RACGP Submission to the National Health Reform Agreement Addendum 2020-2025 Mid-term Review

National Health Reform Agreement Addendum 2020-2025

RACGP

About the RACGP

The Royal Australian College of General Practitioners (RACGP) is the voice of general practitioners (GPs) in our growing cities and throughout rural and remote Australia. We are Australia's largest professional general practice organisation representing more than 43,000 urban and rural general practitioner members. For more than 60 years, we've supported the backbone of Australia's health system by setting the standards for education and practice and advocating for better health and well-being for all Australians.

As outlined in the RACGP *Vision for general practice and a sustainable healthcare system* (the 'Vision'), the RACGP has a roadmap for sustainable and high-quality healthcare created through a strong primary care system that keeps patients out of hospital for as long as possible. The Vision places the patient at the centre of care. It highlights the multidisciplinary care approach across primary care should reflect the need for care across the health system integrated into the patient's usual general practice. Price Waterhouse Coopers (PwC) has evaluated the Vision and estimates it could deliver $5.6 billion in benefits and 520,000 quality-adjusted life years over 5 years.[1]

The RACGP has a long and proud history of keeping general practice at the forefront of the quality healthcare agenda, supporting our members in their pursuit of excellence in patient care and community service and, supporting efforts aimed at collaboration and integration to improve quality and safety across the health system.

Overview

The RACGP welcomes the opportunity to provide a submission to the National Health Reform Agreement (NHRA) Addendum 2020-2025 Mid-term Review. The RACGP views this review as a significant opportunity to drive the integration and collaboration between primary and secondary health systems and provide maximum return to both health systems.

The RACGP supports the intent of the NHRA Addendum to improve health outcomes for all Australians and ensure our health system is sustainable. The NHRA Addendum rightly recognises the responsibility of the Commonwealth to consider reforms in primary care designed to improve patient outcomes and reduce avoidable hospital admissions. In doing so, the NHRA Addendum signals to all key stakeholders the need for greater support for general practice, which sits at the heart of the primary care system. However, the NHRA Addendum also has significant gaps that have left the health system fragmented and unsustainable. While the NHRA Addendum discusses reforms in primary care, this has not been accompanied by the additional government investment in general practice required to support any reforms. Further, cost-shifting between primary and secondary care, as well as fragmentation between health, disability, and aged care systems, continue to impact patient outcomes. The RACGP acknowledges governments have already taken some actions to improve the health system through the NHRA Addendum but notes these are yet to significantly impact the delivery of primary care. The NHRA Addendum needs to devote greater attention to empowering innovation in primary care and instituting long-term reform to general practice to ensure its financial sustainability and the sustainability of its workforce.

For the NHRA to achieve its goals, significant investment in and prioritisation of primary care will be necessary. Primary care is already the most cost-effective and affordable part of Australia's health system. However, significant reform is needed to ensure it can better interact with the hospital system as patients move between primary and secondary health. The NHRA is an opportunity to implement reforms that enhance the collaboration and integration of primary and secondary care. This integration needs to not just be at the planning and governance level but within the digital environment as well. Underpinning many important reforms will integrate digital systems that enable fast and secure communication and the sharing of patient data. The NHRA needs to put an end to the practice of requiring named referrals and develop digital systems that allow for electronic referrals and discharge and transfer of patient records. Collaboration between GPs and local hospitals needs to not just be encouraged but incentivised through the creation of MBS items for liaison with hospitals.

The RACGP believes the NHRA also has a significant role to play in growing the general practice workforce. In addition to improving the remuneration of GPs and making general practice a more attractive career choice, the NHRA can implement important hospital reforms to increase exposure to general practice and create new career opportunities for GPs. The NHRA needs to ensure that when a GP refers a patient, services are available for the patient to be referred to. Specialist outpatient clinics are out of reach for too many Australians and funding for these services must be matched with need if we are to see meaningful reductions in waiting lists to receive specialist advice.

Recommendations

There exists a clear gap in the NHRA Addendum regarding support for general practice to reduce demand for hospital services. Any future agreement must be underpinned by significant additional investment in general practice, targeted towards supporting the role of general practice in reducing demand for hospital services and keeping people well in the community.

The RACGP acknowledges input is requested on the key elements outlined in Clause 21 of the Preliminaries to the Addendum, as well as the additional factors nominated by Health Ministers in the lead-up to the mid-term review.

The RACGP's recommendations focus on the following areas outlined in the consultation invitation as they are most relevant to general practice:

***Clause 21, element (a):* Reform in the primary care, aged care, disability, and mental health systems as they relate to the operation of the Addendum.**

- Use stronger language and regulations to prevent public hospital outpatient clinics from controlling referral pathways by requiring named referrals for access and working towards a reduction in the number of MBS items claimed by hospitals. General practice needs to be involved in these reforms to ensure referral pathways have GP input and remain a collaborative action.
- Support hospitals and other health services to use standardised, secure, interoperable digital systems for data sharing, referral and discharge between general practices and hospitals and facilitate fast and easy clinician-to-clinician communication to facilitate referral and discharge and discuss patient care.
- Pilot data-sharing arrangements between hospitals and primary care with the ultimate goal of better identifying at-risk patients, tailoring individual care/reducing low-value care and developing services tailored to the health needs of communities.
- Increase the number of places available for hospital-based doctors in the John Flynn Program and investigate sustainable funding for a program for junior doctors to undertake a rotation in general practice so it can be reintroduced with the goal of encouraging more doctors to embark on careers in primary care.
- Invest in general practice liaison (GPL) units to enable them to better facilitate communication between primary and secondary care.
- Introduce, support and create pathways which enable GPs to liaise with hospitals, in a timely way, regarding their patients' unplanned admission or emergency department (ED) presentation.
- Resume key data gathering activities, as based on the Bettering the Evaluation and Care of Health (BEACH) project.

***Clause 21, element (b):* The impact of external factors on the demand for hospital services and the flow-on effects on Addendum parameters.**

- In the revised NHRA, create an objective to facilitate cooperation between governments around preventative care and social prescribing, to move towards a nationally coordinated social prescribing scheme.

***Outside of Clause 21, additional factors nominated by Health Ministers: Policy* changes and adjustments to the mechanics of the national funding model.**

- In the revised NHRA, create an objective around investigating and supporting the role of general practice in reducing demand for hospital services, accompanied by guaranteed, long-term, recurrent and indexed investment from both Commonwealth and state governments for this purpose.
- Provide funding support for specialist GPs located within hospitals to improve care and create exposure to general practice for junior doctors.
- Reduce the disparity of remuneration between GPs and other specialties to make general practice more attractive to junior doctors.
- Match funding for specialist outpatient clinics to levels of need in the communities they serve.
- Conduct a review of spending with a focus on health economics to identify areas of the highest cost-effectiveness and prioritise the funding of these areas in the future.

Reform in primary care

The RACGP has identified several impacts from reform in the NHRA that will require consideration to primary care, as guided by Clause 21(a) of the NHRA review:

> *Preliminaries to the NHRA Addendum Clause 21(a): Implementation of the long-term reforms and other governance and funding arrangements, and whether practice and policy in place delivers on the objectives of the NHRA and the Addendum.*

The discussion of these impacts has been included below. These not only relate to the various elements of Clause 21(a) of this review but also efforts by the Commonwealth to better integrate the various contributors to the overall health sector.

Hospital and general practice collaboration

Historically Australia has had a siloed approach to healthcare with levels of the health system and health services prioritising their own affairs rather than how they interact and transfer patients between levels and services. To streamline our health system these siloes must be broken down. Stakeholders at all levels should pursue better integration between services collaboration to ensure seamless clinical handover as patients move across the health system. The transfer of patients between primary and secondary care has already been discussed as a significant pain point for patients, and collaboration between hospitals and GPs and the integration of systems will be vital to improve this. The RACGP sees significant opportunities to achieve these goals in the role of GPL units.

While many models for GPL currently exist with some being led by GPs or by nurses, the goals of GPL should be to provide a first point of contact for general practices on matters relating to the hospital. GPL should be able to provide general practices with the information they need to best refer patients to their services and follow up requests by GPs for details of a patient's history within that hospital. Within hospitals GPL can represent the interests of general practice, ensuring hospital policies will be compatible with General practice processes and ensuring the smooth transfer of patients between services.

The RACGP's Vision sees coordinating care with hospitals and health services and helping patients navigate the health system to be an important part of a GP's role. Every day GPs need to make quick decisions about whether they can manage a patient's care in a community setting or if admission to a hospital is best for the patient. Often this is based on the GP's clinical judgement and may lack a full picture of how a hospital will treat a patient and what their capacity is to deliver those services. GPs should be supported to regularly liaise with their local hospital(s) about patients to avoid unnecessary admissions and patient re-admissions to hospital. To fully realise such collaboration additional necessary data sharing and secure two-way electronic communication capabilities will need to be established in all services. The RAGP believes the NHRA should support these communications through new MBS items to ensure GPs can be renumerated when having these conversations and don't need to perform this task unpaid.

Opportunities for reforms to the hospital and general practice interface can be better identified through high-quality data about how general practices are operating. BEACH is a valid and reliable GP dataset in Australia, with almost 1.8 million GP-patient encounter records from 1998 to 2016.[2] The conclusion of BEACH in 2016 left a significant and unfilled gap in

general practice data, and the resumption of data gathering activities should be a key priority for government to inform health reform activities, including the review of the NHRA Addendum.

Referral and discharge

The primary and secondary care systems are not well integrated in Australia. As a result, the transfer of care between them is a significant pain point for patients within the Australian health system.[3] GPs have reported they find the process for referring patients to hospitals unclear and difficult to navigate.[4] GPs are forced to continue using paper-based systems such as fax machines to refer patients to hospitals. Communication with other health services can be further complicated if details in common databases like Healthdirect or the National Health Services Directory aren't up to date. Many hospitals will have unique templates GPs are required to use to refer patients but provide little guidance on how to fill them out and update them without notifying referring GPs.[5] These templates rarely integrate with practice management software, requiring GPs to fill them out manually, taking time away from seeing patients. These templates can turn referrals into a bureaucratic mess, requiring GPs to spend valuable time sorting through PDFs, and going back and forth with hospitals about which template is the correct version. Rejection of referrals for administrative and bureaucratic reasons can be distressing for patients whose care is now being delayed. GPs also need to do this in their own time unpaid or require a patient to attend the practice so they can claim Medicare rebates while the GP fills out paperwork.

Once a patient is referred GPs have little information about how long they need to wait to be seen and GPs are often unclear about how best to advocate for patients who need to be moved up the waiting lists due to complexity or vulnerability.[4] If GPs had better information about when their patients will be seen they could better prepare patients for hospital to improve their outcomes during admission. Once a patient is discharged from hospital, too often discharge summaries provide insufficient information to enable best-practice care by GPs. A study of hospital discharge summaries found that 76% did not provide a full list of medications provided to the patient during hospitalisation and 79% did not contain full results from pathology tests.[6] 23% took more than 5 business days to arrive at the GP and 45% were not received before the GP had a follow-up appointment with the patient.[6] 8% of known hospitalisations did not result in a discharge summary and 13% of discharge summarised were illegible due to poor handwriting or faxing/scanning errors.[6] Instances of patient allergies not being reported to GPs have also been reported.

The hospital referral process can also be more costly for the federal government where hospitals pressure patients and GPs to provide named referrals, shifting costs away from public hospitals and onto Medicare.[7] Requirements for named referrals have been particularly frustrating for GPs whose compliant referrals are rejected for not naming a specialist when there is no legal requirement to do this. Where hospitals pressure referring GPs for named referrals, it is questionable whether the business roles in Schedule G of the NHRA are being adhered to in practice and whether the underlying principles of the NHRA, including the principle of patient choice, are being respected. GPs can be reluctant to raise complaints against the hospital or debate the regulations with them as this could further delay patient care and many ultimately provide a named referral to ensure the patient is seen as soon as possible. Ultimately the practice of named referrals uses money that has been allocated for primary health to pay for the hospital sector. Hospitals need to be accountable for using the funding set aside for them effectively and not seek to use funds that have been established for other parts of the system. The NHRA must work towards reducing the volume of MBS items claimed by hospitals to ensure the financial sustainability of Medicare and the health system overall.

To modernise the referral and discharge process, the NHRA should require hospitals and other health services to use standardised, secure, interoperable digital systems for referral and discharge between general practices and hospitals that are compatible with existing general practice management systems. The system should be able to display patient information and a patient's place on waiting lists in real-time for both GPs and hospitals. The system should allow a GP to electronically refer a patient and see how long the patient will be waiting to receive treatment. Such a system should

require the same information, in the same format be requested from referring GPs regardless of which hospital or health service they are referring to. Integration with existing practice management software would allow much of the form to be automatically completed, allowing GPs to spend more time with patients. Such a system could prompt the GP to address critical referral eligibility criteria, thus avoiding ineligible referrals in many instances. On discharge, the discharge summary could automatically include details such as what medications and tests were provided to the patient during hospitalisation including relevant test results, any adverse reactions to medication and a recommended GP management plan or a hospital escalation pathway if the condition worsens in the community. This system should be created alongside guidelines for hospitals to provide GPs with avenues to advocate for patients who have vulnerabilities to increase transparency and communication between hospitals and GPs. Any system implemented (including current systems) needs to ensure the details of all practices are up to date to ensure services can reliably contact one another.

Preventative health

To reduce hospitalisations over the long term, actions need to be taken before people become unwell, not just after. GPs provide care through a person's entire life cycle and are well-placed to provide preventative healthcare and improve health literacy. Measures to improve health literacy and provide tools to help patients manage their conditions are low-cost measures that noticeably improve patient outcomes.[8] This is an area of health care currently poorly supported by the current level of Medicare rebates and by current health funding models. Fee-for-service and activity-based funding are both models that reward health services for the throughput of patients and have proven highly effective at ensuring large volumes of patients are treated.[8] A drawback of these models is that they can disincentivize preventative healthcare, patient self-management, services that don't require patient attendance and other measures which lead to patients spending less time with health services. With gap fees becoming close to double the rate of a standard consultation, it can be challenging to push for patients to see their GP for preventative healthcare when they feel well and do not have a pressing healthcare need.[9,10] Increasing Medicare rebates would reduce financial barriers to having additional, preventative health discussions between GPs and patients. The increases to bulk billing incentives announced in the 2023 Federal Budget will go a long way in enabling GPs to have preventative health discussions with patients that find care the least accessible. Over the long term, preventative health services will be best funded through ongoing flexible funding delivered to general practices on top of the fee-for-service model.

Social prescribing is an effective treatment regime to improve preventative health outcomes and improve a range of risk factors including isolation and a sedentary lifestyle.[11] As social prescribing is a recently developed treatment regime, not all GPs are familiar with it and may need additional resources and support to bring them into practice. The RACGP recommends future agreements include an objective to facilitate cooperation between governments around preventative care and social prescribing, with the intention of moving towards a nationally coordinated social prescribing scheme. Such a scheme would provide unfamiliar doctors with the tools and support necessary to roll out social prescribing in their practice. As Australia's population ages, social prescribing will become more and more important due to the vulnerability of older Australians to isolation and reduced physical activity.[11]

Voluntary Patient Registration

An ongoing relationship with a GP or practice allows for the provision of continuous and comprehensive care throughout all life stages.[12] An ongoing relationship with a GP allows GPs to make decisions with a comprehensive understanding of the patient's medical history and their social and environmental determinants of health. Patients should be encouraged to form an ongoing therapeutic relationship with their GP, which will lead to both having a holistic understanding of the patient's needs.

The RACGP sees Voluntary Patient Registration (VPR) as a potential method of formalising the doctor-patient relationship and encouraging continuity of care as a patient moves through the health system.[13] While access to primary care for unregistered patients should never be compromised, the RACGP supports additional health supports, services and incentives being made available to registered patients. VPR can facilitate better integration between hospital and GP systems by assisting hospitals to quickly access a patient's medical records, transfer hospital records to the general

practice and communicate with the patient's regular GP to collaborate in care. VPR can also be a mechanism to provide practices with flexible funding to facilitate areas of patient care that fee-for-service funding currently poorly renumerates. Under the RACGP Vision, the fee-for-service model is simplified and complemented by the introduction of more blended funding to support comprehensive and continuous care.

The RACGP is cautiously supportive of the recently announced MyMedicare patient registration program. The RACGP will work with the government to ensure MyMedicare has the right model for patients and GPs. For the RACGP to support MyMedicare, at a minimum it must:

- Be voluntary and flexible with fee for service remaining the central funding pillar of general practice.
- Be GP-led with multidisciplinary teams based within general practice.
- Not be tied to compulsory bulk billing.
- Include additional investment in GPs to support the delivery of comprehensive and coordinated care for enrolled patients.
- Be backed by transparency and rigorous review including review and evaluation of the impact of MyMedicare on care and practice viability.
- Ensure resulting savings be invested into general practice in a transparent process.

Virtual models of care

COVID-19 has introduced a wave of digital innovation and proved the effectiveness of telehealth and other digital health technologies. The RACGP sees these innovations as exciting opportunities to improve the quality and increase the accessibility of primary care, reduce unnecessary face-to-face outpatient appointments and emergency department presentations and enable greater collaboration with GPs and other health services. Successful virtual models will need to be underpinned by fast and secure two-way data-sharing arrangements between health systems. Digital patient records could be easily and securely transferred from general practice to the hospital through an integrated digital system.

Hospitals receive significant disincentives for virtual models of care for patients the hospital is caring for but is not currently admitted or accepted to an outpatient clinic. Reforms should be made to hospital payment schemes to facilitate funding of virtual initiatives aimed at reducing hospitalisations and facilitating the easier transfer of care to a patient's GP.

Hospital-in-the-home models of care have proved invaluable during the COVID-19 pandemic and continue to be an important part of administering care while keeping hospital beds available. A virtual model of care in the home opens opportunities to more easily involve a patient's GP as part of their hospital-in-the-home care. To facilitate this, the NHRA needs to implement reforms to allow GPs to claim MBS items for telehealth consultations with a patient receiving hospital-in-the-home care for health issues unrelated to their hospitalisation.

The RACGP wishes to also highlight the apparent prioritization of videoconferencing in the MBS's approach to telehealth despite both patients and GPs consistently demonstrating a preference for telephone consultations where they are available. The RACGP encourages governments to support patient access to telehealth without preferencing one technology over another to prioritise access to care.

External factors and their impacts on hospitals

The RACGP has identified several external factors impacting hospital demand that will require consideration to primary care, as guided by Clause 21(b) of the NHRA review:

> *Preliminaries to the NHRA Addendum Clause 21(b): The impact of external factors on the demand for hospital services and the flow-on effects on Addendum parameters.*

The discussion of these factors has been included below. These not only relate to the various elements of Clause 21(b) of this review but also efforts by the Commonwealth to better support access to general practice care for all patients.

Access to primary care

General practice is the bedrock of the Australian healthcare system. Australians see their GP more than any other health professional, with 9 out of 10 people seeing their GP at least once a year.[14] Care in general practice is also considerably more affordable than hospital care, with one average hospital admission being over $1000 more expensive than a patient seeing their GP for 20 minutes twice a week for an entire year.[10,15] Accessible primary care is essential to facilitating timely discharge from the hospital and the smooth running of outpatient clinics by ensuring as much care is possible if provided in the community and reserving hospitals and outpatient clinics for those that need them. Unfortunately, Australians are currently experiencing a number of barriers to accessing primary care in their communities including difficulty finding GPs with the flexibility to bulk bill. When patients delay receiving care, their conditions can worsen, requiring admission to a hospital when their level of need exceeds what can be provided within primary care. Those who seek care but cannot afford to attend a general practice will often present to the emergency department where they know they will receive care if they wait long enough.[16,17] A study by the University of Wollongong found that almost 20% of emergency department presentations listed the lack of cost associated with seeing a doctor at an emergency department as an important reason for their attendance. Despite their commendable efforts, emergency departments are being pushed to their limit across Australia and waiting lists for care in hospitals have blown out to multiple years.[18,19]

General practices have been significantly impacted by the Medicare rebate freeze between 2013 and 2018 and the continued low indexation of Medicare. Estimates suggest these factors together have resulted in primary care being underfunded by $3.8 billion.[20] This underfunding has either needed to be absorbed by practices that continue bulk billing or general practices must move to mixed billing and charge gap fees for many patients. RACGP fellows have reported that their current fee for a 20-minute consultation is almost twice the applicable MBS rebate.[9,10] 70% of Fellows surveyed reported that the fee they charge for a standard consultation is too low and does not reflect fair remuneration for the service provided. with so many GPs feeling that their work is being undervalued, it's understandable that 25% intend to retire in the next 5 years and only 11% of Specialist Training Program Interns are interested in pursuing a career in general practice.[9,21] 53% of practices expect to increase their fees for a 20-minute consultation and 60% are looking to change their billing models to reduce the proportion of bulk billing.[22] The rate of bulk billing has already dropped from 86.9% to 83.6% between June and December 2022.[23]

The RACGP has welcomed the significant investment in the accessibility of general practice by the Federal government in the recent 2023 Federal budget as a game-changer for the profession. The tripling of bulk billing incentives, increased indexation of Medicare, support for longer telehealth items and measures to increase access to after-hours care will all make it easier for patients to access care, especially those who face significant financial barriers. Following this initial investment in general practice, it is critical we see ongoing funding for high-quality general practice care, including the permanent continuation of measures introduced in the 2023 Federal budget.

The RACGP recognises the federal government's efforts to increase access to primary care and reduce pressure on emergency departments through the creation of urgent care centres including the eight new clinics announced in the 2023 Federal Budget. The RACGP maintains its position that to ensure continuity of care, it's best practice that a patient is seen by their usual GP for acute health needs and that GPs have the flexibility to bulk-bill patients as required. The RACGP supports practices that wish to operate as urgent care centres receiving funds for necessary upgrades to existing infrastructure. To ensure urgent care centres are used as intended, health services need clear guidance about when to refer someone to an urgent care centre and when an urgent care centre should refer someone either to an emergency department or back to their usual GP. The RACGP reiterates its position that it is highly unlikely that urgent care centres will be able to remain financially viable using current consultation items and additional funding will need to be introduced for service delivery to adequately support this unique environment.

Chronic conditions and multimorbidity

As Australia's population lives longer and becomes older, we see continued increases in the rates of people living with chronic health conditions and multimorbidity. These conditions are complex and can require longer hospital admissions and regular follow-ups in hospital outpatient clinics even if they are stable. Such patients can be challenging to manage

in both primary and secondary care settings. To better manage chronic health conditions and multimorbidity within hospitals, the RACGP highlights the potential for GPs to be employed within hospitals. GPs' generalist training leads itself to be well suited to managing multimorbidity and chronic disease and helping patients move between different health services and specialties.

The RACGP envisions GPs can be used in hospitals to coordinate the care of patients with complex needs and/or experiencing multimorbidity and to manage the transfer of patient care from the hospital back to the community. GPs within hospitals can also play a role in reviewing emergency department admissions to identify preventable admissions and organise community-based treatment and support to prevent readmissions. Placing GPs in hospitals increases the overall capacity of the health system as knowledge is shared between professions through co-location. This knowledge will then be disseminated through the health system as GPs move between primary and secondary care environments. The RACGP believes there is a significant opportunity for incorporating GPs into hospital processes and recommends the future NHRA has an objective around investigating and supporting the role of general practice in reducing demand for hospital services. A larger role for GPs within hospitals would have the additional benefit of providing junior doctors with increased exposure to general practice. Junior doctors' exposure to medical specialities plays a significant role in their decision-making regarding what medical specialty they wish to pursue. With a looming shortage of GPs, junior doctors must receive more exposure to general practice to encourage a career that addressed this workforce shortage.

General practice workforce

An effective primary care system that keeps potentially preventable hospitalisations (PPH) low requires a sustainable workforce of GPs. Australia is facing a looming shortage of GPs, particularly in rural and remote areas.[24] This is expected to be exacerbated with 25% of GPs reporting intentions to retire in the next 5 years.[9] The RACGP notes and applauds the recognition of this shortage in the National Medical Workforce Strategy (NMWS) 2021-2031 in priority four to build the generalist capacity of the medical workforce. However, the RACGP feels the NMWS could have gone further in making general practice a specialty of choice for junior doctors. A range of measures recommended in the RACGP's submission to the NMWS were not adopted such as:

- Reducing the disparity of employment conditions between GPs in training and hospital-based trainees.
- Reducing ways in which the MBS fee-for-service model incentivises sub-specialisation.

Adoption of these measures would go a long way in providing incentives for junior doctors to pursue a career in general practice.

The major reason that junior doctors increasingly pursue specialties other than general practice is the disparity of remuneration between general practice and other specialisations. This disparity begins during a junior doctor's time as a GP registrar and continues even after they achieve fellowship. On average other specialties take home almost twice the salary that the average general practitioner does.[25] This lower remuneration is also tied to an unclear and stress-inducing Medicare regulatory environment which other specialties interact with to a lesser extent than GPs. If governments want junior doctors to pursue general practice as a career, it needs to be made equally financially attractive as other specialties.

Another significant reason that junior doctors don't express an interest in general practice is they don't get to see it in action during their rotations. Most junior doctor training is hospital-based, as such they are mainly exposed to hospital-based specialties during their rotations.[26] Previous programs have shown that when junior doctors receive exposure to general practice they are more likely to pursue it as a career.[27] Those who are exposed to general practice in rural areas are also more likely to practice rural medicine after training.[27] The Pre-vocational General Practice Placements Program (PGPPP) was an important program that allowed junior doctors to gain experience providing medical care in community settings. Analysis of the PGPPP shows that around 9 out of 10 reported the placement 'better informed my career decision' and 'enhanced my understanding of primary care'.[28] The John Flynn program has also already been shown to effectively convert exposure to rural general practice into careers in rural general practice.[29] The RACGP recommends expanding the John Flynn program and investigating sustainable funding for a program for junior doctors to undertake a rotation in general practice.

Due to the over 10-year process it takes for a high school student to become a general practitioner, Australia is unlikely to be able to resolve any GP workforce shortage in the short term without bringing in additional international medical graduates (IMGs) to bolster the GP workforce. The RACGP is supportive of measures to encourage more IMGs to complete their training and practice in Australia. To complete their training, all GP trainees require support. IMGs don't have access to the same support networks and familiarity with the Australian medical and education system that Australian-based trainees benefit from.

The RACGP Fellowship support program has already helped many IMGs achieve fellowship and can be scaled up to support IMG GP trainees into the future. The RACGP calls on the future NHRA to provide funding to support 500 participants per year in the RACGP Fellowship Support Program to support more IMGs to achieve GP fellowship. For Australian-based GPs in training, many will graduate with significant student debts in part due to needing to pay fees to pay for their student placements. While many public hospitals rightly see providing medical student placements as part of their core business, others require medical schools to pay for student placements. These fees charged to medical schools are either passed on to students not enrolled in a commonwealth-supported place or ultimately reduce the resources available for providing high-quality education to commonwealth-supported students. The NHRA needs to establish the transparent and explicit expectation that publicly funded hospitals engage in the training of medical students as part of their core business and must pay for these placements from their own budgets rather than passing the cost onto medical students and training providers.

Increased investment in general practice teams, through the Workforce Incentive Program, is also needed to ensure practices are staffed to support high-quality multidisciplinary care. The RACGP would encourage increases in the WIP funding to better support pharmacists and other allied health staff working in the general practice setting. A 20% increase in payments under the Workforce Incentive Program combined with the uncapping of funding and regularly indexing payments would provide a significant increase in resources for general practices to support the multidisciplinary teams that are crucial to how general practices operate in the Vision.

Aboriginal and Torres Strait Islander workforce

Aboriginal and Torres Strait Islander patients have consistently shown a preference for receiving care from Aboriginal or Torres Strait Islander doctors to ensure cultural safety.[2] To close the gap in Aboriginal health outcomes, having a sizeable Aboriginal and Torres Strait Islander medical workforce that can address the health needs of their community will be crucial. Aboriginal and Torres Strait Islander junior doctors and GP trainees face many additional pressures usually not experienced by their non-indigenous peers which make achieving fellowship more difficult. These pressures include being a first-time educational role model, living away from their community, expectations around continuing cultural obligations during training and working in culturally unsafe environments.[30] To create working environments truly supportive and culturally safe, Aboriginal and Torres Strait Islander voices need to be present at all levels of health organisations. Future agreements need to support governance mechanisms in hospitals to ensure the representation of Aboriginal and Torres Strait Islander people at senior levels within hospitals.

The National Funding Model

The RACGP has provided comments on the operation of the national approach to funding for hospital services, including the National Funding Model, as they relate to the role of general practice in supporting reduced demand for hospital services. The comments in this section reflect the additional elements of the NHRA mid-term review nominated by Health Ministers, as below:

> *Policy changes and adjustments to the mechanics of the national funding model.*
>
> *Reform in the primary care, aged care, disability and mental health systems as they relate to the operation of the Addendum.*

The discussion of these issues has been included below, with a particular focus on the intersection between national funding approaches and the need for greater investment in general practice care.

Funding shift to general practice

To properly implement the integration and collaboration between levels of the health system envisioned in the NHRA, general practice must be supported to maximise its potential, leverage its advantages, and take pressure off of hospitals and outpatient clinics. General practice is the most accessed part of Australia's healthcare system with 189 million GP attendances per year.[14] These services deliver effective care within the community that prevents the emergence of disease and treats conditions in the community before they become severe enough to require hospital care.[31] Lumos data in NSW has found that patients who have their diabetes first diagnosed with a GP experienced lower mortality and fewer hospital admissions than people who received their diabetes diagnosis in a hospital.[32] Patients who see their GP soon after discharge from hospital experience significantly fewer hospital readmissions. Dedicated time for seeing a GP following an unplanned hospital admission will help reduce a person's chance of readmission by up to 24%.[33] Research published by the CSIRO has indicated that up to one in seven hospital discharges results in unplanned readmission within 28 days and many of these patients will have unplanned readmissions multiple times.[34] There is significant potential for hospitalisations to be reduced by encouraging better follow-up care in general practice.

This care is also delivered at a significantly lower cost than care delivered in hospitals. If Australia's health system is to remain financially sustainable, greater diversion funding will be required towards general practices and away from expensive hospital care. This shift in funding will over time lower reduce the demand on hospitals and help keep their costs sustainable by reducing PPH and managing chronic disease in the community rather than hospital. The RACGP acknowledges the focus of the NHRA Addendum on funding for hospital services across Australia through the National Funding Model, as supported by the Independent Hospital and Aged Care Pricing Authority. However, for the NHRA to achieve its goals, significant investment in and prioritisation of primary care will be necessary.

To deliver for GPs the NHRA needs to set out additional funding for general practice that enables them to have longer consultations with patients with lower financial barriers to access. Additional funds and access to data are also needed for general practices to develop programs and services that are tailored to the health needs of their communities.

Funding should be consistent to encourage long-term planning and investment and flexible to allow GPs to invest in services that suit the needs of their community best. In the Productivity Commission's case study Innovations in care for chronic health conditions, the Commission has already identified a number of practices that have taken the initiative and developed such targeted services to address the needs of their community. Such services are low-cost yet provide significant improvements in the quality of life for people managing chronic health conditions.[8]

Needs-based public outpatient funding

Working with other specialists, allied health and diagnostic services are an everyday part of GPs ensuring patients get the correct diagnosis and the best medical advice and treatment, cost must not be a barrier to patients receiving advice from these services. Public outpatient clinics perform this vital role of allowing any patient to receive diagnostics and specialist and allied health advice that can't be provided in general practice. Unfortunately, access to specialist outpatient services is not equal, with 65% of non-admitted patient service events occurring in major cities, 28% in regional areas and 2% in remote areas.[35] This maldistribution of outpatient services leads to patients being forced to travel long distances for care, pay significant out-of-pocket costs for private appointments or delay care. Funding for specialist outpatient services needs to be matched to levels of need in communities. Such an approach would ensure all patients can receive timely access to care, ensuring care is not delayed or becomes more severe.

Role of Primary Health Networks in Funding and Reform

Primary Health Networks (PHNs) present a possible pathway to providing and administering some flexible funding within the primary care sector. However, while the RACGP appreciates the need by the government for management and oversight of additional funding, the RACGP is concerned with this additional layer of bureaucracy. Using PHNs as a delivery mechanism for funding risks delaying funds reaching GPs and therefore patients. Where possible it is the RACGP's preference that funds be provided as directly as possible to GPs to simplify funding programs.

Where funding is allocated through PHNs, they must work closely with local general practices to ensure the delivery of services to the community are aligned with local need and do not duplicate already existing services. Efforts to ensure general practice representation on PHNs will support better-integrated care. RACGP Fellows have noted that insufficient supporting funding and performance monitoring have been applied to the collaborative commissioning processes of PHNs. Shared funding from state and federal governments to support collaborative commissioning with investments in performance monitoring will likely benefit the sustainability of collaborative and integrated models of care and improve the patient journey between the two health systems.

Cost-effectiveness in the health system

The cost to the Australian government of the Australian health system has risen to $105 billion in 2022-23, in addition to the billions spent by state and territory governments.[36] As the Australian population ages this amount will only increase with an expected real-term growth of 2.5% between 2022-23 and 2025-26.[36] These increases will be very difficult to sustain into the future as Australia's slowing labour force reduces taxation revenue.[37] To ensure the financial sustainability of the Australian health system funding needs to be prioritised for areas that demonstrate the highest cost-effectiveness in health economics. General practice has a strong track record of delivering cost-effective care early which keeps people out of hospital. PwC has analysed the potential cost savings to government from providing the investment in general practice sought by the Vision. PwC identified that in the first year after implementation, the investment in general practice sought by the Vision would save $152 million from reduced preventable hospitalisations, $552 million from reduced emergency department presentations and $69 million from unplanned hospital admissions with additional savings over the next 15 years.[1] Too often we have seen health spending committed to: isolated projects targeting specific diseases and reacting to demand rather than investing in cost-effective sectors that will deliver system-wide long-term benefits. To identify areas for future investment, the RACGP recommends the NHRA fund a review of spending in the Australian health system from a health economics perspective to identify areas of the highest cost-effectiveness. Once identified, the NHRA must prioritise funding these areas to deliver long-term sustainability to the Australian healthcare system.

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