General Practice at the crossroads

Dr Simon Torvaldsen
AMA (WA) GP Representative

I enjoy being a GP. The breadth of skills and knowledge, the close and long-term relationships, and the opportunity to make a huge difference to so many people's lives. I suspect most GPs enjoy these aspects of their work as well. And our patients appreciate it.

The problem?

This enjoyment is increasingly being undermined by a government that does not recognise or appreciate the value of general practice or preventative healthcare, with a resultant lack of investment and chronic underfunding. There seems to be an assumption that we can just keep doing more and more for less and less. The government contribution? Incentives to force bulk billing for everyone.

Add to this the various groups chipping away from the sidelines, fragmenting care and trying to remove any perceived "straightforward" consults (which are usually not that straightforward in reality) – and we have the recipe for declining morale, declining workforce, and non-viable practices.

These are issues that can be fixed, resulting in general practices being the "health hubs" of the future where most care is delivered and hospital presentations are minimised. Of course, this requires additional funding and some redesigning, but the cost would actually be low compared to the additional funding being directed to hospital care. If you have time, look at the outcomes achieved in Denmark with this approach – it was so effective they actually closed about half their hospitals.

The alternative is a decline in primary healthcare, increased costs, and the development of a two-tier health system where those who can afford it can access the longer consultations and complex care that is required nowadays; but those who can't (often those who need it most) get the short consults that are all the bulk-billed funding will allow. They will then have to rely on the urgent care centre at $290 per visit, or the even more expensive hospital system, to pick up the pieces. More cost for worse outcomes.

This kind of inequity runs against what I see as the Government's own Labor principles, and is more expensive for worse outcomes.

The solution?

Fundamentally, it has to involve a revamp of the MBS to properly value long consults, and not penalise those who need them, or the doctors providing this complex care. And funding more nursing and allied health within general practices to deliver true team-based, effective primary healthcare. Our practices should be the "hospitals of the future" where the vast bulk of healthcare is delivered.

> **"It's important to appropriately restrict non-GP providers to tasks they can safely perform, and build the practice team as much as possible – where non-GP providers can safely deliver care in a supported team-based setting. And then to properly fund GPs for the increasingly complex care we are providing.**

Unfortunately, we have to accept that with the use of AI and computer algorithms, lesser-trained practitioners can manage some things that previously would have only been safely performed by a GP. Although that does not excuse some of the ridiculous claims of the Pharmacy Guild or the short-sightedness of state government policies, it does mean that shorter consultations are, and will become, less common. We are increasingly doing the job of a consultant physician.

This makes it even more important to appropriately restrict non-GP providers to tasks they can safely perform, and build the practice team as much as possible – where non-GP providers can safely deliver care in a supported team-based setting. And then to fund the GPs properly to provide the increasingly complex care that we are providing.

The result?

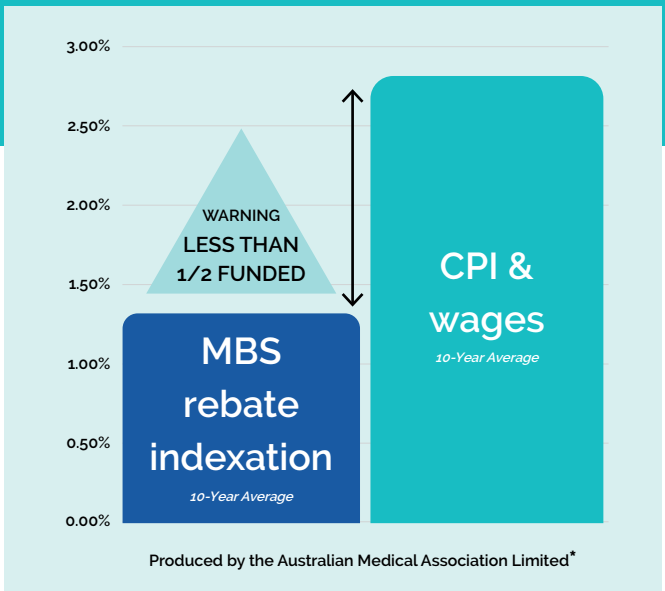
Holistic, high-quality care delivered by a practice team in a safe, cost-effective environment that delivers excellent health outcomes and job satisfaction, while reducing the burden on our public hospitals.

A pipe dream?

No, this is the policy outlined by the AMA in our Modernise Medicare policy. Government already has a pile of reports supporting this approach. The task is to get attention away from the bulk-billing mantra as the measure of success and on to real outcomes.

As a GP, this is one of the key things your membership is buying. Our future and that of Australian healthcare depends on it. We must not rest until real reform is achieved. ■

MBS framework for GP consultations is failing patients with complex or chronic conditions



Primary healthcare is the frontline of Australia's health system – the first and most frequent point of contact for patients – and at its heart is General Practice, which plays a critical role in ensuring people receive the right care, at the right time, in the right place. A strong general practice sector is essential for a high-quality, equitable and sustainable health system, but it is under increasing pressure; and affordability and access remain key issues for patients.

The federal AMA, as part of its Modernise Medicare campaign, is pushing for urgent reforms to general consultation items in the MBS so they meet the needs of patients, particularly those with complex and chronic disease.

"For more than 40 years, the structure for GP consultations has remained largely unchanged. Yet, the needs of patients have evolved dramatically," the AMA says.

"Today, Australians are living longer, often with multiple chronic conditions, complex mental health needs, and a greater reliance on their GP for ongoing, coordinated care. The current MBS structure does not reflect this reality, and is failing to provide patients with adequate support."

The AMA is proposing a new seven-tier structure for MBS consultation items that puts patients at the centre of care.

Level	Consultation length	Proposed rebate (2025 baseline)
Level 1	0-5 minutes	No change
Level 2	6-15 minutes	$46.15
Level 3	16-25 minutes	$80.10
Level 4	26-35 minutes	$114.50
Level 5	36-45 minutes	$152.65
Level 6	46-59 minutes	$190.85
Level 7	60+ minutes	$267.05

"This model ensures patients – particularly those with complex or chronic conditions – can spend the time they need with their GP without facing higher out-of-pocket costs," the AMA says. "It removes the systemic disincentive for longer consultations and supports GPs to deliver the kind of care that leads to better health outcomes."

The reformed structure, based on extensive engagement with GPs across Australia, provides for seven levels of consultation, ranging from less than five minutes to more than an hour.

"Under the current system, the MBS framework for GP consultations does not provide enough support for patients with complex conditions who need to spend more time with a GP," the AMA says.

"The proposed structure provides extra support for longer, better-funded consultations, allowing patients to discuss all their concerns in one visit.

"The new structure increases rebates for longer consultations, reducing the financial burden on patients who need more time, and making it more affordable to access the care they need."

The AMA says Patient-Reported Indicator Surveys (PaRIS) from the Organisation for Economic Co-operation and Development confirm that patients with an ongoing relationship with their GP experience better care coordination, higher trust, and improved health outcomes.

"This proposed reform supports continuity by enabling patients to spend more time with their GP," the AMA says. "It ensures they are not disadvantaged by a funding model that rewards short consultations, and will ease pressure on our stretched public hospital system by improving access to care through general practice."

MBS time-tiered items for primary care are under review by the Department of Health, and whether the current time tiers appropriately support contemporary clinical practice is one of the key issues being addressed. ■

- The Modernise Medicare campaign can be viewed at: **ama.com.au/modernise-medicare/for-australia**.
- The proposed reform to time-tiered consultations (also part of the AMA's 2026-2027 Pre-Budget Submission to government) can be accessed at: **ama.com.au/articles/ama-pre-budget-submission-2026-2027**.

cpd home EA

***Sources:** CPI: https://www.abs.gov.au/statistics/economy/price-indexes-and-inflation/consumer-price-index-australia/latest-release*
Wages: https://www.abs.gov.au/statistics/labour/earnings-and-working-conditions/average-weekly-earnings-australia/latest-release
Medicare Statistics: https://medicarestatistics.humanservices.gov.au/statistics/mbs_item.html

Assessing fitness to drive

New assessment tools are needed to help GPs decide if a patient is fit to drive

The federal AMA says a national review of fitness-to-drive medical standards provides an opportunity not only to update clinical guidance, but also to address the practical realities that doctors face in making licensing decisions.

Assessing a patient's fitness to drive is one of the challenging responsibilities faced by GPs, who must balance patient independence, employment, social participation and quality of life with broader public safety obligations.

This becomes particularly challenging when assessments involve cognitive impairment, one of the most complex aspects of fitness-to-drive decision-making.

While conditions such as epilepsy, diabetes and visual impairment often have clearly defined clinical thresholds, fitness-to-drive decisions involving dementia, mild cognitive impairment and other neurocognitive disorders frequently require the doctor to make nuanced judgements in circumstances of considerable uncertainty.

GPs are often required to piece together information from multiple imperfect sources. Patients with cognitive impairment may have limited insight into their own driving performance, and family members may provide conflicting accounts.

Functional capacity can also vary significantly over time and between environments. Yet, clinicians are expected to make decisions that may have profound implications for the patient and the wider community.

The federal AMA submission on assessing fitness to drive

In a submission to the National Transport Commission's current review of Assessing Fitness to Drive (AFTD) standards, the federal AMA says it is concerned that many practitioners continue to rely on cognitive assessment tools such as the General Practitioner Assessment of Cognition and Mini-Mental State Examination.

"While such tools may provide useful information, they were not designed to answer the specific question of whether a person can safely operate a motor vehicle," the federal AMA submission says.

"This contributes to variability in assessment practices and uncertainty in decision-making. The review should examine whether additional guidance, validated assessment pathways, and stronger links between cognitive screening and functional driving assessment are required."

The AMA supports further investigation of evidence-based tools that may improve consistency, objectivity and confidence in AFTD decisions.

"Recent discussions within the AMA Council of General Practice highlighted growing interest in validated assessment tools that may assist practitioners when assessing cognitively complex patients.

"Such tools have the potential to improve consistency between practitioners, reduce reliance on subjective judgement alone, and provide additional support for difficult clinical decisions.

"Importantly, the AMA does not support replacing clinical judgement with a technological solution. Fitness-to-drive assessments require consideration of the patient's broader medical condition, functional status, personal circumstances and risk factors. However, appropriately validated tools may provide clinicians with more objective information and improve the transparency and defensibility of decisions."

The AMA says the review should consider how emerging assessment tools, digital supports and evidence-based screening methods can be appropriately incorporated into future approaches to AFTD. It says the focus should be on improving consistency, reducing variability, and supporting practitioners faced with increasingly complex decisions.

One of the most under-recognised consequences of AFTD decisions is the impact they can have on the therapeutic relationship between doctor and patient.

"Unlike most clinical decisions, fitness-to-drive assessments can directly affect a person's independence, employment, financial security, social participation, and overall wellbeing. Losing the ability to drive may have profound effects – particularly for older Australians, people living in regional or rural areas, and individuals who rely on their licence for work or caring responsibilities.

"As a result, practitioners are frequently required to deliver decisions that patients strongly disagree with. Decisions to restrict or remove driving privileges can lead to conflict, complaints, deterioration in trust, and disengagement from ongoing medical care.

Recent discussions within the AMA Council of General Practice highlighted growing interest in validated assessment tools that may assist practitioners when assessing cognitively complex patients. Importantly, the AMA does not support replacing clinical judgement with a technological solution.

"The AMA is concerned that some patients may become reluctant to disclose symptoms, cognitive decline or safety concerns because they fear licensing consequences. This creates a significant tension between public safety objectives and open, effective healthcare.

"The review should acknowledge that the burden of implementing the standards does not sit solely within the technical assessment process. It also sits within the consultation room, where practitioners must navigate difficult conversations that can permanently alter longstanding therapeutic relationships."

The AMA believes current discussions about AFTD often underestimate the responsibility placed on medical practitioners. Clinicians are expected to make high-stakes decisions affecting both public safety and individual liberty, often without access to the assessment services, referral pathways or implementation supports needed to make those decisions with confidence.

It says delays in access to occupational therapy driving assessments and on-road testing can result in prolonged uncertainty for patients, inconsistent decision-making, and unnecessary pressure on treating practitioners. In many areas, waiting times can be substantial, eligibility criteria restrictive, and private assessments prohibitively expensive.

"In rural and remote regions, this is compounded with access to on-road driving assessments being limited or non-existent.

"These barriers can delay decision-making, create uncertainty for patients and practitioners, and limit the practical application of the standards. An evidence-based standard is of limited value if patients cannot readily access the assessments required to apply it."

The submission notes that the consequences of losing a driver's licence are not experienced equally across Australia. In metropolitan areas, alternative transport options may be available. In rural and remote communities, licence loss can affect access to healthcare, employment, education, and community participation.

"These realities should be considered when developing implementation pathways and assessment supports."

The AMA also notes ongoing concerns regarding medico-legal responsibility and the defensibility of clinical decisions.

"Practitioners require confidence that decisions made in good faith, in accordance with the standards, will be supported by regulators and licensing authorities."

"The review should consider opportunities to strengthen implementation resources, improve education and training, clarify pathways for escalation and referral, and provide greater support for practitioners managing complex cases."

The AMA says it strongly supports the continued role of the AFTD standards as the nationally agreed framework for assessing fitness to drive.

"General practitioners value the standards and use them regularly in practice because they provide a consistent, evidence-based foundation for making difficult decisions.

"The standards help practitioners explain decisions to patients and families, reduce variation in clinical practice, and support a common approach across jurisdictions.

"Importantly, the standards provide practitioners with an objective framework for decisions that would otherwise rely heavily on individual judgement. This is particularly important when practitioners are required to recommend licence restrictions, periodic review, or licence cancellation.

"The existence of nationally recognised standards helps shift these conversations away from a personal judgement by the practitioner and towards a transparent discussion based on agreed clinical guidance. The AMA believes maintaining national consistency should remain a central objective of the review.

"As the standards evolve, however, the review should place equal emphasis on implementation and usability. A technically sound standard that is difficult to apply consistently in clinical practice risks undermining both practitioner confidence and road safety outcomes."

In closing its submission, the federal AMA recommends that the review:

- maintains nationally consistent, evidence-based medical standards for driver licensing;
- recognises the impact of fitness-to-drive assessments on the therapeutic relationship and patient care;
- improves access to specialist and on-road assessment services;
- supports development and evaluation of validated assessment tools that assist clinical decision-making;
- strengthens education, guidance and implementation support for health practitioners; and
- ensures proposed changes are practical, feasible, and capable of consistent application across Australia.

More GPs than ever are working in rural WA

The latest annual workforce survey from Rural Health West shows there are 1,067 GPs servicing communities in the South-West, Great Southern, Mid-West, Wheatbelt, Goldfields, Pilbara and Kimberley regions – an increase of 58 doctors from the previous year. This 5.7% growth represents the largest annual increase in rural GP numbers in more than a decade.

That number includes 30 more resident GPs living and working in rural communities, reversing the trend of an increasing reliance on fly-in, fly-out and drive-in, drive-out models.

The Rural General Practice in Western Australia: Annual Workforce Update, a survey snapshot of GP numbers as at November 2025, also points to improving workforce stability.

Overall GP turnover is steady at 13.2%, continuing a longer-term downward trend that suggests more doctors are choosing to remain in regional communities.

In the Goldfields, GP turnover is below 10% for the first time in a decade, while the Pilbara has had a significant turnaround, gaining 11 GPs (14.3% growth), after several years of exceptionally high turnover.

There is also an increase in the number of female GPs, who now represent almost 50% of the workforce. There are an extra 41 female GPs (8.5% growth) compared to 2024, taking the total to 526, and continuing an upward trend since Rural Health West started reporting annually in 2001.

"Behind every one of these numbers is a doctor providing care to a rural community, supporting patients, and helping to ensure people can access healthcare closer to home," Rural Health West CEO Professor Catherine Elliott said.

"It's particularly encouraging to see growth in resident GPs, because doctors who live in their communities become part of the fabric of those towns. They support local schools, businesses and sporting clubs, supervise future health professionals, and provide the continuity of care that rural patients value."

Prof Elliott said these results reinforced the importance of investing in workforce retention initiatives. One such initiative is Rural Health West's statewide network of Health Professionals Networks which connect more than 5,500 health professionals across regional WA through education, professional development, networking and peer support.

"Retention doesn't happen by accident," Prof Elliott said.

"We consistently hear that health professionals who feel connected to their colleagues and communities are more likely to remain working in rural areas. That's why investment in initiatives such as Health Professionals Networks is so important – they help build the professional and personal connections that encourage people to stay."

The report says there are 217 community general practices as at 30 November 2025, nine greater than in 2024. Of these, 140 were group practices (64.5% of total), 50 were solo practices (23%) and 27 (12.4%) were Aboriginal Community Controlled Health Services.

There were 176 rural GP proceduralists recorded, one fewer than in 2024. Over the past 10 years, the proportion of proceduralists in the workforce has fallen from 22.9% in 2015 to 16.5% in 2025.

The report says the number of rural GP proceduralists performing more than one procedure has also decreased markedly in the past two decades. In 2007, there were 14 GPs (7.3% of proceduralists) who practised all three procedures – anaesthetics, obstetrics and general surgery – and 68 (35.4%) who practised two procedures. In 2025, only one GP (0.6% of proceduralists) practised all three procedures, and only 10 (5.7%) practised two.

Prof Elliott said Rural Health West continues to hear concerns about the financial viability of GP services in many smaller communities. Local governments are increasingly stepping in to provide financial and in-kind support to help maintain access to healthcare.

"Healthcare funding is not traditionally a local government responsibility, and there is growing recognition that more sustainable long-term solutions are needed," she said. ■

Scan the QR code to read the full report.

What patients don't tell us

Anna Pitman
Founder & Director, ACP Consulting Group

Recently, my husband came home from a long shift and, as we often do, we debriefed over dinner. He's a doctor, and our conversations frequently return to the same challenge. Not a lack of clinical knowledge. Not a lack of care. Time.

He spoke about the tension of trying to understand what was really happening for a patient while balancing waiting rooms, competing priorities, and the reality that the next patient was already due. Whether in general practice or the emergency department, many doctors are expected to make critical decisions within extraordinarily compressed timeframes.

As the wife of a doctor, I often find myself disheartened by how our healthcare system is set up. We ask doctors to build trust, gather information, assess risk, formulate diagnoses, educate patients and document consultations in a matter of minutes. Then we wonder why important information sometimes remains hidden.

Because patients do not always tell us everything.

Sometimes they are embarrassed, fear judgement, worry about being perceived as difficult, or come from cultures where certain topics are not openly discussed. And sometimes, the inherent power differential between doctor and patient makes honesty feel unsafe.

The irony is that some of the most clinically significant information often sits beneath the surface: the patient experiencing depression who insists they're simply tired; the teenager reluctant to discuss substance use; or the patient who leaves the consultation confused but unwilling to say so. In each of these situations, the challenge is not a lack of clinical expertise. The challenge is disclosure.

Psychological safety is the belief that it is safe to speak openly without fear of embarrassment, judgement or negative consequences. Patients are far more likely to disclose important information when they feel respected, heard and understood.

This matters because modern medicine is increasingly managing problems that cannot be fully understood through a blood test, scan or physical examination alone. Rising rates of mental ill-health, loneliness, chronic disease and family violence mean that some of the most important diagnostic information now sits within a patient's story. The challenge is that people rarely share their most vulnerable truths unless they feel psychologically safe enough to do so.

This is why communication skills are not simply "soft skills". They are clinical skills.

In my work as an executive coach, I have observed five behaviours that consistently help create psychological safety in conversations. I have shared them below.

None of these behaviours require longer consultations. They simply help patients share the information that matters most.

As healthcare becomes increasingly complex, psychological safety deserves to be viewed as more than a communication skill. It is a clinical asset.

Five ways to encourage psychosocial safety for patients

1. **Curiosity before diagnosis.** Rather than moving immediately into problem-solving, clinicians can create space for patients to tell the broader story. Questions such as, "What concerns you most about this?" or "What impact is this having on your life?" often uncover information that sits below the presenting complaint.
2. **Listening for what is not being said.** Hesitation, changes in tone, incomplete answers, or topics that are quickly dismissed can often signal issues that patients find difficult to discuss.
3. **Reflective listening.** Reflecting back on what has been heard helps patients feel understood and encourages them to elaborate further.
4. **Becoming comfortable with silence.** Research has shown that physicians frequently interrupt patients early in consultations, with one landmark study finding interruptions occurred after an average of just 18 seconds.[1] While understandable, given the pressures clinicians face, it serves as a reminder that some of the most important information may emerge when we resist the urge to move too quickly into problem-solving.
5. **Replacing judgement with inquiry.** Questions that begin with "Why didn't you...?" can unintentionally create defensiveness. Questions that begin with "What got in the way of you taking your medications on time...?" invite explanation, partnership and honesty.

Reference: 1. Beckman HB, Frankel RM. The effect of physician behaviour on the collection of data. Ann Intern Med. 1984;101(5):692–696.

GPs in WA now trained to treat patients with ADHD

More ADHD care is available across the State after 64 GPs completed a specialist training program

Sixty-four WA general practitioners have completed specialist training that allows them to manage patients with ADHD.

More than a third of the newly trained GPs are based in regional and rural WA.

Following the strong interest from doctors, the State Government says additional training opportunities will become available in the coming months.

The ADHD GP Training Program, funded through a $1.3 million election commitment, was developed by the Royal Australian College of General Practitioners in partnership with the Australasian ADHD Professionals Association, with oversight from WA Health.

Trained GPs, once authorised by the Department of Health, can assess, treat and provide ongoing management for patients aged over 10 with uncomplicated ADHD, and they will be able to prescribe ADHD stimulant medicines in accordance with legislative and clinical requirements.

However, patients who present with more complex needs will continue to be referred to paediatricians and psychiatrists, in line with the strong clinical safeguards that remain a focal point for the program's model of care.

The overall aim of the landmark program is to help reduce reliance on these specialist services and improve access to timely care – especially in rural, remote and underserved communities so children and families get the care they need, no matter where they live.

ADHD WA wraparound services are also being expanded, thanks to $1.2 million in government funding, to provide more practical support for children and adolescents with diagnosed or suspected ADHD, as well as their parents and carers.

KEY FACTS

- **Specialist ADHD training has been completed by 64 WA GPs.**
- **The program will improve access to ADHD care, particularly in country communities.**
- **More ADHD GP training opportunities will be offered in the coming months.**
- **ADHD WA will also deliver expanded wraparound support services for families.**

> **"This program is about reducing those barriers in a safe way so more Western Australians can access timely care, and we can free up specialists to deal with more complex cases.**

Services include a state-wide telephone and webchat service providing information about ADHD and guidance on non-medication supports, community walk-in enquiry and service navigation support, group therapy programs, school-based programs, and peer support groups for people affected by ADHD.

Health, Mental Health and Preventative Health Minister Meredith Hammat has welcomed the number of metropolitan and regional GPs going through the ADHD training program.

"I know a lot of Western Australians will benefit from this significant step forward in healthcare access," Ms Hammat said. "We're helping more families access timely assessment, treatment and support closer to howme and I look forward to all of these upskilled GPs making a difference in their communities.

"We know some families have faced long wait times and barriers accessing ADHD care, particularly in areas with limited specialist availability.

"This program is about reducing those barriers in a safe way so more Western Australians can access timely care, and we can free up specialists to deal with more complex cases.

"Together with expanded ADHD WA wraparound services, we're putting WA first by ensuring children, young people and families can access the information, support and care they need throughout their ADHD journey." ■

Scan the QR code to view more information on ADHD diagnosis and treatment through GPs, published on the Department of Health website: **health.wa.gov.au**.