Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF DR GERARD INGHAM

I, Dr Gerard Ingham, General Practitioner at Springs Medical, of 10 Hospital St, Daylesford in the State of Victoria, say as follows:

1 I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

Relevant background and experience

2 I have been a rural GP for nearly 30 years. I've had the full experience of rural general practice and watched it change remarkably over this time. Originally my practice was in a converted house working with one other GP. Now I'm in a large purpose-built practice, Springs Medical in Daylesford, with 17 doctors working with other health professionals providing multidisciplinary care to an ageing population with an increasing burden of chronic and complex disease.

3 I teach GP registrars in my practice, as well as medical students from Deakin University when they undertake a year-long placement at Springs Medical. In the past, I have performed a number of senior education and supervisory roles across north-west Victoria and undertaken research in relation to general practice and primary care.

4 I am also a Deputy Director of the Australian Government's Professional Services Review Panel. The Panel investigates whether a practitioner has engaged in inappropriate practice. I am also involved in the Medicare Benefits Schedule (**MBS**) Taskforce, reviewing Medicare for the Australian Government.

5 I am a fellow of the Royal Australian College of General Practitioners (**FRACGP**), and hold:

(a) a Bachelor of Medicine, Bachelor of Surgery from the University of Melbourne;

(b) a Diploma with the Royal Australian and New Zealand College of Obstetricians (**DRANZCOG**); and

(c) a Graduate Certificate in Health Professional Education (Australia) (**GCHPE**) from Monash University.

6 Attached to this statement and marked '**GI-1**' is a copy of my curriculum vitae.

Current role and responsibilities

7 I work three days a week as a GP at Springs Medical, and teach medical students and supervise junior GPs in my practice. I work as a teacher and research academic for the remainder of the week. I often visit other rural practices and teach other GP teachers. I provide on-call services in Daylesford, including overnight care, approximately one day a fortnight.

8 Springs Medical has 17 general practitioners as well as practice nurses, physiotherapists, psychologists, a diabetes educator, an oncology masseur, a podiatrist, an audiologist, an exercise physiologist and visiting general surgeons. We run a wellness program for people with chronic disease called 'Spring in your Step'. We also manage inpatients at Daylesford Hospital and provide on-call services through the local urgent care facility for emergency situations 24 hours a day, seven days a week. In 2018, Springs Medical was awarded the Royal Australian College of General Practitioners (**RACGP**) Victorian practice of the year award.

9 I believe in the four Cs of general practice: we are often the first point of Contact; we offer Continuity of care; we understand and serve people in their Context (which includes understanding the community in which they are living, their other illnesses and their background); and we are the Coordinators of care.

Where do rural GPs fit within the mental health system?

10 A rural GP deals with the broad breadth of primary care presentations. We are often the entry point into the mental health system for those in rural areas.

11 The RACGP report, 'General Practice Health of the Nation 2018', at pages 2-4, notes that GPs are the most accessible health practitioner. The same report notes that patients talk to their GP about mental health *more than any other health issue.* This is in stark contrast to the perception of many that we deal mostly with coughs and colds and blood pressure.

Attached to this statement and marked '**GI-2**' is an extract of the RACGP report, the relevant pages of which are pages 2-4.

12 People will seek help from their GP about a mental health issue when they want their GP to help them figure out what exactly is wrong and what help they might need. In my view, a GP will also be the one who recognises that a person's problem is either partly or wholly a mental health issue despite only physical symptoms being noticed by the patient. These psychosomatic presentations are very common.

13 I see GPs as both the gap-fillers and the glue of the mental health system. Because there are often less services in rural areas, my experience is that a rural GP has to fulfil these roles even more than their city cousins.

14 By filling the gap, I mean we provide services when there is no other service available for a person's mental health problem or when the help is not available at that time or at that place.

15 It is important to note that GPs are not just seeing patients with simple mental illness. We see patients who will not be managed by the regional psychiatric service because the problems fall outside of the types of mental health issues that they manage even though the problems can be very complex and challenging. I will see patients with borderline personality disorder (**BPD**), patients with chronic pain who also suffer depression, or patients with a dual diagnosis of mental health disorder and drug and alcohol disorder.

16 In filling the gap, I will also see and stabilise the acutely psychotic patient because the major psychiatric service is 45km away. I will help fill out Centrelink forms or reports because a social worker is not available, or the psychiatrist doesn't have time. I will provide counselling when the patient can't afford a psychologist or because I have known the patient for many years and have built up the trust to enable me to be best placed to help. If a patient needs to be seen today our practice will see them today. We can't send a patient to the practice down the road because it is 30 minutes away and probably has no more free appointments than we do. We turn nobody away in an emergency and we provide a '24/7' service.

17 By being the glue, I mean that GPs provide cohesion between health professionals and between episodes of care over time. I will help my patients find the right mental health service. I will also point them to other relevant services such as housing support, sexual assault counselling, parenting support or financial counselling. I also have my ear to the ground for the return of mental health problems. When I am seeing people for other routine care, I might pick up the early warning signs of their depression returning. I may hear from a person's family that 'something is not right' and make sure mental health is discussed in the next consultation. I will recognise when it is again time to involve a mental health service or mental health worker. I will remember (or at least have written down) what worked best last time.

18 I am a professional friend to my patients. I don't tell people how to live their lives, but sometimes having someone like me saying 'maybe that's not the right thing to do' can help. I'm also there between the difficult times and am trying to prevent problems happening in the first place.

Who receives treatment for mental health related issues at the Springs Medical in Daylesford?

19 Springs Medical sees anyone who wants to come and see us.

What are the criteria for people affected by mental illness to access your services? Must your patients come from any particular geographic location?

20 There are no criteria for people to access our services.

21 Most of our patients live in the region as we are the only practice servicing the towns of Daylesford, Hepburn, and Trentham.

22 Springs Medical is known to have a particular interest in helping LGBTQI+ patients and patients with HIV, and so sometimes we do get people who come from other areas because they have told us that our practice is more accepting.

23 Springs Medical provides help with drug and alcohol issues, and we provide prescriptions for methadone and suboxone. We sometimes attract people from outside our region for these services because they may not be available where they are living.

What proportion of patients seek assistance from Springs Medical for mental-health related issues? In what proportion of consultations would your doctors deal with mental-health related issues?

24 I would estimate that around 20% of the patients I see come to see me primarily because of mental health issues – mostly about anxiety, depression or psychosomatic symptoms. I think I see a few more than the average GP as I have an interest in mental health.

25 In the past, and up until 2016, a survey known as 'BEACH' (Bettering the Evaluation and Care of Health) was conducted in Australia which provided an analysis of Australian general practice activity. That survey suggests that in 2015-2016, 9.5% of patients saw a GP for 'psychological' reasons increasing from the previously recorded 8.6%. However, 46.3% of patients were seen for 'general and unspecified' reasons. In my view many of those patients seen for 'general and unspecified' reasons would also have, in the fullness of time, a diagnosis that the presenting symptoms were psychosomatic in origin. This would bring the rate of presentations to GPs relevant to mental health problems into the 20% rate I estimate I see.

26 Attached to this statement and marked '**GI-3**' is the relevant extract of the data (being pages 36-45 of the report).

27 I would estimate that many more of the other patients I see (beyond the 20% referred to above) also have an issue that relates to mental health, or I need to take mental health issues into account as part of the consultation. For example, a patient who presents with headaches who lost their sister last year from suicide is suffering in a different way because of their grief. As another example, my experience is that a patient who suffers from anxiety presents differently when they have chest pain, and accurately diagnosing ischaemic chest pain is more challenging in the presence of overlaying anxiety symptoms.

28 Considering mental health issues is part of a GP managing a patient in context. A GP looks after illness and not merely disease. Illness is different from disease. Illness is biological, psychological and social whereas disease is just bio (physical) or just psychological. For example, consider a patient with osteoarthritis of the knees who has chronic pain and is unable to work and is on Workcover. The disease is osteoarthritis. The illness is how the person is with the disease. The illness will include the lowered mood and irritability resulting from chronic pain (the psychological component) and the impact of less money and stopping work reducing contact with workmates (the social component). This patient will not recover if I just manage the disease osteoarthritis with medications or surgery. All components of the illness need to be managed because they all impact on the patient's ability to deal with their pain and to return to work.

Do you assist people affected by mental illness with all degrees of severity and complexity? If not, at what point of severity or complexity do patients with mental health issues need to seek help from other providers?

29 Yes, I see patients affected by mental illness with all degrees of severity and complexity. My experience is that patients fall into one of three groups.

(a) The first group is the high prevalence mental health issues such as the various presentations of anxiety or depression, where the condition exists without any significant comorbidity issues. In these situations, I will work with the patient, and in some circumstances, I will prescribe medication or refer them to a psychologist. It's wonderful to see many of my patients managing these common problems well and return to a full or fuller life.

(b) The second group (which is really the most severe group) is those with severe mental illnesses such as bipolar disorder, schizophrenia or major depression. This is less than 5% of patients with mental health problems that I see. The treatments differ depending on the illness and the person and the severity. The illness will ordinarily be managed with my support by a private psychiatrist or more commonly by the area mental health service (the local one is the Grampians Area Mental Health Service, which is based in Ballarat). Treatment

often involves the prescription of major psychiatric medications and may, though rarely, involve admission to hospital or treatment such as electroconvulsive therapy (**ECT**). The area mental health service will take over primary responsibility for management of the patient while they are severely unwell, and I will continue care when they are stabilised. The world of these patients I often find unimaginable. For example, it is hard to comprehend what it would be like to truly believe other people can read your thoughts.

(c) The third group is the middle ground or what other colleagues have called the 'swamp' of general practice care. My estimate is that more than half of the patients that I see with mental health issues are in this third group. The issues for patients in the swamp are messy and complex and don't fall easily into one camp or another. The messy complexity may be because there is intimate partner violence, previous sexual abuse, co-existing severe chronic disease, social issues (such as poverty or social disconnection), drug and alcohol abuse, or chronic pain. There are also patients with somatic symptom disorder in this middle group. These are patients who present frequently with symptoms that are otherwise medically unexplained. It is often related to anxiety disorder or BPD.

30 For many people in this third group or swamp, seeing a psychiatrist or psychologist alone may not be enough or it may be that the psychiatrist or psychologist won't see them until it is mostly a mental health disorder. For example, the patient who smokes cannabis heavily or drinks heavily may not be offered mental health services because it will be considered futile to undertake counselling or prescribe psychoactive medications. I don't have that luxury! The psychiatrist turns this patient away and they present, often with concerned relatives, at my door in great distress seeking help. I encourage and assist the patient to quit their addiction, but this is harder to achieve when there is mental illness present. I try and manage the patient's mental illness as best as I can, but this can often be quite dangerous. I have to weigh up the benefit of prescribing medications for the patient's mental illness against the potential harm of the medications being fatal in overdose when combined with alcohol or other substances. I try to reduce the risk of overdose by using the assistance of relatives or the local pharmacy to dispense medications in a staggered manner according to need.

31 People with BPD belong in this third group and are sometimes called 'heartsink' patients by doctors. They are also usually not seen by psychiatrists. They are called 'heartsink' as they are hard work and it is hard to see that you are making a difference. A read through of the diagnostic criteria for BPD makes it clear why people with this diagnosis are challenging. People with BPD are emotionally labile and predictably unpredictable. They might agree on a course of action during a consultation but then not follow it through. They have terrible problems with relationships, suicidality, impulsivity and

chronic feelings of worthlessness. People with BPD are seen as manipulative as they will often enquire about the GP's personal life or emotional state during a consultation.

32 However, their behaviour is often fully understandable when you consider that the they are usually damaged by terrible childhood events. It's very hard for patients with BPD to navigate life and trust people when they have been a victim of sexual abuse or have suffered other childhood trauma such as being a forced child migrant. To manage patients with BPD I book them in for review monthly, as a new problem that they need help with reliably arrives within that time. I'm generally not trying to fix them, just improve their lives a little and keep them from harm. I try and keep them away from that unnecessary test or making that potentially disastrous financial decision or burning the bridges with their last remaining friend. There is no telethon or fun run for people with BPD. Their lives are often very sad. I believe I do help. It's great when fate deals them something positive, but that is rarely the case. I appreciate how much care is provided in the community, particularly rural communities, to such patients, as I think health services often have very little to offer.

33 A large constituency of the third group is patients with chronic pain. In my experience, everyone who has chronic pain has a mental health problem related to the cause of the pain, or has a mental health issue because of the pain. My understanding is that the few chronic pain clinics in our region have waiting lists that are years-long, and so I don't bother referring patients to them. Chronic pain needs multidisciplinary management. That is, a well-trained GP, with assistance from a consultant rehabilitation physician, could manage chronic pain with a supportive team of physical therapist, social worker and mental health workers. But my view is that this type of care is not available in our region.

34 The patient with somatic symptom disorder is also in the third group. In my experience, they are best managed by a GP. A GP is better placed to determine if a patient with anxiety and chest pain needs investigating or whether it can be attributed to their mental health. A psychiatrist is less skilled in distinguishing the physical from the psychological than a GP. GPs are able to prevent unnecessary investigations and the anxiety they cause which can result in the situation deteriorating.

35 The patient with multi-morbidity also belongs to the third group and is similarly, in my view, best managed by a GP. If a patient has a mental health problem and another health problem then they need a GP involved to work on both problems simultaneously rather than a psychiatrist managing their mental health while other clinicians manage the patient's other illnesses. Humans are not so easily separated into physical and psychological components. Most people with multi-morbidity need a generalist, not a group of partialists.

Do you have experience of the 'missing middle' – people whose needs are too complex for the primary care system alone but who are not sick enough to obtain access to specialist mental health services? If so, in your experience, how does the mental health system meet or not meet the needs of people who find themselves in that gap?

36 Yes, as noted above, more than half of the patients I see with mental health issues fall within the 'missing middle' category.

37 However, I disagree that they are too sick or complex for the primary care system. My view is that they are best cared for in primary care, but GPs are not resourced to do this. Primary care service providers could be skilled, supported and paid for caring for this group. It's true that not every GP wants to do this work or can do this work. I don't work full-time in general practice in part because this work is too hard to come home from every day. However, many GPs are capable and willing to do this work as part of their day. They could do it extraordinarily well working with mental health teams. We have teams to manage diabetes or other complex health issues that benefit from multidisciplinary GP-coordinated care and this has resulted in significant improvements in care. We have not, to date, developed teams in general practice to manage mental health problems

Briefly, how are mental-health related services provided by GPs funded?

38 Springs Medical is a mixed billing practice; we offer both bulk billing and fee for service. Most of my patients, and particularly those in the 'missing middle' are Health Care Card holders or pensioners and we frequently bulk bill them, meaning the services are largely funded through government.

What are the challenges from a GP perspective in providing and facilitating care for patients with mental-health related conditions, in relation to:

Navigating pathways of care

39 The challenges with navigating pathways of care, in my experience, depend on the nature of the illness or issues. As stated above, for the high prevalence issues such as anxiety or depression, I can often provide the care my patients need. If I need the support of a psychologist, I complete a mental health plan to enable access through Medicare funding.

40 For those with a severe mental health problem, care is normally provided through psychiatric services which will involve me calling the local psychiatric services to arrange a referral. These services don't take everybody and I wish they could broaden their scope, particularly to support my GP colleagues who have told me that they find caring for patients with mental health problems particularly fraught.

41 Once in the mental health system, if the patient has insight into their problem, and agreement on the path forward is reached between the clinicians and the patient, in my view the care is good. Just like with a GP, I believe that the continuing relationship between the clinician and the patient is the key to success. We have had community psychiatric nurses who have worked in our region for a long time and they provide excellent care. Although I'm often busy when they call, I do appreciate their phone calls or contact to update me on the care of our mutual patients.

42 The system as it exists for severe mental health problems does also have some challenges particularly when a patient does not reach a shared understanding with the mental health clinicians about diagnosis and management. From my perspective, for patients with severe mental health problems, the main issue is obtaining access to the system and obtaining an opinion from a psychiatrist, particularly when a patient is seen to be from the 'middle group'.

43 In one situation, I had a patient in their eighties, who came from another area. The patient was on a large amount of antipsychotic and chronic pain medication. It was an astonishing amount of medication for their age and I considered the risk of accidental death from overdose to be high. I managed to cut out some medications, but I wanted the assistance of a psychiatrist regarding the anti-psychotic medication. The patient was purported to have a major mental health diagnosis but I was not convinced of its accuracy. I wanted to know if it was appropriate to reduce those antipsychotic medications to reduce the risk of accidental overdose or if it was wisest to continue on the current regime to avoid a deterioration in her mental health.

44 I referred to the regional mental health service to obtain an opinion. The person accepting the referral is not necessarily a psychiatrist, but can be an occupational therapist, psychologist or other clinician. The referral is to the mental health team, not to a psychiatrist even though all I wanted was the psychiatrist's opinion. They make the assessment as a team. I received a response, but it was not the psychiatric opinion I needed but rather the advice from another clinician. The advice was that I should just keep going. I found it astounding that I could not obtain a consultant psychiatrist's opinion about a patient I was struggling with. The person providing the opinion was not skilled in prescribing. I appreciate that the system is in part set up to manage the load for the too few public psychiatrists we have, but when I need medication advice, I need help from a doctor colleague.

45 For the 'missing middle' group, there is no clear pathway for me to navigate and it is often difficult to work out the best type of care. For most of them I try to navigate the complex issues myself. I don't have a lot of support in terms of other services. I book these patients in for half an hour, once a month, for continuity of care and I chip away as best as I can. It took me many years to understand my role with this group of patients

and hone my skills. The type of care is poorly defined but as stated previously I think the GP is best placed to deliver care to this group. We could provide better service with funding, training and a team-based approach.

Referral options and waiting times

46 For access to a private psychologist, for most patients, I need to complete a mental health plan. If the patient can afford the gap, there is little wait for a private psychologist in my region (about 2-4 weeks on average). I'm not sure if that is the case in other rural areas.

47 I have very few patients who access a private psychiatrist: 70-80% of my patients are pensioners or health care card holders and the proportion is even higher among those with a major mental health disorder. Accessing a psychiatrist who will bulk bill is a significant challenge, particularly in our region. If my patient can pay, then I can arrange for them to see a private psychiatrist in about 2-4 weeks on average. The remainder have to see a psychiatrist through the public system (that is, the area mental health service).

48 For access to a bulk billing or community psychologist, the waiting time fluctuates but is typically around 2-3 months. My view is that the referral process is labyrinthine and bureaucratic. Even though there are only three designated psychologists who provide bulk-billing services, who are all located across the road at Daylesford Community Health Centre, I have to write to Western Victoria Primary Health Network's access service called 'Referral Point'. If I fail to complete one of the questions correctly the referral bounces back to me and I must recomplete it further delaying access to care. The mental health questionnaire includes questions like 'how often have you felt worthless?' which I feel uncomfortable about being compelled to ask the patient to complete.

49 For access to the public health system for psychiatry there is immediate availability of triage and emergency management, but this can still be a challenge. There can be a long wait on the phone to speak to the triage clinician. Sometimes I have had to organise an ambulance to take an acutely unwell patient to care. I've also had to call the police sometimes to take a patient to hospital if I see that the patient is a danger to themselves or to others. That's not easy. The other issue is obtaining access to ongoing care by the service. In my view, access is limited to only those with a major mental health disorder.

Eligibility criteria for services

50 There are practically no issues in terms of eligibility for a private psychiatrist or psychologist. Of course, if the therapeutic relationship is not working, they quickly refer the patient back to me.

51 Only 10 psychology services per calendar year are eligible for a Medicare rebate for psychology services after the GP completes a mental health plan. This is often insufficient for patients with complex mental health problems, for example a patient who after years of mental health problems finally reveals the underlying story of sexual abuse 8 sessions into their 10 sessions is left in a parlous state when their therapy stops soon after. In my view, the calendar year criteria is also ridiculous. A person is better supported if they present later in the calendar year, as they could access their 10 for the current year and another 10 after 1 January.

52 For the public psychiatry service, the patient must have a major mental health disorder, and not co-existent other problems like drug and alcohol issues, to obtain ongoing care.

53 For public psychology, the delay in accessing care means this service cannot be used for short term problems which require immediate access to counselling. So, this is a gap the GP has to fill. The public system for psychology services is also restrained by the 10 sessions per calendar year rule.

Affordability issues

54 As stated above, private psychiatrists are expensive and often my patients can't afford them.

55 Most private psychologists will charge a 'gap fee', being a fee over and above what a person will receive from Medicare. The standard psychologist fee is around $150, but it varies. The amount received back from Medicare is about $85.

Capacity constraints (time pressures, consultation lengths and so on)

56 Mental health consulting takes time and many rural GPs are time poor. The RACGP report, 'General Practice Health of the Nation 2018' (see attachment **GI-2,** the relevant pages of which are pages 7-8) found that, although rural patients had similar rates of GP presentations with mental health problems, there is a lower doctor-patient ratio in outer regional, remote and very remote areas. A third of patients in these areas cannot access a GP within 24 hours. In some areas, the nearest GP may not have an interest or be particularly skilled in mental health. Of course, they will try and fill the gap as best they can.

Are there barriers (from a systems perspective) that act as disincentives for GPs to provide mental health care? If so, what are they?

57 A major barrier for GPs to provide mental health care is that, in my view, GPs are not financially incentivised to provide mental health care. It is well known that a longer a GP spends with a patient, the less they earn per minute. This creates an incentive for rapid-turnover consulting which is not compatible with whole-person care and managing mental health issues.

58 For example, if I undertake two level C, 30-minute consultations per hour, I receive from Medicare a total of $155.60. However, if I attend 6 standard level B consultations of 10 minutes each in the same time (i.e. one hour), I receive $225.60. The hourly expenses to my practice would be the same in both situations, resulting in a $70 difference per hour solely based on Medicare.

59 If I bill 6 patients in the hour rather than 2 patients in the hour, I also have four more opportunities to charge a gap payment if my patients can afford it. In my experience, many patients with mental health problems are on low incomes, making it more likely that they are bulk billed.

60 I also receive phone calls from the regional mental health service to provide updates on the care of my patients with severe mental health conditions. These calls are not funded at all.

61 In my view, this basic problem of longer consulting being less rewarded is compounded by procedural services having a higher value in the MBS system than consulting services. As a rural GP I have excised my fair share of skin cancers. I can spend 20 minutes removing a small skin cancer from the body of a patient and bill item 31367 for which the MBS fee is $213.60. It's relatively simple work and certainly doesn't take much cognitive or emotional toll on the doctor. A 30-minute consult with a patient at risk of suicide is much more demanding work. Relevant items for a 30-minute consult in this circumstance include:

(a) a mental health consult item 2713 valued at $71.70; or

(b) a mental health treatment plan item 2715 at $91.05; or

(c) the provision of focussed psychological strategies item 2721 by a GP with extra training at $92.75.

62 Why would removing a skin cancer be considered more important or valuable work than seeing a patient at risk of suicide? The MBS system provides an incentive for a GP to specialise in skin cancer removal but not in the provision of mental health. I notice 'skin

clinics' in our regional cities and in Melbourne but I have personally not seen clinics of GPs specialising in mental health – in my view, they would be unprofitable.

63 In my view the payments do not reflect the care and value that I bring when managing mental health problems. I have highly refined skills in mental health care that are more nuanced than my procedural skills. I have also improved more lives with counselling than I have with offering blood pressure medication. The mental health work I do is relatively underpaid and time-poor rural GPs are probably less likely to do it.

64 Working as a GP with an interest in mental health is also hard work. I find I can no longer work full-time in general practice as I need time to recover from consulting. The poor mental health of doctors is well-known. My understanding is that supervision and counselling from a colleague is the norm for a psychologist, but not so for a GP with a caseload of patients with mental health issues. In the past, I've developed informal networks within the practice or with local doctors to debrief. It's great to get together and support each other. We can even find meaning in the wonderful resilience of our patients and the understanding they can bring to our own lives. In my view, GPs should adopt a culture of formal supervision as I believe it would benefit our discipline.

65 GPs also work largely alone with their patients in mental health rather than in the teams that exist for other health problems. Nearly all of my patients with diabetes see a diabetes educator who works in my practice and I can discuss their management with her. In comparison, I am often the only clinician for my mental health patients, or the other clinician involved is not in my practice. Working with patients on my own is particularly the case with patients from the 'missing middle'.

66 The final barrier is that there is not really a well-developed training pathway to develop the necessary skills to be an effective GP in mental health.

What training is available for GP's to increase their skills and knowledge base in mental health? How is it funded? How could it be improved?

67 In my experience, most GPs have inadequate exposure to mental health and the treatment of mental health problems likely to be managed by a GP during their primary medical degree. What is taught is mostly about managing either severe mental health disorders or the management of simple presentations of anxiety or depression. Most of what I have learned about helping patients in the 'messy middle' has been learning by doing or through my role as a teacher rather than through academic training.

68 It must be confronting for the junior doctor commencing GP training to suddenly find themselves cast as a sage for their patients. One of the teaching sessions I run for junior GPs is on helping patients to cope with life's challenges. How do you help a person who attends after the death of a family member, or after they have been

assaulted, or if they are being bullied at work, or if their partner has left them? In my view, GPs are trained to manage the disease outcomes that eventuate when patients don't cope – depression, PTSD, substance abuse - but not how to manage this preventative opportunity.

69 Another observation of mine is that the less skilled and comfortable a GP is with mental health problems, or the less time they have, the more likely they are to prescribe medications. For example, the distressed patient after a traumatic event is more likely to be prescribed sedatives or the patient with low mood that is not sufficient to justify the prescription of an antidepressant may still be prescribed them. The lack of skills or time can contribute to inappropriate or unnecessary prescribing. The solution to this is to provide GPs with enough time and skills.

70 There are levels of accredited mental health training which then allows GPs to access specific MBS items:

(a) the RACGP offers Level 1 Mental Health Skills Training, which requires a GP to complete a 6 to 7 hours mental health skills training course. It provides basic mental health skills. Once completed, the GP can access MBS items 2715 (attendance of 20-40 minutes to prepare a GP mental health treatment plan) and 2717 (attendance for at least 40 minutes to prepare a GP mental health treatment plan). Without this training a GP can still provide a mental health care plan but has to use a MBS item number that is worth a few dollars less.

(b) the RACGP also offers a Level 2 Focussed Psychological Strategies Skills Training which is completed over 20 hours and then allows the GP to access four additional MBS items (2721, 2723, 2725 and 2727) which similarly allow a slightly larger MBS fee than standard consulting when the GP employs particular psychological techniques.

71 There are also Masters degrees and other training which allow a GP to undertake detailed training in mental health, but there are no current financial benefits to doing this.

72 GPs can become GP anaesthetists or GP obstetricians through undertaking a further 6-12 months of specialised training in these disciplines and access the Medicare item numbers of the relevant specialty. It is not currently possible to be a GP psychiatrist and access the item numbers used by psychiatrists. I think this should be addressed. It would also be useful if this qualification was recognised by the Commonwealth government for MBS purposes but also more generally. For example, it infuriates me that my diagnosis of a mental health disorder is not accepted for the purposes of determining whether a patient can access a disability support pension and the patient must instead attend a psychiatrist – when they are in my view expensive and scarce.

73 I think the training of GPs in general in mental health could be improved. In addition to adding the special interest qualification of GP Psychiatry for those who want to take their skills further, we do need training for all GPs in the skills for the 'messy middle'. This would, in my opinion, best be achieved by discussion of our challenging cases with peers and GP experts in a group learning environment and through consultation observation to improve consulting skills. The most important skill, I believe, is active listening and I have experienced how this can be improved by training. Currently I can be funded $2000 a day to undergo training in emergency medicine so I can better serve my rural community but I receive nothing if I undertake training in mental health. I think GPs should be paid to take time out from their practice to obtain the requisite skills in mental health care.

In your experience, in relation to the needs of people affected by mental illness for clinical treatment:

Is supply keeping up with demand? What gaps have you observed?

74 There is an enormous unmet demand. I have found that there is a shortage of available good quality, affordable private psychiatrists for patients with severe mental illness. If there was more psychiatrist availability, I am sure there is the demand.

75 If GPs were appropriately rewarded for providing mental health care by the introduction of higher rebates or new items there would be increased GP care of patients with mental health problems.

76 There is also an unmet demand for psychologist services. I understand the psychologist MBS item numbers had to be restricted from 18 per calendar year when the program was initially introduced down to 10 services per calendar year because the demand for services resulted in the program exceeding the planned budget. If psychologist services were to return to 18 per calendar year, in my view they could be used by patients and clinicians appropriately.

77 I appreciate that cost-benefit needs consideration. There would be greater costs to having more psychiatrists, new GP item numbers and an increase in the annual allowance of psychologist visits. However, there would not be the same level of questioning if patients could not access relevant services for cancer care or for a heart attack. There could be mechanisms introduced to reduce the risk of additional items for mental health care being abused.

78 The gaps in demand include the gap in care for the 'missing middle' I have described previously - particularly patients with chronic pain or drug and alcohol issues or BPD . The patient on low income who needs immediate mental health support for a psychologist sometimes cannot access care. The GP is required to fill these gaps and in

my experience the likelihood of this happening will vary depending on the area. In rural areas, as there are fewer mental health services and fewer GPs available, the patient is more likely to be unable to access the care they need.

79 The access to public psychiatry is restricted to a narrow band of patients and mostly this is done through the team rather than a therapeutic relationship with a psychiatrist. Often this works well, but not always. I believe the service would be better with more psychiatrists available for patients in the public health system.

80 At times I have found the availability of services for patients with severe mental health illness to be patchy. Earlier this year, I had a person brought in by a worried relative Sunday afternoon to Daylesford Hospital for urgent care. The patient was talking a million miles an hour, and she had trashed her house and smashed her phone. I formed the opinion she was having a manic episode, and in my view, she was not safe to go home to the care of her family. She was unwell and not really attached to reality. I was concerned for her safety. I rang the local **CAT** (Crisis Assessment Team). We use the same access number as the general public. I was confronted by the recorded message reassuring me to 'please wait you are first in the queue'. I waited on the phone for 1.5 hours. I figured it wouldn't take long for the one person in front of me to be managed and I urgently needed help for my patient and couldn't afford to hang up and ring back later only to find myself further back in the queue. There was no facility to leave a message for a call back. In the end I had to ask a nurse to hold the phone for some of the time as I had other patients to see. I think the reason for the delay was that it was the intake worker's lunch break, and he or she was probably the only person available to take my call on a Sunday. This is not great for the patient accessing the services, and a waste of my time.

81 The intake workers initial response was 'OK I'll give the patient a call to assess'. The relative of the patient had offered to drive the patient to Ballarat for assessment but this was declined by the intake worker. Did the area mental health service not have the capacity to see my patient? My impression is that there were previously more staff available for face-to-face assessments and that, years ago, staff would come to Daylesford to assess the patient in person. Surely in the days of web-conferencing, a state-wide telehealth service could operate after hours for urgent mental health problems when a clinician needs support. We have such services available for emergency care. In my view, it is unacceptable that we have to rely on a presumably understaffed local service when central support and coordination would be more effective. Clinicians also need a separate service from the general public when seeking support.

82 There is also a gap in availability of inpatient care for patients who need this level of care for their severe mental illness. There are private psychiatric hospitals in Melbourne

but none in rural or regional areas. Patients with substance abuse as well as mental health disorders must go to Melbourne for detox as we cannot care for them locally.

83 The public psychiatric facilities in Ballarat are for severe mental illness only and although I have never visited them, I am concerned that they are not an environment that is conducive to recovery. One patient of mine who has a severe mental health problem and was admitted to the hospital in Ballarat told me that he stayed in his room the whole time as he found the shared area unwelcoming and confronting. There was graffiti on the wall in his room from a previous patient that had not been removed and even in the depths of his mental illness, he knew it was wrong that he had to look at the graffiti all day.

If there is unmet need, what needs are the most critical?

84 Considered through the lens of what is 'most critical', in my view the appropriate management of those at risk of suicide from severe mental health conditions is prime. The appropriate management relies on the availability of crisis assessment and intervention services for patients, but also on general practitioner availability. My understanding is that patients with BPD have at least twice the risk of suicide as other members of the population but this risk manifests differently from how it occurs in patients with depression. There is not the progression from feelings of worthlessness through thoughts of suicide to careful planning of suicide. Patients with BPD often have chronic thoughts of worthlessness, so suicide appears to occur impulsively. There may be precipitants such as relationship issues or the disinhibition created by alcohol or substance abuse, but suicide occurs in a less predictable way than in patients with major depression.

85 My point here is that solely providing improvements to crisis services may not be the way to start solving unmet need. I expect many crisis assessment service calls are related to the unmet demand for chronic care, particularly from patients with BPD or anxiety disorder. If the care is episodic rather than continuous, or if there is no suitable ongoing care available, then the merry-go-round will just continue without benefit. CAT teams need to be available and perhaps coordinated on a state-wide basis and include telehealth options, but it is important to have ongoing services that patients can transition to from crisis assessment.

What are the key drivers of unmet need?

86 This is the most difficult question to answer. I think the social determinants of health apply particularly to mental health. Poverty contributes to mental health problems and impacts on the ability to recover from them.

87 Another contributor is the impact of intergenerational poor care. When we fail to care for children, in my view we set off a cascade of mental health problems that can ultimately extend through generations, particularly of those who have suffered sexual abuse or childhood violence or neglect.

88 I believe aspects of current society are contributing factors. Prominent figures, including political leaders, have modelled unhealthy and antisocial behaviours including racism, sexism and bullying. Modern life, including exposure to social media and the myriad of social interactions that time on devices replaces, also come at the cost of mental health, social competency and wellbeing.

89 Overall, our priorities are misguided. I was particularly struck by the recent decision by the New Zealand government to include measures of wellbeing in their economic plan. We live in communities, not economies. If things have to be measured to change, then perhaps we need to take our lead from across the Tasman and start measuring community wellbeing.

90 Finally, some of the unmet need is related to the reduction in stigma of mental illness. Mental illness is being more openly discussed resulting in more people seeking help.

What kinds of impact does unmet need have on people affected by mental illness?

91 At the extreme end, there is always the risk of suicide.

92 But the biggest impact is that, from what I have observed, a lot of people are living in misery. A patient I have with schizophrenia is living with delusions and believes other people can read her thoughts. When I talk to people with untreated depression, I often ask them 'Is there anything you're looking forward to?' A lot of those people tell me 'No'. People with BPD live with chronic feelings of emptiness and abandonment. People live with chronic pain, or spend their days in the trap of substance abuse.

If a person has a chronic mental illness but are not in 'crisis' where do they go for immediate support?

93 They go to their GP. This is exactly the gap-filling role I have described. The psychologist is often not immediately available and other than crisis services the regional mental health service operates on an appointment model.

How does the complexity of the mental health system (variability between geographic areas, overlaps/duplications between different levels of government, and gaps) impact on people's ability to access services and navigate the system? What tools are in place currently to help people navigate the system? How effective are they?

94 I find the mental health referral network relatively simple to understand. If a patient needs public mental health services, I refer to the regional mental health service for severe mental health disorders. For other levels of mental health disorders I refer through Western Victoria Primary Health Network Referral Point to access a psychologist at Daylesford Community Health Centre

95 For private patients I can try and find a psychiatrist to refer to and can easily find a psychologist to refer to. I have to complete a GP mental health treatment plan to refer to a psychologist and a referral letter to refer to a private psychiatrist.

96 The complexity occurs when other services are needed, and they often are. For example, patients with mental health illnesses often need drug and alcohol counselling, housing support, social work, legal assistance, and financial assistance. It is not very clear to me how these services can be accessed. I rarely receive communication from other providers, which in turn makes it hard for me to coordinate care and share their understanding with other members of a team.

97 The GP should be the coordinator of care. Our health system operates with the GP acting as gatekeeper for strong evidence-based reasons. Self-referral creates increased cost and can result in inappropriate, poorly-coordinated care.

98 For patients trying to obtain services online for mental health issues there are also limitations. In recent work awaiting publication it was found that most websites such as Beyond Blue that contain information about mental health conditions to enable appropriate 'self-help' require at least Year 10 reading skills to understand the information. It may assist patients who are literate, but not so well for those who aren't or who can't access internet services. While many other services are being improved by information and services provided over the internet, I don't see this playing a large role in the mental health sphere. Improvement in mental health does significantly come from the personal connection between the patient/client and health care provider.

What are the barriers to collaboration between mental health service providers?

99 The collaboration barriers can be significant and provide an impediment to good quality care. There are barriers when the service providers work for different services, and there are financial barriers for a GP to be involved in communication with other providers.

100 If a psychologist or mental health nurse is working in the practice with me, the communication is great. We can have brief informal verbal handovers in addition to the required written communication. I begin to understand how they work and can refer appropriately.

101 With a psychologist outside of my practice, there is no possibility of informal communication or the development of a relationship between clinicians.

102 In general, however, communication is reasonable, as psychologists are required to communicate with me and rely on me for referrals. The same applies for private psychiatrists.

103 For patients with severe mental health disorders who are being case managed by the regional mental health service, I have found the communication to be of variable quality. The psychiatrists generally send me a fax outlining medication change. Most GPs are set up to receive secure messaging through services such as Argus so a fax does not reach us as quickly as a secure message. Other than this minor concern, I have found communication about medication change occurs reasonably promptly.

104 The other clinicians in the mental health team of the area mental health service communicate infrequently. It does tend to depend upon the clinician, and I suspect they would say it depends upon the GP as well. We can be hard to catch for verbal communication. Telephone calls are not remunerated by Medicare, and it is difficult to interrupt a GP during consultations with their other patients. When we try and return the call to the mental health clinician, we have to go through switchboard to reach them and often by the time we have finished consulting and can make the call, the relevant clinician is no longer on duty. We can end up playing phone tag or communication ends up not happening.

105 Written discharge summaries for when a patient leaves hospital or when a patient stops being case managed and is being handed back to the GP can arrive weeks after the event. I have described previously the difficulties in obtaining an opinion from a public psychiatrist. For patients who have been accepted within the system, I have been able to speak to the public psychiatrist about some patients. This tends to happen more when the patient has a good advocate, or carer, encouraging collaboration.

106 Other relevant providers such as social workers, housing workers, financial counsellors, drug and alcohol workers rarely communicate with me.

107 Communication is improved if clinicians are located together on site. Communication is better if it is verbal and if a relationship can subsequently develop between clinicians. If GPs were paid for case conferences with other mental health clinicians, then I suspect

systems would develop to allow this to occur. I can envisage a GP making consultation spaces available for telephone conversations with other clinicians.

Are there notable examples of the health system facilitating collaboration (features that work particularly well?)?

108 I have worked with one private psychologist in my practice for nearly 30 years. I know how he works and can select patients well for him. In addition to my referral, for particular patients who I am concerned about or who I want to alert him to an issue I didn't want to put in the letter, I can easily have a quick word on the days we are in the practice together. He has also been great support to me, and I have learned a great deal from him.

109 In the past, we have had a mental health nurse in the practice funded by the government to help with patients at high risk of suicide or readmission to hospital. The qualified mental health nurse kept in regular contact with the patient between their contacts with me. In addition, the nurse provided patient care and advocacy, wrote detailed notes in my health records system and assisted with communication with other providers such as psychologists or psychiatrists. We worked as a team for the patient. The funding for this service recently changed and a different nurse is now in the community health centre. There is now minimal contact between me and the nurse. I don't know when the nurse is seeing the patient or what the nurse is doing with the patient. I can't read the nurses notes in my file. Many of my patients have disengaged from the service.

From a GP's perspective:

What do you think are the most significant challenges facing the mental health system in meeting the needs of people affected by mental health?

110 Meeting the needs of the 'missing middle' is the main issue. My view is that this challenge could be met in primary care, in multidisciplinary GP teams. We need more training and assistance to help us manage this cohort.

What do you think are the critical elements of a well-functioning mental health system?

111 A well-functioning mental health system would operate in the best interest of the patient and would allow communication and collaboration between providers. Appropriate care would be selected and made available to the patient. All teams would involve the patient's GP who in most cases is likely to be the coordinator of the team. In the case of a severely unwell person, the team would include a psychiatrist.

What changes do you think would bring about lasting improvements to help people affected by mental illness, in relation to:

Access to treatment and services;

Navigating the mental health system;

Getting help to people when they first need it?

112 There is a need to look at the system entirely and challenge the idea of it running the way it's always run. There can be improvements in the primary care management of mental health that I believe would make a significant difference. A GP is often better placed than a psychiatrist to manage many of the mental health conditions that present and particularly when there is multi-morbidity.

113 A team-based model that has more clinicians working in GP clinics would make a significant difference. Currently the (under)funded team is a GP and a psychologist. The psychologist is limited to 10 visits a year. This model is proving inadequate.

114 It's hard to imagine working in a general practice now without a practice nurse doing the many things GPs did previously like immunisations and dressings. I now ask nurses for advice on these issues as they are the acknowledged experts. Nurses completing this work have freed me to provide other care. I would like to think in the future we will wonder how patients with mental illness were managed without a mental health nurse. The mental health nurse could:

(a) maintain contact with the patient between my consultations;

(b) contact the patient by telephone or undertake face to face consultations;

(c) provide counselling, organise or administer medications, manage team communications, and complete relevant paperwork; and

(d) assist with routine physical care such as blood pressure checks or assisting a patient to quit smoking.

115 To add to the GP and psychologist and mental health nurse in the team, there are circumstances where a social worker would be valuable in assisting navigation of the various social supports for patients. A drug and alcohol worker would often be useful, and a physiotherapist would aid the management of patient with chronic pain. The health workers needed for each particular team would be selected based on the patient's need.

116 The team could be funded and coordinated through existing processes. If a GP completed a mental health plan, other services could be made available under the plan. For example, once the plan is completed a patient might be eligible for 10 psychology

consultations and 10 other consultations per year with a nurse, social worker, drug and alcohol worker or physiotherapist. In other words, completion of a mental health plan enables a more expanded team than the current GP and psychologist team.

117 Currently all patients receive Medicare funding for only 10 psychologist sessions per calendar year. There are clearly patients who need more services and, as stated above, many would benefit from services with other clinicians. I suggest that patients with a confirmed diagnosis of a severe mental health disorder (schizophrenia, major depression, bipolar disorder) or belonging to the missing middle (drug and alcohol abuse, poverty, chronic pain, BPD) are eligible to more or an extended range of services. There should be greater differentiation of care available. It could be that patients receiving the top-tier level of services need an annual review with a psychiatrist or GP psychiatrist to confirm appropriateness of the model developed and care provided.

118 One of the current barriers to good communication, collaboration and communication from a GP perspective is that Medicare only funds GPs for patient attendance services and not for telephone or written communication with patients or for communication with other clinicians. There are funds for case conferences with other clinicians but there must be at least two other clinicians involved in the conference in addition to the GP. It is nigh on impossible to arrange a case conference like this if all the clinicians aren't in the same building. Most conversations GPs have with other clinicians are one at a time and these are unfunded. If coordinated care is vital to good management of patients with mental health problems and we operate in a fee for service environment, then payment for communication needs to be allowed. There should be time-based items for conversations between the GP and relevant mental health clinicians.

119 GPs need to be more appropriately remunerated for mental health work to encourage them to do it. The standard consultation items and the mental health items should be remunerated similarly to procedural medicine.

120 GPs require more training and support to improve their skills in managing patients with mental health problems, particularly those from the 'missing middle'. GPs should be funded to undertake further training in mental health in the same way rural GPs are funded to undertake emergency, obstetric or anaesthetic training. This training would in my opinion ideally involve expert-facilitated case-based discussion rather than being didactic presentations or online modules. Expertise in mental health is developed by reflection and learning with peers and experts in our discipline.

121 I think there is merit in developing GP psychiatrists who should be given access to the MBS items for psychiatrist. This should occur through a similar process to that developed for GP obstetricians and GP anaesthetists, but the training must be relevant

to the GP practice of psychiatry which is likely to be different from mainstream psychiatry as it involves care of the missing middle.

122 I think a state-wide video conferencing facility where people could access prompt, appropriate and face-to-face advice in emergency situations or after hours should be considered.

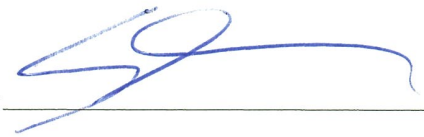
Drawing on your experience, how do you think the Royal Commission can make more than incremental change in helping GP's to meet the needs of their patients with mental health problems?

123 Change is difficult in complex health systems. A useful approach may be Lewin's three-stage model in developing and maintaining change in health systems.

124 In this model the first phase is called 'unfreezing'. That is, what current beliefs, attitudes, or systems need to be unfrozen or changed? How can this best be accomplished? If clinicians or patients aren't convinced of the need for change it is unlikely to be accepted.

125 The second phase is called 'movement' and is the change itself. There are often unforeseen consequences or complexities encountered and again the goodwill of those involved will soon be lost if the change cannot be rapidly adjusted in response to feedback. The change needs to be developed with clinicians likely to be delivering the new model and the patients and carers involved.

126 The final phase is 'refreezing' which is supporting the changes and seeing if they are achieving what was intended. To oversee dramatic changes there needs to be a body responsible for these three phases of change that would ideally involve consumers, clinicians and health administrators. There is a role for research to develop and evaluate change to the mental health system.

sign here ► 

print name Dr Gerard Ingham

date 5th July 2019

Royal Commission into
Victoria's Mental Health System

ATTACHMENT GI-1

This is the attachment marked 'GI-1' referred to in the witness statement of Dr Gerard Ingham dated 5th July 2019.

Fax: 03-53481447

Daylesford VIC 3460

Dr Gerard Ingham

Objective

Experience

1987 - 1990

Hospital Resident

- Positions at Victorian and United Kingdom hospitals

1991–2019

Rural General Practitioner

- I am one of four practice principals at Springs Medical that formed from the amalgamation of two previous smaller GP businesses. In January 2010 we moved into a purpose-built facility opposite Daylesford Hospital. In addition to 16 general practitioners, Springs Medical accommodates practice nurses, physiotherapists, psychologists, podiatrist, exercise physiologist, audiologist, diabetes educator and visiting general surgeons. In 2018 we were awarded RACGP Victorian practice of the year.
- Special clinical interests include counselling, methadone prescribing, HIV medicine/prescribing (Alfred Hospital).
- I involve myself in all facets of rural general practice including inpatient care at Daylesford hospital, nursing home visits and home visits. Through participation in after-hours roster at Daylesford Hospital I assist in the provision of emergency care for the 7000 people in the district. The nearest regional facility is 45km away in Ballarat.
- Obstetric care at Daylesford Hospital until the service was closed in 2008.

1992 - 2019

GP Academic – Supervisor, Educator, Researcher

- As a GP Supervisor I have taught GP Registrars in my practice since 1992.
- I have taught medical students intermittently for many years and currently am involved in teaching Deakin University students during their 40-week placement in our practice
- As Director of Training for Victoria Felix Medical Education 2003 – 2004, I was responsible for the delivery of GP vocational training in NW Victoria following regionalisation of GP training.
- As a Medical Educator (RACGP Training Program, then Victoria Felix Medical Education, then Beyond Medical Education and now Murray Coast City Country) I have run educational workshops for both GP Registrars and GP Supervisors as well as keynote presentations in other regions of Australia.
- For the Australian General Practice Training Program in 2007 I co-ordinated the development of a GP Supervisor curriculum and in 2009 an orientation manual for new Medical Educators. I have presented yearly at the annual GPET convention on a wide variety of topics relating to postgraduate GP training.
- I codeveloped Random Case Analysis as a supervision method of GP

registrars in Australia. I have undertaken two further research projects on the use of RCA in supervision and assessment.

- I was awarded GPET Medical Educator of the Year in 2014. This was the peak award for Medical Educators in vocational GP training.
- Currently undertaking RACGP ERG grant funded research into a safety checklist for registrars in early GP training with a paper recently accepted for publication with Education for Primary Care

Other Positions

- Chairperson Medical Staff Group Daylesford Hospital (1992 – 2005, 2009-current)
- Senior Lecturer Melbourne University (1998 – 2002) Department of General Practice
- Board Member Victoria Faculty RACGP (2004 to 2006)
- Inaugural co-ordinator Australian Medical Educators Network 2004 – 2005 and member of the executive. This organisation represented medical educators in the Australian General Practice Training Program and was the forerunner to GPME.
- Professional Services Review Tribunal Panel Member 2003 to 2010 and reappointed 2012 as a Deputy Director.
- Medicare Taskforce 2016-2019 Principles and Rules Subcommittee

Education

1986 M.B.,B.S. (University of Melbourne)
1991 D.R.A.N.Z.C.O.G.
1994 F.R.A.C.G.P.
2012 GCHPE (Monash University)

1986 M.B.,B.S. (University of Melbourne)
1991 D.R.A.N.Z.C.O.G.
1994 F.R.A.C.G.P.
2012 GCHPE (Monash University)

Journal Publications

1. Ingham G. Avoiding 'consultation interruptus' - a model for the daily supervision and teaching of general practice registrars. Australian family physician. 2012;41(8):627-9.
2. Morgan S, Ingham G. Random case analysis - a new framework for Australian general practice training. Australian family physician. 2013;42(1-2):69-73.
3. Morgan S, Ingham G, Kinsman L, Fry J. Clinical supervision using random case analysis in general practice training. Education for primary care : an official publication of the Association of Course Organisers, National Association of GP Tutors, World Organisation of Family Doctors. 2015;26(1):40-6.
4. Ingham G, O'Meara P, Fry J, Crothers N. GP supervisors--an investigation into their motivations and teaching activities. Australian family physician. 2014;43(11):808-12.
5. Ingham G, Morgan S, Kinsman L, Fry J. Are GP supervisors confident they can assess registrar competence and safety, and what methods do they use? Australian family physician. 2015;44(4):236-40.
6. Ingham G, Fry J, Ward B. Adding random case analysis to direct observation (ARCADO) - Updating the external clinical teaching visit to improve general practice registrar assessments. Australian family physician. 2016;45(12):918-20.
7. Ingham G, Fry J, Morgan S, Ward B. ARCADO - Adding random case analysis to direct observation in workplace-based formative assessment of general practice registrars. BMC medical education. 2015;15:218.
8. Morgan S, Ingham G, Wearne S, Saltis T, Canalese R, McArthur L. Towards an educational continuing professional development (EdCPD) curriculum for Australian general practice supervisors. Australian family physician. 2015;44(11):854-8.
9. Ingham G, Fry J. A blended supervision model in Australian General Practice Training. Australian Family physician 2016; 45 (5) 343-346.

Royal Commission into
Victoria's Mental Health System

ATTACHMENT GI-2

This is the attachment marked 'GI-2' referred to in the witness statement of Dr Gerard Ingham dated 5th July 2019.

Royal Commission into Victoria's Mental Health System

RACGP

GENERAL PRACTICE HEALTH OF THE NATION

2018

An annual insight into the state of general practice

Current and emerging issues

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

Common health issues experienced by patients

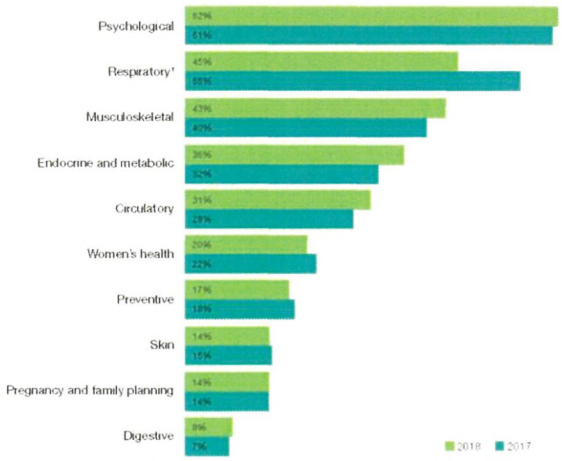
Psychological issues (eg depression, mood disorders, anxiety) remain the most common health issue managed by GPs. These results confirm the *General Practice: Health of the Nation 2017* report, which featured almost identical findings.

Figure 2 suggests that patients may be choosing a GP with particular personal characteristics to manage different health concerns. For example, younger and female GPs are more likely to provide pregnancy and family planning care.

It should be noted that most GPs manage patients with multiple health concerns, with around one in four (23%) of Australians experiencing two or more chronic conditions.[2]

FIGURE 1

Patients talk to their GP about mental health more than any other health issue*



*Showing top 10 of 17 categories.

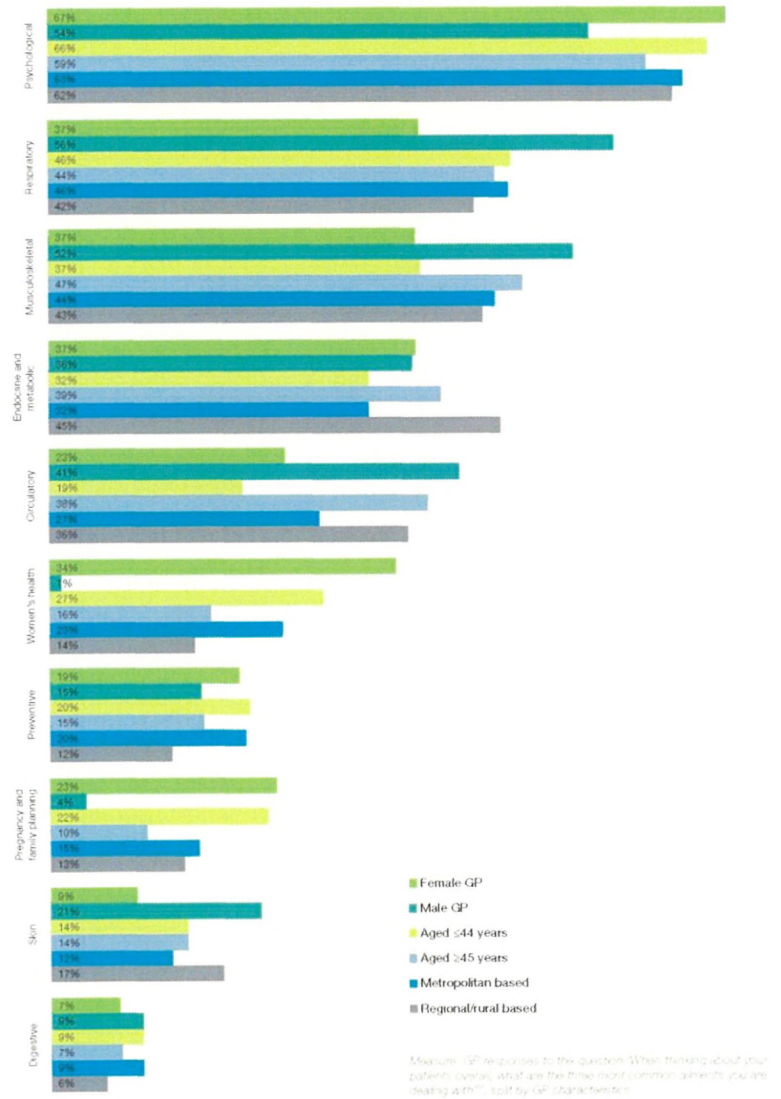
†Difference in respiratory presentations is likely a reflection of survey timing – 2017 was completed during late July (peak influenza season), 2018 was completed early April.

Measure: GP responses to the question 'When thinking about your patient overall, what are the three most common ailments you are dealing with?', showing results from 2017 and 2018.

Source: BY Sweeney, General Practice, May 2018.

FIGURE 2

Commonly managed health concerns vary according to a practitioner's personal characteristics



Measure: GP responses to the question 'When thinking about your patients overall, what are the three most common ailments you are dealing with?', split by GP characteristics

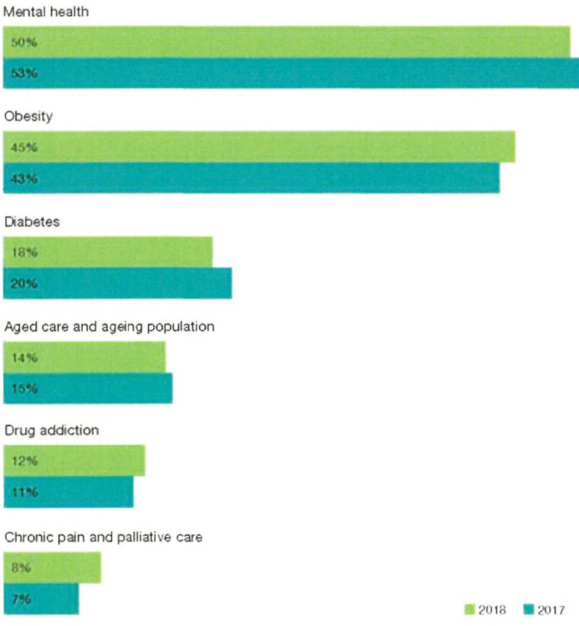
Source: Ed Sweeney, General Practice: May 2018

In addition to being the most common reason patients visit their GP, mental health was also identified as the health issue causing GPs the most concern for the future, followed by obesity.

Mental health continues to be the number one health issue causing GPs the most concern for the future

FIGURE 3

Mental health and obesity are causing GPs the most concern for the future*



*Showing top six HEF response categories

Measure: GP responses to the question 'What are the emerging patient health issues causing you the most concern for the future?'

Source: Ki Sweeney, General Practice, May 2018

General practice access

Patient access to and experience of general practice

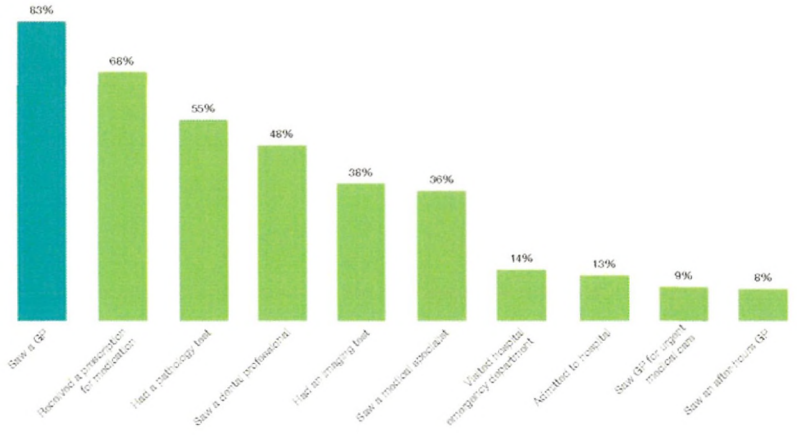
Australians access general practice more than any other area of the health system,[5] with over 87.8% of the population visiting their GP at least once each year.[1]

Patients report they visit their GP more than they receive prescriptions, have pathology or imaging tests, or see non-GP specialists.[6]

87.8%
of the population visit their GP each year[1]

FIGURE 6

Patients see their GP more than any other health professional



Measure: Patient responses to the question 'Since [month] last year, have you [insert category]?'
Source: Australian Bureau of Statistics, Patient experience in Australia: Summary of findings, 2016-17, Cat no. 4839.0, Canberra: ABS, 2017

The majority of patients report having a preferred GP, and that they are able to see that GP when needed.[5]

More than four out of five patients (84%) report that they visit their GP multiple times a year, including 12% who report seeing their GP 12 or more times. Female patients visit their GP more frequently than male patients.[5]

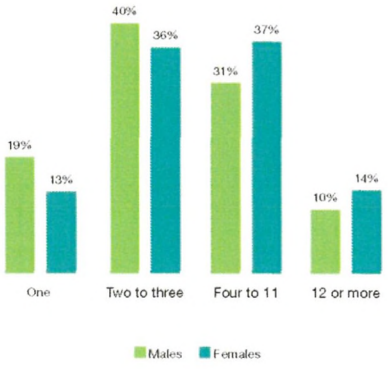
General Practice: Health of the Nation 2017 showed that the more disadvantaged a patient (in socioeconomic terms), the more frequently they visited their GP. This trend is seen again in the most recent data.[5]

Patient age also has an effect on frequency of GP visits, with patients visiting more frequently as they get older.[5]

78.2%
of patients have a preferred GP[5]

FIGURE 7

Most patients visit their GP multiple times a year

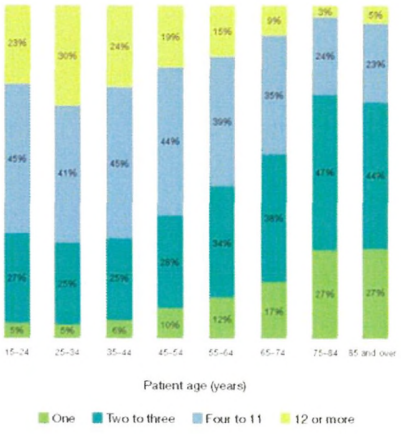


Measure: Patient responses to the question 'Since [month] last year, how many times did you see a GP for your own health?', split by patient gender

Source: Australian Bureau of Statistics, Patient experience in Australia: Summary of findings, 2016–17, Cat no. 4839.0, Canberra: ABS, 2017

FIGURE 8

Older patients visit their GP much more frequently than younger patients



Measure: Patient responses to the question 'Since [month] last year, how many times did you see a GP for your own health?', split by patient age

Source: Australian Bureau of Statistics, Patient experience in Australia: Summary of findings, 2016–17, Cat no. 4839.0, Canberra: ABS, 2017

Royal Commission into
Victoria's Mental Health System

ATTACHMENT GI-3

This is the attachment marked 'GI-3' referred to in the witness statement of Dr Gerard Ingham dated 5th July 2019

THE UNIVERSITY OF SYDNEY

A decade of Australian general practice activity

2006–07 to 2015–16

Family Medicine Research Centre

GENERAL PRACTICE SERIES **N°41**

A decade of Australian general practice activity 2006–07 to 2015–16

BEACH

Bettering the Evaluation and Care of Health

Helena Britt, Graeme C Miller, Clare Bayram, Joan Henderson, Lisa Valenti,
Christopher Harrison, Ying Pan, Janice Charles,
Allan J Pollack, Timothy Chambers, Julie Gordon, Carmen Wong,

THE UNIVERSITY OF SYDNEY

Family Medicine Research Centre
Sydney School of Public Health
University of Sydney

GENERAL PRACTICE SERIES NUMBER 41
September 2016

SYDNEY UNIVERSITY PRESS

Published 2016 by Sydney University Press
SYDNEY UNIVERSITY PRESS
University of Sydney Library
sydney.edu.au/sup

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This publication is part of the General practice series based on results from the BEACH program conducted by the Family Medicine Research Centre (FMRC). A complete list of the Centre's publications is available from the FMRC's website <sydney.edu.au/medicine/fmrc>.

ISSN 1442-3022
ISBN 9781743325155 (print)
ISBN 9781743325162 (online)

Suggested citation
Britt H, Miller GC, Bayram C, Henderson J, Valenti L, Harrison C, Pan Y, Charles J, Pollack AJ, Chambers T, Gordon J, Wong C. A decade of Australian general practice activity 2006–07 to 2015–16. General practice series no. 41. Sydney: Sydney University Press, 2016
Available at <purl.library.usyd.edu.au/sup/9781743325155>

Keywords
Australia, delivery of health care/statistics and numerical data, family practice/statistics and numerical data, general practice, health services utilization, healthcare surveys/methods.

Companion publication
Britt H, Miller GC, Henderson J, Bayram C, Harrison C, Valenti L, Pan Y, Charles J, Pollack AJ, Wong C, Gordon J. General practice activity in Australia 2015–16. General practice series no. 40. Sydney: Sydney University Press, 2016
Available at <purl.library.usyd.edu.au/sup/9781743325131>

Cover design by Miguel Yamin

Printed in Australia

Table 6.1: Characteristics of patients at encounters, 2006–07 to 2015–16

	Rate per 100 encounters (95% CI)										
	2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	2012–13	2013–14	2014–15	2015–16	↑↓[a]
Patient characteristics	(*n* = 91,805)	(*n* = 95,898)	(*n* = 96,688)	(*n* = 101,349)	(*n* = 95,839)	(*n* = 99,030)	(*n* = 98,564)	(*n* = 95,879)	(*n* = 98,879)	(*n* = 97,398)	
Sex (missing *n*)[b]	(765)	(876)	(867)	(931)	(888)	(842)	(823)	(927)	(880)	(828)	
Male	43.7 (42.9–44.5)	42.9 (42.1–43.7)	42.4 (41.5–43.3)	43.1 (42.3–43.9)	42.9 (42.0–43.7)	43.5 (42.7–44.3)	43.3 (42.5–44.1)	43.1 (42.2–44.0)	42.9 (42.0–43.7)	43.4 (42.5–44.2)	—
Female	56.3 (55.5–57.1)	57.1 (56.3–57.9)	57.6 (56.7–58.5)	56.9 (56.1–57.7)	57.1 (56.3–58.0)	56.5 (55.7–57.3)	56.7 (55.9–57.5)	56.9 (56.0–57.8)	57.1 (56.3–58.0)	56.6 (55.8–57.5)	—
Age group (missing *n*)[b]	(779)	(784)	(704)	(781)	(771)	(793)	(825)	(814)	(855)	(847)	
< 1 year	1.8 (1.7–2.0)	2.0 (1.8–2.1)	2.0 (1.8–2.1)	2.1 (1.9–2.3)	1.8 (1.7–2.0)	1.8 (1.7–1.9)	1.8 (1.7–1.9)	1.9 (1.7–2.0)	1.9 (1.7–2.0)	1.7 (1.6–1.9)	—
1–4 years	4.1 (3.9–4.4)	4.3 (4.1–4.6)	4.2 (4.0–4.4)	4.7 (4.5–5.0)	4.6 (4.3–4.9)	4.4 (4.2–4.7)	4.5 (4.2–4.8)	4.2 (3.9–4.5)	4.5 (4.2–4.7)	4.3 (4.0–4.6)	—
5–14 years	5.6 (5.3–5.9)	5.5 (5.2–5.8)	5.3 (5.1–5.6)	5.7 (5.4–6.0)	5.5 (5.2–5.8)	5.3 (5.1–5.6)	5.2 (4.9–5.5)	5.1 (4.8–5.4)	5.2 (4.9–5.5)	5.3 (5.0–5.6)	—
15–24 years	9.1 (8.6–9.5)	9.5 (9.0–9.9)	8.4 (8.0–8.9)	8.6 (8.2–9.0)	8.7 (8.3–9.1)	8.5 (8.1–8.9)	8.2 (7.7–8.6)	7.7 (7.3–8.1)	8.2 (7.8–8.6)	7.9 (7.5–8.3)	↓
25–44 years	23.3 (22.6–24.0)	23.4 (22.7–24.1)	21.4 (20.7–22.1)	22.9 (22.1–23.6)	22.8 (22.0–23.5)	22.6 (21.7–23.4)	22.2 (21.4–23.1)	21.5 (20.7–22.3)	22.3 (21.4–23.1)	22.8 (21.9–23.7)	—
45–64 years	28.2 (27.6–28.7)	28.1 (27.5–28.6)	29.1 (28.5–29.6)	28.2 (27.7–28.8)	27.7 (27.1–28.2)	27.7 (27.1–28.3)	27.6 (27.0–28.2)	27.1 (26.6–27.7)	27.3 (26.7–27.8)	27.2 (26.6–27.8)	—
65–74 years	12.7 (12.2–13.2)	12.6 (12.1–13.1)	13.4 (12.9–13.9)	12.7 (12.2–13.2)	13.3 (12.7–13.8)	13.4 (12.8–13.9)	14.2 (13.6–14.7)	14.9 (14.4–15.5)	14.2 (13.7–14.8)	14.7 (14.1–15.3)	↑
75+ years	15.2 (14.4–16.0)	14.7 (13.9–15.5)	16.2 (15.4–17.0)	15.1 (14.3–16.0)	15.7 (14.8–16.6)	16.3 (15.3–17.3)	16.3 (15.4–17.3)	17.6 (16.6–18.5)	16.5 (15.6–17.4)	16.0 (15.0–16.9)	—

(continued)

Table 6.1 (continued): Characteristics of patients at encounters, 2006–07 to 2015–16

Patient characteristics	Rate per 100 encounters (95% CI) 2006–07 (*n* = 91,805)	2007–08 (*n* = 95,898)	2008–09 (*n* = 96,688)	2009–10 (*n* = 101,349)	2010–11 (*n* = 95,839)	2011–12 (*n* = 99,030)	2012–13 (*n* = 98,564)	2013–14 (*n* = 95,879)	2014–15 (*n* = 98,728)	2015–16 (*n* = 97,398)	↑↓(a)
Other characteristics(b)											
New patient to practice	8.7 (7.9–9.4)	8.6 (7.8–9.4)	5.9 (5.5–6.3)	7.7 (7.1–8.3)	7.3 (6.6–7.9)	7.9 (7.0–8.8)	7.2 (6.6–7.9)	6.6 (6.0–7.1)	6.3 (5.8–6.9)	7.3 (6.5–8.0)	—
Commonwealth concession card	45.4 (43.8–46.9)	45.5 (44.0–47.1)	45.7 (44.3–47.0)	45.9 (44.3–47.4)	44.9 (43.3–46.4)	44.7 (43.1–46.2)	46.0 (44.4–47.6)	43.5 (41.9–45.1)	46.2 (44.6–47.9)	46.2 (44.4–47.9)	—
Repatriation Health Card	3.4 (3.2–3.7)	3.1 (2.8–3.3)	3.1 (2.9–3.4)	2.9 (2.7–3.2)	2.5 (2.3–2.7)	2.4 (2.2–2.7)	2.3 (2.1–2.5)	2.2 (2.0–2.4)	2.1 (2.0–2.3)	1.8 (1.7–2.0)	↓
Non-English-speaking background	8.0 (6.5–9.5)	11.0 (9.2–12.8)	10.4 (8.7–12.1)	9.0 (7.3–10.6)	10.7 (8.9–12.5)	11.3 (9.4–13.2)	12.0 (10.0–14.0)	10.0 (8.2–11.8)	10.2 (8.6–11.9)	10.5 (8.5–12.5)	—
Aboriginal person and/or Torres Strait Islander	1.0 (0.7–1.3)	1.0 (0.8–1.3)	0.9 (0.6–1.1)	1.3 (1.0–1.6)	1.2 (0.9–1.5)	1.6 (1.2–1.9)	1.5 (1.2–1.9)	1.7 (1.3–2.1)	1.7 (1.3–2.1)	1.5 (1.2–1.8)	—

(a) The direction and type of change from 2006–07 to 2015–16 is indicated for each result: ↑/↓ indicates a statistically significant change (increase or decrease) in 2015–16 compared with 2006–07; — indicates there was no significant change in 2015–16 compared with 2006–07.

(b) Missing data removed.

Note: CI – confidence interval.

Table 6.2: Number of patient reasons for encounter, 2006–07 to 2015–16

Number of reasons for encounter	Rate per 100 encounters (95% CI) 2006–07 (*n* = 91,805)	2007–08 (*n* = 95,898)	2008–09 (*n* = 96,688)	2009–10 (*n* = 101,349)	2010–11 (*n* = 95,839)	2011–12 (*n* = 99,030)	2012–13 (*n* = 98,564)	2013–14 (*n* = 95,879)	2014–15 (*n* = 98,728)	2015–16 (*n* = 97,398)	↑↓(a)
One RFE	60.6 (59.4–61.9)	58.9 (57.7–60.2)	56.6 (55.5–57.8)	57.7 (56.5–58.9)	57.6 (56.3–58.8)	57.9 (56.6–59.1)	58.0 (56.8–59.3)	57.7 (56.4–59.0)	58.5 (57.3–59.7)	58.7 (57.4–60.0)	—
Two RFEs	27.9 (27.2–28.7)	29.1 (28.5–29.8)	30.3 (29.6–30.9)	29.7 (29.0–30.4)	29.4 (28.7–30.1)	29.6 (28.9–30.3)	29.4 (28.7–30.1)	29.4 (28.7–30.1)	29.4 (28.6–30.1)	29.6 (28.8–30.5)	↑
Three RFEs	11.4 (10.7–12.2)	11.9 (11.2–12.6)	13.1 (12.4–13.8)	12.6 (11.9–13.4)	13.0 (12.3–13.8)	12.6 (11.8–13.3)	12.5 (11.9–13.2)	12.9 (12.1–13.7)	12.1 (11.4–12.8)	11.7 (11.1–12.4)	—

(a) The direction and type of change from 2006–07 to 2015–16 is indicated for each result: ↑/↓ indicates a statistically significant change; and — indicates no significant difference between 2006–07 and 2015–16.

Note: CI – confidence interval; RFE – reason for encounter.

Table 6.3: Patient reasons for encounter by ICPC-2 component, 2006–07 to 2015–16

ICPC-2 component	Rate per 100 encounters (95% CI) 2006–07 (*n* = 91,805)	2007–08 (*n* = 95,898)	2008–09 (*n* = 96,688)	2009–10 (*n* = 101,349)	2010–11 (*n* = 95,839)	2011–12 (*n* = 99,030)	2012–13 (*n* = 98,564)	2013–14 (*n* = 95,879)	2014–15 (*n* = 98,728)	2015–16 (*n* = 97,398)	↑↓ (a)
Symptoms and complaints	65.2 (63.4–67.1)	65.1 (63.2–67.0)	66.3 (64.6–68.0)	65.1 (63.1–67.0)	66.8 (64.7–68.9)	66.6 (64.7–68.5)	64.3 (62.4–66.2)	62.5 (60.6–64.4)	65.6 (63.7–67.4)	63.8 (61.8–65.8)	—
Diagnosis, diseases	30.5 (28.9–32.2)	30.4 (28.9–31.9)	30.3 (28.8–31.8)	30.7 (29.1–32.3)	30.9 (29.4–32.3)	29.3 (27.8–30.8)	29.8 (28.3–31.4)	29.7 (28.1–31.2)	28.7 (27.3–30.0)	27.6 (26.2–29.1)	—
Infections	8.0 (7.5–8.6)	7.9 (7.4–8.4)	7.9 (7.4–8.4)	7.9 (7.4–8.5)	7.7 (7.2–8.2)	7.3 (6.8–7.7)	7.6 (7.1–8.1)	6.8 (6.3–7.3)	7.0 (6.6–7.4)	6.6 (6.2–7.0)	↓
Injuries	4.3 (4.1–4.5)	4.5 (4.3–4.7)	4.3 (4.1–4.5)	4.6 (4.4–4.9)	4.4 (4.2–4.6)	4.4 (4.2–4.6)	4.2 (4.0–4.4)	4.5 (4.3–4.8)	4.4 (4.1–4.6)	4.3 (4.1–4.5)	—
Neoplasms	1.2 (1.0–1.3)	1.2 (1.0–1.3)	1.0 (0.9–1.1)	1.1 (1.0–1.2)	1.1 (1.0–1.2)	1.0 (0.9–1.1)	1.0 (0.9–1.2)	1.0 (0.9–1.1)	1.0 (0.9–1.1)	1.0 (0.9–1.1)	—
Congenital anomalies	0.3 (0.2–0.3)	0.3 (0.2–0.3)	0.2 (0.2–0.3)	0.3 (0.2–0.3)	0.2 (0.2–0.3)	0.2 (0.2–0.3)	0.2 (0.2–0.3)	0.2 (0.2–0.3)	0.2 (0.2–0.3)	0.2 (0.2–0.3)	—
Other diagnoses, diseases	16.8 (15.6–18.0)	16.6 (15.4–17.7)	16.8 (15.7–18.0)	16.8 (15.6–17.9)	17.4 (16.4–18.5)	16.4 (15.3–17.5)	16.8 (15.7–17.9)	17.1 (15.9–18.2)	16.1 (15.1–17.1)	15.5 (14.4–16.6)	—
Diagnostic and preventive procedures	24.8 (23.8–25.7)	25.6 (24.7–26.5)	26.9 (26.0–27.8)	27.0 (26.0–27.9)	25.1 (24.1–26.1)	24.6 (23.6–25.5)	24.6 (23.6–25.6)	26.4 (25.3–27.4)	23.0 (22.2–23.8)	24.0 (23.0–24.9)	—
Medications, treatments and therapeutics	14.2 (13.5–14.8)	15.1 (14.3–15.8)	15.3 (14.6–15.9)	14.1 (13.4–14.8)	14.5 (13.8–15.2)	15.0 (14.2–15.8)	15.4 (14.7–16.2)	16.2 (15.5–17.0)	16.1 (15.3–16.9)	16.1 (15.4–16.8)	↑
Test results	6.9 (6.5–7.3)	7.6 (7.2–8.1)	7.8 (7.4–8.2)	8.1 (7.7–8.6)	8.0 (7.5–8.5)	8.5 (8.1–9.0)	9.1 (8.6–9.5)	9.4 (8.9–9.9)	9.5 (9.0–9.9)	10.2 (9.7–10.7)	↑
Referrals and other RFEs	7.3 (6.9–7.8)	6.8 (6.4–7.2)	7.5 (7.0–7.9)	7.6 (7.2–8.1)	7.5 (7.1–7.9)	7.7 (7.3–8.2)	8.1 (7.5–8.6)	7.9 (7.4–8.4)	7.5 (7.1–7.9)	7.6 (7.2–8.0)	—
Administrative	1.9 (1.7–2.0)	2.4 (2.2–2.5)	2.4 (2.2–2.6)	2.4 (2.2–2.6)	2.6 (2.4–2.8)	3.0 (2.7–3.2)	3.2 (3.0–3.4)	3.3 (3.1–3.5)	3.3 (3.1–3.5)	3.8 (3.5–4.1)	↑
Total RFEs	150.8 (148.9–152.7)	153.0 (151.1–154.8)	156.5 (154.7–158.2)	155.0 (153.1–156.8)	155.5 (153.5–157.5)	154.7 (152.8–156.7)	154.5 (152.7–156.3)	155.3 (153.3–157.3)	153.6 (151.8–155.4)	153.1 (151.2–155.0)	—

(a) The direction and type of change from 2006–07 to 2015–16 is indicated for each result: ↑/↓ indicates a statistically significant change (increase or decrease) in 2015–16 compared with 2006–07; and — indicates there was no significant change in 2015–16 compared with 2006–07.

Note: CI – confidence interval; ICPC-2 – International Classification of Primary Care - Version 2; RFE – reason for encounter.

Table 6.4: Patient reasons for encounter by ICPC-2 chapter, 2006–07 to 2015–16

	Rate per 100 encounters (95% CI)										
	2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	2012–13	2013–14	2014–15	2015–16	↑↓[a]
ICPC-2 chapter	(*n* = 91,805)	(*n* = 95,898)	(*n* = 96,688)	(*n* = 101,349)	(*n* = 95,839)	(*n* = 99,030)	(*n* = 98,564)	(*n* = 95,879)	(*n* = 98,728)	(*n* = 97,398)	
General & unspecified	37.8 (36.7–38.9)	40.1 (39.0–41.3)	40.7 (39.7–41.8)	42.8 (41.6–44.0)	41.1 (39.8–42.4)	42.3 (41.1–43.6)	44.6 (43.3–45.8)	45.3 (43.9–46.6)	45.0 (43.8–46.2)	46.3 (45.0–47.6)	↑
Respiratory	20.7 (19.9–21.6)	20.6 (19.8–21.5)	22.0 (21.2–22.9)	22.8 (21.9–23.8)	21.7 (20.9–22.6)	21.3 (20.3–22.2)	20.8 (19.9–21.7)	19.1 (18.2–19.9)	19.3 (18.4–20.1)	20.2 (19.3–21.2)	—
Musculoskeletal	16.1 (15.6–16.6)	15.4 (14.9–15.9)	16.1 (15.5–16.6)	15.4 (14.7–16.2)	15.3 (14.9–15.8)	15.8 (15.3–16.3)	15.8 (15.2–16.3)	15.6 (15.1–16.1)	15.9 (15.5–16.4)	15.3 (14.8–15.9)	—
Skin	15.7 (15.1–16.3)	15.4 (14.7–16.0)	15.0 (14.6–15.5)	14.7 (14.2–15.3)	15.2 (14.8–15.7)	15.0 (14.4–15.5)	14.9 (14.3–15.5)	15.8 (15.1–16.4)	15.1 (14.6–15.6)	15.3 (14.7–15.9)	—
Digestive	10.1 (9.7–10.5)	10.3 (10.0–10.7)	9.8 (9.4–10.1)	9.8 (9.5–10.1)	10.2 (9.8–10.6)	10.2 (9.9–10.6)	9.5 (9.1–9.9)	9.7 (9.4–10.1)	9.8 (9.5–10.2)	9.3 (8.9–9.6)	↓
Psychological	7.4 (7.1–7.8)	7.8 (7.4–8.2)	8.6 (8.2–9.1)	8.4 (8.0–8.9)	9.0 (8.6–9.4)	8.9 (8.4–9.4)	9.3 (8.8–9.8)	9.3 (8.8–9.7)	9.5 (9.0–10.0)	9.0 (8.6–9.5)	↑
Circulatory	11.2 (10.7–11.8)	11.2 (10.6–11.8)	11.5 (10.9–12.0)	10.0 (9.5–10.5)	10.5 (10.0–11.1)	10.2 (9.6–10.7)	9.1 (8.7–9.6)	10.0 (9.4–10.6)	8.8 (8.3–9.2)	8.2 (7.7–8.6)	↓
Endocrine & metabolic	6.4 (6.1–6.8)	6.5 (6.1–6.8)	6.9 (6.5–7.3)	6.1 (5.8–6.4)	6.6 (6.2–6.9)	6.3 (5.9–6.6)	6.2 (5.9–6.6)	6.3 (5.9–6.7)	5.8 (5.5–6.1)	5.9 (5.5–6.3)	—
Female genital system	5.1 (4.7–5.4)	5.2 (4.8–5.6)	5.3 (4.9–5.6)	4.7 (4.4–5.1)	5.0 (4.6–5.3)	4.8 (4.4–5.1)	4.4 (4.0–4.7)	4.7 (4.4–5.0)	4.6 (4.2–5.0)	4.6 (4.2–4.9)	—
Neurological	4.9 (4.7–5.2)	4.8 (4.6–5.0)	4.8 (4.6–5.0)	4.4 (4.1–4.6)	4.6 (4.4–4.9)	4.5 (4.3–4.8)	4.4 (4.2–4.6)	4.3 (4.1–4.5)	4.5 (4.3–4.7)	4.4 (4.2–4.7)	↓
Ear	3.5 (3.4–3.7)	3.6 (3.4–3.8)	3.7 (3.5–3.9)	3.6 (3.4–3.8)	3.7 (3.5–3.9)	3.4 (3.3–3.6)	3.6 (3.4–3.7)	3.4 (3.2–3.5)	3.4 (3.2–3.5)	3.3 (3.1–3.5)	—
Pregnancy & family planning	3.3 (3.0–3.6)	3.2 (3.0–3.5)	3.1 (2.8–3.3)	3.4 (3.2–3.7)	3.4 (3.1–3.7)	3.3 (3.1–3.6)	3.3 (3.0–3.5)	3.0 (2.8–3.2)	3.5 (3.2–3.8)	3.0 (2.7–3.2)	—
Urology	2.6 (2.4–2.7)	2.5 (2.4–2.7)	2.7 (2.5–2.8)	2.6 (2.5–2.8)	2.7 (2.6–2.9)	2.6 (2.4–2.7)	2.7 (2.6–2.9)	2.8 (2.6–2.9)	2.7 (2.5–2.8)	2.7 (2.5–2.8)	—

(continued)

Table 6.4 (continued): Patient reasons for encounter by ICPC-2 chapter, 2006–07 to 2015–16

ICPC-2 chapter	Rate per 100 encounters (95% CI) 2006–07 (*n* = 91,805)	2007–08 (*n* = 95,898)	2008–09 (*n* = 96,688)	2009–10 (*n* = 101,349)	2010–11 (*n* = 95,839)	2011–12 (*n* = 99,030)	2012–13 (*n* = 98,564)	2013–14 (*n* = 95,879)	2014–15 (*n* = 98,728)	2015–16 (*n* = 97,398)	↑/↓[a]
Eye	2.5 (2.4–2.7)	2.5 (2.4–2.6)	2.6 (2.4–2.7)	2.3 (2.2–2.5)	2.4 (2.3–2.6)	2.3 (2.1–2.4)	2.0 (1.9–2.2)	2.0 (1.9–2.2)	2.1 (2.0–2.2)	2.1 (2.0–2.2)	↓
Blood & blood-forming organs	1.2 (1.1–1.4)	1.4 (1.2–1.5)	1.4 (1.3–1.6)	1.4 (1.2–1.5)	1.6 (1.4–1.8)	1.7 (1.5–1.8)	1.7 (1.5–1.9)	1.7 (1.6–1.9)	1.5 (1.3–1.7)	1.4 (1.2–1.5)	—
Male genital system	1.2 (1.1–1.3)	1.2 (1.1–1.3)	1.3 (1.2–1.4)	1.2 (1.1–1.4)	1.3 (1.2–1.3)	1.2 (1.1–1.3)	1.2 (1.1–1.3)	1.2 (1.1–1.3)	1.1 (1.0–1.3)	1.1 (1.0–1.2)	—
Social	0.9 (0.8–1.0)	1.1 (1.0–1.2)	0.9 (0.9–1.0)	1.2 (1.1–1.3)	1.0 (0.9–1.1)	0.9 (0.8–1.0)	1.1 (1.0–1.2)	1.1 (1.0–1.2)	1.0 (0.9–1.1)	1.0 (0.9–1.1)	—
Total RFEs	**150.8 (148.9–152.7)**	**153.0 (151.1–154.8)**	**156.5 (154.7–158.2)**	**155.0 (153.1–156.8)**	**155.5 (153.5–157.5)**	**154.7 (152.8–156.7)**	**154.5 (152.7–156.3)**	**155.3 (153.3–157.3)**	**153.6 (151.8–155.4)**	**153.1 (151.2–155.0)**	—

(a) The direction and type of change from 2006–07 to 2015–16 is indicated for each result: ↑/↓ indicates a statistically significant change (increase or decrease) in 2015–16 compared with 2006–07; ↑/↓ indicates a marginally significant change in 2015–16 compared with 2006–07; and — indicates there was no significant change in 2015–16 compared with 2006–07.

Note: CI – confidence interval; ICPC-2 – International Classification of Primary Care - Version 2; RFE – reason for encounter.

Table 6.5: Proportion of encounters with at least one patient reason for encounter by ICPC-2 chapter, 2006–07 to 2015–16

ICPC-2 chapter	Proportion (95% CI) 2006–07 (*n* = 91,805)	2007–08 (*n* = 95,898)	2008–09 (*n* = 96,688)	2009–10 (*n* = 101,349)	2010–11 (*n* = 95,839)	2011–12 (*n* = 99,030)	2012–13 (*n* = 98,564)	2013–14 (*n* = 95,879)	2014–15 (*n* = 98,728)	2015–16 (*n* = 97,398)	↑↓[a]
General & unspecified	33.9 (33.1–34.8)	35.7 (34.8–36.6)	35.9 (35.1–36.7)	37.5 (36.6–38.5)	36.0 (35.0–37.0)	37.1 (36.1–38.0)	38.9 (37.9–39.9)	39.3 (38.2–40.3)	39.1 (38.1–40.0)	40.4 (39.4–41.5)	↑
Respiratory	17.6 (17.0–18.3)	17.5 (16.8–18.1)	18.8 (18.1–19.4)	19.2 (18.6–19.9)	18.2 (17.6–18.8)	17.8 (17.1–18.4)	17.6 (16.9–18.3)	16.5 (15.8–17.1)	16.2 (15.6–16.8)	17.1 (16.4–17.8)	—
Skin	14.6 (14.1–15.2)	14.3 (13.7–14.8)	14.1 (13.7–14.5)	13.9 (13.4–14.4)	14.3 (13.8–14.7)	14.0 (13.6–14.5)	14.1 (13.5–14.6)	14.8 (14.2–15.4)	14.3 (13.8–14.8)	14.5 (14.0–15.0)	—
Musculoskeletal	14.9 (14.4–15.3)	14.3 (13.9–14.8)	14.6 (14.2–15.0)	14.2 (13.5–14.9)	14.1 (13.7–14.5)	14.4 (14.0–14.9)	14.4 (14.0–14.9)	14.4 (14.0–14.9)	14.7 (14.3–15.1)	14.1 (13.7–14.6)	—
Digestive	8.8 (8.5–9.1)	9.0 (8.7–9.3)	8.6 (8.3–8.9)	8.6 (8.3–8.8)	8.9 (8.7–9.2)	8.9 (8.6–9.2)	8.4 (8.1–8.7)	8.7 (8.4–8.9)	8.7 (8.4–9.0)	8.2 (7.9–8.5)	↓
Psychological	6.8 (6.4–7.1)	7.1 (6.7–7.4)	7.8 (7.4–8.1)	7.6 (7.2–7.9)	8.1 (7.7–8.4)	7.9 (7.5–8.3)	8.3 (7.9–8.7)	8.4 (8.0–8.8)	8.4 (8.0–8.8)	8.1 (7.7–8.5)	↑
Circulatory	10.7 (10.1–11.2)	10.7 (10.2–11.3)	10.9 (10.4–11.4)	9.5 (9.1–10.0)	10.0 (9.5–10.5)	9.6 (9.1–10.1)	8.7 (8.3–9.2)	9.6 (9.0–10.1)	8.4 (7.9–8.8)	7.9 (7.4–8.3)	↓
Endocrine & metabolic	6.2 (5.8–6.5)	6.2 (5.9–6.5)	6.5 (6.2–6.9)	5.8 (5.5–6.1)	6.3 (6.0–6.6)	6.0 (5.6–6.3)	6.0 (5.7–6.3)	6.0 (5.7–6.4)	5.5 (5.2–5.8)	5.7 (5.3–6.0)	—
Neurological	4.7 (4.5–4.9)	4.6 (4.4–4.8)	4.6 (4.4–4.8)	4.2 (4.0–4.4)	4.5 (4.3–4.7)	4.4 (4.2–4.5)	4.2 (4.0–4.4)	4.1 (3.9–4.3)	4.3 (4.1–4.5)	4.3 (4.1–4.5)	↓
Female genital system	4.7 (4.3–5.0)	4.7 (4.4–5.1)	4.8 (4.5–5.1)	4.3 (4.0–4.6)	4.5 (4.2–4.8)	4.3 (4.0–4.6)	4.0 (3.7–4.3)	4.4 (4.1–4.7)	4.2 (3.9–4.5)	4.2 (3.9–4.5)	—
Ear	3.4 (3.3–3.6)	3.5 (3.3–3.6)	3.6 (3.4–3.8)	3.4 (3.3–3.6)	3.6 (3.4–3.7)	3.3 (3.2–3.5)	3.4 (3.3–3.6)	3.2 (3.1–3.4)	3.3 (3.1–3.4)	3.2 (3.0–3.3)	—
Pregnancy & family planning	3.2 (2.9–3.4)	3.1 (2.9–3.4)	3.0 (2.7–3.2)	3.3 (3.0–3.6)	3.3 (3.0–3.6)	3.2 (3.0–3.4)	3.2 (2.9–3.4)	2.9 (2.7–3.1)	3.4 (3.1–3.7)	2.9 (2.6–3.1)	—
Urology	2.4 (2.2–2.5)	2.3 (2.2–2.4)	2.5 (2.3–2.6)	2.4 (2.3–2.5)	2.4 (2.3–2.5)	2.3 (2.2–2.5)	2.5 (2.4–2.6)	2.5 (2.4–2.7)	2.5 (2.4–2.6)	2.4 (2.3–2.5)	—

(continued)

Table 6.5 (continued): Proportion of encounters with at least one patient reason for encounter by ICPC-2 chapter, 2006–07 to 2015–16

	Proportion (95% CI)										
ICPC-2 chapter	2006–07 (*n* = 91,805)	2007–08 (*n* = 95,898)	2008–09 (*n* = 96,688)	2009–10 (*n* = 101,349)	2010–11 (*n* = 95,839)	2011–12 (*n* = 99,030)	2012–13 (*n* = 98,564)	2013–14 (*n* = 95,879)	2014–15 (*n* = 98,728)	2015–16 (*n* = 97,398)	↑↓[a]
Eye	2.4 (2.2–2.5)	2.4 (2.2–2.5)	2.4 (2.3–2.5)	2.2 (2.1–2.3)	2.2 (2.1–2.4)	2.1 (2.0–2.3)	1.9 (1.8–2.0)	1.9 (1.8–2.1)	2.0 (1.9–2.1)	1.9 (1.8–2.1)	↓
Blood & blood-forming organs	1.2 (1.1–1.4)	1.4 (1.2–1.5)	1.4 (1.3–1.6)	1.4 (1.2–1.5)	1.6 (1.4–1.8)	1.7 (1.5–1.8)	1.7 (1.5–1.9)	1.7 (1.6–1.9)	1.5 (1.3–1.7)	1.4 (1.2–1.5)	—
Male genital system	1.2 (1.1–1.3)	1.2 (1.1–1.3)	1.3 (1.2–1.4)	1.2 (1.1–1.3)	1.2 (1.1–1.3)	1.2 (1.1–1.3)	1.1 (1.0–1.2)	1.2 (1.1–1.3)	1.1 (1.0–1.2)	1.1 (1.0–1.2)	—
Social	0.9 (0.8–0.9)	1.1 (1.0–1.2)	0.9 (0.8–1.0)	1.1 (1.0–1.2)	1.0 (0.9–1.1)	0.9 (0.8–1.0)	1.0 (0.9–1.1)	1.1 (1.0–1.2)	1.0 (0.9–1.1)	1.0 (0.9–1.1)	—

(a) The direction and type of change from 2006–07 to 2015–16 is indicated for each result: ↑/↓ indicates a statistically significant change (increase or decrease) in 2015–16 compared with 2006–07; ↑/↓ indicates a marginally significant change in 2015–16 compared with 2006–07; and — indicates there was no significant change in 2015–16 compared with 2006–07.

Note: CI – confidence interval; ICPC-2 – International Classification of Primary Care - Version 2; RFE – reason for encounter.

Table 6.6: Most frequent patient reasons for encounter, 2006–07 to 2015–16

Patient reason for encounter	Rate per 100 encounters (95% CI)										↑/↓[a]
	2006–07 (*n* = 91,805)	2007–08 (*n* = 95,898)	2008–09 (*n* = 96,688)	2009–10 (*n* = 101,349)	2010–11 (*n* = 95,839)	2011–12 (*n* = 99,030)	2012–13 (*n* = 98,564)	2013–14 (*n* = 95,879)	2014–15 (*n* = 98,728)	2015–16 (*n* = 97,398)	
Prescription – all*	11.8 (11.2–12.4)	12.6 (11.9–13.2)	12.6 (12.0–13.2)	11.6 (11.0–12.2)	12.0 (11.4–12.7)	12.6 (11.9–13.4)	12.7 (12.0–13.5)	13.3 (12.5–14.0)	13.4 (12.7–14.1)	13.5 (12.8–14.1)	↑
Check-up – all*	14.6 (13.9–15.2)	14.5 (13.8–15.1)	15.1 (14.5–15.8)	13.9 (13.3–14.5)	13.7 (13.0–14.3)	13.6 (13.0–14.3)	13.1 (12.4–13.7)	14.2 (13.5–14.8)	13.2 (12.6–13.8)	12.3 (11.7–13.0)	↓
Test results*	6.9 (6.5–7.3)	7.6 (7.2–8.1)	7.8 (7.4–8.2)	8.1 (7.7–8.6)	8.0 (7.5–8.5)	8.5 (8.1–9.0)	9.1 (8.6–9.5)	9.4 (8.9–9.9)	9.5 (9.0–9.9)	10.2 (9.7–10.7)	↑
Cough	5.8 (5.4–6.2)	6.2 (5.8–6.7)	6.8 (6.3–7.2)	6.9 (6.4–7.3)	6.7 (6.3–7.1)	6.7 (6.2–7.1)	6.3 (5.8–6.8)	5.5 (5.1–5.9)	6.3 (5.8–6.7)	6.2 (5.8–6.6)	—
Immunisation/ vaccination – all*	4.3 (3.9–4.7)	4.8 (4.4–5.1)	5.3 (4.8–5.7)	6.5 (5.9–7.0)	4.8 (4.4–5.3)	4.2 (3.8–4.6)	4.6 (4.1–5.0)	5.2 (4.6–5.8)	3.4 (3.1–3.6)	5.0 (4.4–5.6)	—
Administrative procedure – all*	1.9 (1.7–2.0)	2.4 (2.2–2.5)	2.4 (2.2–2.6)	2.4 (2.2–2.6)	2.6 (2.4–2.8)	3.0 (2.7–3.2)	3.2 (3.0–3.4)	3.3 (3.1–3.5)	3.3 (3.1–3.5)	3.8 (3.5–4.1)	↑
Back complaint*	3.2 (3.0–3.4)	3.2 (3.0–3.4)	3.1 (2.9–3.3)	3.1 (2.9–3.3)	3.1 (3.0–3.3)	3.1 (2.9–3.3)	3.2 (3.0–3.4)	3.2 (3.0–3.5)	3.4 (3.2–3.6)	3.1 (2.9–3.3)	—
Rash*	2.8 (2.6–3.0)	2.5 (2.3–2.6)	2.6 (2.5–2.8)	2.4 (2.2–2.6)	2.7 (2.5–2.9)	2.6 (2.5–2.8)	2.6 (2.4–2.8)	2.6 (2.4–2.8)	2.7 (2.5–2.9)	2.7 (2.5–2.9)	—
Throat complaint	3.3 (3.1–3.6)	3.3 (3.0–3.6)	3.2 (2.9–3.5)	2.9 (2.7–3.2)	3.1 (2.8–3.4)	3.2 (2.9–3.5)	2.5 (2.3–2.7)	2.5 (2.3–2.7)	2.9 (2.6–3.1)	2.7 (2.5–3.0)	↓
Blood test – all*	2.5 (2.3–2.7)	2.6 (2.4–2.8)	2.8 (2.6–3.1)	2.4 (2.2–2.7)	2.6 (2.4–2.8)	2.8 (2.6–3.1)	2.9 (2.6–3.1)	2.7 (2.4–2.9)	2.3 (2.1–2.5)	2.2 (2.0–2.5)	—
Fever	1.8 (1.6–2.0)	2.1 (1.8–2.5)	1.9 (1.7–2.1)	2.2 (2.0–2.5)	2.0 (1.8–2.3)	1.9 (1.7–2.1)	1.9 (1.7–2.1)	1.8 (1.5–2.1)	1.8 (1.7–2.0)	2.2 (1.9–2.4)	—
Depression*	2.0 (1.8–2.1)	2.1 (1.9–2.2)	2.1 (1.9–2.2)	2.2 (2.0–2.3)	2.2 (2.1–2.4)	2.2 (2.1–2.4)	2.3 (2.1–2.5)	2.1 (2.0–2.3)	2.3 (2.1–2.4)	2.0 (1.8–2.1)	—
Abdominal pain*	2.2 (2.1–2.3)	2.2 (2.0–2.3)	2.1 (1.9–2.2)	2.0 (1.8–2.1)	2.2 (2.1–2.3)	2.2 (2.1–2.4)	2.0 (1.9–2.2)	2.1 (1.9–2.2)	2.1 (2.0–2.3)	1.9 (1.7–2.0)	↓
Upper respiratory tract infection	2.4 (2.1–2.7)	2.2 (2.0–2.5)	2.3 (2.0–2.6)	2.2 (1.9–2.5)	2.0 (1.8–2.3)	1.9 (1.7–2.1)	2.3 (2.0–2.5)	1.7 (1.5–1.9)	2.1 (1.8–2.4)	1.7 (1.5–1.9)	↓

(continued)

Table 6.6 (continued): Most frequent patient reasons for encounter, 2006–07 to 2015–16

Patient reason for encounter	Rate per 100 encounters (95% CI)										↑(a) ↓
	2006–07 (*n* = 91,805)	2007–08 (*n* = 95,898)	2008–09 (*n* = 96,688)	2009–10 (*n* = 101,349)	2010–11 (*n* = 95,839)	2011–12 (*n* = 99,030)	2012–13 (*n* = 98,564)	2013–14 (*n* = 95,879)	2014–15 (*n* = 98,728)	2015–16 (*n* = 97,398)	
Headache*	1.9 (1.7–2.0)	1.9 (1.8–2.1)	1.9 (1.8–2.1)	1.8 (1.6–1.9)	1.7 (1.6–1.9)	1.8 (1.7–2.0)	1.7 (1.5–1.8)	1.5 (1.4–1.6)	1.7 (1.5–1.8)	1.7 (1.5–1.8)	—
Skin symptom/complaint, other	1.4 (1.3–1.5)	1.4 (1.3–1.5)	1.5 (1.4–1.6)	1.6 (1.5–1.7)	1.5 (1.4–1.7)	1.6 (1.4–1.7)	1.5 (1.4–1.7)	1.8 (1.7–2.0)	1.6 (1.5–1.7)	1.6 (1.5–1.8)	↑
Sneezing/nasal congestion	1.1 (0.9–1.2)	1.4 (1.2–1.6)	1.3 (1.1–1.5)	1.6 (1.3–1.8)	1.4 (1.2–1.7)	1.5 (1.3–1.7)	1.2 (1.1–1.4)	1.2 (1.0–1.4)	1.3 (1.1–1.5)	1.5 (1.3–1.7)	↑
Hypertension/high blood pressure*	2.1 (1.8–2.5)	2.1 (1.8–2.3)	2.1 (1.9–2.4)	2.0 (1.7–2.3)	1.9 (1.7–2.2)	1.8 (1.5–2.0)	1.9 (1.7–2.2)	1.9 (1.6–2.2)	1.5 (1.3–1.7)	1.5 (1.3–1.7)	↓
Anxiety*	1.0 (0.9–1.1)	1.1 (1.0–1.2)	1.1 (1.0–1.3)	1.1 (1.0–1.2)	1.2 (1.1–1.3)	1.2 (1.1–1.3)	1.4 (1.2–1.5)	1.4 (1.3–1.6)	1.5 (1.3–1.6)	1.5 (1.3–1.6)	↑
Other referrals NEC	0.9 (0.8–1.0)	0.9 (0.8–1.0)	1.0 (0.9–1.0)	1.0 (0.9–1.1)	1.1 (1.0–1.2)	1.2 (1.1–1.3)	1.3 (1.2–1.5)	1.4 (1.3–1.5)	1.5 (1.4–1.6)	1.4 (1.3–1.6)	↑
Weakness/tiredness	1.4 (1.2–1.5)	1.4 (1.2–1.5)	1.5 (1.4–1.6)	1.4 (1.3–1.5)	1.3 (1.2–1.5)	1.4 (1.3–1.5)	1.4 (1.3–1.5)	1.4 (1.2–1.5)	1.5 (1.4–1.6)	1.4 (1.3–1.6)	—
Knee symptom/complaint	1.3 (1.2–1.4)	1.3 (1.2–1.4)	1.3 (1.2–1.4)	1.4 (1.2–1.5)	1.3 (1.2–1.4)	1.4 (1.3–1.5)	1.5 (1.4–1.6)	1.3 (1.2–1.4)	1.5 (1.4–1.6)	1.4 (1.3–1.5)	—
Observation/health education/advice/diet – all*	1.7 (1.5–1.8)	1.8 (1.6–2.0)	1.6 (1.5–1.8)	1.9 (1.7–2.1)	1.8 (1.5–2.1)	1.6 (1.5–1.8)	1.6 (1.5–1.8)	1.7 (1.6–1.9)	1.5 (1.4–1.7)	1.4 (1.3–1.5)	↓
Ear pain/earache	1.4 (1.3–1.5)	1.4 (1.3–1.5)	1.4 (1.3–1.6)	1.3 (1.2–1.4)	1.5 (1.3–1.6)	1.3 (1.2–1.4)	1.3 (1.2–1.4)	1.2 (1.1–1.3)	1.2 (1.1–1.3)	1.2 (1.1–1.3)	↓
Diabetes – all*	1.1 (1.0–1.2)	1.3 (1.1–1.4)	1.2 (1.1–1.4)	1.2 (1.0–1.3)	1.4 (1.3–1.6)	1.3 (1.1–1.4)	1.4 (1.3–1.6)	1.4 (1.2–1.5)	1.3 (1.1–1.4)	1.2 (1.0–1.3)	—
Shoulder symptom/complaint	1.2 (1.1–1.3)	1.0 (0.9–1.1)	1.4 (1.3–1.5)	1.1 (1.0–1.3)	1.2 (1.1–1.2)	1.2 (1.1–1.3)	1.3 (1.2–1.4)	1.2 (1.1–1.3)	1.3 (1.2–1.4)	1.2 (1.1–1.3)	—
Foot/toe complaint	1.1 (1.0–1.2)	1.1 (1.0–1.2)	1.1 (1.0–1.2)	1.1 (1.0–1.1)	1.1 (1.0–1.1)	1.1 (1.0–1.2)	1.2 (1.1–1.3)	1.1 (1.0–1.2)	1.1 (1.0–1.2)	1.1 (1.0–1.2)	—
Diarrhoea	1.3 (1.2–1.5)	1.4 (1.3–1.6)	1.3 (1.2–1.4)	1.2 (1.1–1.4)	1.2 (1.1–1.3)	1.4 (1.2–1.5)	1.2 (1.1–1.3)	1.2 (1.1–1.3)	1.3 (1.2–1.4)	1.1 (1.0–1.2)	↓

(continued)

Table 6.6 (continued): Most frequent patient reasons for encounter, 2006–07 to 2015–16

Patient reasons for encounter	Rate per 100 encounters (95% CI)										
	2006–07 (*n* = 91,805)	2007–08 (*n* = 95,898)	2008–09 (*n* = 96,688)	2009–10 (*n* = 101,349)	2010–11 (*n* = 95,839)	2011–12 (*n* = 99,030)	2012–13 (*n* = 98,564)	2013–14 (*n* = 95,879)	2014–15 (*n* = 98,728)	2015–16 (*n* = 97,398)	↑↓(a)
Sleep disturbance	1.1 (1.0–1.1)	1.0 (0.9–1.1)	1.1 (1.0–1.2)	1.1 (1.0–1.2)	1.1 (1.0–1.2)	1.0 (0.9–1.1)	1.1 (1.0–1.2)	1.0 (0.9–1.1)	1.2 (1.1–1.3)	1.1 (1.0–1.2)	—
Swelling (skin)*	1.1 (1.0–1.2)	1.1 (1.0–1.2)	1.1 (1.0–1.2)	1.0 (0.9–1.1)	1.1 (1.0–1.2)	1.1 (1.0–1.2)	1.0 (1.0–1.1)	1.0 (0.9–1.1)	1.0 (0.9–1.1)	1.1 (1.0–1.2)	
Vertigo/dizziness	1.1 (1.0–1.2)	1.1 (1.0–1.2)	1.2 (1.1–1.3)	1.0 (0.9–1.0)	1.1 (1.1–1.2)	1.1 (1.0–1.2)	1.0 (0.9–1.1)	1.0 (1.0–1.1)	1.1 (1.0–1.2)	1.0 (0.9–1.1)	—
Follow-up encounter NOS	0.8 (0.6–0.9)	0.6 (0.5–0.7)	0.7 (0.6–0.8)	0.8 (0.7–0.9)	0.8 (0.7–0.9)	0.9 (0.7–1.0)	1.0 (0.9–1.1)	0.9 (0.7–1.0)	0.9 (0.8–1.0)	0.9 (0.7–1.0)	—
Leg/thigh complaint	1.0 (1.0–1.1)	0.9 (0.8–1.0)	1.0 (1.0–1.1)	0.9 (0.8–1.0)	0.9 (0.8–1.0)	0.9 (0.9–1.0)	1.0 (0.9–1.1)	1.0 (0.9–1.0)	1.0 (0.9–1.0)	0.8 (0.7–0.9)	↓
Vomiting	1.0 (0.9–1.1)	1.1 (1.0–1.2)	0.8 (0.7–0.9)	0.9 (0.8–1.0)	0.9 (0.8–1.0)	0.9 (0.8–1.0)	0.7 (0.7–0.8)	0.8 (0.8–0.9)	0.7 (0.7–0.8)	0.8 (0.7–0.9)	↓
Other reason for encounter NEC	1.0 (0.9–1.2)	0.7 (0.6–0.9)	0.8 (0.7–1.0)	0.9 (0.8–1.0)	1.0 (0.8–1.1)	0.9 (0.7–1.1)	1.0 (0.7–1.3)	0.8 (0.7–0.9)	0.7 (0.6–0.9)	0.7 (0.6–0.9)	↓
Chest pain NOS	1.2 (1.1–1.3)	1.1 (1.0–1.1)	0.9 (0.8–1.0)	1.0 (0.9–1.1)	0.9 (0.9–1.0)	0.9 (0.8–1.0)	0.9 (0.8–1.0)	0.9 (0.8–0.9)	0.9 (0.8–0.9)	0.7 (0.7–0.8)	↓
Total RFEs	150.8 (148.9–152.7)	153.0 (151.1–154.8)	156.5 (154.7–158.2)	155.0 (153.1–156.8)	155.5 (153.5–157.5)	154.7 (152.8–156.7)	154.5 (152.7–156.3)	155.3 (153.3–157.3)	153.6 (151.8–155.4)	153.1 (151.2–155.0)	—

(a) The direction and type of change from 2006–07 to 2015–16 is indicated for each result: ↑/↓ indicates a statistically significant change (increase or decrease) in 2015–16 compared with 2006–07; ↑/↓ indicates a marginally significant change in 2015–16 compared with 2006–07; — indicates there was no significant change in 2015–16 compared with 2006–07.

* Includes multiple ICPC-2 or ICPC-2 PLUS codes (see Appendix 4, Table A4.1, <hdl.handle.net/2123/15482>).

Note: CI – confidence interval; NOS – not otherwise specified; RFE – reason for encounter; NEC – not elsewhere classified. This table includes individual RFEs that were recorded at a rate of ≥ 1.0 per 100 encounters in any year.