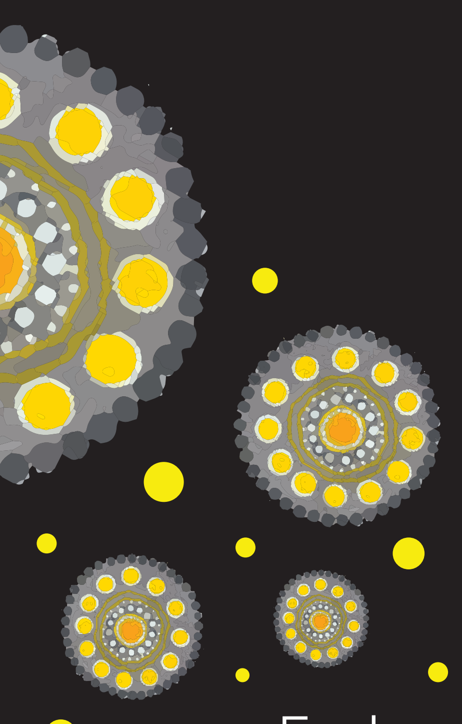
December 2023

Beyond burnout

Supporting our General Practitioners



Evohealth acknowledges that we work on the traditional lands of many Aboriginal clans, tribes, and nations.

We commit to working in collaboration with Aboriginal and Torres Strait Islander communities and peoples to improve health, emotional and social well-being outcomes in the spirit of partnership.

About **Evohealth**

The delivery of healthcare is complex.
Our focus is not.

Better health for all Australians.

BEYOND BURNOUT:

SUPPORTING OUR
GENERAL PRACTITIONERS

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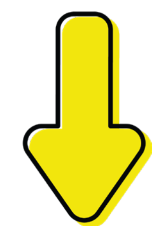
THE PRIMARY CARE **TICKING TIME BOMB**

It is no secret that the supply of general practitioners (GPs) in Australia is set to be outstripped by demand in the coming years. [1] Australia has an ageing population with a growing burden of chronic disease compounded by an increase in mental health conditions arising during the COVID-19 pandemic. This has led to a greater demand for complex patient care. As the gateway to the health system, the demand and pressure on our GPs is at an all-time high. Without enough GPs to meet this demand, there is a significant risk that more and more Australians will not be able to access timely care leading to poorer health outcomes and increased strain on our already suffering health system.

It is alarming that in recent years the number of GPs indicating they will leave the profession prematurely is increasing. [2, 3]

ONLY 43% INTEND TO PRACTICE IN 10 YEARS' TIME [3]



SHORTFALL OF **11,392 GPs** BY 2032 [1]

GENERAL PRACTICE **NOT 1ST CHOICE** FOR UP TO 40% OF GP REGISTRARS [4]

LESS THAN 4 IN 10 PRACTISING GPs WOULD RECOMMEND THEIR PROFESSION TO JUNIOR DOCTORS [3]

> Our primary health system is on the brink of a crisis if swift and targeted action is not taken to retain and grow our GP workforce. The fact is, that there cannot be healthcare without healthcare professionals, and primary care cannot exist without GPs.

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FUNDING **PRESSURES**

There is no shortage of media and reports examining the pressures that GPs face in practice, with most focusing on our current funding system, Medicare. [2, 5, 6] Described as a 'general practice system designed for an earlier era,' Medicare has been critiqued for not keeping pace with changes in healthcare needs and making the delivery of tailored wholistic care near impossible. [6] It has been suggested that the funding model leads to working in silos rather than supporting the pursuit of the gold standard team-based or multi-disciplinary approach to patient care. [2, 5]

For the past 40 years Australian GPs have almost exclusively been paid via a fee-for-service model which incentivises short consultations. [5] During the same time period, other countries, including the United Kingdom, New Zealand and France have overhauled funding to include multiple or blended models. These offer greater flexibility in funding aligned with patients' individual care needs. [5]

Unsurprisingly, this is taking a toll on Australian GPs, with many reporting concerns about financial viability and level of care they can provide. [2, 3] It is frequently reported that clinics will close with an exodus of GPs from the workforce at a time when system capacity critical. [1, 3]

Given the challenges of primary care funding and the increasing impact on the primary care workforce, policy and programs to grow and retain the GP workforce have focused on providing financial incentives.

These incentives are primarily centred on improving training and attracting GPs to work in historically underserviced areas, such as rural and remote communities. [7-14] With the shortage of GPs predicted to become a nationwide issue, in the near future, it is clear these programs are not having the desired impact.

While much of current and future workforce shortages may be explained by funding pressures; we cannot afford to assume this is the only contributing factor. Further interrogation of additional drivers behind the impending exodus of GPs must be examined, so that as a nation we can champion reform to ensure an adequate supply of GPs into the future.

This article 'Beyond burnout: Supporting our General Practitioners to stay in the job' presents a unique perspective on what additional job design factors must be considered and addressed to create a sustainable GP workforce in Australia.

THE GP SUPPLY-DEMAND CONUNDRUM

Over the past few decades, modelling of GP services in Australia continually predicts that demand will outpace supply if the status quo continues (Figure 1). While there has been marginal growth in the total number of GPs in the past five years [2, 3] this has not and will not be enough to stem the impending supply challenge.

Workforce modelling reveals a shortfall of 11,392 GPs by 2032. (Figure 1).

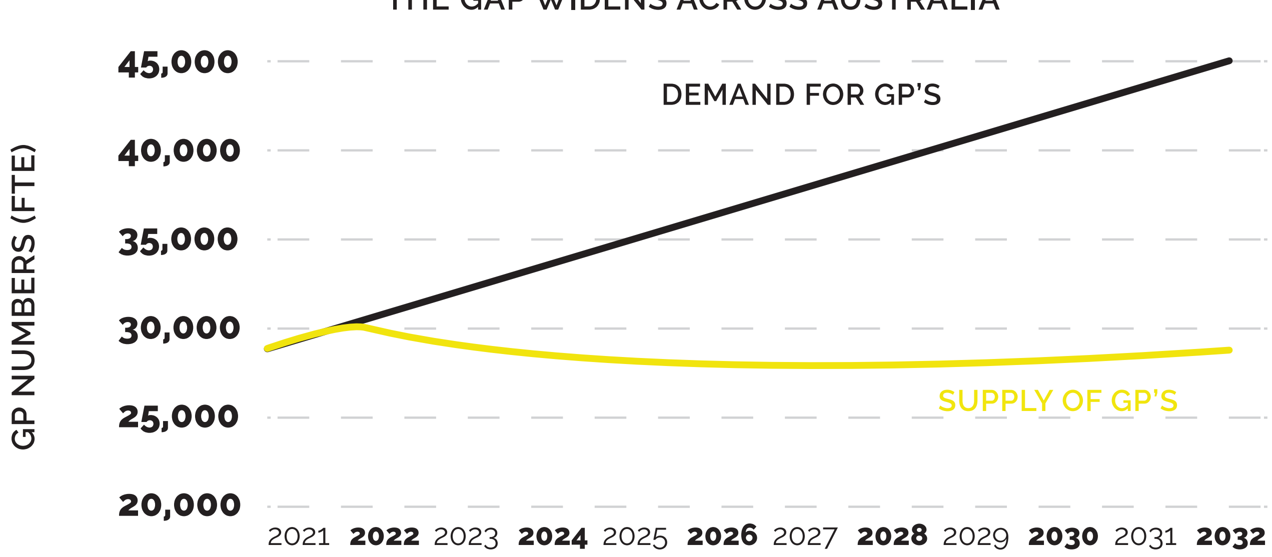


Figure 11. The gap in future demand for GPs vs supply [1] *Source: Deloitte Access Economics (2022)*

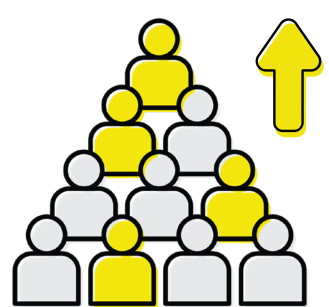
While the issue of undersupply and maldistribution of GPs has been felt disproportionately by our rural and remote communities in the past, this is set to change. [1] In fact, modelling reveals that current policies and initiatives will ensure future adequate numbers of GPs to meet demand in regional and remote areas. In a surprising reverse trend, metropolitan areas will struggle for workforce capacity in the coming years. [1]

Now more than ever we need to not only retain but grow the GP workforce. In the current climate this seems unlikely with more GPs indicating intent to leave the profession due to growing professional demands. [2, 3]

GPs WILL VOTE **WITH THEIR FEET**

There is an increasing number of GPs who are expressing their desire to leave the profession. Since 2017, the proportion of GP's intending to prematurely leave the profession within five years has risen by 11 per cent, [2] while less than half of GPs (43 per cent) have indicated that they intend to still be practising in ten years' time. [2, 3]

Retention does not discriminate against age with younger GPs increasingly likely to leave the profession. The proportion of GPs under 45 years old intending on practising in ten years dropping from 90 per cent in 2017 to 80 per cent in 2022. [2] More GPs are also reducing the numbers of hours they work with a five per cent increase in GPs practicing fewer than 40 hours a week from 2017 to 2023. [2, 3]



Proportion of GPs who would not recommend general practice as a career is also on the rise **from 24% in 2021 to 39% in 2023**

The proportion of GPs who would not recommend general practice as a career is also on the rise from 24 per cent in 2021 to 39 per cent in 2023. [2, 3] In recent years general practice has continued to decline in popularity with less than 14 per cent of medical graduates indicating they would choose it as their preferred medical speciality in 2023. [15-17]
A further shift to favour other medical and surgical specialities also occurs during the first years of training as up to 40 per cent of GP registrars state that a career in general practice was not their first speciality of choice. [4]

While this does not appear to have had a direct impact on new GPs entering the workforce to date, recent modelling suggests that this will lead to a steady decline in the number of GPs over the next ten years. [1] It is only a matter of time before this negative sentiment begins to impact on the incoming GP workforce and further intensifies the future supply/demand challenge.

MORE THAN **JUST MONEY**

The ever-increasing pressures of a strained healthcare and funding system are frequently identified as the primary cause for GP dissatisfaction and future inadequate supply of workforce. While funding cannot be ignored, other factors must be considered. Analysis of job design is integral, particularly to understand why general practice is less appealing when compared to other specialist pathways. Unpacking the core elements of the GP role, beyond funding, must be included in designing policy to attract and retain GP workforce so that time and resources are spent on developing targeted programs that will affect real and significant change.

Our research reveals seven key areas (Figure 2) that must be addressed in order to reverse the decline in the number of GPs available to deliver care in Australia's primary health system. Considering each of these challenges along with system and funding pressures may provide much needed insight into how to improve GP recruitment and retention for the future. Each are considered in further detail below:

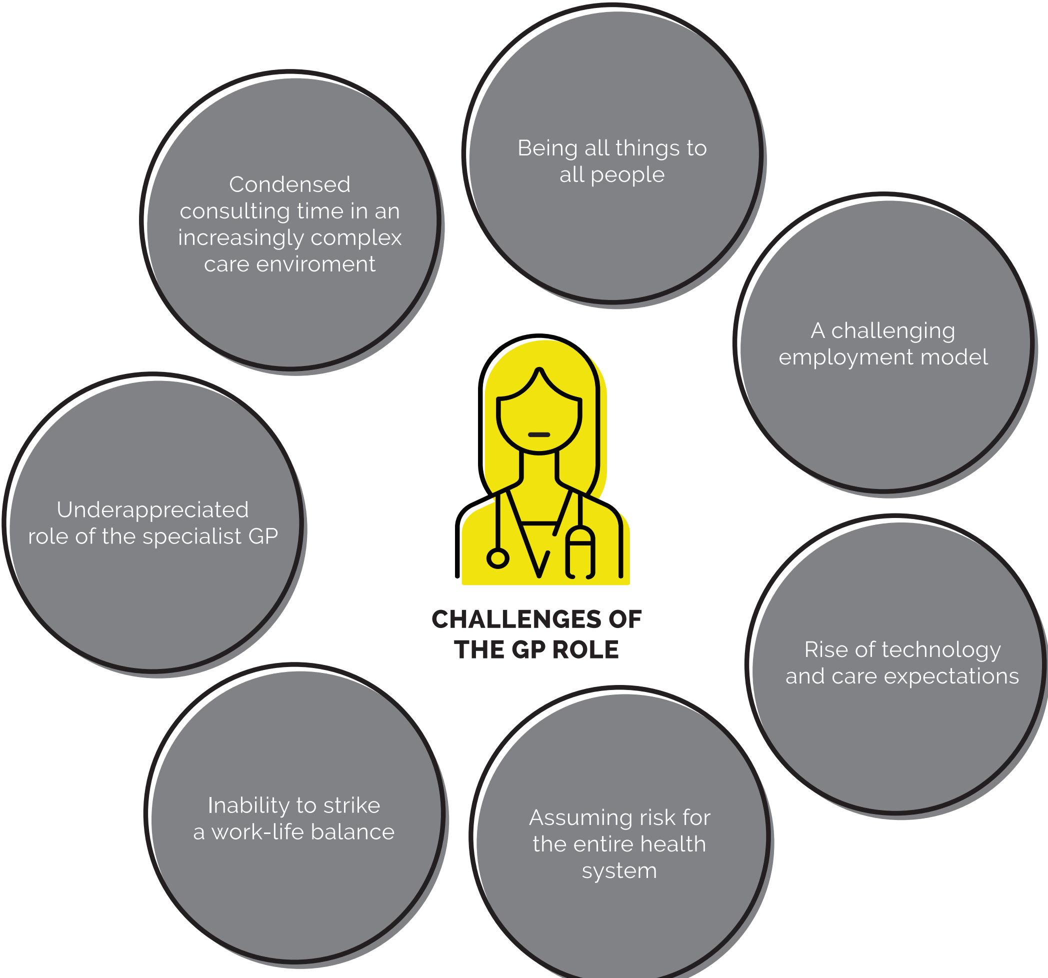


Figure 2. Aspects of the GP's job by design that make it unattractive

1. CONDENSED CONSULTATION TIME IN AN INCREASING COMPLEX CARE ENVIRONMENT

Through no fault of their own, GP consultations are driven by the unit of time they are allowed to bill for, rather than the needs and complexity of patient care. [2, 5, 17] This limits time to get to know and understand patients and diminishes the doctor-patient relationship crucial for effective continuity of care.

The benefit of primary care is seen in incremental improvements over time. Without time allowed to understand patients, their life and struggles, this benefit can't be realised and the joy of helping a patient progress on their care journey is lost. As evidence-based practitioners who often sought a job in primary care so they could cultivate wholistic and longer-term care for their patients, the cognitive dissonance of compromising the care they want to provide in the current system may be too much.

2. BEING ALL THINGS TO ALL PEOPLE

The increasing complexity of healthcare, including the rise of multimorbidity and polypharmacy, is making the job of GPs increasingly difficult. [5] GPs are expected to have oversight over all the latest advancements in disease presentations, diagnosis, testing procedures, and treatment guidelines, as well as preventative health. This is a very broad scope of practice that is challenging to maintain. Particularly so, given the rapid advancement of medicine and technology, with information doubling every 73 days.

> *It is estimated that medical knowledge in 1950 doubled every 50 years; in 1980, 7 years; and in 2010, 3.5 years. In 2020 it [was] projected to be 0.2 years—just 73 days.*
>
> **- Peter Denson, MD [18]**

3. ASSUMING RISK FOR THE ENTIRE HEALTH SYSTEM

GPs deal with uncertainty every day when they assess, diagnose, treat and refer patients. Whilst they are highly trained for this role, the risks involved and fear of litigation if something goes wrong have been cited by some as a deterrent for continuing in clinical practice. [19, 20] One Australian study found that 48 per cent of GPs believed they would consider retiring early from practice due to medicolegal risk. [20]

As the gatekeepers and co-ordinators of the greater health system, GPs in England have described themselves as 'the paid risk-taker for the NHS'. That is, they provide less costly care than other specialists but may potentially result in greater errors due to the pressures of the system and the breadth of issues they encounter in practice. [19] A similar sentiment would likely hold true for Australian GPs.

We already know Australian GPs are facing unmanageable workloads and increasing complexity of cases with less time to give their patients. This along with poor work-life balance may lead to potential errors. [21] We must assist GPs to manage this, as Australians cannot risk losing them as a result.

4. THE UNDERAPPRECIATED ROLE OF THE SPECIALIST GP

The practice of medicine has seen a shift in the past few decades with increasing specialisation and sub-specialisation of medical fields. [22] As specialist medical practitioners defined by their broad remit, GPs play a central role in Australia's health system. [23] They are one of the most accessed health professionals, yet unfortunately, the critical role of the GP is often under recognised and undervalued. [23]

Feeling valued and supported is essential to performance in any job, without it, motivation to persist in the role may diminish and with it, our critical GP workforce.

In 2021, over one third of GPs reported dissatisfaction with the level of recognition they received for their care of patients within the health system. [24]

Given their role as a gatekeeper to patient care, GPs have a critical role to play in multi-disciplinary team (MDT) care. MDTs support effective clinical decision making and coordination of patient care and is considered best practice. Being part of a MDT may have dual benefits, improving job satisfaction and appreciation of the GP by other specialist groups. MDT in general practice is underutilised. The reasons cited are multifactorial - inadequate funding, lack of referral pathways, service capacity and training.

5. RISE OF TECHNOLOGY AND CARE EXPECTATIONS

Rapid advances in technology and ease of access to information mean the modern patient is more informed than ever. Armed with an internet worth of information and misinformation at their fingertips, patients want to be involved in clinical care decisions. Expectations and demands from patients have increased, leading to a shift in clinician/patient relationships, creating new challenges for GPs to navigate, having to contend with misinformation and in some cases diminished authority.

Whilst providing many important new opportunities, an increase in consultations via telehealth and the risks of technology failures has made patient care more logistically complex. As a result, GPs are grappling with how to provide quality care without physical assessment, increasing concerns about the risks of missing critical information.

6. A CHALLENGING EMPLOYMENT MODEL

Most GPs in Australia (85 per cent) primarily work in group practices (corporate and non-corporate). [2, 3] Many of these GPs are engaged as independent contractors through a services agreement with the practice. Under this model, GPs are contractors and not employees. They negotiate fees and working arrangements, and as such, miss out on entitlements such as annual, personal and long service leave. They must also manage their own Goods and Services Tax (GST), taxes, superannuation, and insurance. The benefit of this arrangement, however, is flexibility to choose where and when they work.

All of this comes at a cost both financially and in terms of their time. GPs often need to pay for an accountant who understands these services agreements and the nuances of working in the medical industry. This further adds to the administration and cost of being a GP, particularly in comparison to their public hospital counterparts.

Potentially, being responsible for the viability of their own business has complicated the art of practising medicine for our GPs, who already experience a high administrative burden and compounds the challenges of attaining a satisfactory work life balance.

7. INABILITY TO STRIKE A WORK-LIFE BALANCE

Work-life balance is essential for a health and wellbeing, and when optimised is protective against burnout, poor practice, and errors. [21, 25] In recent years Australian GPs have increasingly reported that their work-life balance is poor, with less than half of the GPs in one survey reporting good balance and more than half agreeing that the positive work-life balance is declining. [2, 26] Increasing workloads have been identified as one major contributor with overbooked GPs describing the disturbing experience of a lack of control between work and everyday life. [26]

To further complicate the issue, it may be more difficult to take leave (e.g., sick leave and annual leave) as there is no redundancy built into the employment model. It seems unreasonable in the twenty first century to expect the people that care for us to sacrifice their own health and wellbeing in the line of duty.

GP job design does not exist in a vacuum and dissatisfaction with one element may lead to others or compound together. This coupled with system and financial pressures means that GPs may leave the job at a time when we need them most.

WHAT HAS BEEN DONE?

Globally and in Australia, over the past ten years, there have been many policy and program interventions have been aimed at improving the distribution of, and access to GPs with the majority focusing on financial incentives. [5, 27, 28]

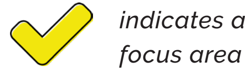
Policy and programs relating to the health workforce, inclusive of GPs, in general target the re-distribution of workforce to locations, disciplines and specialties needed most by Australians. [5, 27, 28] Others seek to incentivise practices to maintain accreditation standards, update systems and processes to ultimately improve patient care. [8] This focus on patient and health system need is essential, as is addressing the wants and needs of the workforce itself. Interventions targeting job design are missing from the current approach to the problem.

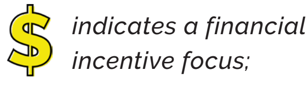
Table 1 provides a snapshot of some of the recent policies and programs targeting the Australian health workforce including GPs.

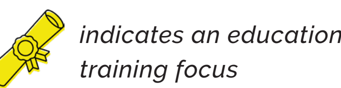
Table 1. Policies and programs relating to GPs and the medical workforce

POLICY/ PROGRAM	FOCUS		
	PATIENT	GP	SYSTEM
2023 - General Practice Grants Program [8] • Funding for general practices and eligible Aboriginal Community Controlled Health Organisations to make investments in innovation, training, equipment, and minor capital works to: ◊ Enhance digital health capability; ◊ Upgrade infection prevention and control arrangements; ◊ Maintain and/or achieve accreditation.		$	✓
Australia's Primary Health Care 10 Year Plan 2022 – 2032 [10] • Aims to strengthen primary care as part of the health system and guide reform to improve people's experience of care, improve the health of populations, improve the cost-efficiency of the health system and improve the work life of health care providers. ◊ Objectives include: improving access, closing the gap, keeping people well in the community, supporting continuity of care, integrating systems, embracing new technologies and methods, and supporting safety and quality in care. ◊ The plan describes workforce as one of six enablers with a focus on training and growing the workforce, recognising its needs to be valued and supported.	✓	$ (diploma icon)	✓

POLICY/ PROGRAM	FOCUS: PATIENT	FOCUS: GP	FOCUS: SYSTEM
2021 - John Flynn Prevocational Doctor Program [11] • Increased and streamlined opportunities to work and train in rural, regional and remote primary care for hospital-based doctors.	✓	$	✓
National Medical Workforce Strategy 2021 – 2031 [13] • Guide national long term medical workforce planning by: ◊ Collating and leveraging data to inform planning of policy and initiatives. ◊ Ensuring the skill mix of doctors and balance of specialties, subspecialties and generalists, and distribution of these meets the needs of Australian patients. ◊ Consideration of doctor wellbeing and career progression, mobility and flexibility.		✓	✓
2020 - Workforce Incentive Program* [14] • Provides financial incentives directly to GPs to work rurally and incentives to rural practices to engage other health professionals to improve access to GPs and allied health services in regional, rural and remote areas.	✓	$	
2020 - Bonded Medical Program* [7] • Funds places for medical students who must work for three years in an approved rural, regional or remote location upon graduation to address areas with workforce shortages.	✓	📜	
2019 - Distribution Priority Areas [9] • Classifies areas to identify where is in greatest need of health professionals (including GPs) and offers additional incentives and support for training to entice people to work in these areas.	✓		✓
Stronger Rural Health Strategy 2018 - 2028 [12] • Growing supply and quality of rural health workforce by enabling rural training, incentivising rural practice and distributing international medical graduates to areas of greatest need.	✓	$ 📜	✓


indicates a focus area


indicates a financial incentive focus;


indicates an education/ training focus

**Is a part of the stronger rural health strategy*

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Policy and programs seeking to attract and retain medical professionals to rural areas often offer funding for initial or ongoing training and financial incentives for practising rurally. Yet these programs neglect to address social and lifestyle factors, such as work for partners, education offerings, extra-curricular activities and cultural isolation. Many studies have shown these factors prevent GPs from working or remaining in rural practice. [29-33]

The policies in Table 1 rarely mention the elements of GP job design that may make it a less desirable career option (Table 1). Some policies do mention the importance of maintaining the workforce's wellbeing, however it seems that beyond this no one has asked or attempted to address the potential deficiencies in the job itself.

Figure 3 reveals the imbalance of current targeted interventions toward workforce distribution and funding incentives, amongst others. Yet we know these policy and programs are not having the desired impact, with the GP workforce facing a bleak future. It is time then to consider a more wholistic approach to attracting and retaining this critical health workforce, by balancing out policies and programs.

Policy and programs are focussed on increasing the size of and access to the workforce not the job itself

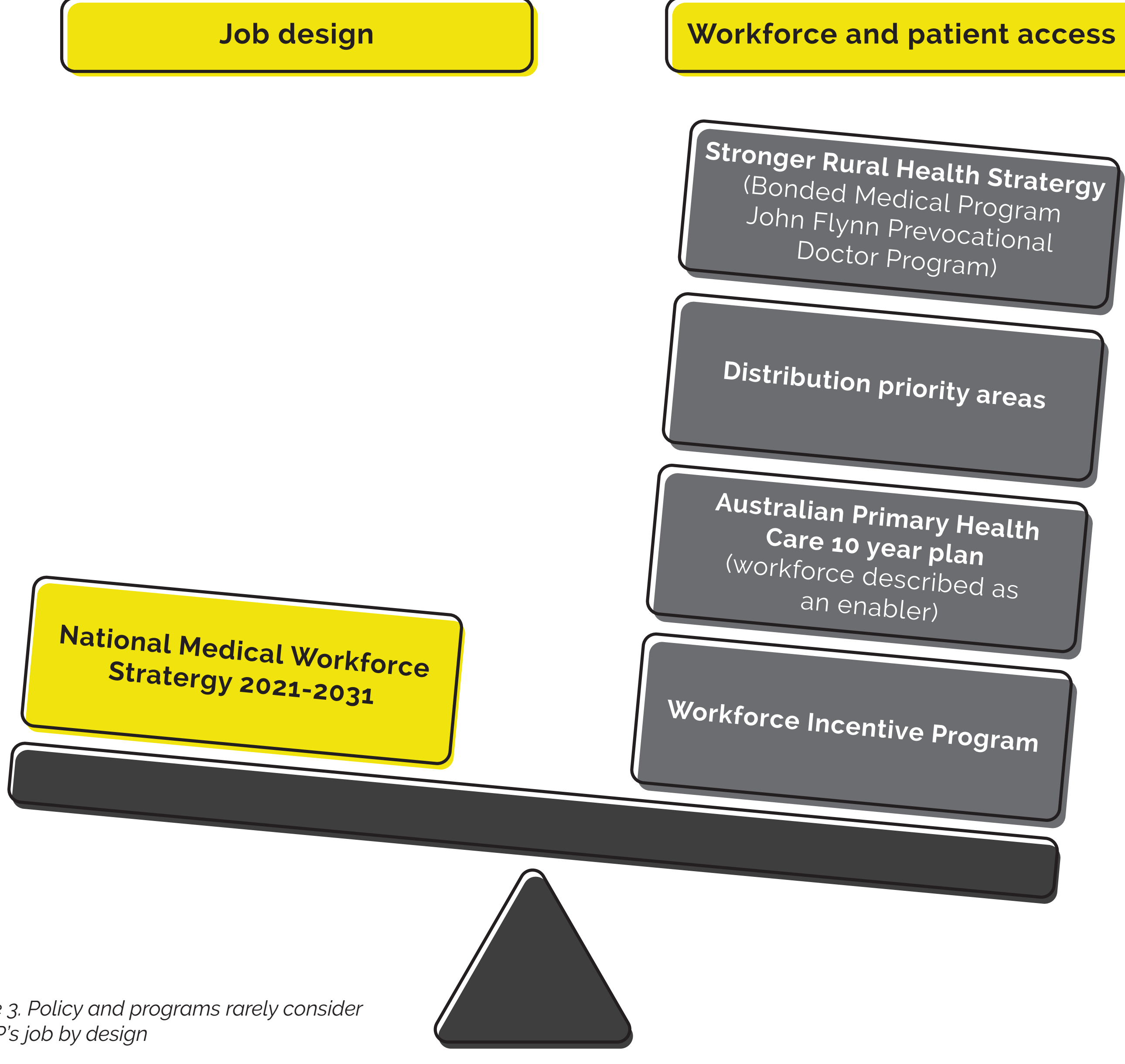

Figure 3. Policy and programs rarely consider the GP's job by design

BEYOND **BURNOUT**

The solution to this crisis sits within the profession. Policy makers need to consult and co-design future workforce policy and programs with the profession to address all elements of the role, along with the planned reforms to the system and model of care itself.

We propose three recommendations for Government and policymakers to ensure that we avoid our GPs from burning out and the next generation of Australians has access to quality primary care providers:

RECOMMENDATION 1

Fund research into the root causes of dissatisfaction amongst GPs, from graduate medical students through to experienced practitioners. This research must include all elements of GP job design such as employment/contracting arrangements through to work life balance.

RECOMMENDATION 2

Through the Primary Health Networks, **co-design of a pilot model of service delivery** that reduces the administrative burden that GP currently face and allow more time for clinical care. This could include investing in technology and infrastructure that streamlines paperwork and record keeping, as well as reducing the regulatory burden of compliance with various reporting requirements.

RECOMMENDATION 3

Leverage existing MDT policies and increase funding, to ensure that GPs remain as the primary gatekeeper to the health system and coordinator of patient care.

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Date of preparation: December 2023 .

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Photo Credits: Cover Photo by Aleksey Kuprikov
Page 12 Photo by Marcelo Leal

Suggested citation: Evohealth. 2023. *Beyond Burnout: Supporting our General Practitioners*

December 2023

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