General Practice Crisis Summit

White paper

General Practice Crisis Summit: White paper

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We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.

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Contents

Purpose of this document

This document was produced by the RACGP as an overview of the discussion and recommendations put forward at the General Practice Crisis Summit held on 5 October 2022 in Canberra.

The General Practice Crisis Summit was convened to gather general practice leaders and healthcare stakeholders, including peak bodies, health organisations, consumer representatives, clinicians and academics, to discuss the future of patient care and general practice, and to highlight possible solutions for reform.

Efforts were made to ensure that a diverse range of viewpoints and experiences were represented at the Summit – incorporating participants from a mix of regions, health professions, genders, backgrounds, and organisations.

This document captures and reflects the key recurring and well-supported themes raised throughout the Summit. These discussions were centred around the following key topic areas and prompt questions.

Funding and fragmentation: What funding model is required to support general practice's leading role in providing patient-centred, continuous and coordinated care, and to ensure equitable access to this care?
General practice workforce: How can we address and reverse the erosion of the general practice workforce, ensuring general practice is an attractive career path with long-term career sustainability?
General practice data: How can we improve the capture, linkage and meaningful use of data (including patient experience, clinician experience and quality patient outcomes) to support equitable general practice-based care?

Each of the above topic sessions were informed by presentations from subject matter experts.

The recommendations in the paper do not necessarily articulate RACGP or participant position. Rather, this paper captures the consensus statements made during the General Practice Crisis Summit.

Summit participants were given the opportunity to review and provide feedback regarding this White paper to ensure it is an accurate reflection of the discussion on the day.

The RACGP will use the discussions and recommendations put forward at the Summit to inform future RACGP policy and advocacy activities.

Executive summary

Introduction

Australians deserve access to a quality, comprehensive, connected primary care sector that provides them with coordinated care led by their general practitioner (GP). However, timely and equitable access to general practice services, particularly in rural and remote areas, is a growing issue.

On 5 October 2022, the Royal Australian College of General Practitioners (RACGP) held the General Practice Crisis Summit in Canberra to discuss and recommend solutions to the critical challenges impacting patient access to affordable, quality care from a financially viable general practice sector.

These challenges are complex and multifaceted, all issues are interconnected, and changes to one have foreseeable ripple effects on all others.[1] There is unprecedented demand for health services as the population ages and rates of chronic disease and psychological distress increase. Hospital and emergency department demand continues to skyrocket, resulting in ramping, suboptimal healthcare delivery, poorer patient outcomes, and increasing secondary and tertiary health expenditure.

Decades of significant underfunding and cost-cutting has left general practice on the brink of collapse. Almost half of practicing GPs have indicated that it is no longer financially sustainable for them to continue working in general practice. The proportion of bulk-billed GP services dropped for the first time in almost two decades, and experts predict a shortfall of 11,392 GPs, or almost 28% of the general practice workforce, by 2032.[2] Medical student interest in general practice as a career is now at a low of just 13.8%.

The COVID-19 pandemic and recent natural disasters have compounded these issues, highlighting the gaps and inequities in the current delivery of primary care, exacerbating workforce burnout and draining resources within general practice. In addition to the increasing costs of living, out-of-pocket costs for patients accessing care have risen by 48% over the past decade, reflecting how Medicare patient rebates have failed to keep pace with the growing cost of delivering healthcare.[3]

Discussion

Evidence shows that a well-supported general practice sector will result in efficiencies for primary and secondary care and the broader healthcare system.[4–6] Generalist approaches to complex health concerns offer integrative care that enables quality cost-effective tertiary care.[7,8] Local and international evidence clearly demonstrates that better support for, and use of, general practice is associated with:

- better health outcomes for patients
- lower emergency department presentations and hospital use
- decreased hospital readmission rates
- significant savings for the healthcare system.

This document summarises the discussion at the General Practice Crisis Summit and provides an overview of the recommendations put forward in the following three key areas:

- funding and fragmentation
- general practice workforce
- general practice data.

Discussion topic 1: Funding and fragmentation

General practice urgently requires significant and sustained investment. Flexible and blended payment models, which are appropriately and regularly indexed with pricing set through an independent pricing process, are required to support the delivery of quality healthcare in an equitable manner. These models should retain a simplified core approach of fee-for-service, and re-balance funding towards supporting patient access to longer consultations, which would enable the provision of comprehensive care that addresses optimal health promotion, prevention, treatment and management of chronic health conditions.

Investment by all current funders needs to significantly increase, and additional funders should be considered to support the provision of high-quality care in general practice. This should lead to a funding model with substantial and well-coordinated contributions from local, state, territory and federal governments to structurally reduce fragmentation and the tendency to cost-shift between silos. This should be set out through key structures, such as the National Health Reform Agreement.

Discussion topic 2: General practice workforce

General practice needs to be a more attractive career choice for both doctors in training and those already in the profession. Early and sustained exposure to general practice, alongside greater support and training for general practice leaders across all spectrums of medicine, including clinical, academia and education, will help to achieve this and promote a shift towards increased respect for the valuable role that GPs play in ensuring the health and wellbeing of all Australians. While broader measures to enhance the general practice workforce will help address some issues around distribution, targeted solutions are urgently required to fill workforce gaps in rural and remote areas.

Discussion topic 3: General practice data

GPs should be empowered to collect, analyse and use their data. This requires interoperability between systems, standards to support interoperability and information transfer, a clear framework for data governance, and ultimately linkage of data across the education, health, social services and justice sectors. GPs must have ownership of and lead governance over their curated data and intellectual property. To ensure a culture of continuous quality improvement, general practice must be appropriately supported to analyse their own data and draw meaningful and actionable insights. Research by GPs requires significant and ongoing investment to ensure a sustainable academic sector that generates high-quality evidence to improve general practice care.

Conclusion

Urgent investment in general practice is needed to ensure that the health system is supported to meet the current and future health needs of all people in Australia. Significant investment will also reinforce general practice as a sustainable and attractive career path for future doctors, helping to address workforce shortages, and future-proofing the provision of effective and efficient patient care in the community.

A well-resourced general practice sector will provide tailored, flexible, focused whole-person care across the lifespan of citizens. Summit participants agreed we must see a broad shift away from acute hospital-based care and towards maximising patient health and wellbeing over time This can be done through increased support for prevention activities, health promotion, early intervention, detection and generalist chronic disease, and mental health management within a primary care setting led by general practice. We must acknowledge that discreet episodic care by individuals does not facilitate these outcomes, and truly integrated multidisciplinary care over time requires appropriate investment, incentive and appropriate linkages back to general practice.

Participants agreed that the consequence of not addressing the general practice crisis will be a far more expensive and inefficient system, with non-GP specialist dominated care and greater inequalities in access to healthcare across the country. Without urgent action on the short-term priorities, medium- and long-term aspirations will become irrelevant.

The recommendations outlined in this paper are intended to inform and prompt discussion around current and future health reform.

Thank you to all those who took the time to attend the Summit and work collaboratively towards meaningful solutions to address the challenges facing general practice, now and into the future.

1. Implementing reform

Any reform activities must involve patients and GPs from the outset, incorporating patient needs, funding approaches, and structures that encourage and support GP engagement. This will ensure that any new models of care do not compromise either the safety and wellbeing of patients or the viability of general practice.

> Health reform must be undertaken in partnership with patients and general practices. Nothing about us, without us.

GPs, together with their patients, are experts in patient care, navigating the health system and ensuring optimal health outcomes. The unique frontline experience means that GPs are well placed to provide advice on health policy and funding reform, and their input is critical to ensure fit-for-purpose approaches.

GP leadership and involvement in research and policy development will also help to present evidence-based alternatives to hospital-centric solutions for population health needs, providing more options focused on better support for, and utilisation of, primary care. Administrative or political decisions that are made without adequate consultation and agreement from those working in the sector will not only lack the insight required to make changes a success, but will also further alienate the sector, exacerbating current workforce shortages.

As stated above, it is also essential that health reform involves patients from inception. GPs will continue to advocate strongly for patients to have a voice in future health reform, in the same way that we advocate every day for their access to affordable and quality healthcare.

We also acknowledge that any discussion about health system reform, including the first point of access in terms of primary healthcare, needs to address appropriate responses to cultural, ethnic, language and faith/religion diversity for both patients and those working in the sector.

2. Discussion summaries

2.1. Focus area: Funding general practice's leading role in patient-centred, continuous and coordinated care

This discussion focused on the importance of affordable and accessible care, as well as reducing fragmentation within the health system.

Funding for primary care as a proportion of total government healthcare spend is in decline, and funding for patient care through GPs and general practice services represents only 7.4% of total government health expenditure in Australia. The lack of investment in general practice is counterintuitive, given GPs are Australia's most accessible doctors.

Supporting patients to see their GP and general practice team ensures that they are healthier, happier and are able to productively participate in society. Importantly, GPs keep patients out of expensive and often distressing hospital care. There is strong international evidence that GPs and stronger primary care health systems help to lower healthcare costs and deliver improved and more equitable health outcomes.[9,10]

Currently, most funding for general practice in Australia is provided through a fee-for-service model under the Medicare Benefits Schedule (MBS), with a portion of additional funding available through specific incentive programs. The MBS itself has remained largely unchanged since its inception in 1984. It was designed and implemented before the management of multiple chronic diseases was commonplace, and before technology existed to facilitate the delivery of some healthcare safely without face-to-face consultations.

Given the rising prevalence of chronic disease, the ageing population and increasing multimorbidity, Summit participants broadly agreed that the MBS no longer prioritises the type of healthcare Australians need. It overvalues procedural medicine, rather than consultation-based medicine, and rewards rapid throughput of patients, rather than quality time spent with patients to better manage their health and build an ongoing therapeutic relationship. This misaligned funding makes the provision of high-quality, person-centred general practice inevitably unsustainable.[11]

Further, as has been well documented, patient rebates provided under the fee-for-service model have failed to keep pace with the increasing time and complexity of general practice care, and do not reflect the cost of providing safe and high-quality care. In 2022, the government increased Medicare patient rebates by just 1.6%. This represented a 65c increase to the patient rebate for a standard level B consultation. Inflation over the same period was 6.1%.[2]

A permanent and sustainable approach

Summit participants discussed working towards a new funding model for general practice, which:

- retains the foundation of fee-for-service payments through a simplified MBS
- better recognises the value of consultive services in addition to procedural activities
- incorporates blended funding (on top of fee-for-service) that is adjusted for clinical complexity and social need
- involves appropriate and regular indexation of any rebates or payments via an independent general practice pricing authority
- receives significant integrated funding contributions from government funders, including state, territory, and federal funding
- carefully considers the role of private insurers as potential contributors to primary care funding, and the safeguards required for this to occur equitably
- supports multidisciplinary team-based care
- features localised flexibility to address areas of market failure and underserved communities, especially for rural and remote areas
- effectively balances funding between the practitioner and the practice.

2.1.1. Short-term measures: Initial investment to address the rising cost of care

High upfront costs for patients seeking healthcare directly affects their ability to access timely care for both the management and treatment of chronic and complex conditions and for acute or urgent problems. This negatively impacts health and wellbeing, as the severity of many health conditions are exacerbated without access to regular, urgent or preventive medical care when required. Experience has shown that this leads to further and unnecessary increases in healthcare cost.

Costs can be a substantial barrier to access, with 1.3 million Australians already delaying or avoiding accessing healthcare due to cost. Certain community groups, particularly those more likely to have more complex health needs, are especially vulnerable.[1]

Initial targeted approach

Initial measures proposed at the Summit to support patient care through general practice include:

- an immediate injection of funding through the MBS, raising all patient rebates for general practice attendance items by at least 20%
- a significant increase in the bulk-billing incentives by three times; for example, increasing the fee for MBS item 10990 from $7.75 to $23.25
- lowering the Extended Medicare Safety Net threshold from $717.90 to $500
- adjustments to standard general practice consultation items, including reweighting time tiers and reducing the time intervals for standard consult items
- uncapping incentive payments, including those paid under the Practice Incentive Program (PIP) and Workforce Incentive Program (WIP)

- appropriate indexation for all funding mechanisms, including fee-for-service and block payments
- uncapping the number of services available per patient under MBS item 10997, which covers a service provided to a person with chronic disease by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner.

This suite of initial solutions was proposed by Summit participants as a first-line crisis intervention to address the urgent need for affordable general practice care across Australia, particularly for disadvantaged communities, and to prevent any more general practices from closing.

A key element of these initial measures is to resolve disparities in patient rebates for general practice consultations. Currently, the rebate values for standard GP consultations drop in value every minute, disadvantaging patients who require more time with their GP and GPs who provide high-value care for complex patients. This is due to both poor weighting of rebate values and overly lengthy time intervals. Participants agreed that we need to address the patient rebate disparities, and rebalance support towards longer consultations to enable comprehensive care that addresses optimal prevention, health promotion, treatment and management of chronic health conditions.

Summit participants were all cognisant of the need for cost-effective, high-value healthcare. While participants recognised that the solutions outlined above represent a significant increase in investment in the short term, ensuring that people can access general practice for preventive care, health promotion and early intervention will reduce future demand for expensive secondary and tertiary health services. This will generate savings for the broader health system.

Structural reform

Although the above measures will help address the immediate general practice crisis, participants highlighted that it is important not to lose sight of the large-scale structural reform required to fix the broader health system. Reforms should recognise the increasing importance of the role GPs play in diagnosis, treatment and management, health system stewardship and care coordination, especially given the growing complexity of the health system and shifting population health needs.

> Participants discussed the need for system change that is based on the principle of general practice and primary healthcare as the cornerstone of improved health and quality healthcare. This needs to be based on a socially accountable framework, as the root of ill-health is too often related to socioeconomic determinants.

Voluntary patient enrolment (VPE) is a potential mechanism that can enable continuity of care and supports additional funding in addition to current fee-for-service funding.[12,13] Some participants discussed how the introduction of a sustainable and fit-for-purpose model of VPE could allow practices to establish proactive, team-based care with continuous quality improvement for a defined population of patients. VPE could also enable patient access to a range of modalities of care, including video, telephone, SMS and email, increasing the efficiency of the system if properly supported. Summit participants noted that adequate blended payments to practices would be an essential element of VPE.

The introduction of new structures, such as VPE, would potentially drive much of the change needed within the system to support better patient access to high-quality, continuous care. While it is acknowledged that the full implementation of VPE might not be feasible in the short term, participants raised the importance of beginning to lay the groundwork for this type of structural reform in the near future.

> Participants were clear that they did not support capitation or a shift to a UK-style model of capitation in Australia, noting that VPE does not equate to capitation. Participants also flagged that the introduction of VPE would need to be carefully considered in consultation with the sector to ensure that it aligns with the business model and employment structures currently used within general practice. It must not contribute to any additional employment costs for practices or reduce the flexibility of employment options in general practice.

2.1.2. Medium-term measures: Setting up the structures for reform

Discussion on medium-term reform focused on the structures and processes needed to adapt our current funding and health system to meet demand and changing patient needs.

Participants recommended an independent general practice pricing authority be established and funded to evaluate and set pricing for general practice activities. This will encompass all general practice funding streams, including MBS patient rebates, as well as any block funding. This could be modelled on the Independent Health and Aged Care Pricing Authority, which sets national efficient price and national efficient cost to calculate funding of public health and aged care services. The pricing authority should oversee the regular and appropriate indexation of MBS rebates and other general practice payments.

Funders for primary care

Currently, the primary sources of funding for general practice are investment by the Federal Government and patient contributions.[14] This contrasts with hospitals and other care providers that receive significant state and local government funding. Participants strongly recommended that long-term reforms incorporate greater funding for general practice from additional sources, particularly state and territory government funding.

Summit participants indicated that they would expect to see at least a 10% shift in state and territory health funding allocated to primary care and held independently for distribution towards key priorities. This would focus on reducing demand on emergency departments, potentially preventable hospitalisations and unplanned admissions. This redistribution of funding could be coded into key intergovernmental agreements, such as the National Health Reform Agreement. It should begin with an initial 2–3% in funding from state and territory governments, as suggested in the *Shifting the dial: 5 year productivity review* report from the Productivity Commission, that would grow to 10% over the next five years and into the longer term. We would anticipate that as state and territory governments see the overall health spend reduce as a consequence of their investment, they would voluntarily increase the percentage of health spending allocated towards general practice to increase long-term savings.

To address issues with fragmentation of federal and state funding, some participants suggested funding for general practice from all governments could be pooled. This would alleviate issues of service duplication and fragmentation of care where different programs with a similar intent are developed, funded and implemented by both federal and state/territory governments independently, therefore reducing costs at a whole-of-system level. The pooled funding could be tailored to support local needs and facilitate meaningful data and feedback loops to identify inefficiencies or issues. However, participants suggested that further work would be needed to consider the practical implementation of this approach.

Whole-of-practice care

In the medium-term, participants also indicated a need for funding directed towards ‘whole of practice’ capacity and development, supporting the essential work of multidisciplinary teams in patient care and disease prevention, health promotion, treatment and management. It was noted that primary care teams should be funded in ways that respect the expertise and training of all primary healthcare professionals. Funding should support primary healthcare professionals to practice within their scope of professional expertise and in close collaboration with general practice teams.

2.1.3. Long-term measures: A permanent sustainable funding model for general practice

Once the immediate crisis in general practice funding is addressed and the appropriate structures are in place to support reform, participants advised on the key elements for a permanent and sustainable funding model.

Participants agreed that long-term reform should focus broadly on implementing and maintaining a sustainable healthcare system. This should occur by shifting focus from reactive, disease-focused, hospital-based care to proactive, GP-led community-based health promotion, prevention, treatment and management of mental health issues and chronic multimorbidity. Based on this shift, by the end of the next

decade it would be expected that the proportion of funding for general practice would increase significantly via well-considered and industry-approved blended funding models, creating savings from, and slowing the trajectory to, expensive tertiary care.

Blended funding models

Summit discussions highlighted that a blended funding model supports multiple funding streams to be delivered via a variety of mechanisms; for example, through a mix of fee-for-service and block funding. This model offers flexibility and can provide significant advantages over solely fee-for-service funding, particularly for people with chronic and complex needs. A mixed approach can better support continuity of high-quality care, which is associated with improved outcomes for both the patient and the health system.[15] This flexible model of funding also supports complex care, preventive care, health promotion, care coordination and care for underserved populations within general practice.

While Australia's general practice system already represents a partially blended funding model through the mix of fee-for-service and block funding delivered through the PIP and WIP, the current system is heavily weighted towards fee-for-service. Additional funding over and above fee-for-service is required to provide balance between various funding streams for a truly blended model. **This should be achieved through additional investment, not a redirection of fee-for-service funding to block payments.**

A fee-for-service model is, and should remain, the foundational platform for general practice funding and the primary means of support for patients accessing Australian general practice services. Fee-for-service ensures that patient care is supported, regardless of the size of the practice they attend, their geographic location or any other limiting factors.

However, we need to see action to simplify and streamline the MBS, reducing complexity and supporting GPs to deliver high-quality continuous services to all their patients.

More flexible funding

One of the key issues raised with the current approach and historical reforms is the lack of flexibility to tailor funding towards the needs and services in the local community, and to address equity. This is particularly important in areas of market failure, such as rural and remote Australia, which face unique challenges to organising and delivering healthcare. Isolation and limited access to healthcare services mean they require a unique approach.

Participants supported the principle of removing bureaucratic barriers to access funding, particularly for chronic disease treatment and management. They were also supportive of the intention to allow greater flexibility in the use of funding to achieve better workforce recruitment, retention and models of care that suit community needs. Participants advised they would expect to see co-commissioning arrangements, including general practice input and appropriate remuneration, to support the flexible use of funds to meet local needs. As part of the new funding model, it was suggested there should also be consideration of salaried approaches for underserved communities and areas of market failure, with ongoing evaluation and benchmarking. The impact of certain solutions in these areas on the viability of existing general practices should also be carefully considered.

Potential role for private health insurance

Increased involvement of private health insurance in general practice, with specific safeguards and limitations in place to maintain clinical autonomy and patient choice, was raised as an option to support the delivery of patient services. This funding could play a role in improving chronic disease management and treatment, preventive care, health promotion, and reducing hospital admissions. Greater funding for chronic disease programs and allied health supports that enable GPs to deliver comprehensive could be explored. If implemented, this would need to be carefully managed to maintain the separation of Medicare and private health insurance, integrating with and augmenting GP-led care, rather than duplicating services.[16]

While attendees agreed that private health insurance could provide an additional source of funding for the sector, significant concerns were also raised. It was noted this could undermine the autonomy of the treating practitioner and the options available to patients in the formulation of their individualised management plans. There were also concerns about inequitable access to care. The consensus among Summit attendees was that Australia should not go down a path of a US-style managed care system, whereby patient access to care is dependent on their level of private health insurance cover.

Other proposed measures

Summit participants also discussed the potential benefits of offering training in value-based healthcare, health economics, data analysis and management, outcome measurement, and other related disciplines so that GPs can have meaningful input into the design and delivery of primary care services in Australia.

Further areas raised for consideration by Summit participants included issues relating to general practices as small/medium businesses (ie payroll tax) and support for after-hours funding in general practice. These were not discussed in detail, but are flagged in this White paper for consideration, given they relate to the broader funding approach to general practice.

2.1.4. Summary of recommendations

The below recommendations are intended to be reflective of the discussion undertaken at the General Practice Crisis Summit and do not represent RACGP-endorsed policy.

Timeframe	Solution
Short term	Raise MBS patient rebates for general practice care by at least 20%
	Increase the bulk-billing incentives by three times
	Lower the Extended Medicare Safety Net threshold from $717.90 to $500
	Adjust standard general practice consultation MBS items to reweight time tiers, reduce the time intervals (eg five-minute increments) and ensure longer consultations are appropriately valued
	Uncap and properly index general practice incentive payments, including those paid under the PIP and WIP
	Uncap MBS item 10997 to allow for more than five services per patient in a calendar year
	Begin to introduce VPE as the gateway to supporting ongoing telehealth, care continuity and primary care reform funding, with equitable allocation to both practice and practitioner
Medium term	Introduce an independent general practice pricing authority to evaluate and set pricing for general practice activities on which MBS patient rebates and other payments will be fixed
	Regular and appropriate indexation of MBS rebates and other general practice payments, as overseen by the independent general practice pricing authority
	Shift 10% of state and territory health funding towards general practice-led preventive health, and hospital and emergency department avoidance activity, held external to state governments, utilising the National Health Reform Agreement
Long term	Consider pooled funding and co-commissioning approaches that include general practice input and appropriate remuneration, inclusive of all practices within the region
	Consider salaried models of care for underserved communities and areas of market failure, with ongoing evaluation and benchmarking

2.2. Focus area: General practice as an attractive career path with long-term career sustainability

Australians deserve access to healthcare from an appropriately qualified doctor. GPs are specialist doctors who have trained for at least 10 years to make complex diagnostic decisions and work with patients to treat, manage and coordinate their health problems. Without GPs at the heart of primary care, patients lose access to the critical generalist medical skills that GPs possess, and are more likely to experience fragmented and expensive care, and worse health outcomes.[17]

Australia is facing a shortage of GPs alongside worsening maldistribution of the current workforce. Medical student interest in general practice as a career is now at an all-time low of just 13.8% and, with almost 40% of GPs aged over 55 years, there are significant concerns about the devastating impact a decline in specialist GP numbers will have on access to care in the community.

The 2022 *General Practice: Health of the Nation* report suggests that one-quarter of GPs plan to retire within the next five years, an increase from 18% in 2021. In real numbers, this equates to more than 7500 GPs,[2] worsening already worrying workforce projections that predict a deficit of 11,517 GPs by 2032.

General practice clinics are already affected by this general practice exodus, with an increasing proportion of practice owners reporting that sourcing and retaining GPs is a key challenge.

We have also seen an increasing concentration of the medical workforce in non-GP specialties. The number of non-GP specialists continues to grow faster (4.5% per year) than the number of GPs (3.5% per year). In 2014 there were 3143 more specialists than GPs, and this grew to 5283 in 2019.[18] This shows the increasing shift away from generalism and generalist approaches and skillsets.

The link between general practice funding and workforce challenges

Summit participants flagged that funding systems play an important part in the attractiveness of the profession and supporting the future general practice workforce. Inadequate remuneration, as both a GP in training and as a specialist GP, is contributing to the reduced interest in general practice as a career choice.[19]

From the outset, choosing a career as a GP is devalued in comparison to other medical careers. The disparity between the average GP in training's income (at the time of commencing general practice training) and hospital-based positions (that would alternatively be available to them) is estimated by the RACGP to be approximately $30,000 per annum.[20] An additional important disincentive is the loss of entitlements, such as parental, study and sick leave.

Many GPs have also identified the lack of varied career paths as a key deterrent to choosing general practice as a career.

Summit participants highlighted that, without immediate and long-term investment in general practice, targeted workforce measures are unlikely to effectively address the issue of the general practice workforce. Significant reform regarding general practice support and funding is required to ensure the sustainability of general practice and the workforce, both now and into the future.

2.2.1. Short-term measures: Urgent measures to address workforce supply

Immediate action is needed to address key gaps within the current workforce and ensure ongoing access to care for all. All participants agreed it was essential that general practice is seen as an attractive career for medical students and doctors, not one that is associated with poor remuneration and excessive red tape.[21]

GPs in training face various financial pressures when they transition from the hospital training environment to general practice in community settings. Disparities in remuneration and benefits between hospital-based doctors (including doctors in hospital-based specialty training programs) and GPs in training are a critical disincentive to pursue a career in general practice. **To ensure the sustainability of the future general practice workforce, participants recommended increasing the base salary for GPs in training to be commensurate with equivalent hospital-based positions.** This will require government support, as training practices are not in a financial position to pay for improved trainee remuneration.

Compliance and red tape

Government Medicare compliance activities were also flagged throughout the Summit as having a disproportionately negative impact on recruitment into general practice training and on the delivery of high-quality care through general practice. More than three-quarters of GPs reported that ensuring compliance with Medicare takes time away from patient-facing care, and 47% indicated that they either avoided providing certain services or avoided claiming patient rebates (despite providing the services) out of fear of Medicare compliance ramifications. **Reducing red tape and the burden of Medicare compliance in general practice is essential to increase the appeal of the profession.** This must comprise a shift from punitive and onerous compliance processes towards a greater focus on provider education, guidance on how to interpret the MBS and simplification of the MBS to reduce the risk of error.

Practically, Summit participants suggested that there should also be a focus on reducing the red tape burden related to credentialing, authority scripts, named referrals and misaligned referral templates.

Broader measures to address urgent workforce supply

Summit participants raised issues around the availability and cost of locum schemes for GPs. Reliable and cost-effective locum schemes, to support GPs to upskill and take time away from practice, are critical. The lack of locum schemes is a well-documented barrier for rural and remote GPs seeking to build advanced skills, and can be a key factor in GPs choosing to practice in rural and remote areas.[22] However, it was acknowledged that this is not a long-term solution to workforce issues, and structural and funding reform to ensure the sustainability and attractiveness of general practice are needed alongside this and other short-term measures.

One of the three designated roles of primary health networks (PHNs) is to work closely with GPs and other health professionals to assess and build the capacity of the health workforce to deliver high-quality care.[23] Rather than just retaining this as a generic aim for PHNs, participants recommended that the Federal Government designates general practice workforce support as a top priority for PHNs across the country, with a proportion of PHN funding designated for this focus area.

Some participants noted that many PHNs are already co-commissioning a range of services and supports in the primary care sector, while others suggested it remained unclear as to where PHN funding, support and research sits within primary care. It was suggested that more structures be put in place for PHNs to work collaboratively with GPs on all primary care activities and funding measures. One key focus of these structures should be on promoting GP visibility of PHN-commissioned programs and services that enable care for patients to be enhanced; for example, care navigation services funded by PHNs.

2.2.2. Medium-term measures: Re-establishing the value and attractiveness of general practice as a career

Participants observed that exposure to general practice during medical school and prevocational years is critical to influencing the attitudes of medical students towards general practice as a career.[24] Currently, medical students and prevocational doctors are exposed to a range of other medical specialties, but do not consistently have an opportunity to undertake a general practice rotation during pre-Fellowship training. There needs to be investment in medical student and junior doctor interest in general practice.

There was widespread support among Summit participants for the introduction of a program that supports all doctors to undertake a 10–12-week rotation in an accredited training general practice. This type of general practice exposure is invaluable for building unique general practice skills across the medical workforce and allowing junior doctors to experience general practice as a potential career. Such a scheme would need to be accompanied by financial support for supervision within the practice to ensure patient safety, and to support a high-quality educational and clinical junior doctor experience.

The skills acquired through practicing medicine in the community are essential for all medical professionals. Quality exposure to general practice for medical students and junior doctors must be prioritised.

The skills acquired through practicing generalism in the community are essential for all medical professionals. Supporting additional prevocational training placements in general practice, and realigning prevocational training requirements to ensure that community-based generalism skills are required, will help to encourage more medical students and prevocational doctors to gain experience in general practice earlier, exposing them to general practice as a career choice. Participants recommend that this scheme include optional placements in Aboriginal Community Controlled Health Services to showcase the value of general practice within these services and promote a valuable experience for junior doctors.

Supporting GPs in training and international medical graduates

The nature of general practice and the structure of general practice training, placements and rotations mean that GPs in training might not be able to remain with one practice long enough to accumulate leave entitlements (eg study leave, sick leave, parental leave). Additionally, there is no mechanism in place to carry forward previously accrued entitlements to subsequent employers. Junior doctors make crucial decisions about their career based on available entitlements and their family and personal circumstances. Some GPs in training have reported that they elected to stay within the hospital system for longer, and delayed applying for general practice training, to access paid parental leave. Some Summit participants recommended that a national body be established, independent of state and territory governments, to protect GPs in training's entitlements and to ensure salary parity with their hospital-based counterparts. Some participants also suggested a single employer model to address disparity in remuneration and employment conditions between GPs in training and their hospital-based counterparts.

It was also noted that international medical graduates (IMGs) have a substantial role in the Australian general practice workforce, particularly in rural and remote areas. IMGs comprise most of the GPs entering the rural workforce and a significant proportion of the existing general practice workforce.[25] Participants acknowledged the benefits of culture and language diversity in the general practice workforce (both IMGs and Australian medical graduates) as being reflective of the Australian population and contributing to health service delivery, which is culturally appropriate and safe.[26]

Many Summit participants flagged the need for **an integrated workforce and support strategy for IMGs** that incorporates more incentives and support, and a reduction of red tape and administrative barriers to working in Australia. This strategy should be implemented by a single entity responsible for streamlining IMG employment, retention and social support.

Valuing general practice

General practice is often not consistently highly valued or respected in the broader health system or within Commonwealth and state authorities. There needs to be a cultural shift towards acknowledging the importance of general practice and appropriately valuing GPs' work, as well as and rejecting task substitution to non-medical health professionals. **A key part of this is supporting GPs to be leaders**

throughout the health system, as well as in medical research and education. Increasing opportunities for GPs to take on visible leadership roles within the healthcare system has the potential to reduce the exodus from the field, and positively influence medical student and junior doctor attitudes towards general practice as a career.[27,28]

Several participants also suggested exploring fast tacking training for interested Fellowship of Australasian College Emergency Medicine holders to enter general practice. This could be considered in further detail as a measure to swiftly address workforce issues.

2.2.3. Long-term measures: Cementing general practice as an appealing and sustainable career choice

In the long-term, Summit participants identified flexible and supported career progression in a connected healthcare environment, with opportunities and resources to support leadership, as a key priority.
To support and maintain a positive culture within general practice, participants recommended the development of general practice networks that provide localised and tailored support to meet individual needs, including cultural and lifestyle support, mentoring and leadership. These could incorporate dedicated support and role-modelling for new GPs in the first few years of Fellowship, as well as support for GPs relocating to work in areas of need (eg rural and remote areas).

Additional long-term measures will be required to address workforce distribution across Australia, particularly in rural and remote areas, and areas of significant growth. While it is expected that broad measures to increase the number of GPs will help to alleviate many access issues, there will need to be ongoing monitoring of workforce data, as well as research into workforce distribution and modelling. This will help to promote a sustainable and long-term approach to the general practice workforce, ensuring that governments are able to understand and address any ongoing issues.

Solutions for underserved communities

As highlighted in the section on funding reform, there needs to be significant attention given to developing appropriate solutions for workforce and service gaps in underserved communities and areas of market failure. More flexible employment structures (eg salaried roles) could be a key measure to attract GPs to rural and remote areas, as well as other areas of workforce need.

Evidence shows that the two key drivers of GPs choosing to work in rural areas are: (1) the quality and duration of the rural training experience; and (2) having grown up in, or spent a considerable time living in, a rural community.[29] Summit participants discussed a range of initiatives aimed at training rural GPs, attracting experienced GPs to rural areas and supporting existing rural GPs. These could include:

- a whole-of-community approach to settle GPs into rural communities; for example, supporting the GP to find accommodation, childcare or education options for their children and work for their partner
- increased support for rural GP supervisors, including increased funding for compensation, and access to training and professional development
- increasing support for GPs training in rural communities; for example, bursaries to train in rural communities, travel expenses and accommodation provision
- models of support from ‘sibling’ metropolitan practices (eg provision of regular in-person and/or telehealth locum GP assistance).

Participants also raised the potential of incentives to encourage new doctors to choose general practice as a career; for example, a bonus structure for completing general practice training or a student loan rebate after a set number of years working in general practice. Some of these incentives were contentious and garnered opposition from other attendees.

Several participants also discussed a directive for governments to invest in infrastructure that supports the training and retention of GPs according to local needs. Summit participants also raised the narrative of the essential value of the GP in the rural and remote context for reducing ill-health in the community, and minimising the need to access secondary and tertiary services.

2.2.4. Summary of recommendations

The below recommendations are intended to be reflective of the discussion undertaken at the General Practice Crisis Summit and do not represent RACGP-endorsed policy.

Timeframe	Solution
Short term	Increase the base salary for GPs in training to be commensurate with equivalent hospital-based positions
	Reduce red tape in general practice, including streamlining and simplification of the Medicare system, and realign Medicare compliance approach to be less punitive and more educational/preventive
	Introduce reliable and cost-effective locum schemes, including support for GPs to upskill
	Designate general practice workforce support as a top priority for PHNs, and increase visibility and engagement with PHN co-commissioned measures
Medium term	Introduce a program to increase exposure to general practice in prevocational training years
	GP in training entitlements and employment conditions be reviewed to ensure salary and leave entitlement parity with hospital-based counterparts to improve the attractiveness of general practice as a career. This includes consideration of a single-employer model to address disparity in remuneration and employment conditions
	Introduce an integrated strategy for IMGs that incorporates more incentives and support, reducing red tape and administrative barriers
	Consider a single entity that streamlines IMG introduction, employment and retention
	Increase leadership opportunities and incentives for GPs in health services, medical education and research
Long term	Build infrastructure according to local needs, supporting the training and retention of GPs
	Develop general practice networks that provide tailored support to meet individual needs, including cultural and lifestyle support, mentoring and leadership
	Introduce flexible employment structures for underserved communities and areas of market failure

2.3. Focus area: Capture, linkage and meaningful use of data to support equitable general practice-based care

There is great innovative potential in general practice, given its position embedded in the community and at the frontline of health service delivery. GPs have the ability to recognise changes in population health and wellbeing that have not yet progressed upstream.

Participants acknowledged that the collection of health data at a general practice level has the potential to facilitate increased efficiencies in care delivery, create more proactive preventive interventions, identify at-risk populations, inform health strategy and planning, support quality-improvement initiatives in Australian general practice and support judiciously targeted investment.

Currently, comprehensive general practice data, including outcomes data, are not consistently available for policy, research and quality-improvement purposes. They are also not consistently linked with other data (eg hospital data) to support evaluation and research, high-quality patient care and more informed delivery of care within the practice. Data linkage should aim to inform opportunities to improve patient experience and outcomes and overall health system efficiency.

While GPs are often the 'information managers' and advocates for their patients, they are not well supported to engage with, use and safeguard their own valuable data, and often general practice data are used for a range of purposes without GPs' full involvement and knowledge. Research with GPs should be prioritised over research on GPs and their services. Further, many GPs who undertake research often lose income to become academic leaders, disincentivising GPs from doing research or higher degrees.

2.3.1. Short-term measures: Defining the approach and addressing initial barriers

Analysis of healthcare-generated data has the potential to anticipate and better treat illnesses, improve coordination of care across the system and to recognise individuals who are at significant risk of serious health problems. Participants noted that, with the increase in available technology, there are many ways to collect data across the healthcare sector, but there are not consistent ways to make the data usable or broadly available.

Improvements to data collection, linkage and use will be reliant on improving the digital systems that underpin general practice and the broader healthcare system. Data should be readily available to GPs and other practice staff to support quality improvement and better patient outcomes.

GPs must have ownership of their data and should lead data governance over their curated intellectual property. Reforms in this area, in the short term and beyond, should reflect the critical role of GPs in collecting, curating and managing their data within general practice.

A strategic approach to general practice data

To guide the approach to data and digital health in general practice, participants were in broad agreement that there needs to be an overarching data strategy for general practice. This strategy should clearly articulate the key purpose and enablers for data collection, linkage and use in general practice, as well as the value and importance of general practice data to the practice and to their patients. GPs and their patients need to be aware of how their data, including patient records, are being used and for what purpose.

The strategy should incorporate the following principles:

- Shared data from general practice should be used for service planning, resource allocation, quality improvement and research.
- Shared data from general practice must not be used for disciplining or penalising general practice.
- GPs must be recognised partners in the governance of data collection and usage activities, including research and evaluation, from design to delivery.
- General practice data are owned by general practices and GPs. These data have value, and the ownership of these data by GPs needs to be addressed in its use. Data should be used to demonstrate outcomes and value so that savings can be invested back into primary care.
- Protection of data is critical to address privacy and security concerns. Data should be de-identified but able to be linked regionally. It should be able to be re-identified back at the practice to facilitate support for individual patients.
- Transparent and ethical frameworks should guide the capture and sharing of general practice data and highlight the uses of data captured in general practice.

The past two decades have seen widespread adoption of clinical information systems (CIS) in general practice. The future of safe and efficient patient care largely depends on these systems. **Participants agreed that there is an urgent need for an uplift in the way general practice CIS present and share data about patients both inside (imported data) and outside (exported data) general practices**. Participants flagged that the current interface with the My Health Record (MyHR) is so poor that it is almost unusable. It was also noted that the current expectation that GPs will routinely interact with multiple parallel systems, ignoring the time and workload constraints of GPs, is unrealistic.

Supports for interoperability and improved data quality

Participants supported the urgent development and adoption of standards to assist with the interoperability of information transfer between parts of the health system, including the residential aged care system, which should be developed through a collaboration of users, experts in clinical informatics and vendors of clinical information systems. The standards must support the standardised structure, content and management of clinical records.[30] It was recognised at the Summit that increased interoperability might also increase privacy and security concerns, requires complex planning and financial and time investment, and should be supported by education and training to increase uptake, adoption and safety.

There would also be benefit in using general practice networks (as identified in focus areas 1 and 2) to **create local learning health systems that can promote learning from their data to facilitate quality improvement**. It is expected that these networks would help to support peer-based learning and help address any issues or barriers that arise at a local level. These could be based on the learnings from the successes and challenges of the Australian Primary Care Collaboratives Program, and should link into current primary care infrastructure, such as PHNs.

Improved data quality will drive research across the healthcare sector and support quality improvement activities, leading to safer systems and improved quality of care. Comprehensive datasets might be available through systems, such as MyHR; however, this is dependent on the submission of complete and high-quality data. A key barrier to data entry by general practice is the lack of funding offered for collecting valuable population health information, as this is a manual task requiring significant staff time. As such, there must be immediate consideration of measures to support general practice staff to collect and code data gathered within their practice.

Research in general practice

Increasing research in general practice through greater investment from the National Health and Medical Research Council (NHMRC) and the Medical Research Future Fund should also be a key priority over the short term and into the future. There needs to be a renewed focus on supporting research in general practice, including adequate funding to document the care provided to patients, their health outcomes and the resulting impact on the healthcare system more broadly. General practice research must be driven and led by GPs who can interpret data and analyse results informed by their clinical and academic experience of the unique context of general practice care. Increased general practice research can support meaningful quality-improvement activities to drive improvements in patient health outcomes and safety, and to analyse different models of care.

It is important that, from the outset, any new initiatives promoting data collection, linkage and use should limit any additional administrative burden to preserve our expert GPs for patient-facing services.

2.3.2. Medium-term measures: Embedding high-quality data collection and heightening data linkage

Summit participants acknowledged and flagged the significant work in data collection being undertaken by various research groups, as well as ongoing work by PHNs to support greater data collection. Participants emphasised that collaborative action across the sector is an important element of the medium-term approach.

Measuring outcomes and experiences

Participants noted that in the medium term, there should be a growing focus on supporting general practices to seamlessly collect and use patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs) to measure the patient experience of receiving healthcare and outcomes that patients value. These should be used to guide improvement, including via the general practice networks outlined above in the short-term measures. Further, indicators of quality and outcome measurements should be developed in collaboration with GPs to ensure they are contextually relevant, fit for purpose and are interpreted appropriately. There should also be consideration of the limitations of PROMs and PREMs in certain circumstances.

Working towards systematically embedding PROMs and PREMs will be critical to facilitating improved patient care and demonstrating the superior outcomes and benefits delivered by general practice, including economic outcomes. However, participants noted the broader use of this data will rely critically on fostering trust between key stakeholders, including GPs, PHNs and local hospital districts.[31] There needs to be a national and comprehensive approach to data governance that includes GPs, with adequate security measures to promote this trust.[32]

Government and key stakeholders, including GPs, should be working collaboratively with software developers to support ongoing improvements that promote the capture of quality data and build on previous work to improve clinical information systems. **This approach should include greater incentives for all participants to support quality data capture and work towards near real-time data extraction to support quality improvement and research.**

As part of this, Summit participants advocated strongly for the introduction of improvements to user interfaces, coding and security within clinical software systems, as well as minimum coding and data standards for the health system. Participants advised they would also expect to see seamless use of external data, for example, MyHR, in the clinical workflow, rather than as a parallel system.

Gaps in healthcare provider knowledge of digital health systems and data, including collection, linkage and use, should be addressed to support best practice in this area. Summit participants support adopting a central approach to improving the data and digital health curriculum in medicine, from undergraduate to specialty training and ongoing. This is important across the health system to support the linkage of data between primary, secondary and tertiary care. The educational approach should address the good use of clinical information systems, enhancing data quality through best practice data collection and the ethical use of data in healthcare.

Supporting data linkage

In terms of broader data linkage across the health system, **participants firmly agreed on the need for significant advancements in this area across the medium term.** This should include the upscaling and wider rollout of successful data linkage projects, incorporate robust security and privacy measures to protect the personal health data of patients, and support transparency of data collection and use. There must also be a focus on involving and upskilling GPs in data analysis and interpretation, ensuring they are involved at every stage of data collection and use, and ensuring they can access data for their own quality-improvement activities.

Participants also raised the importance of robust monitoring and reporting of GP and staff satisfaction with data measures and digital health implementations, to help to ensure any measures introduced are fit for purpose and acceptable to those working in general practice and providing patient care. This initiative would support a broader shift towards GP leadership in data governance and use. GPs should have ownership of their data throughout any linkage processes.

General practice research

Participants highlighted general practice research as a key focus in the medium term and beyond. Producing evidence to underpin clinical practice in primary care requires a thorough understanding of the general practice context. The active participation of GPs and their practice teams is essential for successful research and research translation in the primary care setting. **To build a robust general practice research sector, participants identified the need to support practices and GPs to participate in general practice research, including funding of higher degree by research scholarships (including part-time options), fellowships and grants, to sustain general practice researchers throughout their careers.**

Importantly, work to support general practice research should also build on already established research programs based on general practice data and practice-based research networks. Summit participants flagged that an investment in primary care researchers can be used to develop methodology to use the data we do have more effectively.

There was also broad agreement around the re-introduction of funding for high-quality longitudinal studies in general practice. One of the key challenges facing general practice is the lack of evidence generated through these long-term studies, such as the now discontinued Bettering the Evaluation and Care of Health (BEACH) and Medicine in Australia: Balancing Employment and Life (MABEL) studies.

2.3.3. Long-term measures: Achieving one integrated system of data collection, sharing and usage

Many Summit participants agreed that the aim of reforms to general practice data should be to produce an integrated health system that uses a shared system for the purposes of clinical care, research and health service improvement. High levels of interoperability and continuous software improvement will result in improved access to the most current and correct information, and enable high-quality care for people across Australia. Systems should be well designed and support users with low levels of digital literacy, particularly those in overburdened sectors, such as aged care.

Lastly, participants identified that robust data linkage through an overarching national approach, that incorporates data from various sectors, is also important. This would include health, justice, social services and education data to drive equitable investment that is allocated according to social determinant modifiers. **Seamless sharing of relevant data should occur within all levels of the health system, informing clinical decision-making, more personalised care, local quality improvement and health system planning.** A key use of general practice data is to identify high-value general practice activities, as well as unmet patient needs or other gaps or inefficiencies in primary care, to invest in evidence-based initiatives to further strengthen general practice, primary care and patient outcomes.

2.3.4. Summary of recommendations

The below recommendations are intended to be reflective of the discussion undertaken at the General Practice Crisis Summit and do not represent RACGP-endorsed policy.

Timeframe	Solution
Short term	Introduce overarching data strategy for general practice
	Create standards to assist with interoperability of information transfer between parts of the health system
	Support a significant uplift in the CIS to be able to seamlessly present and share data about the patients GPs care for
	Introduce funding to support general practice staff to collect and code data gathered within their practice
	Create general practice networks to create local learning systems that can promote learning from their data to facilitate quality improvement
	Increase research within, for and by general practice through greater investment from the NHMRC
Medium term	Apply a national approach to data governance, transparency and security structures to promote trust
	Adopt a central approach to improving the data and digital health curriculum in medicine, from undergraduate to specialty training and ongoing
	Implement greater incentives for all participants to support quality data capture and working towards near real-time data extraction to support quality improvement and research
	Upscale key data linkage projects, incorporating robust security and privacy measures
	Introduce robust monitoring and reporting on GP and staff satisfaction, with data measures and digital health implementations
	Implement support for practices and GPs to participate in general practice research, including funding of scholarships, fellowships and grants, and practice-based research networks
	Re-introduce funding for high-quality longitudinal studies in general practice
Long term	Support robust data linkage through an overarching national approach that incorporates data from various sectors, including health, justice, social services and education

3. Additional post-Summit feedback

Following the General Practice Crisis Summit, participants were given the opportunity to review a draft of this White paper and provide their feedback. Feedback that reflected the recommendations discussed at the Summit was incorporated into the White paper (as above), while any new content has been noted below.

The new content included comments on the following topics.

Topic 1

- Appropriate responses to cultural, ethnic, language and faith/religion diversity in those accessing primary care.
- Weighting in Medicare item numbers for GPs to work on a team-based care model inclusive of nursing, allied health, bicultural support workers and interpreters to enable integrated care and support those factors.
- Addressing those with chronic illness or palliative illness (including survivors of childhood trauma and domestic and family violence) via the Medicare Safety Net threshold.
- Rather than a general practice pricing authority, introducing an overarching body that covers hospital care, primary care and other social supports.
- The need for consideration of the potential tax and employment implications of the introduction of voluntary patient enrolment (VPE).
- Support for GPs to spend time on paperwork for disability pension or National Disability Insurance Scheme access applications for patients.
- The value of embedding pharmacists within general practice.
- Planning for the approach to VPE to address GPs with specific interests.
- A forum for discussion about the way that GPs can contribute to the broader context of healthcare.

Topic 2

- Using the Workforce Incentive Program to incentivise older GPs to stay and not retire, with an annual boost in funding for GPs over 60 years of age.
- Embedding reward for experience/career progression into funding models.
- Recognising the interface of the private medical business model on the economies of the health system.
- Curriculum training and pathways around working with priority population groups with complex healthcare needs and barriers posed through structural inequities; for example, patients with unresolved asylum seeker claims.
- Education and research with a dedicated focus on multicultural health, noting that disparities and solutions cannot be advocated, tracked or progressed as a matter of routine practice.
- Consideration of workforce issues related to changes in the Practice Experience Program and Section 19AB restrictions and exemptions.

Topic 3

- Fostering innovation via adequate research infrastructure, linking to specific learning health systems.
- Education for patients on the importance of data collection.
- Capturing data via coding of diagnoses using the International Classification of Diseases-10.
- Gaps in research into the provision of general practice services to culturally and linguistically diverse (CALD) patients, including costs.
- Significant deficits in data capture relating to culture and language diversity through general practice software systems.
- Publishing data on CALD populations in each of the 31 PHN catchment areas in respect to demographic profiles, health status and inequity data.
- This White paper forming part of a longitudinal process of assessing progress, with key performance indicators to be revisited over time.

4. Contributors

The RACGP again thanks all individuals and organisations that contributed to the General Practice Crisis Summit and the development of this document. We particularly acknowledge the input and advice provided by those involved in the running of the General Practice Crisis Summit and the following authors and reviewers of the paper:

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