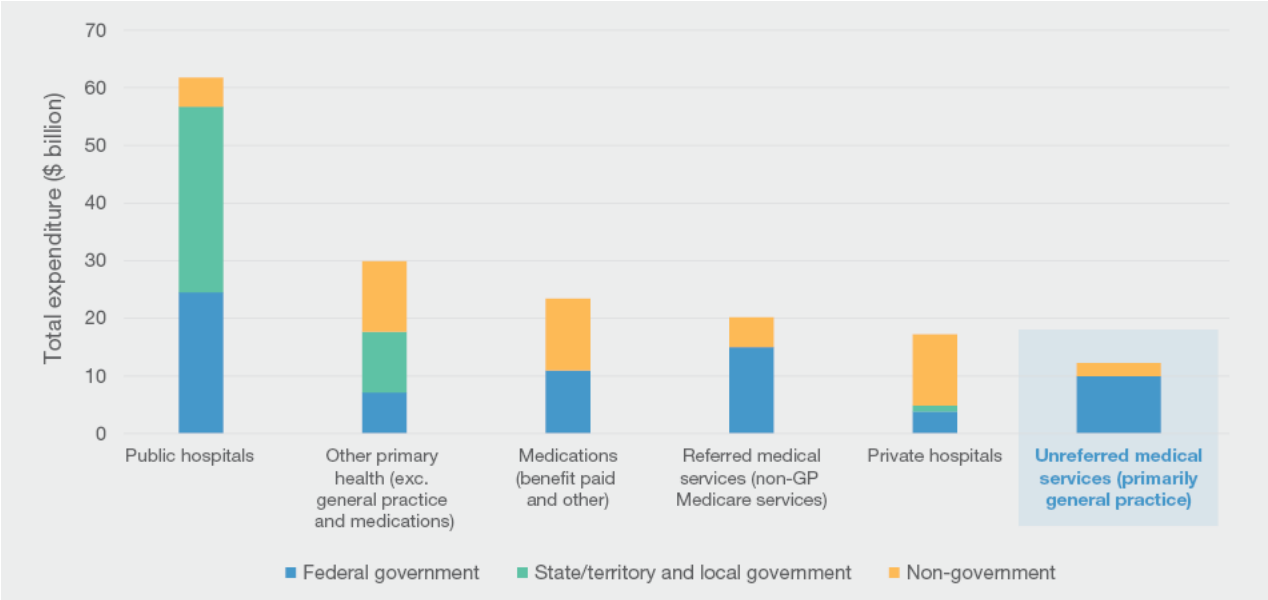
> ‘ Taken together, this means GPs provide more than twice the number of episodes of care a year than hospitals, for one-sixth of the expenditure amount.’

Australian healthcare expenditure is projected to increase faster than ever over the next 40 years, growing from 19% of total government spending in 2021–22 to 26% in 2060–61. Funding for public hospitals is projected to be the fastest-growing component, nearly doubling between 2020–21 and 2031–32. Per-person spending on public hospitals is expected to rise from $880 in 2020–21 to $1190 in 2031–32. MBS spending per person will increase from $1110 to $1280 between 2020–21 and 2031–32, while Pharmaceutical Benefits Scheme (PBS) spending per person will increase from $540 to $590 over the same period.[39]

The projected doubling in hospital expenditure highlights the need to establish more long-term preventive health measures that will deliver better outcomes for an ageing population and constrain unsustainable increases in healthcare expenditure. Primary care reduces downstream costs through early identification and management of health risks.

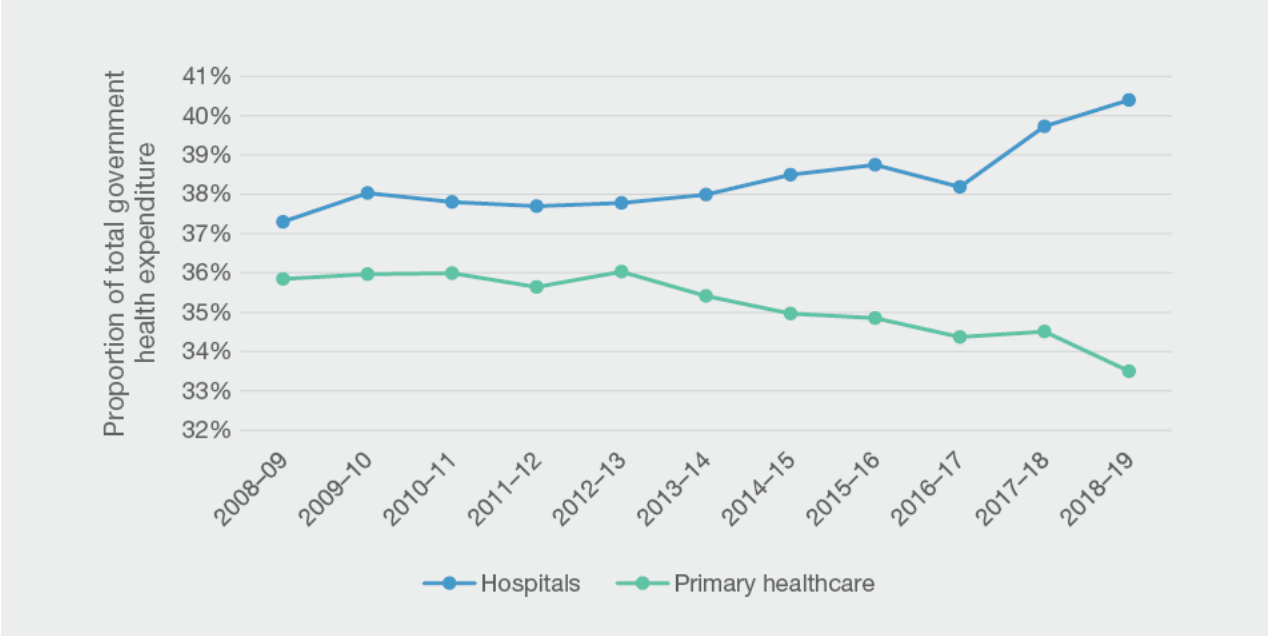
Developing new models of care will improve collaboration between primary care and secondary/tertiary care across the federal, state and territory funding divide. It will also assist in creating continuous and coordinated care pathways, reducing duplication of services and wasted health resources.

Figure 29. Government expenditure on general practice compared to spending on other areas of the health system



Measure: Total government (state/territory and federal) and non-government expenditure on health, by area of expenditure, 2018–19.
Data source: Australian Institute of Health and Welfare. Health expenditure Australia 2018–19. Health and welfare expenditure series Cat. No. HWE 80. Canberra: AIHW, 2020.

Figure 30. Total government expenditure on primary care is declining



Measure: Government expenditure on primary care and hospital services, 2008–09 to 2018–19.
Data source: Australian Institute of Health and Welfare. Health expenditure Australia 2018–19. Health and welfare expenditure series Cat. No. HWE 80. Canberra: AIHW, 2020.

§ Calculated using 2018–19 dollars for total government expenditure on general practice (Productivity Commission, 2020), against 2018–19 total government expenditure on health (AIHW, 2020).

1. Department of Health. Annual Medicare statistics: Financial year 1984–85 to 2020–21. Canberra: DoH, 2021.
34. Productivity Commission. Innovations in Care for Chronic Health Conditions, in Productivity Reform Case Study. Canberra: Productivity Commission, 2021.
35. PricewaterhouseCoopers. Economic benefits of the RACGP's Vision for general practice and sustainable healthcare system. Melbourne: PwC, 2020.
36. Productivity Commission. Report on government services. Canberra: Productivity Commission, 2020.
37. Australian Institute of Health and Welfare. Health expenditure Australia 2018–19. Canberra: AIHW, 2020.
38. Australian Institute of Health and Welfare. Australia's hospitals at a glance 2018–19. Canberra: AIHW, 2020.
39. Commonwealth of Australia. 2021 Intergenerational Report. Canberra: Treasury, 2021.

3.2 General practice billing

3.2.1 Bulk billing

In 2020–21, 89% of patient services in general practice were bulk billed (ie provided with no out-of-pocket cost to the patient). With the exception of COVID-related face-to-face services[¶], the bulk-billing rate was higher for new telehealth and COVID-19 vaccination MBS items introduced in response to the pandemic. For example, 100% of vaccine items [#], 98% of phone and 94% of video items were bulk billed, compared to 86% of all non-COVID-related and non-telehealth general practice items.[1]

Most patients access multiple services from their GP throughout the year. The median percentage of patients who had all of their general practice services bulk billed in 2018–19 was 64%, an increase from 58% in 2012–13.[40]

Patients who receive many services each year – such as older patients with chronic diseases – are more likely to hold concession cards and to have those services bulk billed. This inflates the levels of bulk billing each year.

One in five (22%) GPs works at a practice that bulk bills all their patients, and 64% of GPs reported bulk billing the majority of their patients.[3]

Bulk-billing rates vary between regions, from 32.9% of patients in the Australian Capital Territory (ACT) electorate of Canberra to 96.7% of patients in the New South Wales (NSW) electorate of Chifley (Figure 31).

Figure 31. Bulk-billing rates vary across Australia

Electorates with lowest proportion of bulk-billed patients		
ACT	Canberra	32.9%
WA	Curtin	36.9%
ACT	Bean	38.5%
QLD	Brisbane	38.8%
NSW	Warringah	39.1%
VIC	Goldstein	40.0%
VIC	Higgins	40.8%
TAS	Clark	41.4%
QLD	Griffith	42.4%
TAS	Franklin	42.8%

Electorates with highest proportion of bulk-billed patients		
VIC	Lalor	91.8%
NSW	Parramatta	92.1%
NSW	Greenway	92.6%
NSW	Watson	93.0%
NSW	Macarthur	93.6%
NSW	McMahon	94.7%
NSW	Blaxland	95.7%
NSW	Werriwa	95.9%
NSW	Fowler	96.1%
NSW	Chifley	96.7%

Measure: Percentage of patients with all GP non-referred attendances bulk billed in 2018-19, by electorate.
Source: Senate Community Affairs Committee. GP Bulk-Billing Rates by Electorate, Answers to Questions on Notice, Supplementary Budget Estimates 2019-2020. Ref No: SQ19-000826 (2020).

The rate of growth in bulk billing of general practice items has been in decline for several years. The RACGP has long predicted the growth in bulk billing of general practice services would halt or reverse, meaning more patients would face an out-of-pocket cost to see their GP. In 2020–21, there appears to be an artificial inflation of bulk-billing rates due to COVID-19. Although overall bulk billing of general practice services has increased by 1.3%, when new MBS items for COVID-19 vaccinations and telehealth are removed (just over 42 million services), the remaining 129 million services were bulk billed at lower rates than seen since 2016–17. (Figure 32)

A range of factors may be artificially inflating bulk billing, including:

- mandatory bulk billing for telehealth in the first quarter of 2020–21
- lockdowns in Australia's two largest states for more than half the year, which drove telehealth usage
- consumer expectations set through mandatory bulk billing in the previous year
- GP behaviour in response to the economic impact of the pandemic on their patients.

It may be that in the post-COVID world, bulk-billing rates will be lower as the impacts of the pandemic lessen.

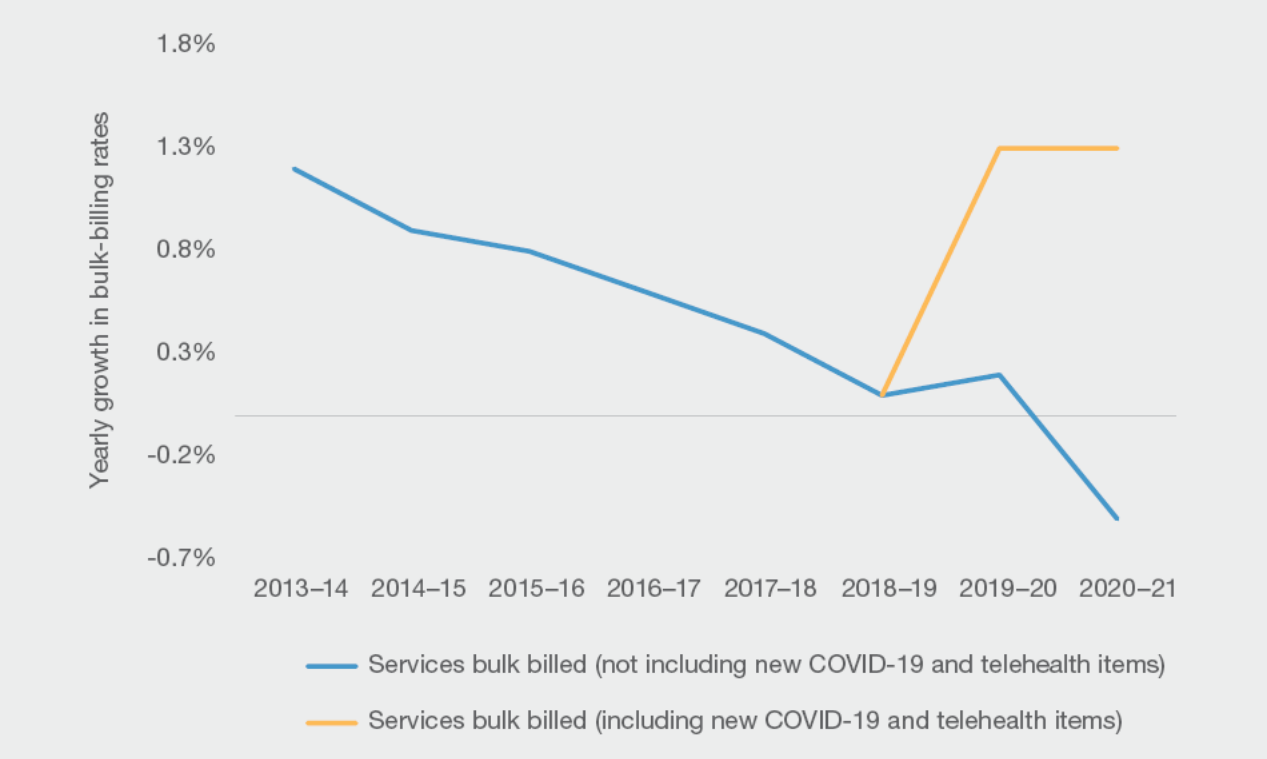
A central tenet of the Australian healthcare system is that doctors can set their own fees. When Medicare was first introduced in the 1970s, the intention was that the government would fund up to 85% of the doctor's fee and patients would pay the remainder. This policy setting changed in 2005, when the Medicare benefit was increased to 100% of the MBS schedule fee** for GP services, and modest incentives were introduced to increase falling rates of bulk-billed services.

This policy change, combined with the increased supply of medical graduates creating greater competition in many localities and, in 2020, mandatory bulk billing of COVID-19 item numbers, has pushed official bulk-billing rates to record levels.

Except for COVID-vaccine items, GPs are no longer required to bulk bill the new MBS items introduced in response to the pandemic. However, GPs continue to bulk bill COVID-related items at a higher rate, particularly telehealth.

Mixed billing – when the GP privately bills some services and bulk bills others – is a way for practices to ensure the costs of providing patient care are covered. Most GPs have an ongoing relationship with many of their patients and, through mixed billing, can ensure those patients who can least afford out-of-pocket costs are bulk billed.

Figure 32. Growth in bulk billing of general practice services has been affected by the pandemic



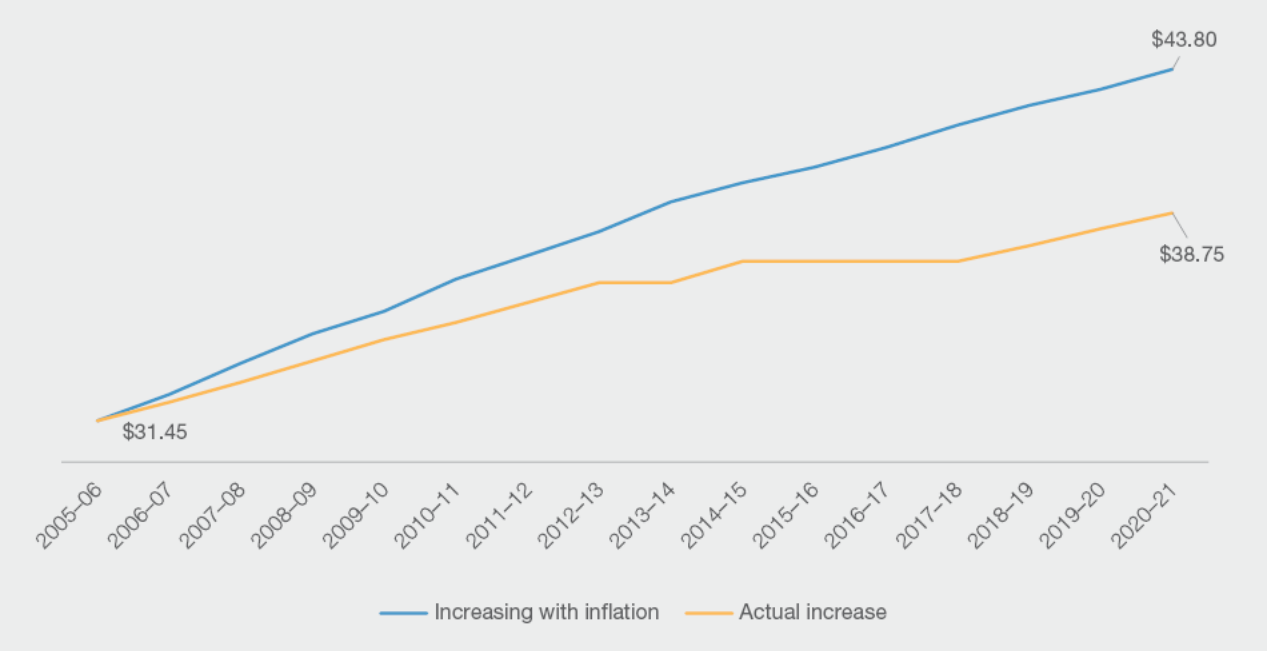
New COVID-19 and telehealth items include: COVID-Face-to-Face, COVID-Phone, COVID-Video, COVID-Vaccine and Non-COVID-Video groupings.

Measure: Growth in percentage of bulk-billed services in category 'Broad type of services: GP non-referred attendances', Australia wide, split by COVID-19, telehealth.

Base: Population-level data.

Source: Department of Health. Annual Medicare statistics – Financial year 1984–85 to 2020–21. Canberra: DoH, 2021.

Figure 33. The value of MBS patient rebates falls further each year



Measure: Actual increase in MBS item 23 (standard GP consultation lasting up to 20 minutes) compared to the value had it increased in line with general inflation.
Source: Reserve Bank of Australia Inflation calculator, MBS Online.

Indexation of Medicare rebates has not kept pace with inflation (Figure 33). Average health inflation rates are 3% per year, with practice costs rising by a similar amount, while MBS item indexation is set at 0.9% in 2021. This growing gap between the Federal Government's contribution to the cost of general practice care and the cost of providing care is affecting the sustainability of the primary care sector and the out-of-pocket cost for patients to access care. See section 3.2.2 for further discussion.

3.2.2 Out-of-pocket costs

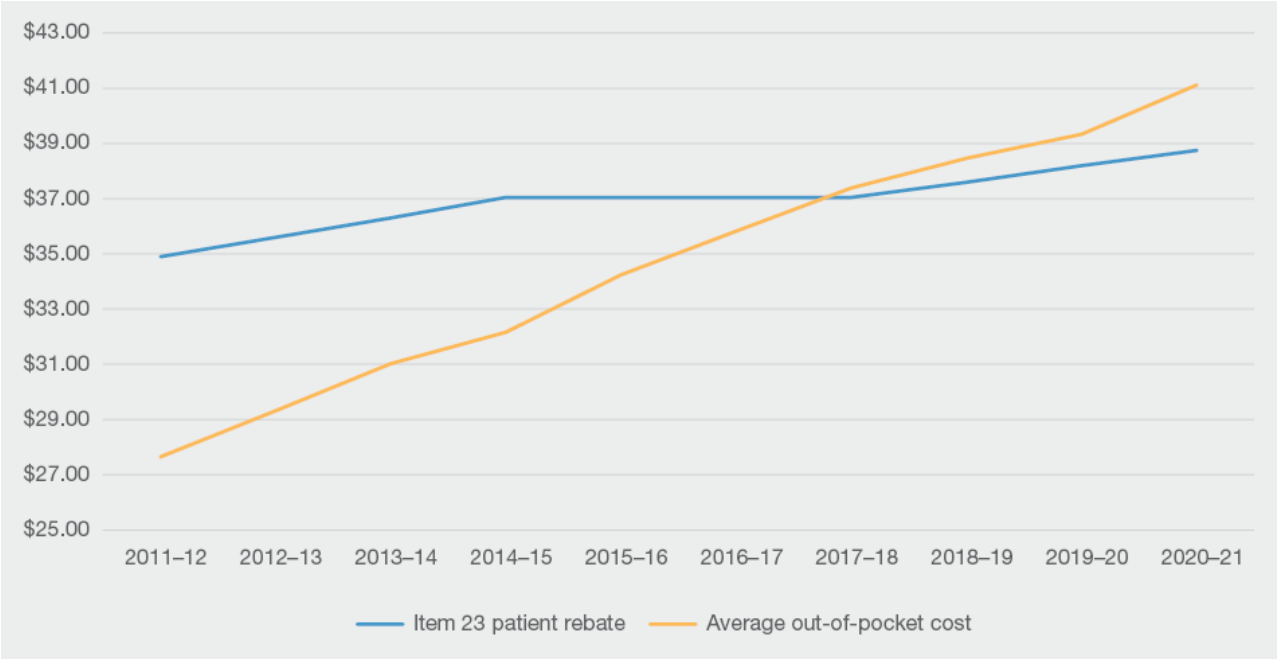
Almost four out of five (78%) GPs work at a practice that privately charges at least some of its patients, with the average reported out-of-pocket cost for a Level B (MBS item 23) consultation $38.80.[3]

Average patient out-of-pocket costs for all GP non-referred attendances have increased by 49% over the past decade and are now a greater amount than the patient rebate for MBS item 23, the most common general practice item. Over the same period, the patient rebate for MBS item 23 has increased by 11%. (Figure 35)

This means a patient attending their GP in 2012 paid an average of $27.65 out of pocket while the Federal Government contributed $34.90 (for MBS item 23). In 2021, that patient would pay $41.12 on average while the Federal Government contributed $38.75 for MBS item 23.(Figure 34)

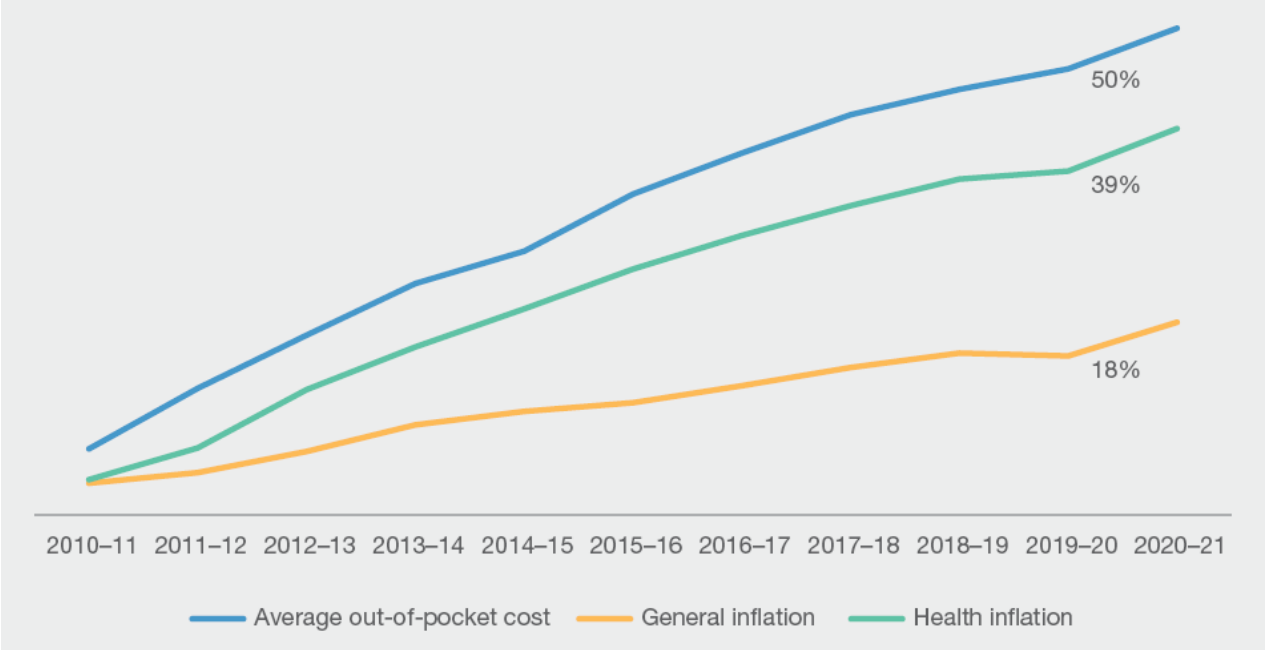
Average out-of-pocket costs vary across Australia, with patients in remote and very remote communities experiencing higher out-of-pocket costs than in other areas.[1]

Figure 34. Growth in patient out-of-pocket costs is outpacing the patient rebate



Measure: Value of MBS item 23 at July 2012 to 2021 and average patient contribution per service in category 'Broad type of services: GP non-referred attendances', Australia wide, 2011–12 to 2020–21.
Base: Population-level data.
Source: Department of Health. Annual Medicare statistics: Financial year 1984–85 to 2020–21. Canberra: DoH, 2021.

Figure 35. Average patient out-of-pocket costs have increased by 50% over the past decade



Measure: Average patient out-of-pocket costs for GP non referred attendances, compared to cumulative general inflation and health inflation rates, 2010–11 to 2020–21.
Sources: Department of Health. Annual Medicare statistics: Financial year 1984–85 to 2020–21. Canberra: DoH, 2021.
Australian Bureau of Statistics 6401.0: Consumer price index. Canberra: ABS, 2021.

¶ COVID-related face-to-face items refer to additional psychological services (MBS items 93300, 93303, 93306, 93309, 93312, 93313, 93316, 93319, 93323, 93326, 93327, 93330, 93333, 93350, 93353, 93356, 93359, 93362, 93365). Just over half (53.8%) of these services were bulk billed in 2020–21.

Due to mandated bulk billing of COVID-19 vaccine items.

** The MBS schedule fee in 2005 was $31.45 for a Level B (item 23) standard GP consultation. The Australian Medical Association's recommended private fee for Item 23 at that time was $54, based on average practice income and costs.

1. Department of Health. Annual Medicare statistics: Financial year 1984–85 to 2020–21. Canberra: DoH, 2021.
3. EY Sweeney. RACGP GP Fellow Survey. Melbourne: EY Sweeney, 2021.
40. Senate Community Affairs Committee. Answers to Questions on Notice, Supplementary Budget Estimates 2019-2020: GP Bulk-Billing Rates by Electorate, Ref No: SQ19-000826. Canberra: Parliament of Australia, 2020.

Chapter 4: Job satisfaction and work–life balance

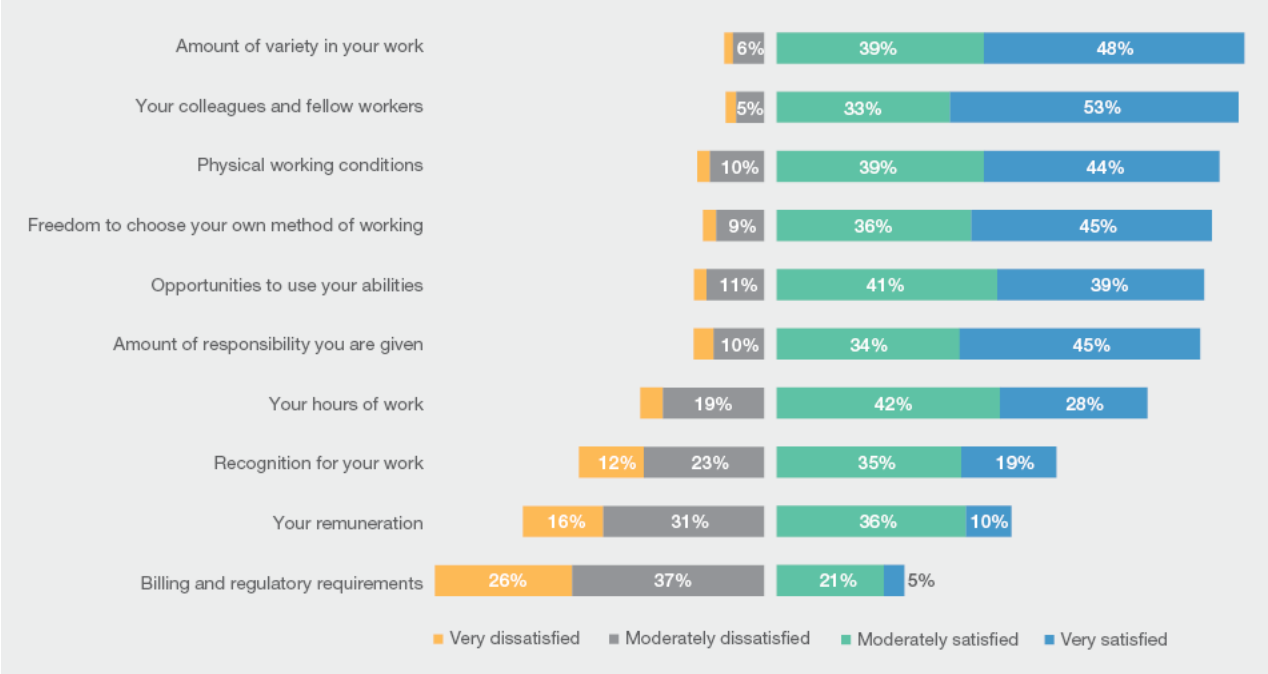
4.1 GP job satisfaction

More than seven in 10 (73%) RACGP Fellows reported they are very satisfied or moderately satisfied with being a GP overall.[3] Similarly, 76% of RACGP members reported that they are satisfied or very satisfied with their career as a GP.[41]

GPs derive their greatest levels of professional satisfaction from the variety in their work, support from their colleagues and fellow workers, physical working conditions, and freedom to choose their own method of working (Figure 36).

More than three in five (63%) GPs reported dissatisfaction with billing and regulatory requirements, with remuneration (47%) and recognition for their work (35%) also highlighted as areas of dissatisfaction (Figure 36). These areas are reflected in the highest-priority health policy issue on which GPs want the government to focus: Medicare rebates and funding reform (see Section 1.2).

Figure 36. GPs are most satisfied with the variety in their work

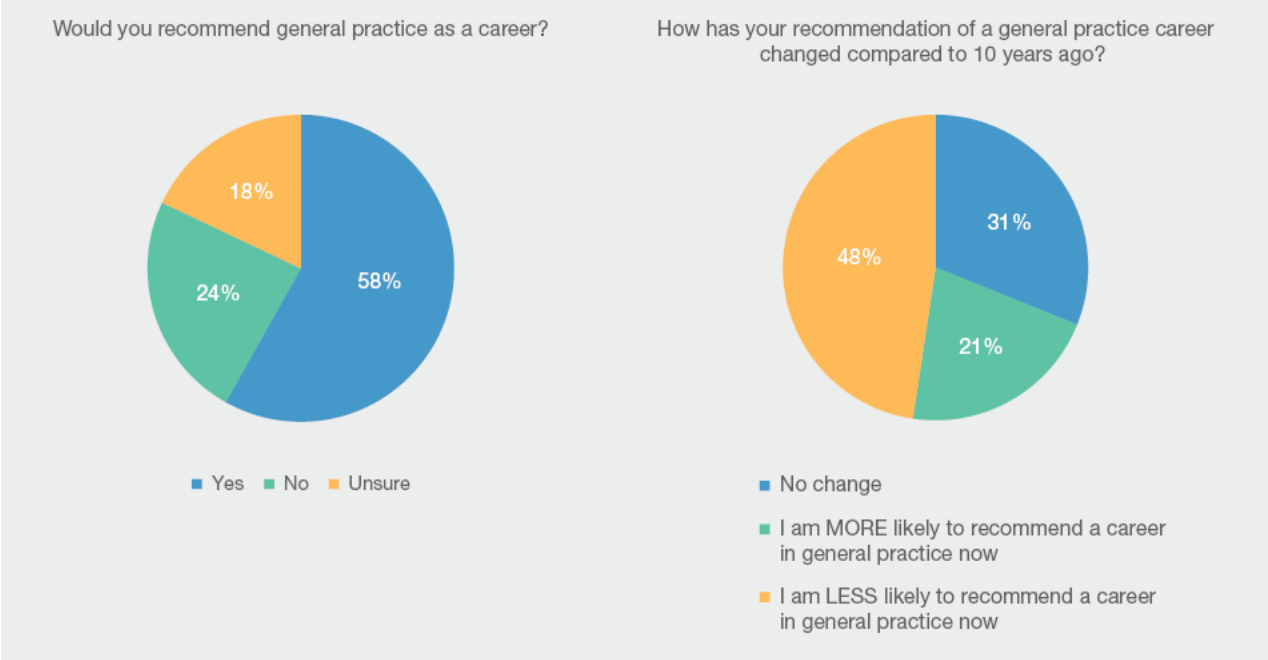


Data of less than 5% not labelled.
Measure: GP responses to the question, 'To what extent are you satisfied or dissatisfied with …?'
Base: Total survey respondents, n = 1358–1378.
Source: EY Sweeney, RACGP GP Fellow Survey, May 2021.

More than half of GPs surveyed said they would recommend general practice as a career to their junior colleagues. However, when asked if their perspective has changed, almost half (48%) indicated they are less likely to recommend a career in general practice now than they were 10 years ago (Figure 37).

Remuneration, recognition and billing requirements attract the lowest levels of satisfaction among those who would not recommend general practice as a career.[3]

Figure 37. Three out of five GPs would recommend general practice as a career



Measure: GP responses to the questions, 'Would you recommend your junior colleagues (medical students, interns, prevocational trainees) choose general practice as a career?' and 'How has your recommendation of a general practice career changed compared to 10 years ago?'
Base: Total survey respondents, n = 1386.
Source: EY Sweeney, RACGP GP Fellow Survey, May 2021.

3. EY Sweeney. RACGP GP Fellow Survey. Melbourne: EY Sweeney, 2021.
41. RACGP. RACGP member census. Melbourne: RACGP, 2021.

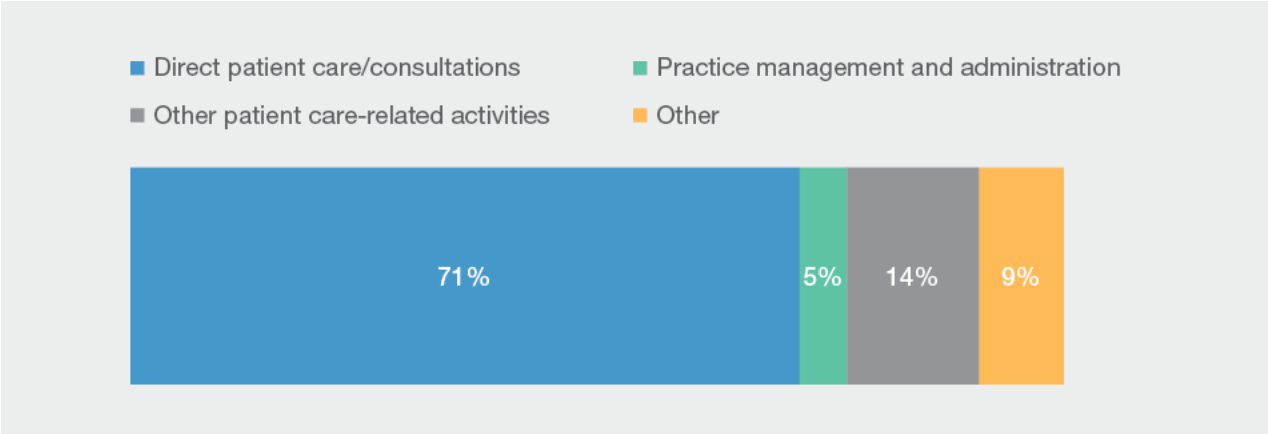
4.2 Variety of work

GPs are very satisfied with the variety that comes with a career in general practice (Figure 36).

As in previous years, GPs spend most of their time in direct patient care or consultations (71%) or in other patient-related activities (14%) (Figure 38). GPs who own their own practice spend a greater proportion of their time in practice management and administration (10%) than non-owners (4%).[3]

More than three in four GPs reported the amount of time spent on care coordination activities (patient follow-up, case conferences, letters related to patient care, etc) has increased over the past 10 years. Almost one in two (46%) GPs reported a significant increase, and one in three (32%) a slight increase.[3]

Figure 38. GPs spend most of their work day in direct patient care



Due to rounding, figures do not add to 100%.
Measure: GP responses to the question, 'What proportion of your hours are spent on the following activities in a typical week?'
Base: Responses to survey question, n = 1373.
Source: EY Sweeney, RACGP GP Fellow Survey, May 2021.

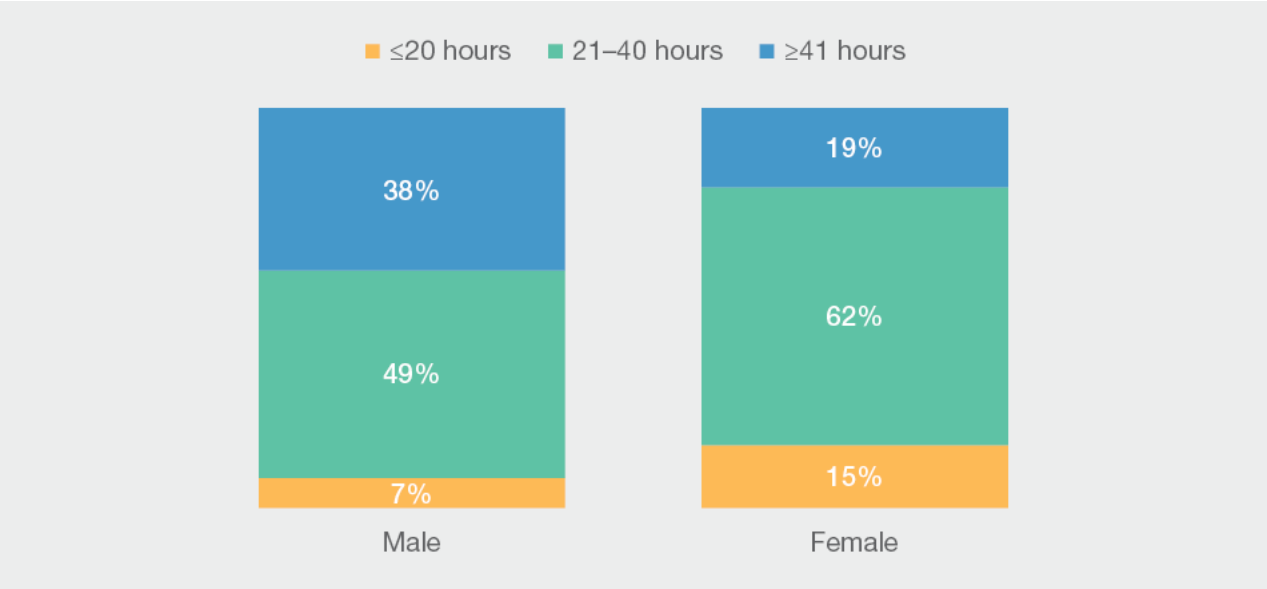
3. EY Sweeney. RACGP GP Fellow Survey. Melbourne: EY Sweeney, 2021.

4.3 Hours of work and work–life balance

GPs reported they see an average of 97 patients per week. This varies according to gender, with male GPs seeing significantly more patients per week (124) than female GPs (84).[3]

Female GPs are more likely to work part time than their male colleagues (Figure 39).

Figure 39. Female GPs are more likely to work part time



Measure: RACGP member response to the question, 'How many hours a week do you work on average?' by gender.
Base: n = 2504.
Source: RACGP. Member census. February 2021.

The average consultation lasts 18.4 minutes. This again varies according to gender, as male GPs reported shorter average consultations (16.8 minutes) than female GPs (19.6 minutes).[3]

The majority (68%) of GPs and GPs in training reported they work an average of fewer than 40 hours per week. The median response is 35 hours per week.[41].

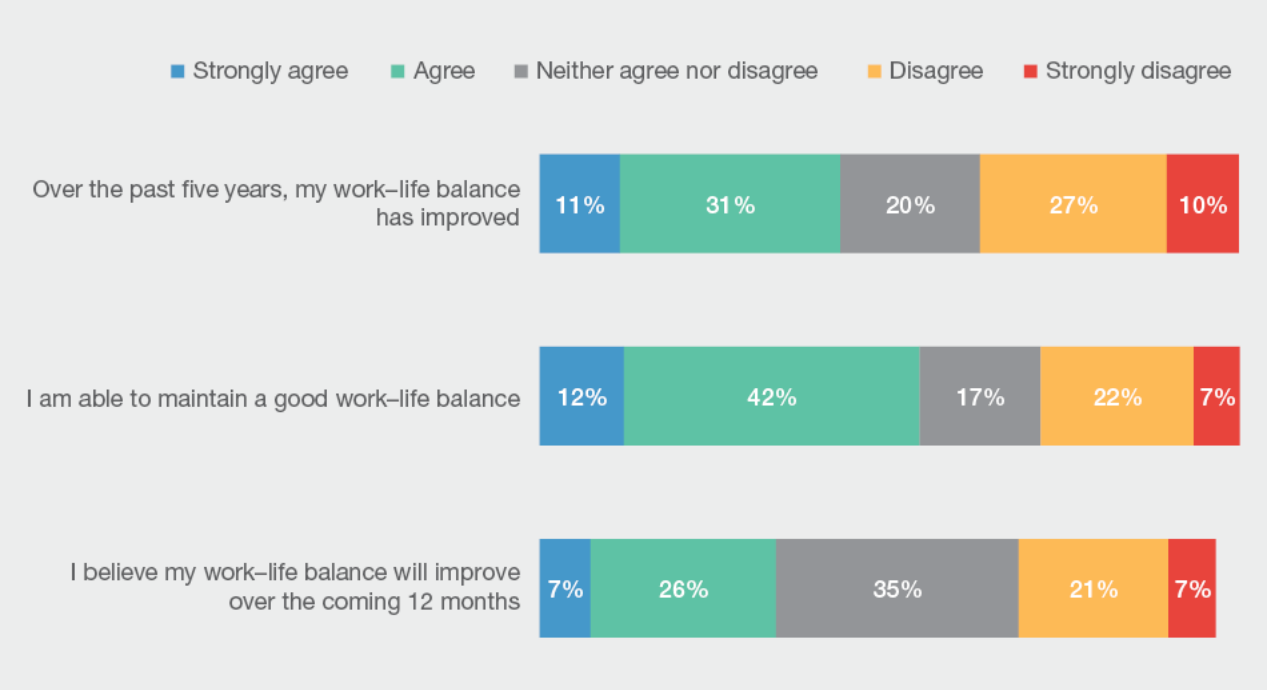
Work hours are decreasing for male and female GPs, with the weekly average falling from 42.4 to 41.8 between 2015 and 2019.[42] More than half (54%) of AGPT Program participants surveyed reported that they intend to work part-time after achieving Fellowship. This has increased from 48% in 2018.[26]

More than half (54%) of GPs reported that they can maintain a good work–life balance (Figure 40), although this figure has decreased by 5% from 2020.

GPs who are practice owners are less likely to report they can maintain a good work–life balance (43%) than GPs who do not own a practice (57%). The proportion of GPs who are practice owners reporting they can maintain a good work–life balance has declined from 51% in 2019.

There is no significant difference between practice owners and non-practice owners in responses to the question about work–life balance improving in the coming 12 months.[3] There have been no significant changes or trends in responses to these questions over the five years of the survey.

Figure 40. The majority of GPs can maintain a good work–life balance



Measure: GP responses to the question, 'To what extent do you agree or disagree with the following statements?'
Base: Responses to survey question, n = 1386.
Source: EY Sweeney, RACGP GP Fellow Survey, May 2021.

3. EY Sweeney. RACGP GP Fellow Survey. Melbourne: EY Sweeney, 2021.
5. Black Dog Institute. Mental health ramifications of COVID-19: The Australian context. Sydney: Black Dog Institute, 2020.
6. RACGP. General Practice: Health of the Nation 2020. East Melbourne: RACGP, 2020.
26. Taylor R, Clarke L, Radloff A. Australian General Practice Training Program: National Report on the 2020 National Registrar Survey. Melbourne: Australian Council for Educational Research, 2021.
41. RACGP. RACGP member census. Melbourne: RACGP, 2021.
42. Department of Health. National health workforce dataset. Canberra: DoH, 2021.

4.4 Challenges of general practice

The most common professional challenge reported by GPs is ensuring fair remuneration for skills and services provided (71%), followed by managing fatigue and burnout (58%), understanding and adhering to regulatory and policy changes (55%), and maintaining work–life balance (55%).[41] These findings align with previous editions of the Health of the Nation report, in which themes of work–life balance and income are consistently reported as top challenges by GPs.[††]

Although challenges reported by GPs can vary over the course of their career, remuneration remains a top priority across the spectrum. Managing fatigue and burnout is most reported by GPs one to four years after Fellowship. Understanding and adhering to regulatory and policy changes, such as MBS rules and Australian Health Practitioner Regulation Agency (AHPRA) legislation, is a particular concern to GPs in the first 12 months after Fellowship (65%) and declines over time. On the other hand, the percentage of GPs reporting that maintaining work–life balance is a challenge increases over time, perhaps as they are more likely to take on greater responsibility for managing and running a practice later in their careers. Similarly, GPs later in their careers are more likely to report that sourcing and retaining quality staff, teaching and supervising, and managing administration and business operations are challenges (Figure 41).

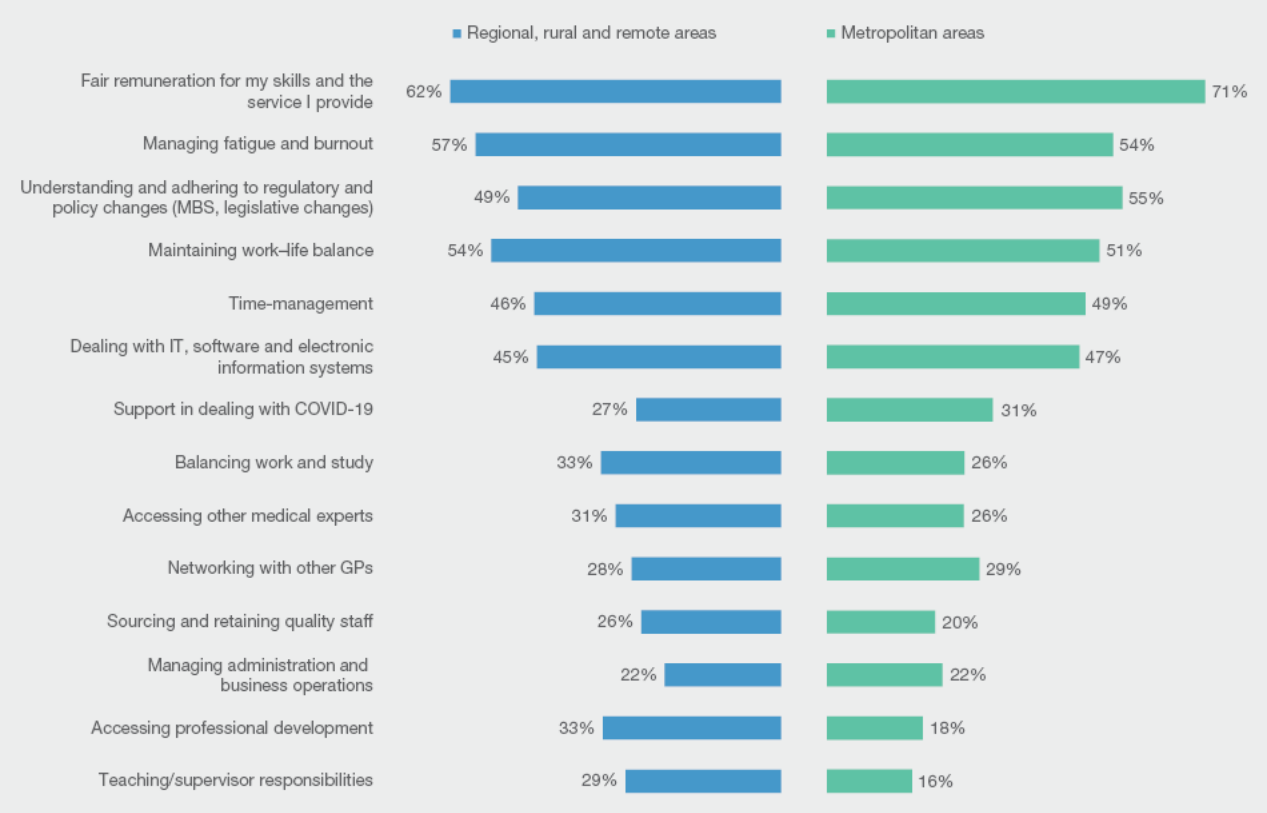
The challenges reported by GPs and GPs in training can also vary according to the location of their practice. For example, GPs working in metropolitan areas are more likely to be concerned with remuneration, understanding regulatory and legislative requirements, and dealing with COVID-19, whereas GPs located outside major cities are more likely to be challenged by balancing work and study, accessing other medical experts, sourcing and retaining quality staff, accessing professional development, and teaching and supervising responsibilities (Figure 42).

These findings align with previous editions of the Health of the Nation report regarding the different challenges faced by GPs practising in metropolitan areas compared to regional and rural areas.[††]

Figure 41. The challenges reported by GPs vary over the course of their career

Measure: Responses to the question, 'Which, if any, of the following are challenges you face working as a GP?', by career stage and membership category.
Base: Fellow survey respondents, n = 1011.
Source: RACGP member census, February 2021.

Figure 42. Challenges reported by GPs vary according to practice rurality



Measure: Responses to the question, 'Which, if any, of the following are challenges you face working as or training to be a GP?', by rurality.
Base: total survey respondents, n = 1196.
Source: RACGP member census, February 2021.

†† Please note the findings are not directly comparable to previous editions of the report due to differences in the survey sample, question response options and measurement of rurality used in the RACGP member census in 2021.

41. RACGP. RACGP member census. Melbourne: RACGP, 2021.

4.5 Experience of practice owners

Half of practice owners (50%) reported being concerned about the long-term viability of their practice, an increase from 37% in 2020. However, the proportion of owners concerned about the short-term viability of their practice is just 4%, which is a marked drop from 20% in last year's survey, completed during the early COVID-19 lockdown.[3]

The impact of Australia's first COVID-19 lockdown, mandated bulk billing of new telehealth MBS item numbers and the temporary decrease in patient presentations resulted in a more immediate concern over viability of practices in April 2020. That concern remains in 2021, but its immediacy has abated.

RACGP members reported that COVID-19 has placed additional financial pressure on practices. This includes increased overheads relating to providing telehealth services (additional administrative time, higher phone bills, the cost of infrastructure upgrades, etc), mandated bulk billing of COVID-19 MBS items, and increased costs of PPE, such as masks and gloves.

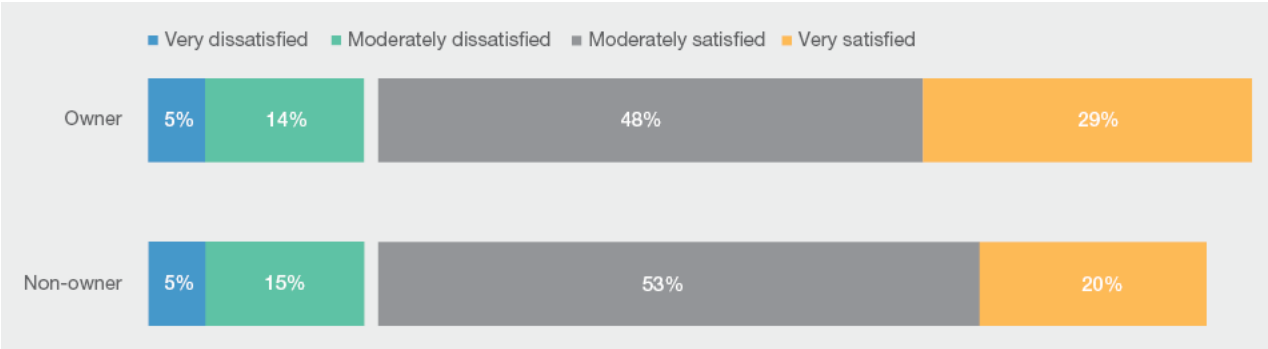
Providing COVID-19 vaccination services incurs additional costs, such as purchasing additional vaccine fridges, website upgrades, battery backups, increased staff costs to provide vaccines after hours, cover for sick or quarantining staff, and the need to respond to increased patient phone calls. Some practices have had to temporarily close due to COVID-19 exposure.

This has coincided with the Federal Government's guaranteed superannuation increase of 0.5% from 1 July 2021, as well as usual increases in award rates. Rental increases have also seen the largest annual growth in more than a decade.[43]

For many outer-metropolitan and inner-regional areas, changes to the government's classification systems for determining areas of workforce need** over the past three years have negatively affected revenue through loss of bulk-billing incentives and also reduced their ability to recruit enough GPs to staff their practices.

Despite these business concerns, GP practice owners reported higher rates of satisfaction with their career in general practice than non-owners (Figure 43). GPs who are practice owners are also more likely (63%) than non-owners (57%) to recommend general practice as a career to junior colleagues.[3]

Figure 43. Practice owners are more satisfied with their career than non-owners



Measure: Responses to the question, 'Taking everything into consideration, how do you feel about your work?' by ownership status.
Base: n = 1386.
Source: EY Sweeney, RACGP GP Fellow Survey, May 2021.

** From 1 July 2019, the Federal Government introduced the Distribution Priority Area classification system, replacing the Districts of Workforce Shortage Assessment Areas for General Practitioners and Bonded Doctors. There was also an update to the Modified Monash Model classification system, effective 1 January 2020. RACGP member feedback indicates that the effects of these changes are being acutely felt in 2021.

3. EY Sweeney. RACGP GP Fellow Survey. Melbourne: EY Sweeney, 2021.
43. CoreLogic. National rents record highest annual growth in over a decade. Sydney: CoreLogic, 2021. [Accessed 3 September 2021]

Chapter 5: The future of the GP workforce

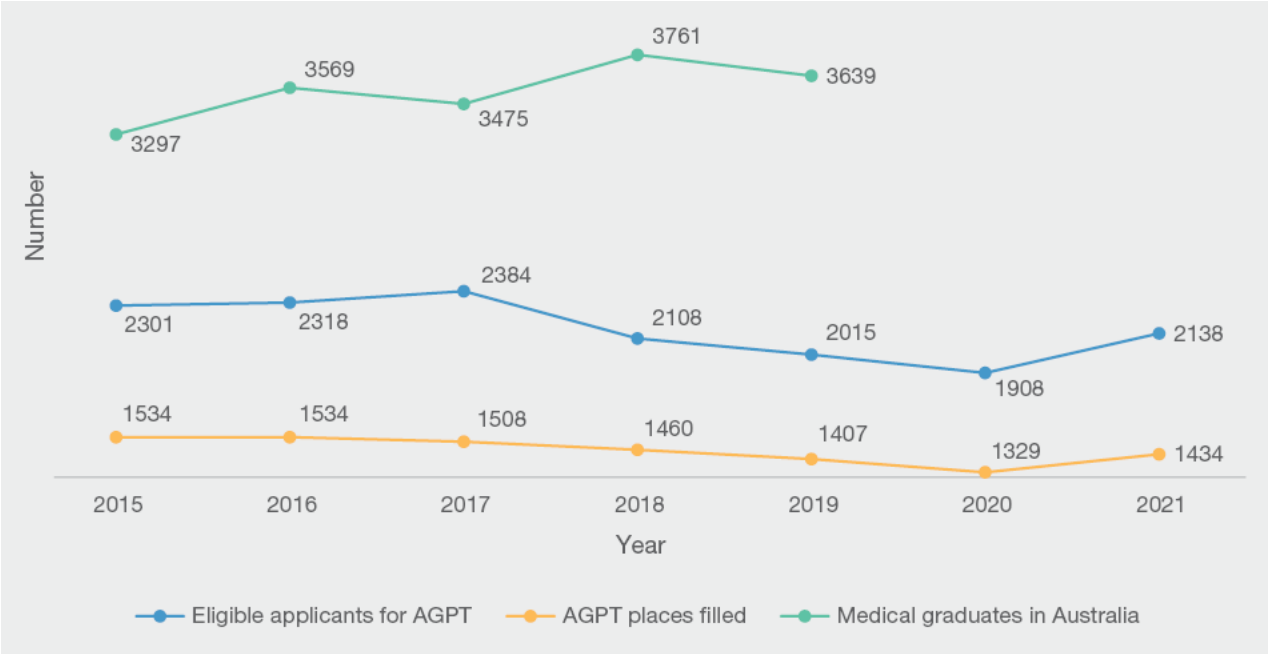
5.1 Interest in entering general practice training

The number of medical graduates in Australia continues to grow, while the proportion of those graduates choosing to enter pre-Fellowship training in general practice is in decline. The number of GP specialists is growing at a rate of 3.5% per year, compared to a yearly increase of 4.5% in the number of non-GP specialists.[24]

Medical graduates' interest in entering the Australian General Practice Training (AGPT) Program has been in decline in recent years; however, the 2021 application round saw the highest number of applicants since 2017 (Figure 44). The AGPT Program is the largest single training pathway to a career in general practice. There are several other pathways to Fellowship, including the RACGP General Practice Experience (GPE) pathway,[††] the Australian College of Rural and Remote Medicine (ACRRM) Independent Pathway and the Remote Vocational Training Scheme.

Interest in joining the RACGP GPE pathway is growing, with the number of new enrolments in the Practice Experience Program (PEP) standard stream increasing by more than 42% since 2019. There were 344 new enrolments during the first three intakes in 2021.[44]

Figure 44. The number of medical graduates applying to the AGPT Program has rebounded



Measure: Number of graduates/applicants/trainees, by year.
Data sources: Department of Health. Health Workforce Division. Unpublished data provided to the RACGP, June 2021.
Medical Deans Australia and New Zealand. Student statistics report August 2019-20. Sydney: Medical Deans, 2020. Sydney: Medical Deans, 2020.

In a 2021 *newsGP* poll, 79% of more than 1250 respondents indicated the best way to attract more medical graduates to general practice was to increase remuneration.[45]

The proportion of final-year medical students listing general practice as their first-preference specialty for the future has fallen to 15.2% in 2019, the lowest number since 2012.[46] Almost one in five prevocational and unaccredited doctors in training (18%) and one in 10 interns (11%) said they intend to pursue training with the RACGP.[25]

The most commonly reported times to decide to specialise in general practice is more than one year out of medical school (37%), after trying another specialty (24%), and early (18%) or late (17%) in a medical degree.[26][26]

The most common reasons for choosing to become a specialist GP are hours and working conditions (78%), diversity of patients and medical presentations (65%), building long-term relationships with patients (59%), and social responsibility or to support the community (33%).[26]

†† Commencing in 2019, the RACGP's GPE pathway comprises the PEP standard and PEP specialist streams. GPE is a self-directed education pathway to support non-vocationally registered doctors on their journey to Fellowship of the RACGP. The PEP is partially funded under the Federal Government's Stronger Rural Health Strategy for doctors based in rural areas (MMM areas 2–7).

24. Scott A. The evolution of the medical workforce. Melbourne: The Melbourne Institute, 2021.
25. Australian Health Practitioner Regulation Agency, Medical Board of Australia. Medical Training Survey 2020. Melbourne: AHPRA, 2021.
26. Taylor R, Clarke L, Radloff A. Australian General Practice Training Program: National Report on the 2020 National Registrar Survey. Melbourne: Australian Council for Educational Research, 2021.
44. RACGP. Training data. 2021. Unpublished data.
45. RACGP. newsGP poll. Melbourne: RACGP, 2021.
46. Medical Deans Australia and New Zealand. Medical Schools Outcomes Database: National Data Report 2020. Sydney: Medical Deans, 2020.

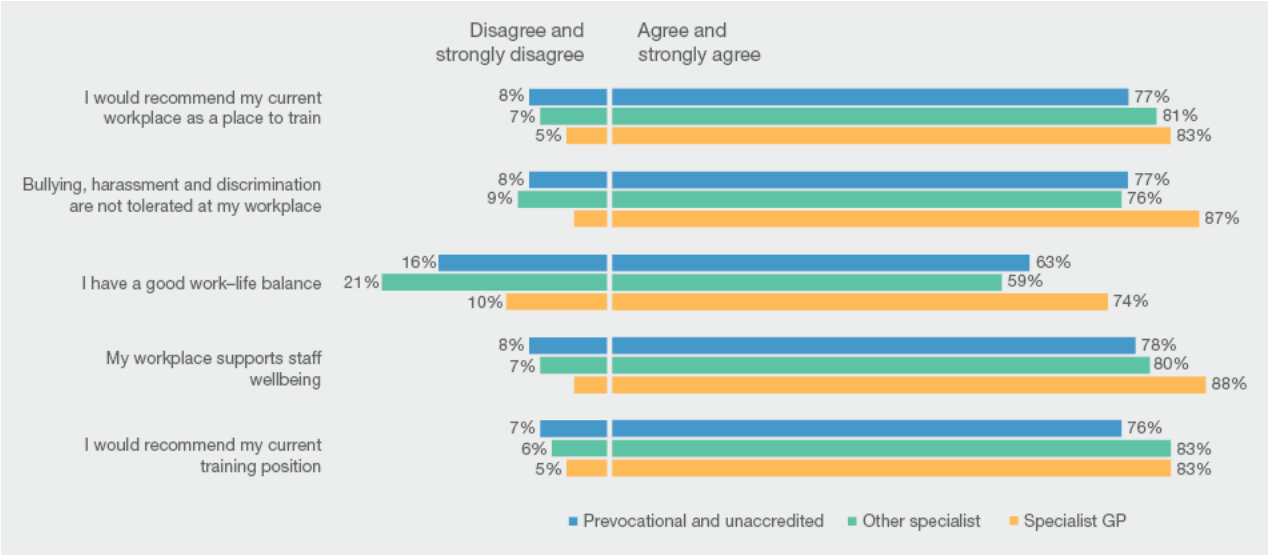
5.2 Satisfaction and work–life balance

GPs in training reported high rates of satisfaction with their training position and workplace compared to their peers in non-GP specialist training (Figure 45).

There is substantial interest among respondents in supporting general practice training once they have achieved Fellowship, with a majority interested in becoming a general practice supervisor (57%) and/or medical educator (51%).[47]

Among PEP standard participants, 87% reported they would recommend the program to other doctors.[48]

Figure 45. GPs in training are very satisfied with elements of their training and workplace



Data of less than 5% not labelled.

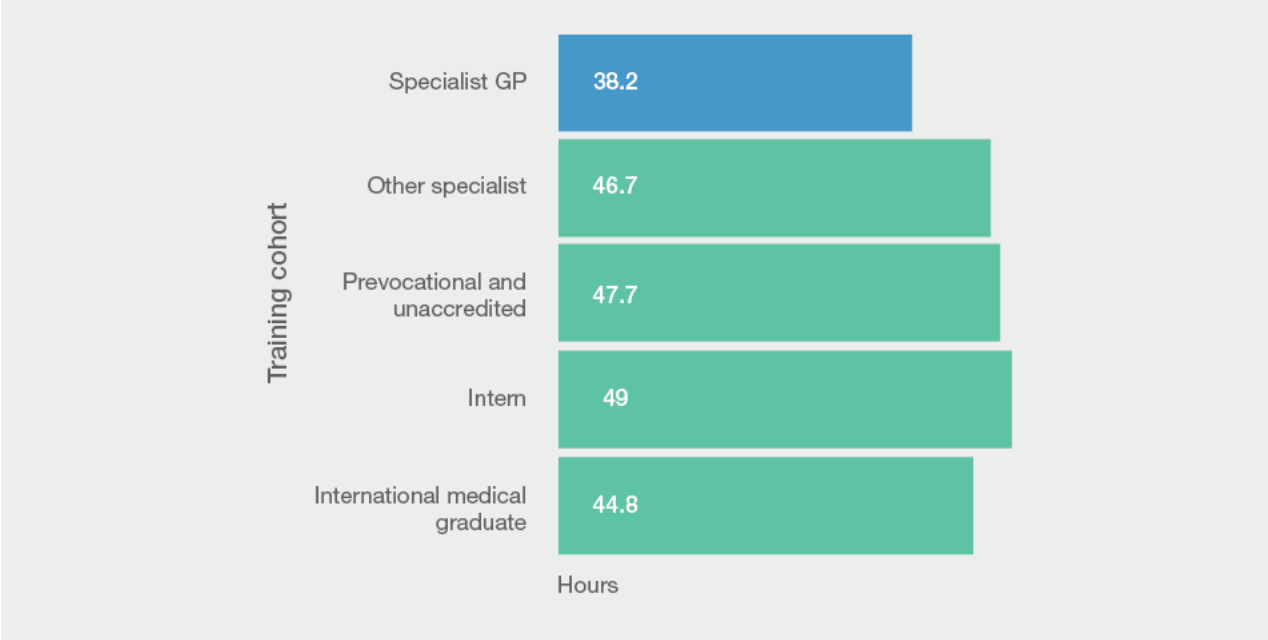
Specialist GP includes respondents from AGPT Program, Remote Vocational Training Scheme, the RACGP PEP Program and the ACRRM Independent Pathway.
Measure: Responses to questions regarding training setting and workplace, as listed, by training cohort.
Base: total sample: prevocational and unaccredited = 5158, other specialist = 9020, specialist GP = 3132.
Source: Medical Board of Australia and AHPRA. Medical Training Survey 2020: National report. Melbourne: MBA and AHPRA, 2020.

More than half (59%) of GPs in training surveyed reported that it is moderately or very difficult to maintain a healthy work–life balance while in training, whereas less than one-quarter (23%) expect this to be the case once they achieve Fellowship.[47]

One in five GPs in training reported high rates of burnout according to the Maslach Burnout Inventory measures of emotional exhaustion or depersonalisation.[47]

Three-quarters (76%) of GPs in training surveyed reported that they have their own GP, an increase from 70% in 2017.[47]

Figure 46. Average hours worked per week, as reported by training cohort



Specialist GP includes respondents from AGPT Program, Remote Vocational Training Scheme, the RACGP PEP and the ACRRM Independent Pathway.
Measure: Average aggregated results in response to the question, 'On average in the past month, how many hours per week have you worked?', by training cohort.
Base: specialist GP = 2635, other specialist = 7301, prevocational and unaccredited = 4136, interns = 1033, IMGs = 1784.
Data source: Medical Board of Australia and AHPRA. Medical Training Survey 2020: National report. Melbourne: MBA and AHPRA, 2020.

Two-thirds (68%) of male GPs in training reported that they intend to work full time after attaining Fellowship, compared to one-third (34%) of female GPs in training.[47]

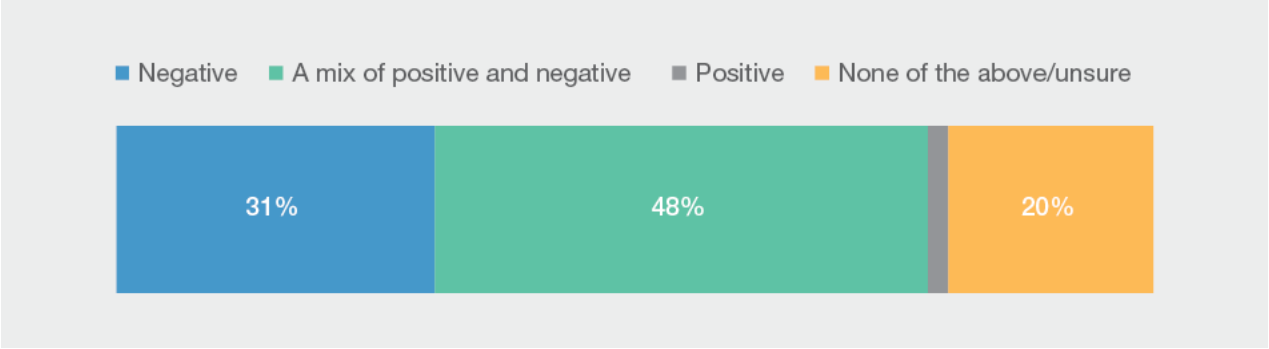
Nearly a third (31%) of surveyed GPs in full-time training reported undertaking additional employment, most commonly hospital locum work (53%). The most often cited reasons for undertaking additional employment were the need for additional income (63%) and pursuing other interests (41%).[47]

47. General Practice Registrars Australia. Benchmarking Report: Insights on employment conditions and overall wellbeing of GP registrars 2019. Melbourne: GPRA, 2021.
48. RACGP Evaluation Team. Practice Experience Program Evaluation Data 2020–2021. Unpublished data. Melbourne: RACGP, 2021.

5.3 Effect of the COVID-19 pandemic on GPs in training

The pandemic has had several effects on the experiences of GPs in training, most commonly disruption to routine teaching (47%), the creation of uncertainty for the remainder of the training year (41%) and disruption to exam preparation due to unconfirmed exam dates (41%).[25]

Figure 47. GPs in training reported mixed effects of COVID-19 on their training



Data of less than 5% not labelled.
Includes respondents from AGPT Program, Remote Vocational Training Scheme, the RACGP PEP and the ACRRM Independent Pathway.
Measure: Responses to question, 'Upon reflection, overall the impacts of COVID-19 on my training have been …'.
Base: n = 2593.
Data source: Medical Board of Australia and AHPRA. Medical Training Survey 2020: National report. Melbourne: MBA and AHPRA, 2020.

Almost 10% of AGPT Program participants surveyed reported that COVID-19 restrictions have prevented them from changing their training practice when planned.[26] Collaboration with other registrars, workshops, progression towards completion, diversity, and exams and assessments were most commonly reported as being very negatively affected by COVID-19.[26]

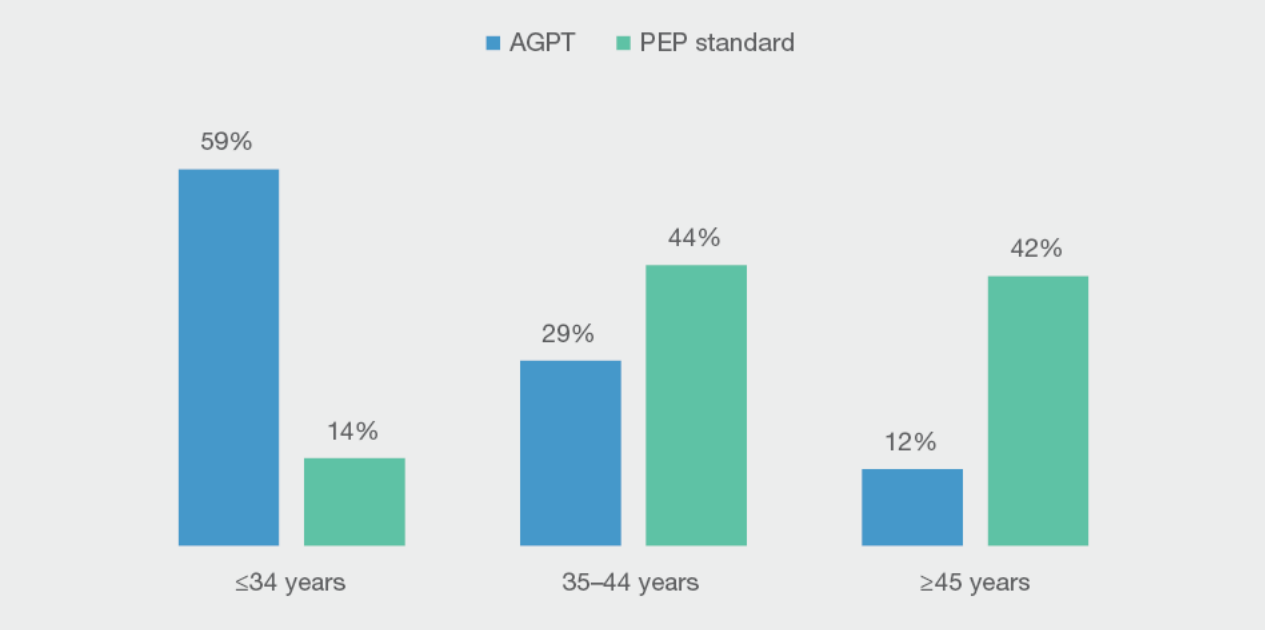
25. Australian Health Practitioner Regulation Agency, Medical Board of Australia. Medical Training Survey 2020. Melbourne: AHPRA, 2021.
26. Taylor R, Clarke L, Radloff A. Australian General Practice Training Program: National Report on the 2020 National Registrar Survey. Melbourne: Australian Council for Educational Research, 2021.

5.4 Trainee and New Fellow demographics

Age of GPs in training

More than half (59%) of AGPT Program participants are aged 34 and under, and 12% are aged 45 and over. By comparison, PEP standard participants are an older cohort of GPs, with only 14% aged 34 and under, and 42% aged 45 and over (Figure 48).

Figure 48. The average age of GPs in training varies by training program



Measure: All GPs in the AGPT Program and the RACGP PEP standard stream (pre- and post-education), 2020–21.
Base: AGPT n = 3774, PEP standard n = 866.
Source: Unpublished training data.

Location of training and preferred location of future practice

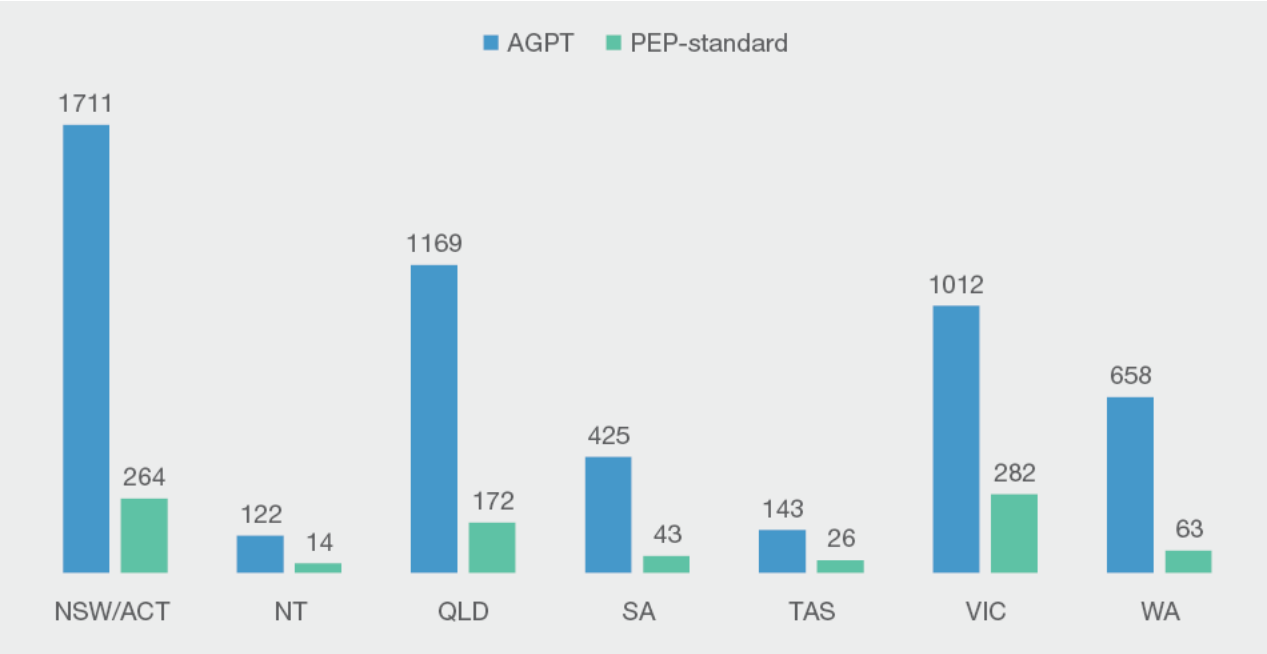
GPs in training are located in all states and territories (Figure 49).

Whereas two out of five GPs in training (44%) reported that they intend to work in urban (metropolitan) areas after attaining Fellowship, a larger proportion (48%) plan to work in rural or a mix of urban and rural locations.[47]

Almost four in five (78%) PEP standard participants work outside major cities in MMM2–7 areas,[44] and almost nine in 10 (88%) of completed PEP standard participants reported they would like to continue to work in their current practice location.[48]

The most common location of primary medical degree among PEP standard participants was India (11%), followed by Australia (9.1%) and Sri Lanka (8.7%).[44]

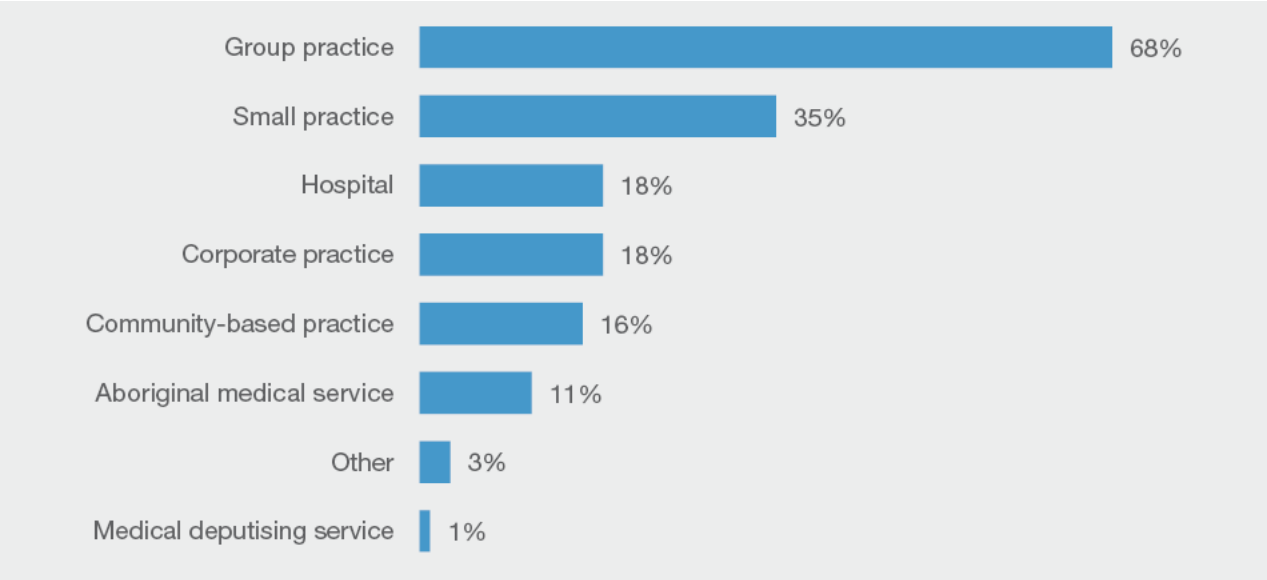
Figure 49. GPs in training are located in all states and territories



Measure: Total number of GPs in the AGPT Program and the RACGP PEP standard stream (pre- and post-education), 2020–21.
Base: AGPT n = 5240, PEP standard n = 866.
Source: Unpublished training data.

Most GPs in training surveyed express a preference to work in a group practice (68%) or corporate practice (18%) setting after attaining Fellowship. More than one-third want to work in a small practice, 16% in community-based practice and 11% in an Aboriginal medical service. Almost one in five (18%) want to work in a hospital (Figure 50).

Figure 50. The majority of GPs in training plan to work in a group practice after attaining Fellowship



Includes respondents from AGPT Program, Remote Vocational Training Scheme, the RACGP PEP and the ACRRM Independent Pathway.
Measure: Responses to the question, 'In the first five years as a Fellow, what clinical settings will you prefer to work in (select all that apply)?'
Base: n = 282.
Source: General Practice Registrars Australia Benchmarking Report 2021.

Number and gender of GPs in training

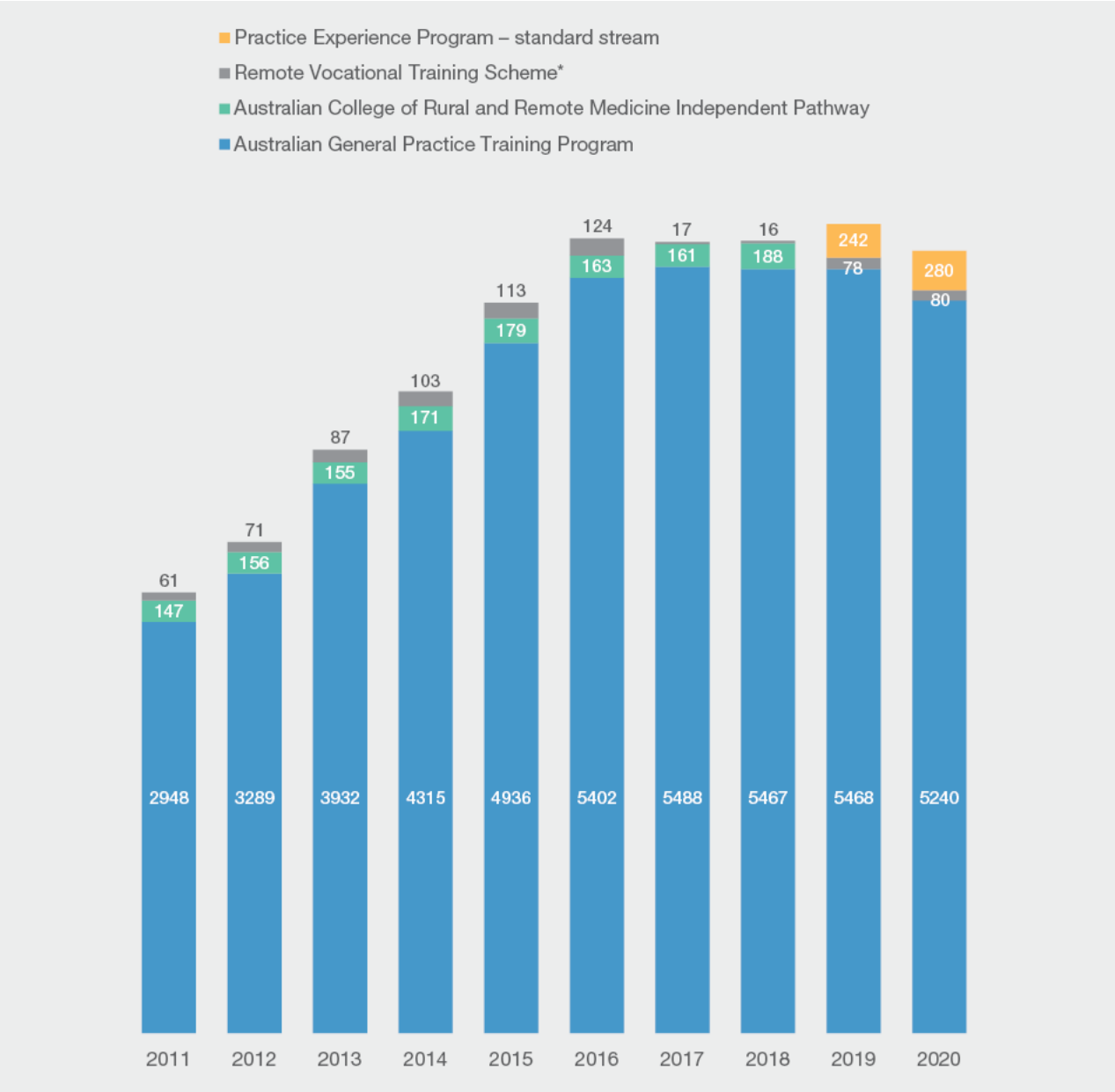
There were more than 5600 GPs in training in the RACGP pathways in 2020, although the number of AGPT Program participants is now at its lowest since 2015 (Figure 51).

Sixty percent of all AGPT Program participants are female.[49] The proportion of first-year female participants declined by 19% between 2017 and 2020, compared to a decline of 1% in the male cohort.[44] This could be related to perceived barriers in accessing entitlements such as parental leave in general practice training compared to hospital-based training.

There are 668 active PEP standard participants in 2021 and 28 PEP specialist participants. To date, 198 PEP standard and six PEP specialist participants have completed the requirements for the program.[44] As stated in Section 5.1, the PEP standard stream cohort is growing each year.

Among PEP standard participants, there is a greater proportion of male (56%) than female (44%) GPs.[44]

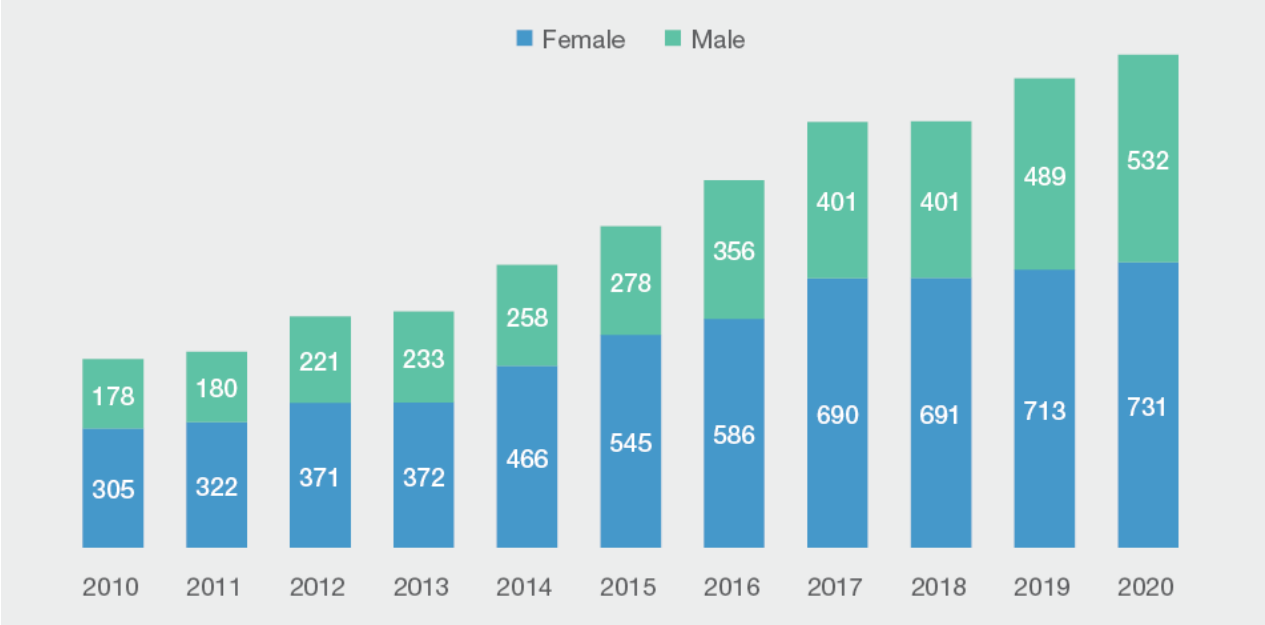
Figure 51. The total number of AGPT Program participants is declining



*ACRRM Independent Pathway training data for 2019 and 2020 and Remote Vocational Training Scheme for 2020 not included.
Measure: Number of GPs in the AGPT Program, RACGP PEP standard stream, ACRRM Independent Pathway and the Remote Vocational Training Scheme, by year.
Data sources: Department of Health. Medical Training Review Panel 19th report. Canberra: DoH, 2016.
Department of Health. Health Workforce Division. Unpublished data provided to the RACGP, July 2021.
Internal RACGP data (unpublished).

The number of New Fellows is growing, with the proportion who are female consistently greater than the proportion that are male (Figure 52). Given female GPs are more likely to work part time (Figure 39) and on average spend more time with patients (Section 4.3), this could have implications for the future GP workforce. A greater headcount of GPs may be required to provide the same number of services.

Figure 52. More New Fellows are female than male



Measure: Number of trainees obtaining Fellowship of the RACGP, by year and gender.
Source: Internal RACGP data.

Aboriginal and Torres Strait Islander GPs in training

There were 79 Aboriginal and Torres Strait Islander GP trainees on the AGPT Program in 2020,[49] an increase from 69 in 2019.[2]

2. RACGP. General Practice: Health of the Nation 2020. East Melbourne: RACGP, 2020.
44. RACGP. Training data. 2021. Unpublished data.
47. General Practice Registrars Australia. Benchmarking Report: Insights on employment conditions and overall wellbeing of GP registrars 2019. Melbourne: GPRA, 2021.
48. RACGP Evaluation Team. Practice Experience Program Evaluation Data 2020–2021. Unpublished data. Melbourne: RACGP, 2021.
49. Department of Health. Unpublished training data provided to the RACGP. 2021.

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RACGP: Healthy Profession. Healthy Australia.

The RACGP is the voice of GPs in our growing cities and throughout rural and remote Australia. For more than 60 years, we have supported the backbone of Australia's health system by setting the standards for education and practice and advocating for better health and wellbeing for all Australians.

We cultivate a stronger profession by helping the GPs of today and tomorrow continue their professional development throughout their careers, from medical students and GPs in training to experienced GPs. We develop resources and guidelines to support GPs in providing their patients with world-class healthcare, and help with the unique issues that affect their practices. We are a point of connection for GPs serving communities in every corner of the country.

Australia's GPs see more than two million patients each week, and support Australians through every stage of life. The scope of general practice is unmatched among medical professionals, so the RACGP supports members to be involved in all areas of care, including aged care, mental health, preventive care and Aboriginal and Torres Strait Islander health.

Patient-centred care is at the heart of every Australian general practice, and at the heart of everything we do.

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