GP access among two samples of people who regularly use illicit drugs in Australia, 2019-2024

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Key Findings

While self-reported health was generally poorer among EDRS participants compared to general population, self-reported GP access has remained relatively consistent with rates observed nationally among age matched peers.

Despite having significantly lower levels of self-reported health, people who inject drugs report significantly lower utilisation of GPs than seen among the general population. This situation has been apparent for the past 5 years and is particularly notable in Darwin, Hobart, Adelaide and Sydney.

However, in some cities – most notably Melbourne and Canberra – IDRS participants reported relatively better utilisation of GPs, comparable to both their EDRS counterparts and the general population. This is despite relatively high financial barriers to access in Canberra. Understanding what has led to these relatively better outcomes for people who inject is critical for improving health outcomes.

Based on two national samples of people who use drugs in Australia and were interviewed as part of the Illicit Drug Reporting System and Ecstasy and Related Drugs Reporting System between 2019 - 2024.

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Introduction

In comparison to similar countries, Australians have a high level of access to general medical practitioners (1). In the most recent Australian Bureau of Statistics Patient Experiences survey (2023-24), 82.6% of Australians had seen a general practitioner (GP) in the past year (2). This percentage generally increased with age, rising from 71% among 15-24 year-olds to 75% of those aged 25-34, 79% for the 35-44 age group, and reaching 84% among 45-54 year olds (2).

General medical practice is an important part of the health system, particularly for acute treatment of uncomplicated medical issues, referral, screening, and managing chronic medical conditions – critically, addressing issues early before they result in the need for a hospitalisation (3). Systematic reviews (4) and large cohort studies (5) have demonstrated that ongoing relationships with a GP results in substantially lower rates of hospitalisation and death; this is also true among people with chronic medical conditions (6).

There is considerable evidence that people who frequently use drugs may also have elevated rates of health concerns, such as mental health problems (7). People who inject drugs have increased rates of liver conditions (8) and cardiac infections (9), and people who use heroin have high rates of chronic obstructive pulmonary disease (10). However, people who use drugs also face significant barriers to GP access including experience of stigma (11), complications from complex living conditions or multiple health conditions (12), and concerns about impacts on treatments of other health conditions (12).

Multiple indicators additionally suggest that GP access is becoming increasingly difficult for Australians with low incomes. Medicare data suggests that the proportion of patients nationally that were *never* bulk-billed for attendances increased from 11.3% in 2022/23 to 14.0% in 2023/24, with proportions varying dramatically across jurisdictions (11.0% in NSW, 20.5% in TAS, and 32.6% in ACT) (13). Independent consumer surveys have also demonstrated that the proportion of GP clinics that will bulk-bill new clients has steadily declined between 2023 and 2025 (national figures: 35.1% in 2023; 24.2% in 2024; 20.7% in 2025), and average out-of-pocket expenses have steadily increased ($40 in 2023; $41 in 2024; $43 in 2025). These trends mask substantial differences in jurisdictions – with *no* practices in Tasmania and just 3% of those in the ACT offering bulk-billing for new patients in 2025; and average out-of-pocket costs of $54 in Tasmania and $52 in the ACT, 25% above the national average (14). Further, the most recent ABS Patient Experiences survey (2023/24, (2)) found that 9% of those in the most socio-economic disadvantaged quintile delayed or skipped seeing a GP due to cost (4% in 2021/22), and 11% delayed or skipped a medication due to cost in 2023/24 (7% in 2021/22).

Given these issues, we aim to describe, and compare, self-reported health and access to GPs among two samples of people who regularly use drugs in Australia between 2019 and 2024.

Methods

Data from the national 2019-2024 Ecstasy and Related Drugs Reporting System (EDRS) and Illicit Drug Reporting System (IDRS) interviews were used for this study.

The EDRS comprises interviews with sentinel samples of people aged 18 years or older who regularly (≥6 days in past 6 months) use ecstasy and/or other illicit stimulants and live in capital cities, recruited via social media, advertisements on websites and via word-of mouth. Data are typically collected between May – July each year, with a target of 100 participants in each capital city. Please refer to the 2024 EDRS Background and Methods document for further information.

The IDRS sample is a sentinel group of people aged 18 years or older who regularly (≥6 days in past 6 months) injected illicit drugs, and had resided in the capital city in which the interview took place for at least ten of the past 12 months. Participants were recruited via advertisements in needle syringe programs and other harm reduction services, and via peer referral. Data are typically collected between May – July each year, with a target of 150 participants in Melbourne and Sydney, and 100 in the remaining capital cities. Please refer to the 2024 IDRS Background and Methods document for further information. For both of these studies, results are not representative of all people who use illicit drugs, nor of use in the general population. Participants provided consent for interviews, and were reimbursed $40 for their time.

Participants in the 2019, 2022, 2023 and 2024 surveys were asked if they had accessed a general practitioner for any reason in the past 6 months. In 2024, they were also asked the Short Form 1 (SF-1) self-assessed health measure "In general, would you say your health is: Excellent, Very good, Good, Fair or Poor?". Australian normative data for this measure are available (15).

GP access among the EDRS and IDRS samples were also compared to national averages from the 2023/24 Patient Experiences Survey, specifically the 25-34, 35-44, and 45-54 age groups which most closely align with the age of EDRS (median age of 23 in 2024) (16) and IDRS (median age of 47 in 2024) participants (17). This survey is a household survey of 26,176 Australians aged 15 or older.

Proportions of participants reporting GP access were reported using 95% confidence intervals using the Wald (normal-approximation) interval; comparisons between proportions were calculated using Pearson chi-square tests of independence.

Results

Self-reported GP access in the six months preceding interview, 2024

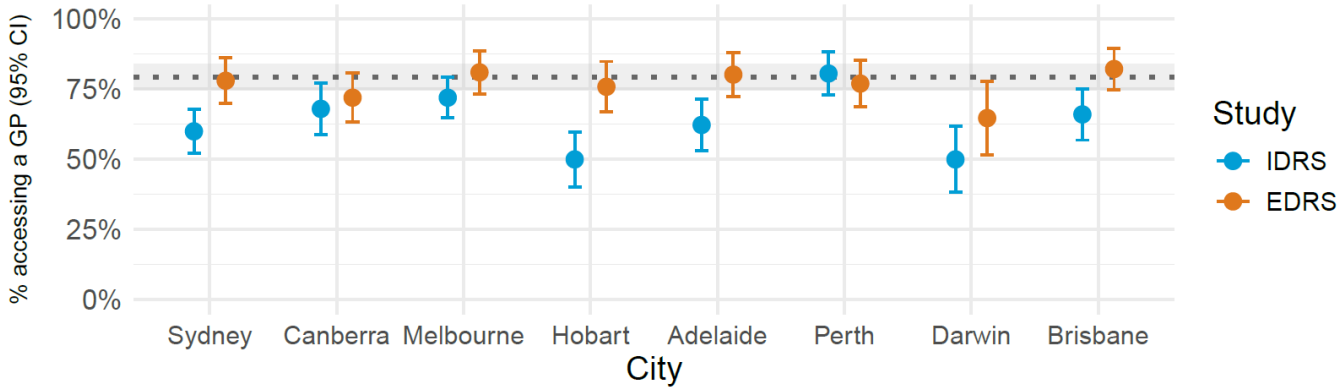
In 2024, 77.2% of EDRS participants and 64.4% of IDRS participants reported attending a GP for any reason in the six months preceding interview. There were no significant differences in GP attendance across different cities for the EDRS ($\chi^2(7)=8.93$, $p=0.257$) (Figure 1), and percentages were largely consistent with those observed in similar age groups in the general population (2).

However, there were significant differences in GP attendance across cities for the IDRS: $\chi^2(7)=33.25$, $p<0.001$***. Pairwise comparisons demonstrated that GP attendance was significantly lower in Hobart and Darwin than in Melbourne and Perth; and that attendance in Perth was also higher than that in Sydney.

To determine if these jurisdictional differences were a demographic difference or a reflection of general levels of accessibility, pairwise comparisons were conducted comparing GP utilisation between the study participants in each city (e.g., IDRS vs EDRS participants in Sydney). GP attendance was significantly lower among IDRS participants, compared to EDRS participants, in Hobart ($\chi^2(1)=13.32$, $p<0.001$***), Adelaide ($\chi^2(1)=8.08$, $p=0.004$**, Sydney ($\chi^2(1)=8.82$, $p=0.003$**), and Brisbane ($\chi^2(1)=6.92$, $p=0.009$**). For all other cities, no significant differences were observed ($p>0.100$) (Figure 1).

In Hobart and Darwin, approximately half of the IDRS sample had recently accessed GPs, which was dramatically lower than the national average for individuals of a similar age (2).

Figure 1. Proportion of IDRS and EDRS participants attending a GP for any reason in the previous six months, by capital city, 2024



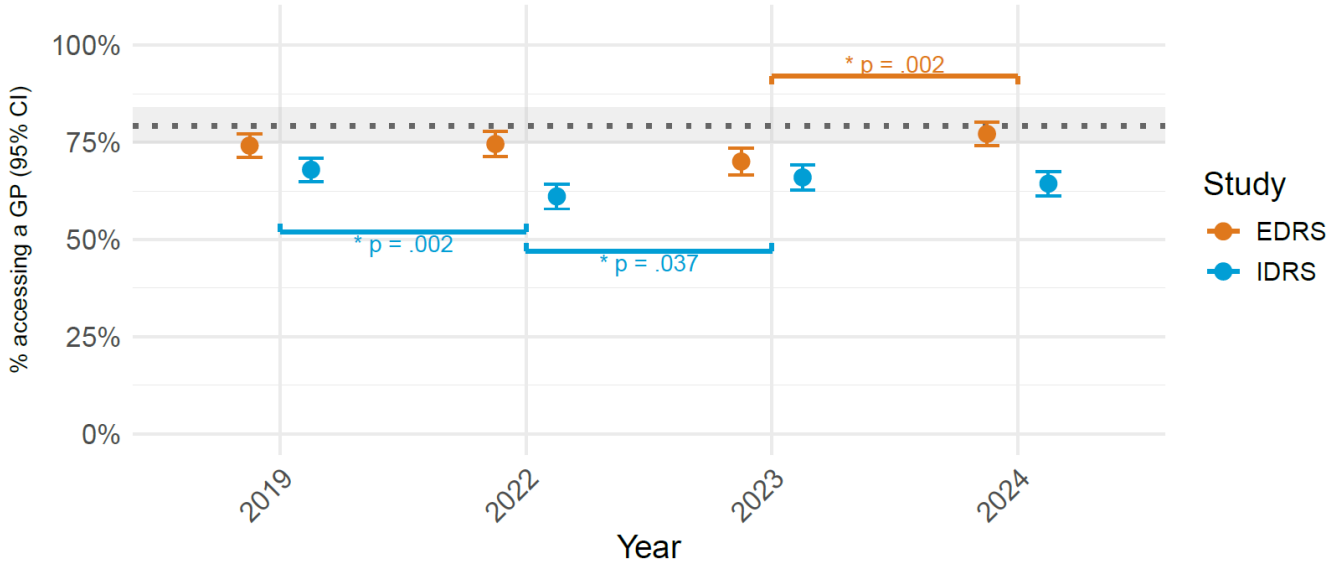
Shaded area = Range for people aged 25–34 and 45–54 from the 2023/24 Patient Experiences Survey (National); Dotted line is rate in 35–44 from this survey

Self-reported GP access in the six months preceding interview, 2019-2024

Reported GP utilisation in the past six months in both the IDRS and EDRS over time is presented in Figure 2. There was an overall difference in GP access over time for the EDRS participants: $\chi^2(3)=9.81$, $p=0.020$*, with a significant increase between 2023 and 2024. For IDRS participants, there was also a significant difference over time: $\chi^2(3)=9.70$, $p=0.021$*. Access in 2022 was significantly lower than in 2019 and in 2023 (Figure 2).

Reported GP access was significantly lower among IDRS participants than EDRS participants in every year other than 2023 (2019: $\chi^2(1)=7.86$, $p=0.005$**; 2022: $\chi^2(1)=32.06$, $p<0.001$**; 2023: $\chi^2(1)=2.90$, $p=0.089$; 2024: $\chi^2(1)=31.25$, $p<0.001$**). GP utilisation among EDRS participants was similar to the rate seen in similar age groups in the general population, with the exception of 2023 (Figure 2).

Figure 2. Proportion of IDRS and EDRS participants attending a GP for any reason in the previous six months, nationally, 2019-2024



Shaded area = Range for people aged 25–34 and 45–54 from the 2023/24 Patient Experiences Survey (National); Dotted line is rate in 35–44 from this survey

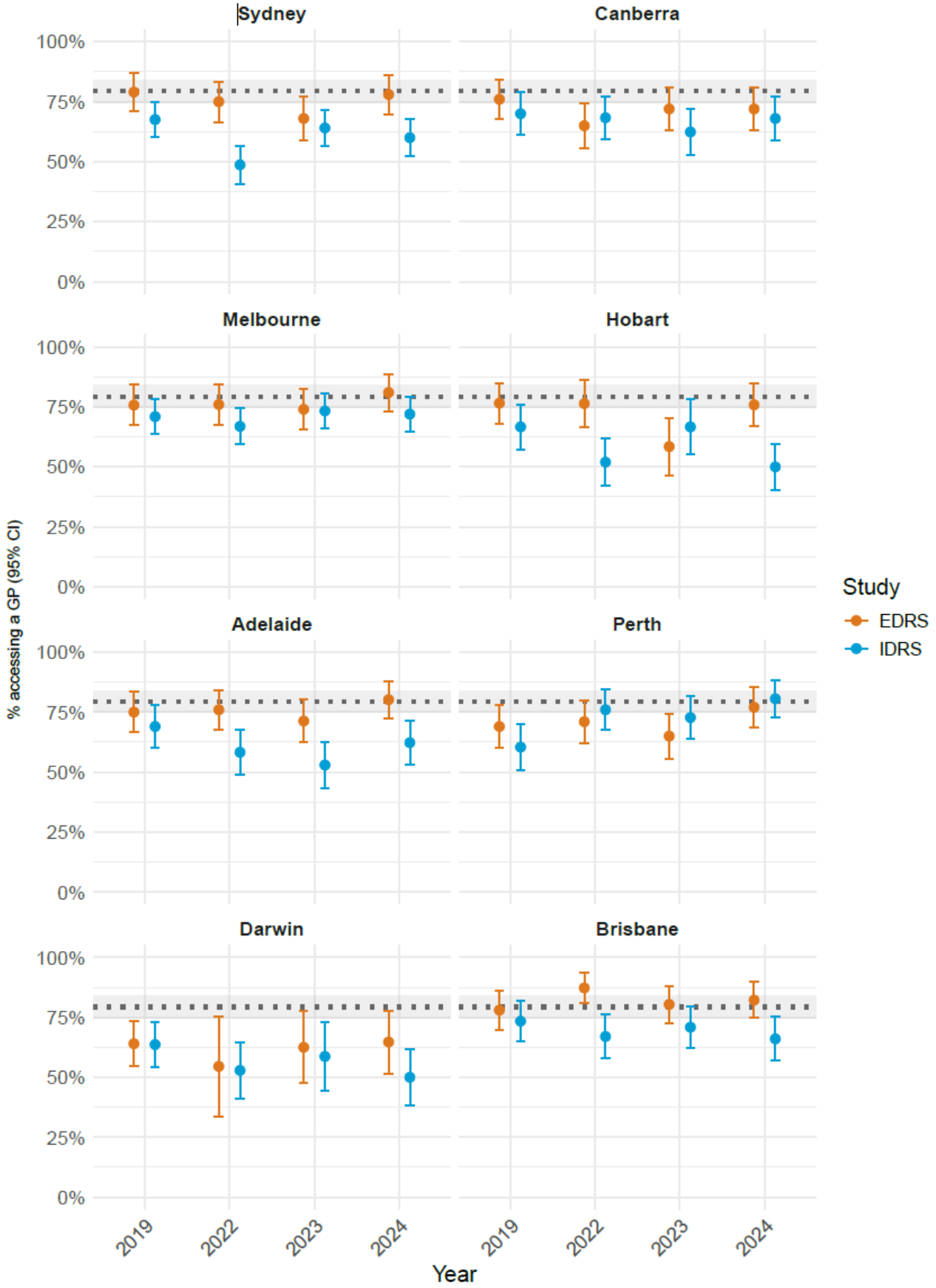
Considering GP access in each study in each capital city (Figure 3), there were no statistically significant changes over time in Canberra, Melbourne, Adelaide, Darwin and Brisbane.

In Sydney, there was a significant change over time among IDRS participants ($\chi^2(3)=12.7$, $p=0.005$), relating to a notable decline between 2019 and 2022, but not for EDRS participants. Similarly, in Perth, there was a significant change over time for IDRS participants ($\chi^2(3)=11.0$, $p=0.0115$), relating to an increase between 2019 and 2022, but not for EDRS participants.

In Hobart, there was a significant change over time among both EDRS participants ($\chi^2(3)=8.3$, $p=0.040$), marked by a decrease between 2022 and 2023 followed by an increase between 2023 and 2024, and among IDRS participants ($\chi^2(3)=9.3$, $p=0.026$), driven by decreases in GP use between 2019 and 2022, and 2023 and 2024.

There were no differences in GP access between IDRS and EDRS participants in Canberra, Melbourne, Perth or Darwin in any of the years between 2019-2024. In 2022 and 2024, GP access among IDRS participants was significantly lower in Sydney, Brisbane, Adelaide and Hobart than amongst their EDRS counterparts in these cities. GP access was also lower among IDRS than EDRS participants in 2023 in Adelaide. It is also noteworthy that GP access among participants in Darwin generally, and for IDRS participants in Adelaide, Hobart and Sydney, are substantially lower than the general population for similar ages (2).

Figure 3. Proportion of IDRS and EDRS participants attending a GP for any reason in the previous six months, by capital city, 2019-2024



Shaded area = Range for people aged 25–34 and 45–54 from the 2023/24 Patient Experiences Survey (National); Dotted line is rate in 35–44 from this survey

Results

Self-reported health, 2024

IDRS and EDRS participants were asked to rate their perceived level of current health using the SF-1; these were compared to the general Australian population (15 or older) from the 2022 National Health Survey (Table 1). EDRS participants differed significantly from the national average across the SF-1 categories ($\chi^2(4)=290.68$, $p<0.0001$), with pairwise comparisons showing significantly lower proportions in the 'excellent' and 'very good' categories than the general population; and more participants in the 'good', 'fair' and 'poor' categories. This same pattern was apparent among IDRS participants compared to the national average ($\chi^2(4)=921.18$, $p<0.001$), with the same findings among the pairwise comparisons.

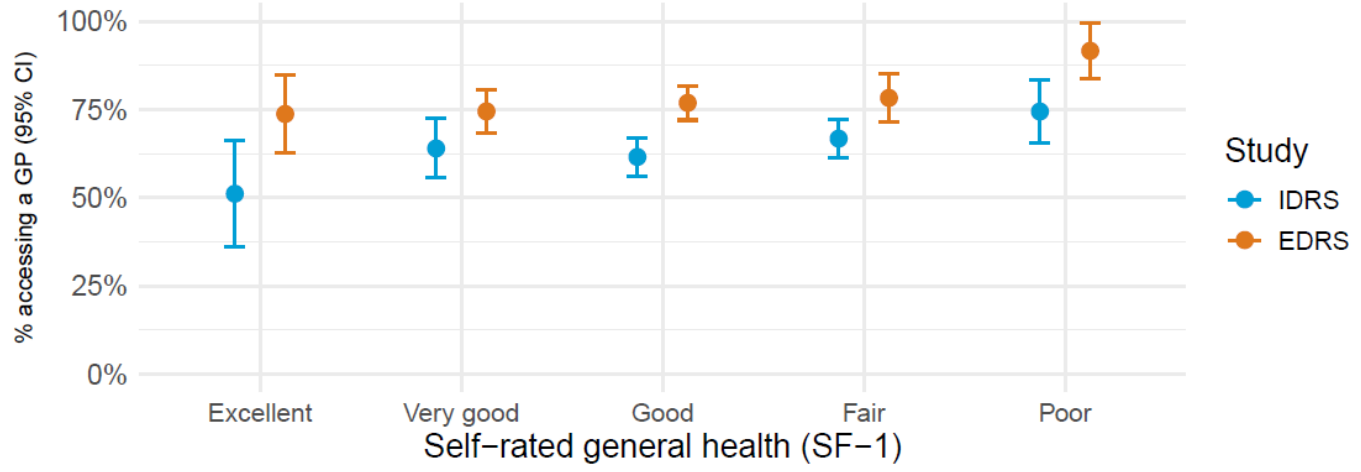
Table 1. Self-reported current health, among IDRS and EDRS participants, 2024, and the general population, 2022

Health category (SF-1)	IDRS 2024 (95% CI) (n=869)	EDRS 2024 (95% CI) (n=738)	AUS 2022 (95% CI) (15+, National Health Survey)
Excellent	4.9% (3.7–6.6)	8.3% (6.5–10.5)	20.2% (19.4–21.0)
Very good	14.4% (12.2–16.9)	27.1% (24.0–30.4)	36.3% (35.3–37.3)
Good	36.2% (33.1–39.5)	38.8% (35.3–42.3)	28.5% (27.4–29.6)
Fair	33.6% (30.5–36.8)	19.4% (16.7–22.4)	11.3% (10.5–12.1)
Poor	10.8% (8.9–13.1)	6.5% (4.9–8.5)	3.8% (3.3–4.3)

General self-reported health was significantly lower among IDRS participants than EDRS participants, overall ($\chi^2(4)=77.60$, $p<0.001$). Pairwise comparisons showed that there was a significantly greater proportion of EDRS participants who reported being in 'excellent' or 'very good' health, compared to IDRS participants; and conversely, a significantly greater proportion of IDRS participants who reported being in 'fair' or 'poor' health, compared to EDRS participants.

As shown in Figure 4 below, GP access was significantly higher among EDRS than IDRS participants at each level of self-rated general health (all bivariate comparisons $p<0.050$).

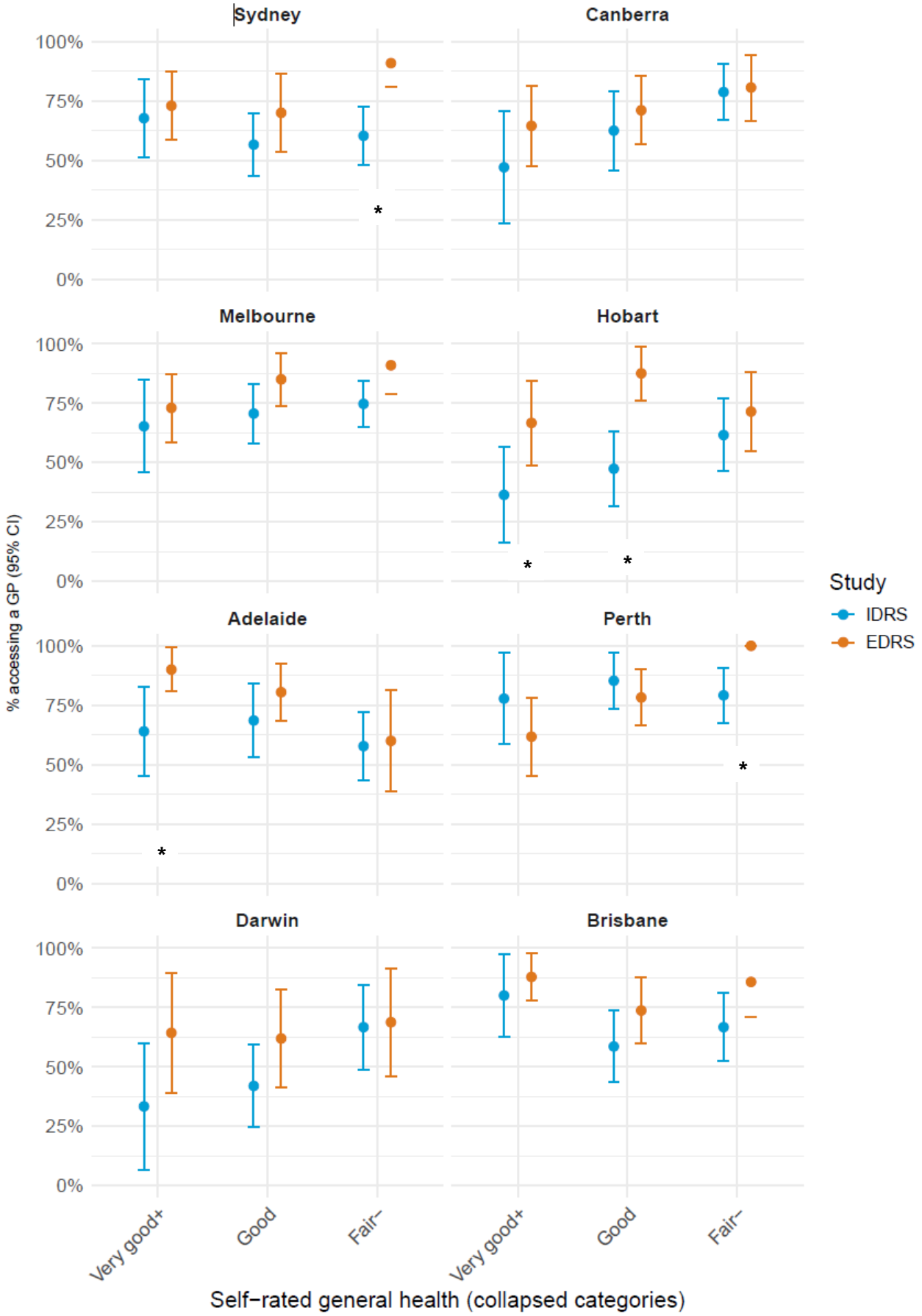
Figure 4. Proportion of IDRS and EDRS participants attending a GP for any reason in the previous six months, stratified by SF-1 self-rated general health, nationally, 2024



Due to small sample sizes, the proportion of participants in each city falling into the 'fair' and 'poor' SF-1 categories were collapsed; and the proportion in the 'excellent' and 'very good' collapsed; to examine differences in GP utilisation in each city stratified by health category (Figure 5). This showed that GP utilisation

was significantly lower among IDRS participants than for EDRS participants in the category with greatest need (fair/poor) in Sydney and Perth in 2024. GP access was also significantly lower among IDRS compared to EDRS participants in other health categories – specifically, in the 'excellent/very good' category in both Hobart and Adelaide, and in the 'good' category in Hobart.

Figure 5. Proportion of IDRS and EDRS participants attending a GP for any reason in the previous six months, stratified by SF-1 self-rated general health and capital city, 2024



Discussion

The data presented here clearly demonstrates that, despite having significantly lower levels of self-reported health, people who inject drugs report significantly lower utilisation of GPs than seen among the general population. This situation has been apparent for the past 5 years and is particularly notable in Darwin, Hobart, Adelaide and Sydney. Among the EDRS sample of people who use illicit stimulants, while self-reported health was generally lower than the national average, GP utilisation has remained relatively consistent with rates observed nationally among age matched peers.

Structural barriers to GP access appear to be increasing, and likely contribute to the patterns of GP utilisation identified here, given that many of the cities with the lowest reported utilisation of GPs also have particularly notable barriers to access. For example, the independent Cleanbill report (14) has demonstrated rapidly declining rates of bulk-billing for new patients nationally, with access particularly low in Tasmania (6.9% of practices in 2023; 0% in 2025); the Northern Territory (20.6% in 2023, 9.5% in 2025) and South Australia (24.2% in 2023, 7.4% in 2025). Similarly, average out-of-pocket costs have increased nationally (and in each of these jurisdictions).

However, cost barriers clearly cannot provide a full explanation for the low levels of GP access among IDRS participants. EDRS participants reported GP utilisation at a level similar to the national average. In Canberra, despite low rates of bulk-billing (3.3% in 2025 (14)), and the second highest average out-of-pocket costs nationally ($52 in 2025 (14)), GP utilisation was similar for IDRS and EDRS participants over the past 5 years, and in keeping with the national average in the general population. By contrast, in Sydney, despite having the highest bulk-billing rate nationally (34.5% in 2025 (14)) and lower average out-of-pocket expenses ($44 in 2025 (14)), GP utilisation among IDRS participants was significantly lower than EDRS participants, and low compared to the general population. Targeted work to understand the reasons for these disparate outcomes, and what has led to the relatively better outcomes for IDRS participants in Canberra and Melbourne, is important.

While urgent attention is needed to reduce financial barriers, there are other options to improve GP access among people who inject drugs, such as low-threshold, primary care models integrated with or implemented alongside harm reduction services (18). Innovative partnerships between a peer-led needle and syringe program and primary practitioners have been well received by consumers in Sydney (19); and co-location of bulk-billing GP services in connection with harm reduction services has led to strong uptake of GP services among clients of the Melbourne Supervised Injecting Centre (20). Qualitative studies with people who inject drugs have demonstrated practical ways for GPs to best meet the needs of this group (21). Training and accreditation programs that recognise trauma-informed and addiction-informed care could address non-financial barriers that appear to disproportionately deter IDRS participants, and systematic reviews have identified that implementing these frameworks is associated with greater satisfaction with services for both clients *and* clinicians (22). Peer-led training on the needs of people with dual diagnoses have led to both short- and long-term increases in understanding and role adequacy for clinicians engaging with the training, and better interactions with clinicians reported by their clients (23). Even brief e-learning modules, with content co-developed by peers, have been demonstrated to have meaningful beneficial impacts on discriminatory attitudes among health providers in New South Wales (24).

In summary, GP utilisation among people who inject drugs is low compared to the general population, despite having relatively poorer levels of self-reported health. Examining patterns of utilisation across capital cities clearly highlights that, while there are clear financial barriers to access impacting people in some jurisdictions, there are areas where access is high despite these financial barriers – understanding the conditions which support this successful outcome is critical.

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