

The impact of COVID-19 on GPs and non-GP specialists in private practice

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About the report

The healthcare system in Australia has not been overwhelmed by the COVID-19 pandemic as initially expected. Nevertheless, there have been significant changes in the use of healthcare from the suspension of non-urgent elective surgery, social distancing restrictions that have discouraged people from leaving home, public fear of contracting or spreading the virus in health facilities, and increased household financial pressure that reduces the affordability of out-of-pocket payments.

The aim of this report is to examine the impact of the COVID-19 pandemic on General Practitioners (GPs) and non-GP specialists working in private practice. It examines the short-term effects on doctors' working patterns and mental health, how doctors have responded and how they have been supported during the pandemic. New evidence is presented from the Medicine in Australia: Balancing Employment and Life (MABEL) COVID-19 Short Online Survey (SOS) – MABEL COVID-19 SOS – which was completed by a representative sample of 2,235 GPs and non-GP specialists between 14 and 24 May 2020, with comparison to the MABEL Wave 11 survey conducted in 2018-19.

Key insights and trends



VARIATION IN WORKLOAD FOR GPs, AND MORE CONSISTENT FALLS FOR NON-GP SPECIALISTS

- For GPs, there is evidence of significant variation in workload as a result of the pandemic. The increase in the number of newly funded Medicare telehealth consultations in April 2020 was accompanied by a reduction in the number of face-to-face consultations, with a net increase in the total volume of services provided.
- For non-GP specialists, new telehealth items and increases in the use of pre-existing telehealth items only partly substituted for the fall in face-to-face consultations, with a net decrease in the volume of consultations provided.
- There is a sharper recovery in the number of Medicare items for non-GP specialists in May 2020 compared to April 2020, whilst the number for GPs fell overall.
- Aggregated Medicare data mask substantial variation, with MABEL COVID-19 SOS data showing increases and decreases in GPs' patient numbers –falls were more likely in both urban areas and affluent areas.
- For non-GP specialists in private practice, there has been a larger and more consistent fall in both patient numbers and hours worked, each of around 30–40 per cent on average, especially for surgeons and anaesthetists because of the suspension of non-urgent elective surgery.
- The changes in workload and working patterns are substantial, and uncertainty remains as to how fast a recovery will take place, and the permanence of the rapid shift to telehealth.



INCREASED USE OF TELEHEALTH

- New telehealth items were introduced gradually, initially for GPs and then for non-GP specialists, to help with protection from infection and to support practices and patients.
- The number of telehealth items fell slightly in May 2020 for GPs and non-GP specialists, after the initial sharp increases in April 2020.
- Use of telehealth is high, with almost all GPs reporting use of telehealth compared to 76 per cent of non-GP specialists. Use of telehealth was lower amongst solo GPs, GPs in the most disadvantaged areas, and GPs in rural areas. There were no differences by GP age or practice size.
- The changing mix of face-to-face and telehealth consultations is significant, with 36 per cent of all consultation items provided by telehealth, compared to 1.3 per cent before the pandemic, when government funding for telehealth was mainly for non-GP specialists seeing patients in rural areas. Most telehealth consultations are by telephone, comprising

96 per cent of GPs' telehealth consultations, and 81 per cent of non-GP specialists. The use of video is relatively low, presumably reflecting practitioner choice, patient preference or issues with access to technology.

- GPs bulk billed 96 per cent of telehealth consultations, reflecting initial restrictions as well as higher bulk billing incentives. Non-GP specialists bulk billed 76 per cent of telehealth consultations.
- Just over 5 per cent of doctors reported they had introduced home monitoring technology for patients as a result of the pandemic.
- Most respondents (84%) thought that telehealth should be permanently funded by Medicare with stronger support from non-GP specialists and female doctors. GPs are more likely to support the funding of telephone consultations compared to video consultations.
- New opportunities for the increased use of telehealth and digital health technologies now exist as policy has quickly developed and there is widespread support from doctors and patients. Though this will improve patient convenience and may increase utilisation for some patients, and potentially lead to new business models in private practice, further research on the effects of telephone and video consultations on the quality and continuity of care is required.



FALLS IN INCOMES AND HIGH FINANCIAL STRESS

- Changes in workload during the pandemic have also reduced incomes, with 65 per cent of GPs and 83 per cent of non-GP specialists reporting a fall in monthly income, and almost one-third of surgeons and anaesthetists reporting a fall in income of 50 per cent or more.
- Thirty-one per cent of GPs and 27 per cent of non-GP specialists reported feeling very or moderately financially stressed about their private practice, particularly for larger non-GP specialist practices.
- GPs in urban areas or in the most affluent areas were more likely to report a fall in income and experience financial stress and mental distress. These practices are worst hit because they were more likely to charge higher fees and bulk bill less before the pandemic, and so the substitution of privately billed face-to-face consultations for bulk billed telehealth consultations has hit them hardest.
- A small proportion of GPs (5.6%) and non-GP specialists (8.4%) thought their practice might be sold or closed in the next six months. These respondents were more likely to be from smaller GPs and non-GP specialist practices, and older non-GP specialists. The pandemic may have brought these decisions forward for those close to retirement.

- The longer term financial health of the sector depends on the mix of services between bulk billed telehealth and full-fee face-to-face consultations going forward, and how practices adapt in the context of Medicare funding. In addition, continuing economic hardship may have some longer-term impacts on the demand for private medical care and potentially on the use of public hospitals.



CHANGES TO PRACTICE ORGANISATION AND INCREASES IN BULK BILLING

- Practices adapted to the changes in workload by introducing new ways to increase revenue and reduce costs such as altering the mix of staff, reducing the numbers of some practice staff (including GPs and allied health) and altering practice staff hours.
- Non-GP specialists were more likely to report changes to practice staff work arrangements compared to GPs.
- Around one-quarter of GPs reported falls in working hours, while one-quarter reported increases in working hours. Female GPs were more likely to report an increase in working hours.
- Eighteen per cent of GPs and 51 per cent of non-GP specialists reported that their practice had applied for the JobKeeper Payment subsidy for their employees, and this was more likely in urban rather than rural areas.
- Both GPs and non-GP specialists have increased the proportion of patients bulk billed for face-to-face consultations (from 62% to 70% for GPs, and from 33% to 39% for non-GP specialists), in addition to the majority bulk billing telehealth consultations.
- The substitution of privately billed face-to-face consultations with bulk billed telehealth consultations may contribute to the fall in income for some, particularly in urban and more affluent areas. Practices are likely to discontinue many of the measures introduced as patient numbers return to pre-pandemic levels, though changes to practice organisation and bulk billing could continue to evolve given the significant changes in the mix of services provided.
- Whether the current higher bulk billing rates for face-to-face consultations return to pre-pandemic levels depends on how responsive patients are in a context of increased economic hardship and financial stress, and also the details around Medicare-funded telehealth.



INCREASED STRESS AND AN INCREASE IN MENTAL ILL-HEALTH

- The significant changes in the mix of care being provided, increased risk to doctors' own health and high levels of uncertainty about revenue flows caused

by the COVID-19 pandemic are having an impact on doctors' levels of stress and mental health.

- Around 60 per cent of doctors reported feeling more stressed than usual, similar for both GPs and non-GP specialists. This was associated with a fall in income.
- Comparing responses from doctors who filled out both the MABEL Wave 11 survey in 2018-19 with the MABEL COVID-19 SOS in May 2020, there is weak evidence of a small increase in the prevalence of probable serious mental illness from 3.1 per cent to 3.3 per cent.
- Those who were financially stressed or who had applied for JobKeeper Payments for their practice staff were more likely to report probable serious mental illness.
- As some increased funding is being provided to support mental health treatment services for doctors, continuing effort and research into preventing and treating mental ill-health amongst doctors is urgently required.



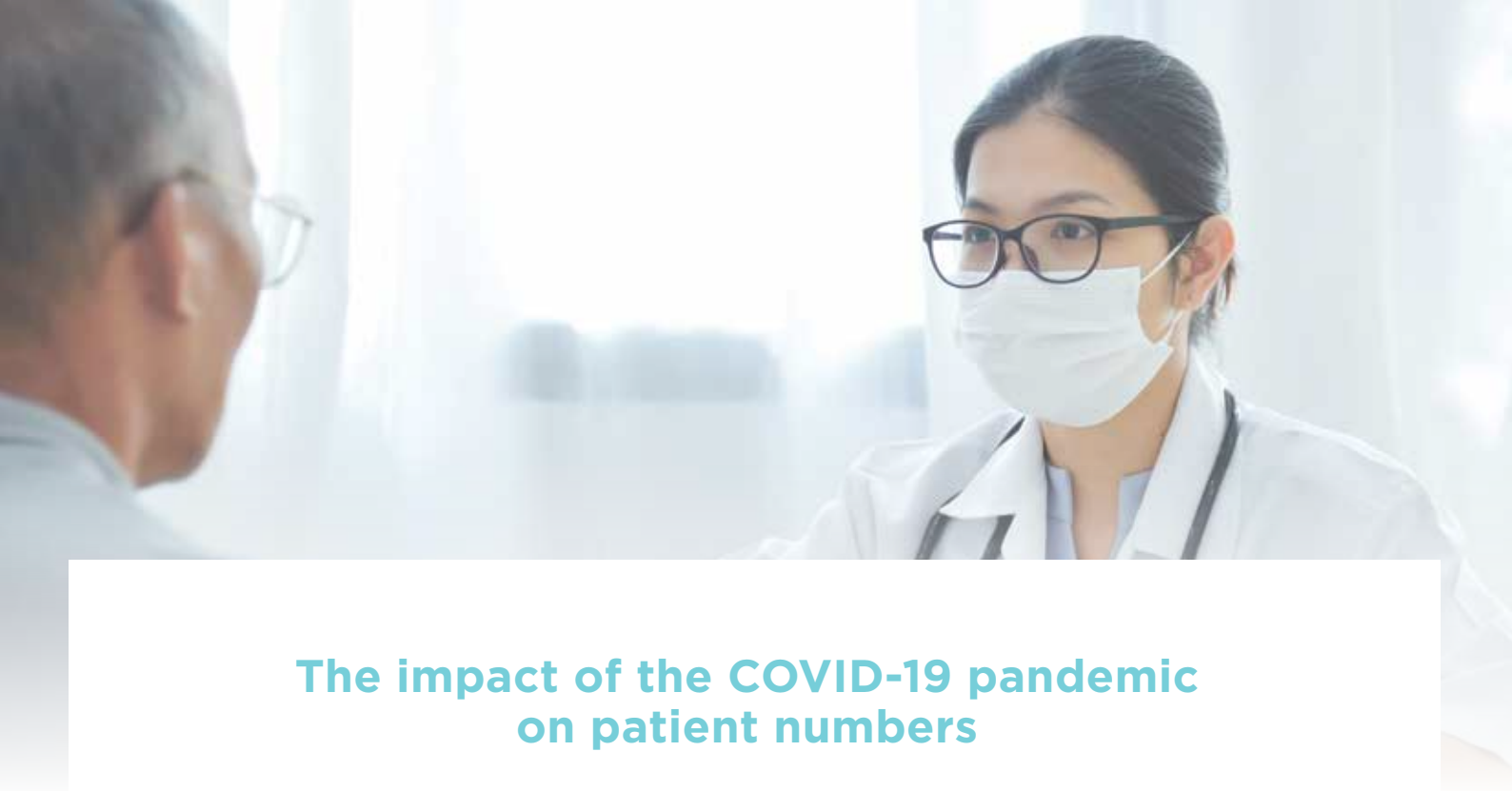
DOCTORS SUPPORTED BY COLLEAGUES, BUT LACK OF PROTECTIVE EQUIPMENT INCREASES STRESS

- The majority of doctors were satisfied with the support they received during the pandemic, with the highest satisfaction expressed for support from colleagues, followed by employers, professional organisations, governments and financial services providers.
- Around half of non-GP specialists and one-third of GPs were dissatisfied with access to PPE, which was also associated with increased feelings of stress.
- GPs as well as many non-GP specialists in emergency departments, intensive care, infectious diseases and respiratory medicine have been at the frontline of the pandemic – it is important to ensure they are properly integrated and supported in the system-level responses to future pandemics.



THE FUTURE

There remains much uncertainty about if and when conditions will return to as they were pre-pandemic. GPs seem to be more pessimistic about the future compared to non-GP specialists. The pandemic and its consequences have accelerated a number of pre-existing trends in the healthcare sector and among the medical workforce. These include increased use of telehealth and lower growth in the use of private medical care, and the creation of new opportunities for improving the delivery of medical care in Australia. How these changes influence the quality, costs and access to healthcare in the future is a key issue going forward as everyone adjusts to the continuing challenges.



The impact of the COVID-19 pandemic on patient numbers

EFFECTS ON GPs

The pandemic has led to significant changes in doctors' working patterns. Medicare data shows a steady upward trend in total unreferral attendances to see vocationally registered GPs from December 2019 through to the end of April 2020 – with a net increase of 7.1 per cent in Medicare items claimed between March and April 2020 (Figure 1). In May 2020 total attendances fell overall. In addition, practice nurse item volumes increased by 67 per cent between March and April 2020, presumably reflecting an increase in influenza vaccinations and triaging patients visiting the practice. This suggests that there was no sudden overall fall in demand for GP services before the telehealth items were introduced.

The overall increase in activity up to April 2020 is because the 4.7 million new telehealth services provided in April 2020 (after their introduction at the end of March 2020) exceeded the fall in the number of face-to-face items to 2.7 million (a fall of 24.4%) in the same month. An explanation for the excess might be because of an increase in demand as patients no longer needed to take time off work to visit a healthcare professional or an increase in GPs more actively following up patients. The increase is not because telehealth consultations were shorter – and therefore a higher number of consultations could be provided each day or for each patient – as only 5.5 per cent of telehealth services were for short consultations (Level A). However, the proportion of Level A face-to-face consultations increased from 2.8 per cent to 12.8 per cent between March and April 2020 (an increase of 232% with the number almost tripling from 323,129 to 1,073,145), perhaps reflecting concerns with physical distancing.

In May 2020 the situation has stabilised with standard (Level B) face-to-face consultations remaining stable, telehealth consultations falling slightly, and longer (Level C+D) face-to-face consultations starting to pick up again.

The survey data delves deeper into these issues and reveal much more variation than the Medicare data. The data reported in the survey are for the first half of May 2020. When asked to estimate the change in patient numbers in the most recent week at work compared to before the pandemic, almost 62 per cent of GPs reported a fall while 22 per cent reported an increase in the number of patients they interacted with (Figure 2). The survey question used the words 'interacted with' to capture both face-to-face and telehealth consultations.

A possible explanation for the difference in results could be that the Medicare data are defined on the basis of services whereas the survey focuses on patient numbers. It may also be that the increase in telehealth consultations reflected in the Medicare data are concentrated in a smaller number of larger practices. We cannot rule out, however, that GPs who were worst affected by the pandemic may have been more likely to complete the MABEL COVID-19 SOS, or that there was recall bias in self-reporting of patient numbers.

GPs in urban areas were much more likely than GPs in rural areas to experience a fall in patient numbers (Figure 3). GPs in rural areas were also more likely to experience an increase or no change in patient numbers relative to GPs in urban areas. GPs in the most affluent areas were more likely to experience a fall in patient numbers. There were no differences by practice size.

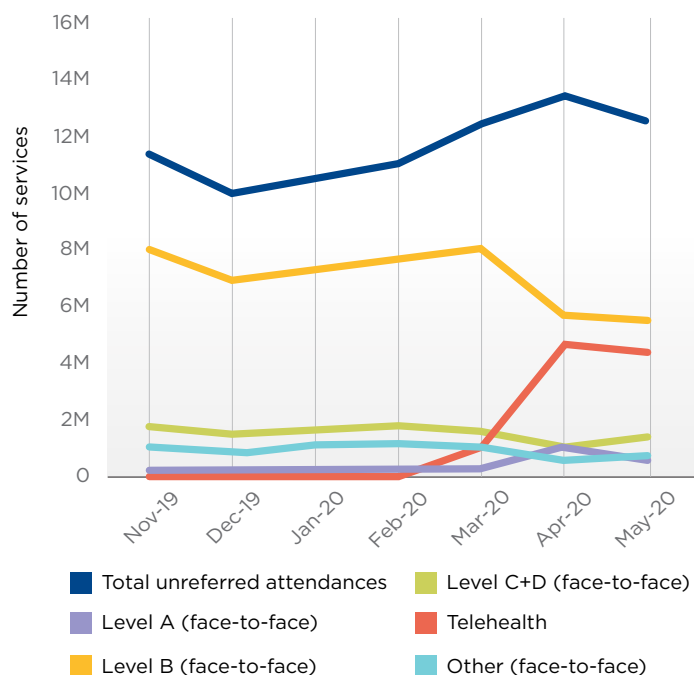


Figure 1. Change in the number of GP Medicare items claimed, November 2019 to May 2020

Source: Department of Health. Notes: Includes all 30 items where an equivalent telehealth item was introduced. Includes Vocationally Registered GPs only, and excludes practice nurse items, enhanced primary care. Figures for Other Medical Practitioners (non-vocationally registered GPs) were similar. <http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/news-2020-03-29-latest-news-March>

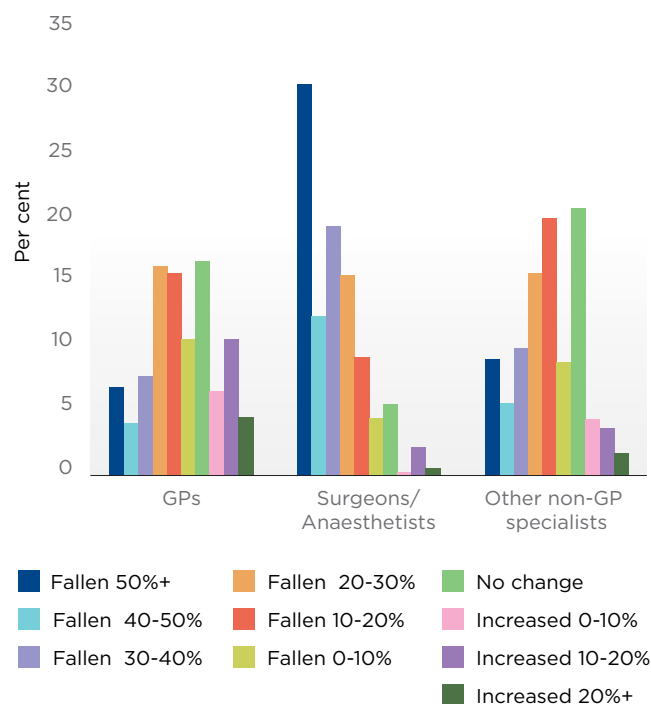


Figure 2. Change in patient numbers, by doctor type

Source: MABEL COVID-19 SOS. 'Comparing your most recent week at work with BEFORE the pandemic, what has been the impact of the COVID-19 pandemic on the average number of patients you interact with per week?'

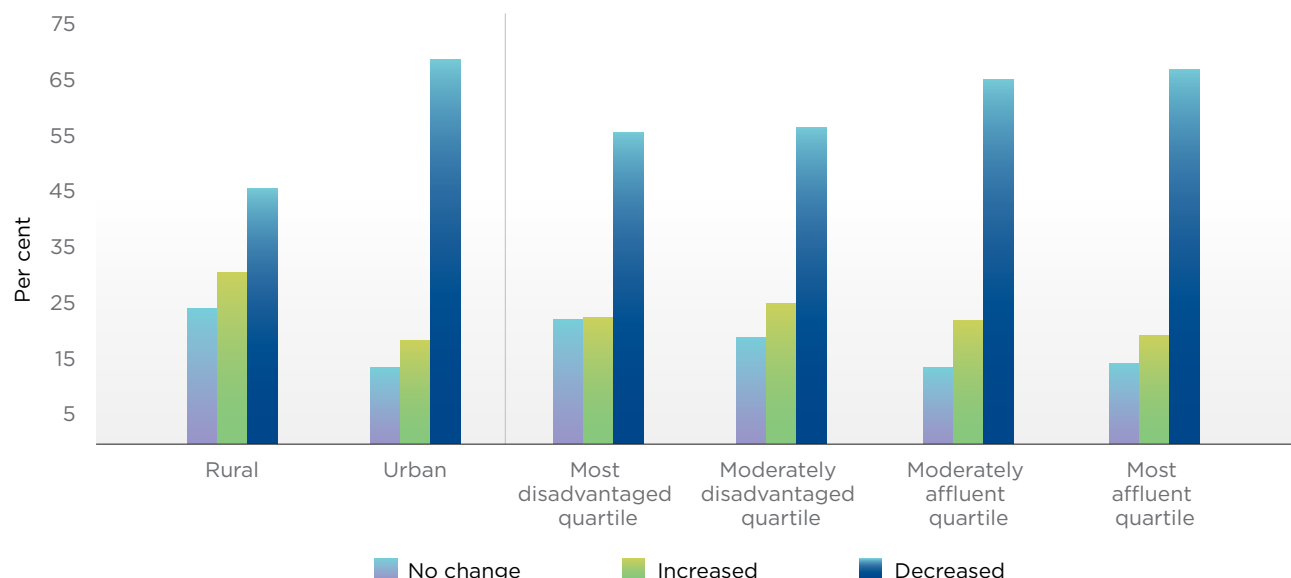


Figure 3. Change in GP patient numbers, by urban-rural and socioeconomic status

Source: MABEL COVID-19 SOS. Rurality is defined using the Modified Monash Model: Urban = MMM category 1, and rural is MMM categories 2-7. Socio-economic status is defined using the ABS SEIFA Index of Disadvantage of the postcode of the GP's practice, and are in quartiles. Most disadvantaged is the top quartile (75% to 100%) of disadvantage. Most affluent is the least disadvantaged bottom quartile (0% to 25%) of disadvantage. <http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/news-2020-03-29-latest-news-March>

EFFECTS ON NON-GP SPECIALISTS

Non-GP specialists have experienced a more consistent and unambiguous fall in activity, driven by the suspension of non-urgent elective surgery on 1 April 2020 before its gradual resumption from late April.

Comparing April with March 2020, Medicare data (Figure 4) shows a 34 per cent fall in operations, a 43 per cent fall in face-to-face attendances and, even after the introduction of new telehealth items, a 15 per cent fall in total specialist attendances (face-to-face and telehealth). However, there are signs of a recovery in May 2020 as total attendances, face-to-face attendances, and operations start to increase and the use of new telehealth items start to fall.

Non-GP specialists also used new telehealth items with 81 per cent of consultations conducted by telephone and 19 per cent by video – a much higher proportion of video consultations compared to GPs'. However, non-GP specialists have had access to telehealth items for longer (since 2011 for patients in rural areas) and so may have already been set up and more predisposed to use video consultations. The use of pre-existing telehealth items increased by 40 per cent in April 2020 compared to March 2020. There has also been a 32 per cent fall in the number of diagnostic and pathology items between March and April 2020.

The MABEL COVID-19 SOS data suggest a more consistent fall in activity for all non-GP specialists. Non-GP specialists reported seeing an average of 35 patients per week in May 2020, compared to 56 patients per week in 2018-19 (as reported in the MABEL Wave 11 survey) – a fall of 37.5 per cent. Overall, 78.3 per cent reported a fall and 7.1 per cent reported an increase in patient numbers (Figure 2). Reflecting the impact of the suspension of non-urgent elective surgery, 91.6 per cent of surgeons and anaesthetists reported a fall in patient numbers compared to 69.2 per cent for other non-GP specialists.

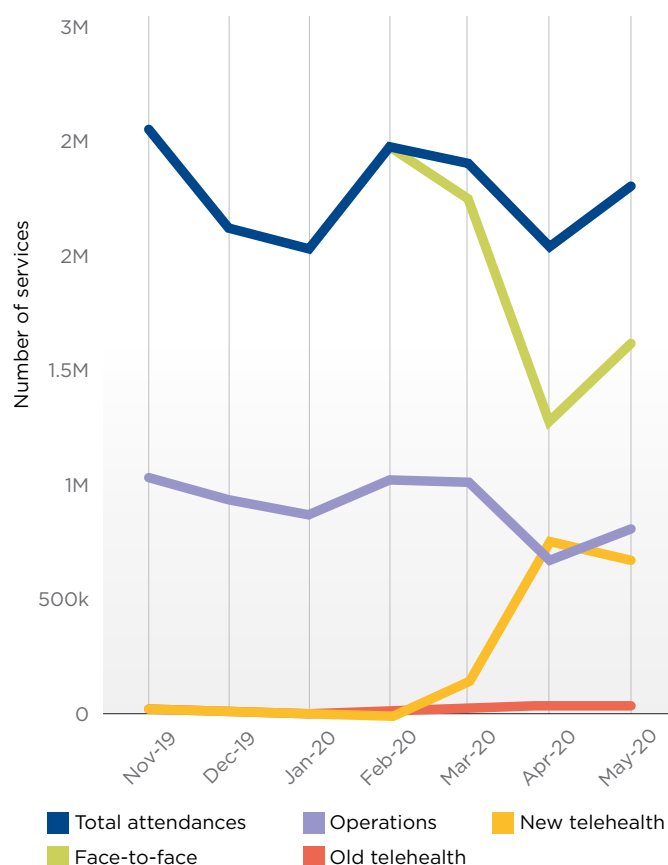


Figure 4. Change in the number of Medicare items claimed by non-GP specialists, November 2019 to May 2020

Source: Department of Health. Total attendances, face-to-face, and telehealth includes all 47 items where a new equivalent telehealth item was introduced¹. Includes attendances by specialists, consultant physicians, geriatric medicine, obstetrics, public health physicians, neurosurgery, anaesthesia, and oral and maxillofacial.



COVID-19 and the use of telehealth

The staged introduction of new Medicare telehealth items was initially a public health measure to help reduce infection from the virus. In combination with related bulk billing incentive payments, Medicare telehealth has also supported private practices financially. As discussed in the previous section of this report, telehealth items have in many cases substituted for face-to-face consultations. Medicare data show that 36 per cent of consultations (35.6 per cent for GPs and 38.5 per cent for non-GP specialists) provided in April were via telehealth, with the majority being conducted as telephone consultations (96.2 per cent for GPs and 81.6 per cent for non-GP specialists).

Ninety six per cent of GPs were using telehealth compared to 76 per cent of non-GP specialists (Figure 5). Solo GPs were less likely to use telehealth than other GPs (78.5 per cent vs 94.8 per cent), and there was lower use of telehealth for GPs in the most disadvantaged areas compared to those in the most affluent areas (86.4 per cent vs 95.5 per cent). GPs in urban areas were slightly more likely to use telehealth compared to GPs in rural areas (95.4 per cent vs 90.8 per cent). There was no association with the age of GPs.

Results from the MABEL COVID-19 SOS show that the switch to telehealth has been dominated by the use of telephone rather than video, in line with Medicare data. For GPs, in their most recent week at work (middle of May 2020), the proportion of consultations conducted by telephone was 40.3 per cent compared to 5.3 per cent for video consultations. These results likely reflect the ease of using the telephone, the initial lack of IT infrastructure to support secure video calls and the difficulties in using video calls among elderly patients. Non-GP specialists may be more established

in the set-up and use of video technology, as they are shown to use the telephone less (23.4 per cent of consultations) and video calls more often (13.8 per cent of consultations) compared to GPs. For GPs, the proportion of consultations by phone and video did not vary across urban and rural areas.

The telehealth items introduced for GPs were initially all required to be bulk billed, but this was subsequently relaxed and the incentive payments to encourage bulk billing for those receiving medical treatment under 16 years of age, concession card holders and vulnerable patients doubled (until 30 September 2020 as at time of writing). GPs reported bulk billing 95.8 per cent of telehealth consultations, compared to 76 per cent of consultations for non-GP specialists. Where GPs did charge a fee (and did not bulk bill) for telehealth consultations, it was \$45 (including the Medicare rebate) on average compared to \$164 for initial consultations by non-GP specialists.

More than 80 per cent of GPs and specialists thought that telehealth should be funded permanently by Medicare. Non-GP specialists were slightly more likely to support video consultations and GPs were more likely to support the funding of telephone consultations rather than video consultations. Female doctors were more likely to agree that telehealth should be funded permanently than males. Support for ongoing Medicare funding of telehealth was also stronger from younger GPs and specialists but was similar across urban and rural areas.

Alongside the introduction of expanded telehealth, the fall in face-to-face consultations may have also promoted expanded use of digital technology to provide increased home monitoring for patients: 5.3 per cent of GPs and 5.4 per cent of non-GP specialists reported that they have introduced home monitoring technology for some patients as a result of the pandemic. This could include remote monitoring for patients with chronic disease.

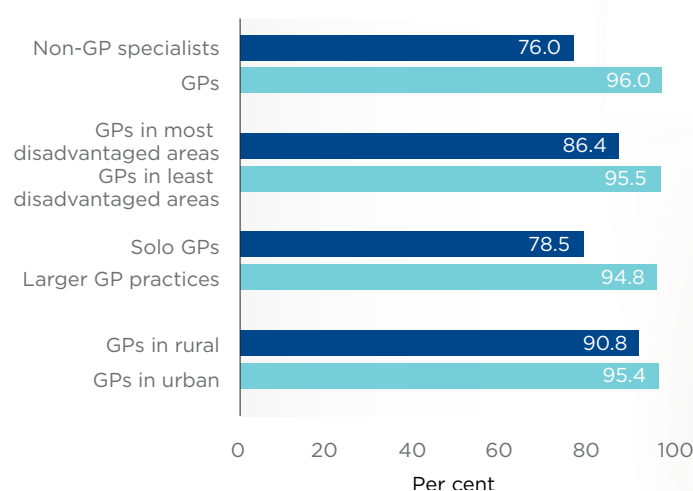


Figure 5. Percentage of doctors using telehealth by doctor type, socioeconomic status, practice size and urban-rural

Source: MABEL COVID-19 SOS. Rurality is defined using the Modified Monash Model: Urban = MMM category 1, and rural is MMM categories 2-7. GPs in most disadvantaged areas are in the top 75 per cent to 100 per cent of disadvantage (SEIFA quartile 1). GPs in least disadvantaged areas are the bottom 0 to 75 per cent of disadvantage (SEIFA quartiles 2-4).

The impact of the pandemic on private practice finances

When asked to compare the monthly total income from working as a doctor (mid-May 2020) to that prior to COVID-19, the percentage of GPs reporting a fall in income was 64.9 per cent, while 13.7 per cent reported an increase. This could reflect the move from privately billed face-to-face consultations to bulk billed telehealth consultations, in addition to the increase in the proportion of face-to-face Level A consultations (Figure 1), and a reduction in non-patient billing revenues (such as rental income from pathology providers and other tenants affected by the pandemic).

For non-GP specialists in private practice, 83 per cent reported a fall in total income from all sources (93.9 per cent for surgeons and anaesthetists and 75.5 per cent for other non-specialists). Non-GP specialists reported larger falls in income compared to GPs (Figure 6), with 31 per cent of surgeons and anaesthetists reporting a fall in income of 50 per cent or more – unsurprising given the temporary suspension of non-urgent elective surgery. Those included in the analysis were undertaking either a mix of public and private work, or undertaking only private work.

Though the Medicare data reveal an overall increase in activity for GPs (Figure 1), this does not necessarily translate to increases in the financial health of all practices. This is mainly because of the substitution of bulk billed telehealth consultations for full-fee face-to face consultations, which may reduce revenue for some practices even if activity levels remain the same or increase. Differences across practices in the use of telehealth, plus differences in bulk billing and fees before COVID-19, mean that there will be much variation in the impact on practice revenues and costs. Since GPs in more affluent areas tend to charge more and bulk bill less, these practices might have been hit hardest.²

Figure 7 confirms this hypothesis: GPs in practices in urban areas or in practices in the most affluent areas were more likely to report a fall income. These were also the areas where GPs reported the largest falls in the number of patients. The fall in patient numbers in these areas (Figure 3) combined with a higher likelihood of private billing (higher fees and lower bulk billing) mean that these practices stood to lose the most with the transition to bulk billed telehealth compared to GPs located in rural areas or the most disadvantaged areas.

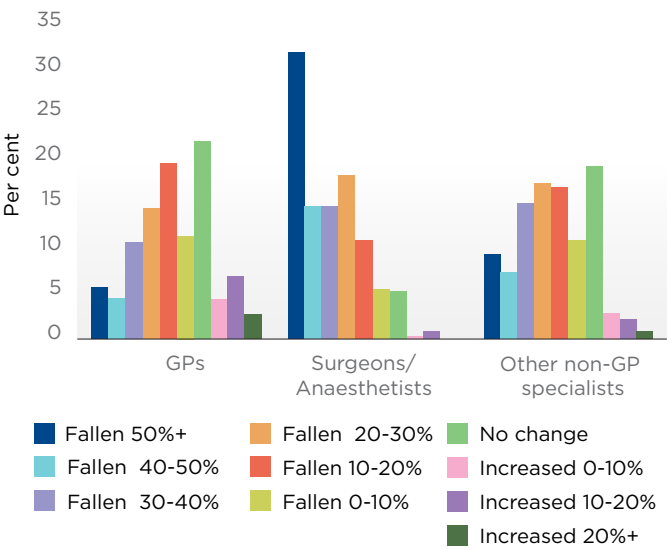


Figure 6. Change in monthly income in mid-May 2020 compared to before the pandemic
Source: MABEL COVID-19 SOS. Note: 'In comparison to BEFORE the COVID-19 pandemic, what has been the impact of the pandemic on your average MONTHLY income from all of the work you do as a doctor?'

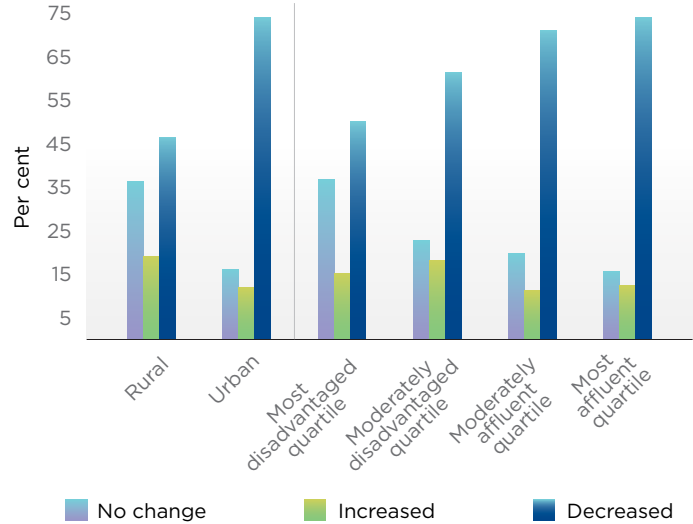


Figure 7. Change in monthly income for GPs, by urban-rural and socioeconomic status
Source: MABEL COVID-19 SOS. Rurality is defined using the Modified Monash Model: Urban = MMM category 1, and rural is MMM categories 2-7. Socioeconomic status is defined using the ABS SEIFA Index of Disadvantage of the postcode of the GP's practice and are in quartiles. Most disadvantaged is the top quartile (75% to 100%) of disadvantage. Least disadvantaged (most affluent) is the bottom quartile (0% to 25%) of disadvantage.

The financial impact of the pandemic is also reflected in a question which asked about the current financial position of respondents' private practice (Figure 8). Just under 31 per cent of GPs described their position as very (7.4 per cent) or moderately (23.5 per cent) financially stressed. Even though non-GP specialists reported the largest falls in patients and income compared to GPs, they were slightly less financially stressed with 27.1 per cent very to moderately financially stressed (6.5 per cent very and 20.6 per cent moderately financially stressed).

The level of financial stress was associated with practice size (Figure 9). For GPs, smaller and larger practices reported higher financial stress, with medium-sized practices doing better. This could be related to economies of scale, where larger practices are more at risk because they have higher fixed costs compared to medium-sized practices, and smaller practices could be less well organised to flexibly and effectively respond to the pandemic. For non-GP specialists, those in large private practices were most likely to be stressed about the financial situation of their private practice, perhaps reflecting a larger share of practice ownership compared to GPs who responded to the survey.

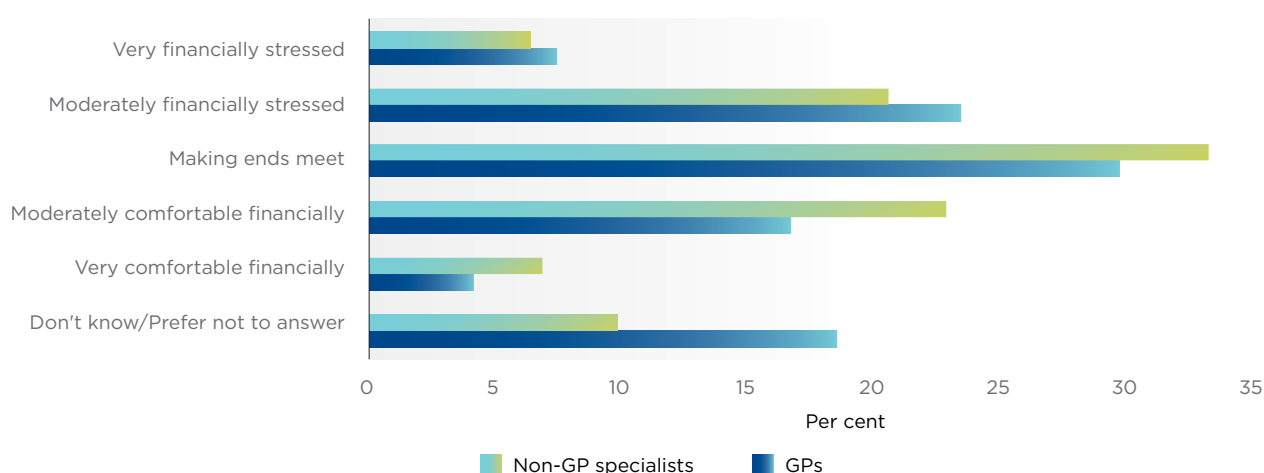


Figure 8. Percentage reporting that their practice is under financial stress

Source: MABEL COVID-19 SOS. Note: 'How would you describe the current financial position of your private practice?'

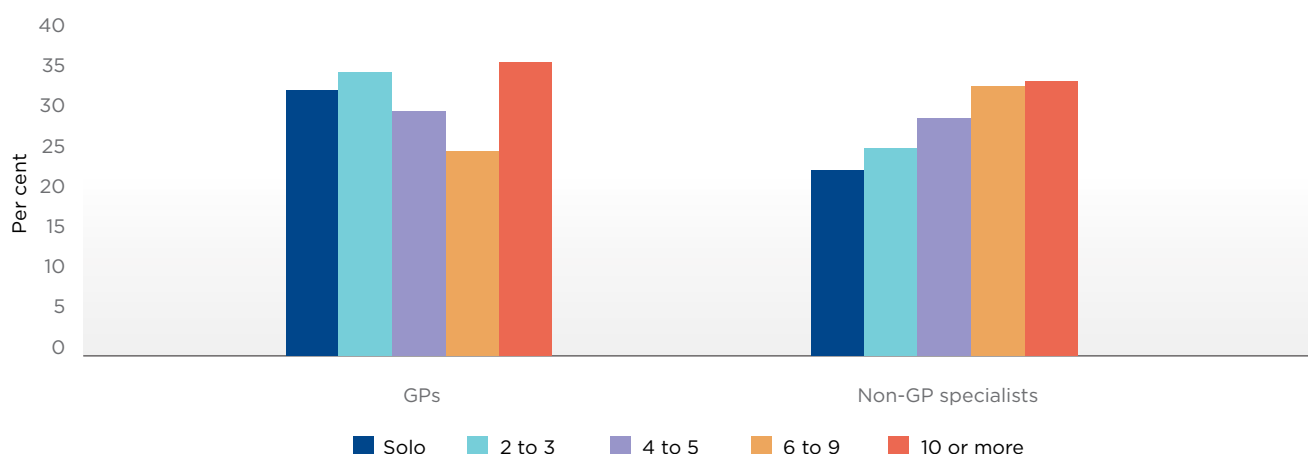


Figure 9. The percentage very or moderately financially stressed about their private practice, by practice size (number of doctors)

Source: MABEL COVID-19 SOS.



Reflecting the findings in Figure 7, the percentage of GPs reporting moderate or high financial stress was also associated with being in an urban area (33.6 per cent were stressed compared to 23.8 per cent in rural areas). Though those in more affluent areas were hardest hit in terms of falls in income, the level of financial stress was only slightly higher (30 per cent) than those in the most disadvantaged areas (27.6 per cent).

When asked about the likelihood that their practice will be closed or sold in the next six months as a result of COVID-19, 5.6 per cent of GPs reported this to be moderately or very likely (Figure 10), compared to 8.4 per cent for non-GP specialists. Practices with two to three GPs were more likely to indicate an

expectation of being sold or closed in the next six months. For non-GP specialists, smaller practices are more likely than larger ones to anticipate that they will be sold or closed. Though GPs over 45 years old were more likely to report potential sale or closure than those under 45 years old, there was a much stronger relationship with age for non-GP specialists, with older non-GP specialists more likely to report likely practice sale or closure (Figure 11). This suggests that the pandemic could encourage those closer to retirement to bring forward the sale or closure of their practice. Though the easing of lockdown measures is resulting in patients returning, this may not happen quickly enough for some practices to remain viable.

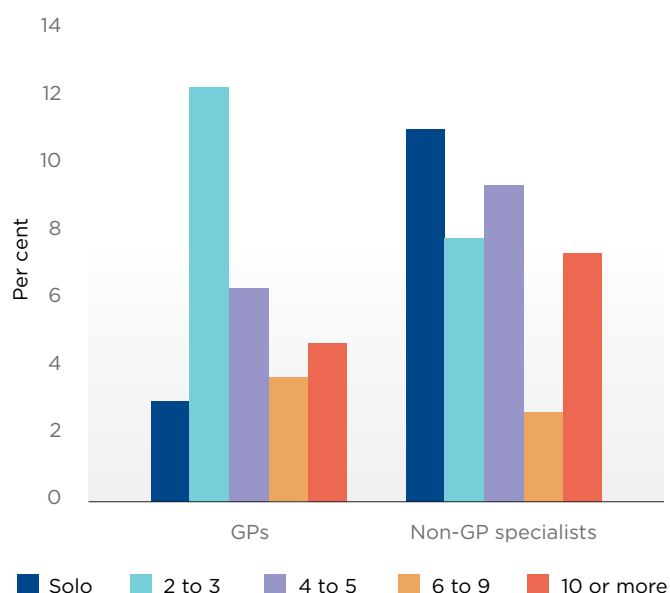


Figure 10. Percentage reporting a high chance that the practice will be sold or closed, by practice size

Source: MABEL COVID-19 SOS. Note: 'As a result of COVID-19, what is the likelihood the practice will be sold or closed within the next 6 months (with a score of 1 being 'very unlikely' and 5 being 'very likely')?' Graph presents the percentage scoring 4 and 5 on this scale.

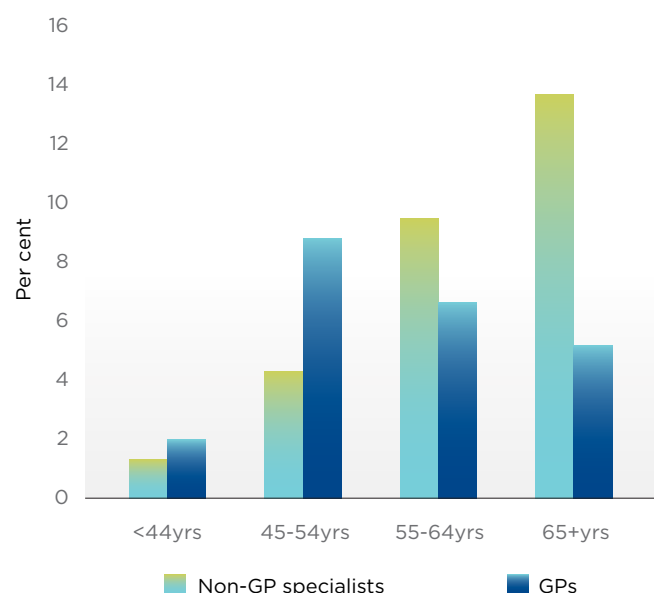


Figure 11. Percentage reporting a high chance that the practice will be sold or closed, by age

Source: MABEL COVID-19 SOS.

How have GPs and other specialists in private practice responded to the pandemic?

To respond to the changes caused by the pandemic, practices that have experienced a fall in patients and income can try to increase revenues and reduce costs. Similarly, practices that have altered the mix of services provided may also be changing the way their practice is organised and staffed.

Similar to small businesses in other sectors, some GP and non-GP specialist practices can access Government support including JobKeeper (for businesses experiencing at least 30% decline in revenue) and cashflow boosts (minimum of \$10,000 for small business with employees), and claim asset write-offs. Practices may have used other strategies as their workflow changed and uncertainty caused by the pandemic persisted, including changes to the mix of staff and working hours.

Only a minority of respondents did not make any changes to the operation of their practices as a result of the pandemic (Figure 12). Reflecting the higher financial pressure experienced by non-GP specialists, this group was more likely to report making changes in most of the categories identified in the survey (e.g. reduced hours of practice staff, encouraged uptake of unused leave, deferred payment of business loans). Thirty eight per cent of GPs and 31 per cent of non-GP specialists reported they had improved the management of the practice, presumably with measures to cope with the changes in workflow and mix of services being provided.

WORKING HOURS

The COVID-19 pandemic has had mixed effects on working hours for GPs. In May 2020 GPs worked 35.4 hours per week on average compared to 34.7 hours in 2018-19 according to the MABEL Wave 11 survey. More than one-quarter (26.9 per cent) of GPs said they had reduced their working hours because of the pandemic, while 23.3 per cent reported an increase in their hours of work. Female GPs were more likely to report an increase in working hours (27.8 per cent) compared to male GPs (19.8 per cent) which may reflect female GPs who typically work part-time increasing their hours. Average working hours for non-GP specialists fell to 35.4 on average in May 2020 from 41.9 hours per week in 2018-19. Fifty-nine per cent of non-GP specialists said they had reduced their working hours because of the pandemic, with 12.7 per cent reporting an increase in working hours.

CHANGES TO BULK BILLING AND FEES

Changes to both the number and mix of services provided may have influenced bulk billing and fees charged. The doubling of bulk billing incentives for telehealth helped maintain incomes. Almost 50 per cent of GPs reported that they had increased the proportion of bulk billed face-to-face consultations on top of 96 per cent of telehealth consultations that are also bulk billed. Meanwhile, 11.5 per cent reported that they had reduced the fee charged for patients that they do not bulk bill.

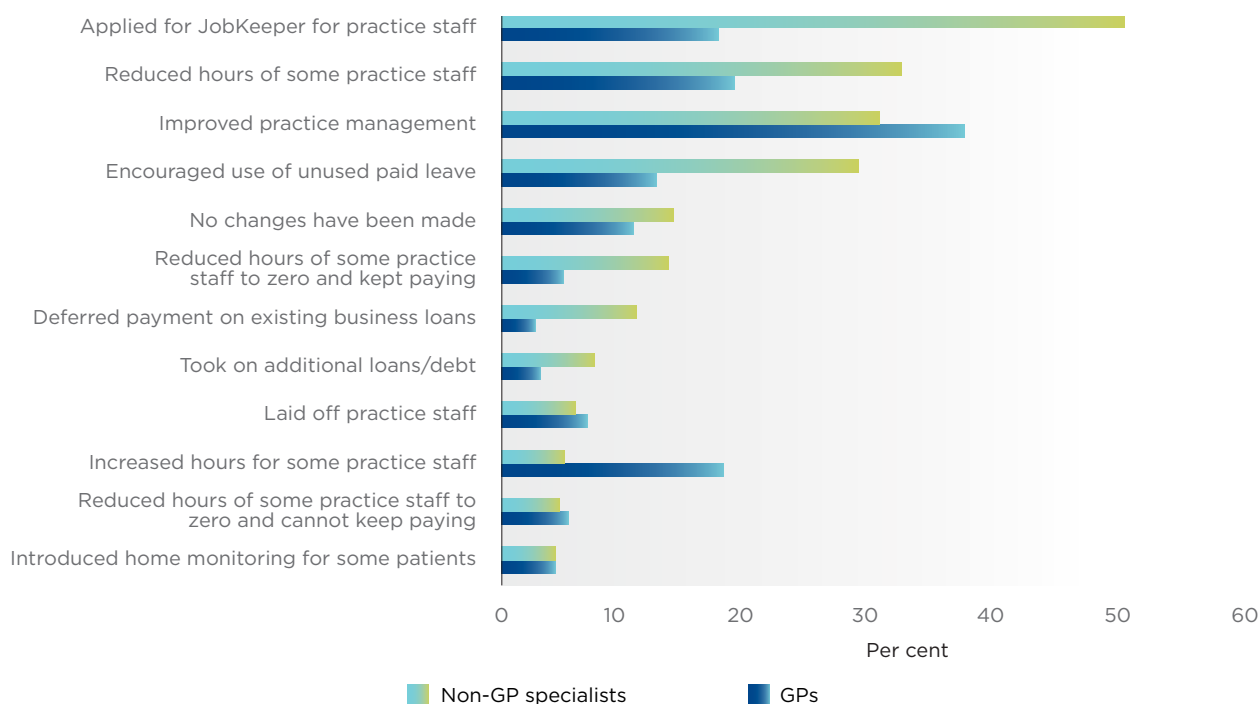


Figure 12. Changes to practice organisation and finances during the pandemic

Source: MABEL COVID-19 SOS. Note: 'As a result of the COVID-19 pandemic, has your practice taken any of the following measures?'

A comparison of the bulk billing rate and fees to pre-pandemic levels shows that the proportion of patients bulk billed for face-to-face consultations has increased from 62.2 per cent in 2018-19 (MABEL Wave 11 survey) to 70.1 per cent in May 2020 (MABEL COVID-19 SOS). The average fee charged remained the same at \$67 (including Medicare rebate) in the same period. Depending on each practice's mix of private and bulk billing before the pandemic, an increase in bulk billing and no change in fees suggests there may have been a fall in practice revenue.

Just over 30 per cent of non-GP specialists reported they had increased the proportion of bulk billed face-to-face consultations, and 11.6 per cent said they reduced fees for these consultations. Comparison of the reported bulk billing rates before and after the pandemic shows that bulk billing has increased from 32.9 per cent in 2018-19 (MABEL Wave 11 survey) to 39 per cent in May 2020 (MABEL COVID-19 SOS), while the average fee for an initial specialist consultation has fallen slightly from \$234 to \$228.

Whether these changes to billing practice are short term remains to be seen. Practices will be influenced by factors such as the possible continuation of Medicare funding for telehealth beyond the end of September 2020 and the end of the JobKeeper Payment scheme.

CHANGES TO PRACTICE COSTS AND EXPENSES

Practices may also have altered their expenses in response to the pandemic. Government subsidies may have helped to prevent significant reductions in staff costs and lay-offs. Eighteen per cent of GP practices

and 51 per cent of non-GP specialists' private practices applied for the JobKeeper Payment. This is consistent with the reported falls in income in Figure 6. Twenty one percent of GPs in urban areas applied for the JobKeeper Payment compared to 11 per cent in rural areas. Applying for JobKeeper Payments indicates a loss of 30 per cent or more in revenue, again supporting the findings in Figure 7.

Twenty-one per cent of GPs reported that the number of GPs in their practice had been reduced as a result of the pandemic (compared to 14 per cent of non-GP specialists) and 3.5 per cent reported that the number of GPs increased. For GPs, the level of staffing was compared with actual staffing levels in 2018-19 in the MABEL Wave 11 survey. The average number of both GPs per practice and the number of allied health professionals has fallen slightly, though the numbers of other practice staff, such as practice nurses, have remained the same (Figure 13).

Though numbers of practice staff remained roughly the same, 30 per cent of GPs and 53 per cent of non-GP specialists reported that their practices had reduced the hours of work for practice staff, 13.5 percent of GPs and 29.5 per cent of non-GP specialists encouraged staff to take unused leave, and between 7-8 per cent of GPs and non-GP specialists reported that practice staff have been laid off (Figure 12).

In terms of practice financing, 3.7 per cent of GPs reported deferring payment on business loans and 4.3 per cent took on additional loans/debt, whereas this was much higher for non-GP specialists (8.5 per cent and 11.8 per cent respectively).

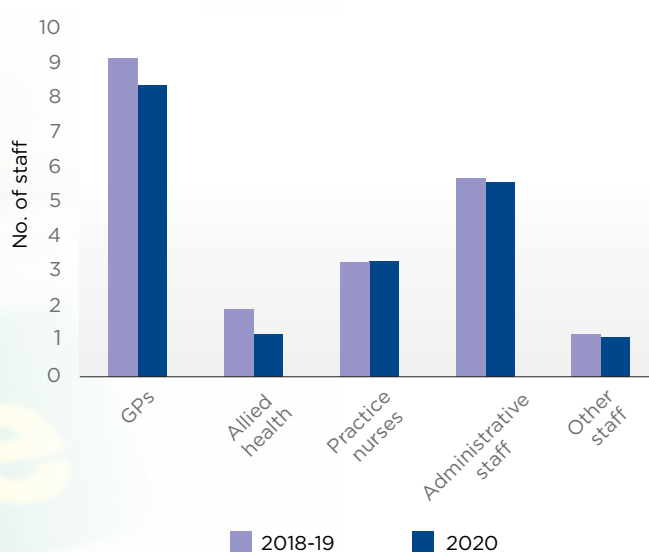


Figure 13. Number of GPs and other practice staff, 2018-19 to 2020

Source: Data from MABEL Wave 11 survey (2018-19) and MABEL COVID-19 SOS (2020)

The impact of the pandemic on doctors' stress and mental health

For both GPs and non-GP specialists, 61 per cent reported feelings of stress more often than usual during the 30-day period mid-April to mid-May 2020. Feelings of stress are defined in the MABEL COVID-19 SOS as “feels tense, restless, nervous or anxious or is unable to sleep at night because his/her mind is troubled all the time.” For GPs, 11.5 per cent reported experiencing these feelings a lot more than usual (12.1 per cent for non-GP specialists) (Figure 14).

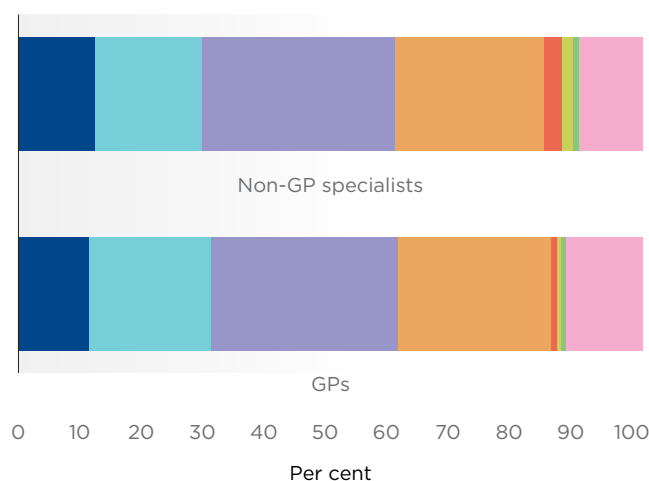
There was an association between feeling stressed and whether doctors had lost income. For GPs and non-GP specialists who reported a fall in income, 34 per cent reported feeling stressed somewhat and a lot more than usual, compared to 19 per cent of those who did not experience a fall in income.

We use the well-established Kessler Psychological Distress Scale (K6) to measure whether respondents have a probable serious mental illness (Figure 15). We compare this measure for 1,120 doctors surveyed in both the MABEL COVID-10 SOS and in the MABEL Wave

11 survey (2018-19). Overall, the proportion of doctors experiencing probable serious mental illness increased slightly from 3.1 per cent to 3.3 per cent.

Males experienced an increase in the prevalence of probable serious mental illness from 2.5 per cent to 3.3 per cent, while the prevalence for females fell from 3.9 per cent to 3.3 per cent. These differences were not statistically significant.

There was some association between poor mental health, financial stress, and whether the practice had applied for the JobKeeper Payment, an indicator of a fall in revenue of greater than 30 per cent. For those who reported practice finances to be moderately or very financially comfortable, 1.8 per cent reported a probable serious mental illness. This increased to 6.2 per cent for those making ends meet and 5.3 per cent for those moderately or very financially stressed. GPs and non-GP specialists who reported their practice had applied for JobKeeper were slightly more likely to report probable serious mental illness (5.5 per cent) compared to those who did not (4.2 per cent).



- A lot more often than usual
- Somewhat more often than usual
- A little more often than usual
- About the same as usual
- A little less than usual
- Somewhat less often than usual
- A lot less than usual
- Never

Figure 14. Percentage reporting feelings of stress in the past 30 days

Source: MABEL COVID-19 SOS. Note: ‘Stress means a state in which a person feels tense, restless, nervous or anxious or is unable to sleep at night because his/her mind is troubled all the time. Describe how your feelings of stress have changed during the PAST 30 DAYS. Have you been stressed:..’

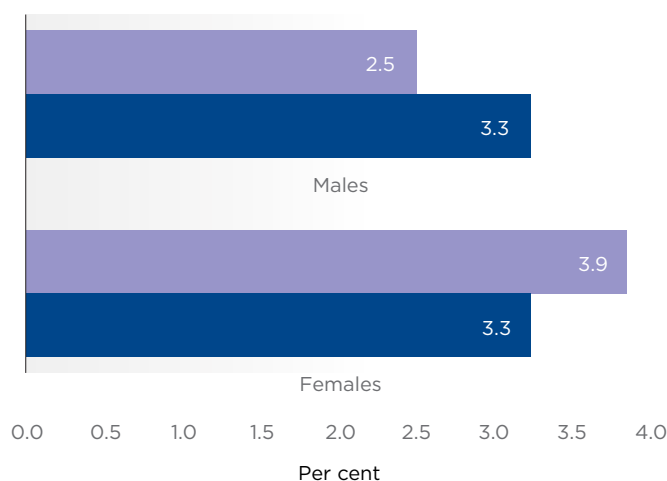


Figure 15. Percentage of doctors with a probable serious mental illness (2018-19 and 2020)

Source: MABEL COVID-19 SOS. Kessler K6.



Have doctors felt supported during the pandemic?

GPs and non-GP specialists were asked how satisfied they have been with support provided to them during the pandemic (Figure 16). A majority was moderately or very satisfied overall. Doctors were most likely to be moderately or very satisfied with the amount of support provided from colleagues and fellow workers (88.2 per cent), followed by their employer (80.2 per cent), professional organisations (77.3 per cent), Commonwealth government (68.7 per cent), State and Territory governments (60.2 per cent) and financial services providers (51.8 per cent).

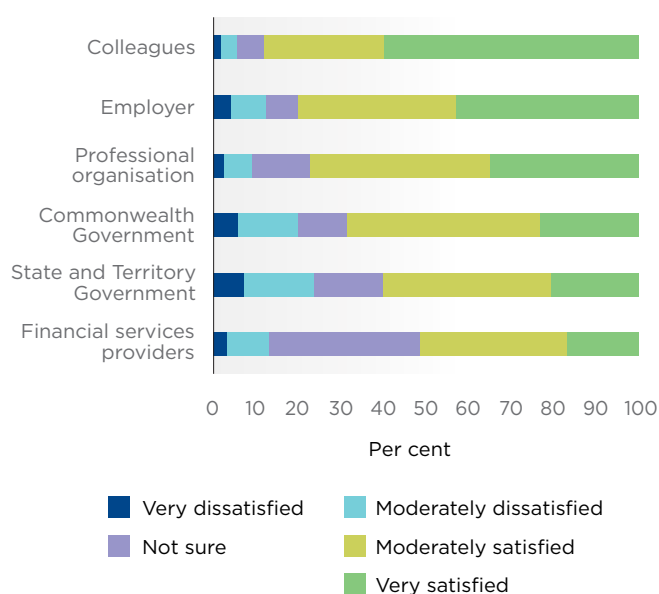


Figure 16. Satisfaction with support provided during the pandemic (GPs and non-GP specialists)

Source: MABEL COVID-19 SOS. Note: 'Please indicate how satisfied or dissatisfied you are with the help offered to you AS A DOCTOR during the COVID-19 pandemic from the following'.

A key issue during the pandemic has been the availability of personal protective equipment (PPE) for health workers at a reasonable cost. Almost 50 per cent of GPs were moderately or very dissatisfied with the ability to access PPE, compared with 32 per cent of non-GP specialists (Figure 17). Higher levels of stress were associated with dissatisfaction with the ability to access PPE (Figure 18).

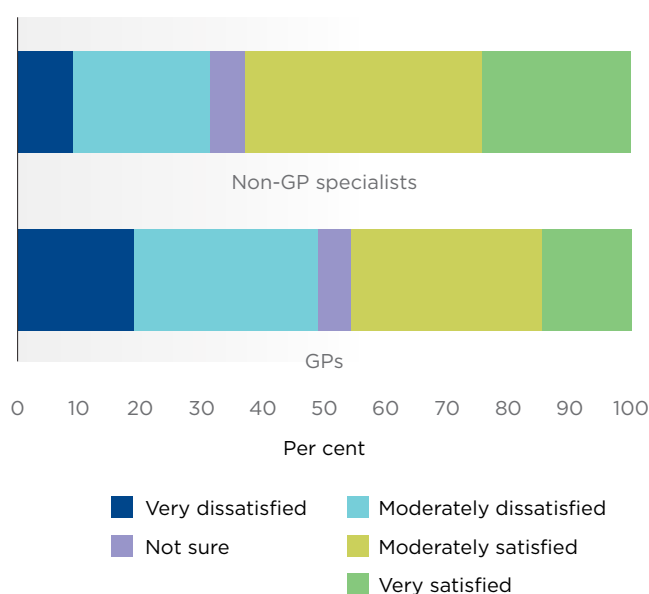


Figure 17. Satisfaction with ability to access personal protective equipment

Source: MABEL COVID-19 SOS. Note: Please indicate your satisfaction with your ability to access appropriate personal protective equipment during the pandemic.

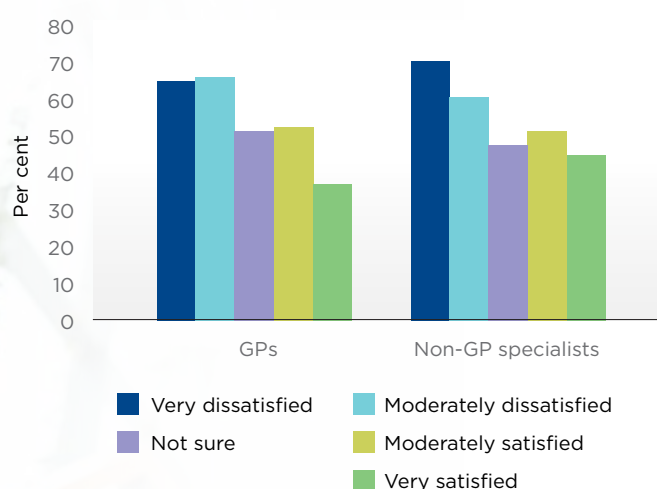


Figure 18. Association between feeling stressed more than usual in the past 30 days and satisfaction with access to personal protective equipment (per cent in each category)

Source: MABEL COVID-19 SOS.



2020 and beyond

As with other areas of the economy, the health sector faces some uncertainty about the near future. Changes in whether and how people interact with the healthcare system depends on how people respond to the lifting of lockdown measures in the short-term, but also the extent and duration of economic hardship caused by the pandemic in the longer term.

Since there is likely to be an increase in economic hardship, and depending on how long the effects of the pandemic last, it is likely to accelerate the already falling growth in the use of private healthcare and decline in private health insurance membership.

This could increase the use of public hospitals but this depends on whether the fall in uptake of private healthcare is for 'necessary' care or medical treatment that is more discretionary or can be delayed. A recent nationally representative survey found that 14 per cent of the population reported that they needed to consult a health professional but chose not to because of the pandemic, and these people were more likely to be financially stressed and mentally distressed.³ These situations may ultimately present as cases of delayed care or become more costly due to the delay in treatment, either in the public or private sector. In terms of unnecessary care, evidence shows that for 21 inpatient procedures undertaken in private hospitals, between 20 per cent and 30 per cent were 'low value' – these could be stopped without any detrimental impact on patients' health.⁴ As activity increases again, it is important to ensure that those with the greatest capacity to benefit from healthcare are given higher priority.

The MABEL COVID-19 SOS asked respondents about changes in patient numbers and whether they would return to normal (Figure 19). Overall, GPs are slightly more pessimistic than non-GP specialists about a complete return to the pre-COVID-19 number of patients in the next 6 months – with 27 per cent of GPs compared to 35 per cent of all other non-GP

specialists expecting patient numbers to return to normal in the next 6 months. Almost 40 per cent of GPs expect patient numbers will remain the same initially and then return to normal within 6 months, compared to 31 per cent of non-GP specialists. Almost 13 per cent of GPs think patient numbers will increase initially and then return to normal, compared to 22.6 per cent for surgeons and anaesthetists, presumably as they see their operating lists recover solidly given the pent-up demand for elective surgery during the pandemic.

How practices will respond is unclear at this stage and depends partly on continuing support from government for Medicare funded telehealth and small business support such as JobKeeper. But it is unclear as to whether the number and type of changes in practice during the pandemic (such as bulk billing, staffing and organisational changes) will continue into the longer term.

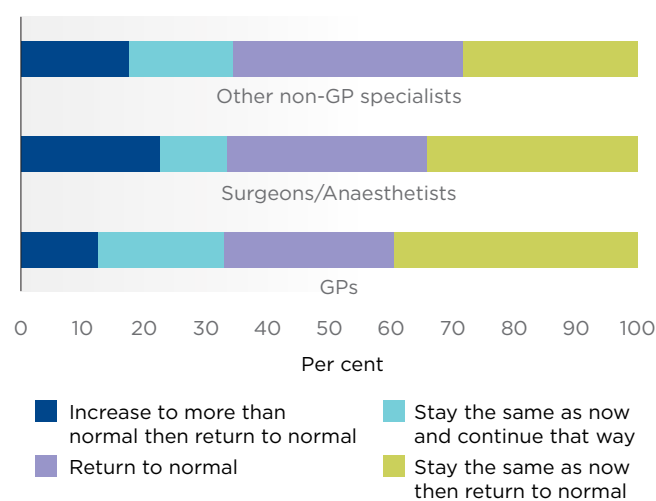


Figure 19. Expectations about changes in patient numbers in the next 6 months

Source: MABEL COVID-19 SOS. Note: 'How do you expect the number of patients you interact with to change over the NEXT SIX MONTHS? (Include ALL patients you interacted with in ALL SETTINGS)'

GP practices in urban areas and those in more affluent areas have experienced the largest falls in patient numbers and income. These are also the practices more likely to charge higher fees and bulk bill less and have suffered most from the move to bulk billed telehealth. It remains to be seen how these practices will adapt if the greater use of telehealth continues. For these practices, the system of fee-for-service is vulnerable to sudden falls in demand. Although fee-for-service has a clear upside when demand increases, it creates financial uncertainty when demand is volatile. More blended forms of payment, including a proportion of revenue that is fixed and not tied to the volume of care, would help smooth out and reduce uncertainty in revenue streams into the future. Exactly how payment models and Medicare payment levels could change is an issue of ongoing debate.

The viability of smaller non-GP specialist practices with older doctors is a potential issue going forward and, to some extent, for GP practices. The ongoing trend towards larger practices in primary care could be replicated and accelerated for non-GP specialist private practices.

There is a possibility that telehealth will create new demand from those who would not initially visit the doctor because of travel costs and the need to take time off work, and who find it difficult to travel due to chronic disease or frailty, for example. Telehealth could also

increase workplace productivity given that it reduces the length of time one has to be absent from work for medical appointments.

The results from MABEL COVID-19 SOS show some evidence of increased use of home monitoring technologies for patients. Driven by changes in funding through Medicare, digital technology providers may accelerate their efforts to support virtual medical care in outpatient and primary care settings, and private practices are likely to build further on the changes made to embrace telehealth. This is important in primary care where the use of telephone consultations has dominated telehealth. At the same time, there is a potential trade-off in quality of care if continuity of care falls – this will need to be monitored as telehealth is expanded.

The pandemic has presented many challenges for GPs and non-GP specialists in private practice. There has been significant turbulence and variation in how the sector has been affected. The pandemic has led to new ways of working, organisation, efficiencies and models of care for patients. It will also likely accelerate some pre-existing trends in the sector. This also depends on how patients react in terms of how they seek and use medical care, particularly if economic hardship continues. Though we face much uncertainty, new opportunities have also been presented to improve efficiency and health outcomes in the Australian healthcare system that should be embraced.



ABOUT THE DATA

We use data from the MABEL COVID-19 Short Online Survey completed between 14–24 May 2020. This was based on some existing questions from the Medicine in Australia: Balancing Employment and Life (MABEL) survey and new questions developed to examine the impact of the pandemic. The analysis is based on responses from 2,235 doctors working in clinical practice (869 GPs and 1,366 non-GP specialists). For non-GP specialists, data are presented only for those 692 respondents undertaking at least some work in private practice. The survey was completed by 2,412 doctors (927 GPs and 1,485 non-GP specialists) of which 177 were not working in clinical practice and so were excluded from the analysis. 16,210 doctors (7,345 GPs and 8,865 non-GP specialists) were invited to participate via email, comprising all who had previously participated in the MABEL survey between 2008 and 2018 and who had a valid email address, providing a response rate of 14.9 per cent (12.6% for GPs and 16.8% for non-GP specialists). One reminder email was sent after six days. All analyses use weights to ensure national representativeness with respect to age, gender, doctor type, number of qualifications, whether qualified overseas, and rurality (Modified Monash Model). For some analyses, where comparative data are available, data from this survey are compared with data from the MABEL Wave 11 survey conducted in 2018-19. Data used from Medicare are publicly available at: http://medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp

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