Attach

RACGP submission

Delivering quality care more efficiently – interim report

September 2025

RACGP

Contents

1. Executive Summary

The Royal Australian College of General Practitioners (RACGP) thanks the Productivity Commission for the opportunity to provide comment on the public consultation *Delivering quality care more efficiently – Interim report*.

Whilst we do not see any specific recommendations that will encourage the realignment of Australia's health system from very expensive hospital services towards prevention-focused multidisciplinary teams working in general practice, we support many of the Commission's recommendations particularly proposals for improved collaborative commissioning partnerships and a National Prevention Investment Framework.

While we are hopeful the recommendation to establish a framework to guide funding for preventive care will lead to greater recognition and support for general practice preventive care, we are concerned the foundational role GPs play in Australia's health system has been underacknowledged in the interim report. Evidence supports the need for GPs to be recognised as key asset in the development of productivity strategies for Australia's healthcare system.

In recognition of the vital role general practice plays in preventive healthcare the College asks for GP representation on the proposed Prevention Framework Advisory Board to ensure appropriate and effective prevention programs are funded and maintained.

In our submission we have taken the opportunity to suggest additional specific measures to reduce red tape that will provide efficiencies in care provision and have called out potential productivity benefits of improved interoperability between government and clinical information systems, which we argue should be prioritised.

We also take opportunity to the insist productivity reforms start with a commitment to embed cultural safety and meaningfully consider social determinants of health in order to achieve greater health equity and address the "Inverse Care Law". This is the only approach that will move Australia closer to addressing the priority metrics identified in Treasurer Jim Chalmers MP's Measuring What Matters framework.

2. Summary of RACGP recommendations

We have made a number of recommendations throughout this submission which are summarised here:

Global recommendations

i. Productivity reforms must start with a commitment to embed cultural safety and meaningfully consider social determinants of health in order to achieve greater health equity and address the "Inverse Care Law". This should be a focus in the final report.
ii. Evidence demonstrating the role of specialist general practitioners in delivering efficient and effective healthcare across care sectors and in preventive health should be acknowledged and leveraged to achieve greater productivity, not just for the healthcare system but in supporting all Australians to live longer, healthier and more productive lives.

In response to Interim Report Recommendation 1.1

iii. GPs be formally and appropriately acknowledged as a medical specialist across the various funding mechanisms, sectors and responsible agencies.
iv. Standardised quality and safety reporting framework requires consultation to develop a common set of indicators and ensure Aboriginal and Torres Strait data sovereignty is embedded.
v. To achieve a consistent response to regulation of artificial intelligence, GPs must be involved in development and post market surveillance systems.

Further opportunities and recommendations

vi. Prioritise work to improve interoperability between government and clinical information systems across the care sector.
vii. Additional initiatives that reduce administrative and regulatory burdens on health practitioners should be identified and progress to improve productivity and free up more time for patient care.

In response to Interim Report Recommendation 2.1

viii. The RACGP's recommendations concerning PHN operations and governance in previous submissions be revisited when considering collaborative commissioning.
ix. GPs must be involved in collaborative commissioning and supported to do so.
x. Closing the Gap reform commitments must be utilized as a guide.
xi. PHNs and LHNs should be able to act locally on social determinants of health, using a similar model to ACCHOs.

Further opportunities and recommendations

xii. Data-sharing agreements and formal governance arrangements are important if GPs are to engage positively in joint commissioning
xiii. Pool hospital and PHN funding and allow greater flexibility in how PHNs are allowed to use funding and commission services.
xiv. Involve local GPs in collaborative commissioning.
xv. Data sharing should align with RACGP's key principles for the secondary use of general practice data by third parties. Secondary use of data must not compromise GP and patient trust. Indigenous data governance and sovereignty principles must be embedded.
xvi. Referral, discharge summaries and information sharing should be standardised so referral information can be made and received in a consistent format across all healthcare sectors.

In response to Interim Report Recommendation 3.1

xvii. GP and Aboriginal and Torres Strait Islander perspectives must be well represented on the Prevention Framework Advisory Board.
xviii. The Preventive Health Investment Framework must:
- consider the four priority reform areas of Closing the Gap in the establishment of any preventive health initiatives
- honour the existing commitments from the National Aboriginal and Torres Strait Islander health plan 2021-2031 and the National Aboriginal and Torres Strait Islander health workforce strategic framework and implementation plan 2021-2031
- incorporate recommendations from key Aboriginal and Torres Strait Islander led initiatives such as Yoorrook Justice Commission's recommendations for health

- focus on investing more resources into areas of disadvantage.

xix. The Preventive Health Investment Framework should also:
- specify types of prevention to be targeted
- support a systematic, nationally scaled and locally implemented approach to social prescribing in Australia
- support investment more resources into areas of disadvantage
- support investment in clinical guidelines that support preventive care.

Further opportunities and recommendations

xx. Health assessments should be available to patients of all ages to improve healthy equity and ensure all Australians have access to appropriate resources and supports to live longer, healthier and more productive lives.

3. Introduction

Every year more than 20 million Australians see a specialist general practitioner (GP) for their essential health care, making GPs the most accessed health professional in the country and the backbone of Australia's health system. GPs provide care through all stages of life and consider patients within their social, cultural and environmental contexts. Those ongoing relationships make general practice a key player in the treatment of acute and chronic health conditions and preventive care.

Given the foundational role GPs play in the healthcare system, the Royal Australian College of General Practitioners (RACGP) thanks the Productivity Commission for the opportunity to provide comment on the public consultation *Delivering quality care more efficiently – Interim report.*

Evidence shows GP care keeps people out of the expensive hospital system and allows them to live longer, healthier and more productive lives. So proposals to deliver quality care more efficiently that do not acknowledge the role of GPs in providing comprehensive, continuous whole of life care will fail to realise the positive and impactful heath system efficiencies they strive to achieve and are unlikely to meaningfully improve patient outcomes.

Therefore, before responding to the Interim Report's recommendations, our submission outlines areas we argue need more considered focus in the Commission's final report, these being: the role of GPs in providing quality, whole of life and preventive care, and embedding cultural safety and addressing the social determinants of health to improve health equity.

In responding to the Interim Report's draft recommendations, we have articulated broad support for many of the proposals, particularly for improved collaborative commissioning partnerships and a National Prevention Investment Framework. We have also offered additional recommendations to be considered in the drafting of the final report.

4.Areas requiring focussed consideration in the final report.

The RACGP's June 2025 submission to this inquiry called for measures to support general practice multidisciplinary teams, general practice-based pharmacists, and health assessments across the lifespan. None of these were specifically endorsed in the interim report.

As a result, the interim report misses opportunities to build on what we know works well – high-performing, enabled and well-funded general practice.

The RACGP is also concerned the interim report makes no commitment to embedded cultural safety in any of its reform proposals, nor does it meaningfully acknowledge the social determinants of health and the importance of adopting a health equity approach to system reforms.

We recommended both matters be given more focussed consideration in the context of potential productivity gains when developing the Commission's final report.

4.1 The role of specialist GPs in quality, whole of life care and preventative health

Generally, the role of the specialist GP in caring for people in sectors of focussed interest (aged care, disability care and veterans care) appears to have been underrecognised, undervalued or at least, underacknowledged in this interim report. GPs provide care through all stages of life and consider patients within their social, cultural and environmental contexts. They have an in-depth understanding of the whole patient and deal with all aspects of physical and mental health.

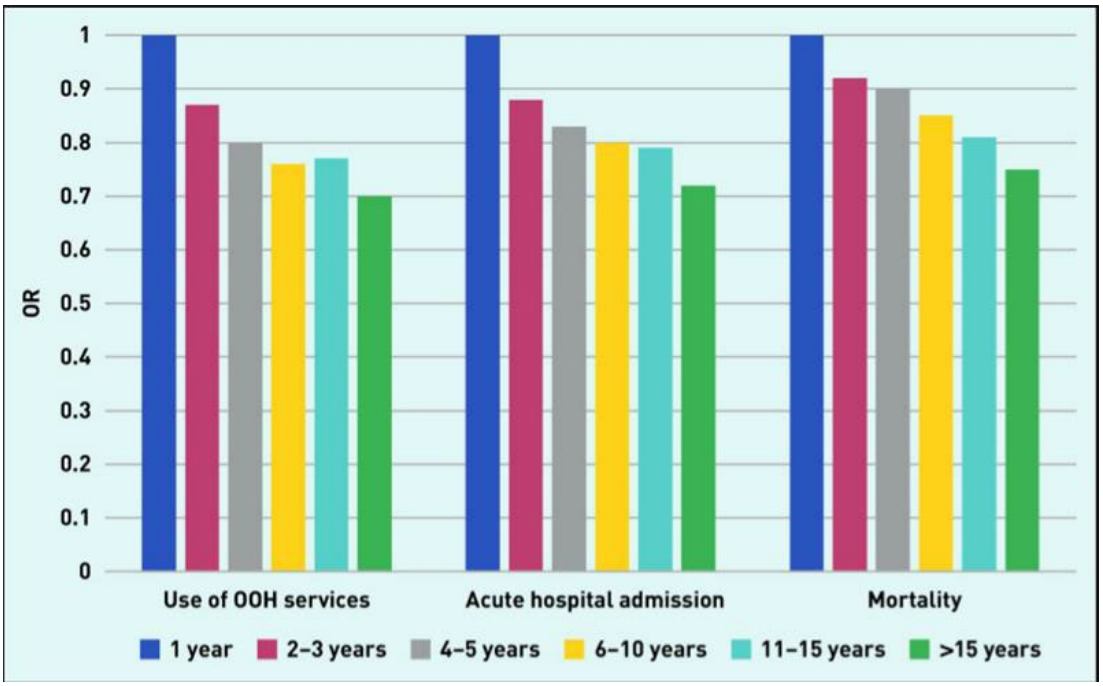
GPs provide regular, trusted and tailored health advice direct to patients, improving targeting of services and increasing patient awareness, understanding and confidence regarding their health and wellbeing. The holistic, patient-centred and relationship-based approach of general practice helps to ensure the effectiveness of preventive activities.

There is substantial evidence showing continuity of care (in the context of the doctor-patient relationship) improves health outcomes, helping people live longer, healthier lives, including:

- University of Cambridge researchers studied over 10 million consultations in English primary care practices over 11 years and found that patients who regularly saw the same GP extended the time between consultations (18% longer) and importantly, did not equate to a need for longer subsequent GP consultations or more emergency department appointments.
- Lumos data in New South Wales demonstrates the benefits of GP access to reduce hospital readmissions and in the management of chronic disease.[1]
- A Norwegian study[2] demonstrated that the length of the patient- same regular general practitioner (RGP) relationship is significantly associated with lower use of out-of-hours (OOH) services and acute hospital admissions and lower mortality.

Figure 1 (below) shows the associations between continuity measures as years with the same regular general practitioner (RGP) and odds for use of out-of-hours (OOH) services, acute hospital admissions and mortality in a 2018 Norwegian study.

Figure 1. Associations between continuity measured as years with the same RGP and odds for use of OOH services, acute hospital admissions, and mortality during 2018.



Source: Sandvik H, Hetlevik Ø, Blinkenberg J, Hunskaar S. Continuity in general practice as predictor of mortality, acute hospitalisation, and use of out-of-hours care: a registry-based observational study in Norway. Br J Gen Pract. 2022 Jan 27;72(715):e84-e90. doi: 10.3399/BJGP.2021.0340. PMID: 34607797; PMCID: PMC8510690.

When considering productivity reforms aimed at improving health system efficiencies and effectiveness the role of specialist GPs in providing care, particularly to at-risk populations cannot be ignored and must be well integrated into new models of care and governance frameworks.

4.2 Embedding cultural safety and addressing the social determinants of health to improve health equity

The RACGP is also concerned the interim report makes no commitment to embedded cultural safety in any of its reform proposals, nor does it meaningfully acknowledge the social determinants of health and the importance of adopting a health equity approach to system reforms.

The health consequences of poverty and adverse social determinants of health limit the choices and agency that people have over their own lives, and through reduced access to health services through a range of reasons. There are multiple determinants of health, as acknowledged in the Department of Health's National Preventive Health Strategy 2021–2030, including environmental, structural, economic, cultural, biomedical, commercial and digital factors, which frequently act adversely on people living in poverty. Rates of chronic conditions are more common in low socioeconomic areas. These include Chronic Obstructive Pulmonary Disease (twice as likely, compared to the highest SES areas); diabetes (1.9 times as likely); Chronic kidney disease (1.6 times as likely); chronic heart disease (1.6 times as likely) and a new cancer diagnosis (1.1 times as likely).[3]

The health outcomes described above and elsewhere show the need for health services accessible to people living in poverty to manage and alleviate these health consequences. However, the difficulty in providing healthcare to those who need it most has become such a recurring problem over such a long time that it was named in 1971 as "The Inverse Care Law": "The availability of good medical care tends to vary with the need for it in the population served."

The solutions to poverty in Australia will be multifaceted and include multiple agencies, including government, non-government and private, and must come from the affected communities themselves. Primary Health Care has as one of its key goals, equity of access and equity of health outcomes.[4] There are several features of Primary Care that help alleviate poverty:

- Affordable care
- Embedded care
- Multidisciplinary care

Aboriginal and Torres Strait Islander people are over-represented in people living in poverty, which is in itself a consequence of centuries of colonisation and racism, the effects of historical and current policy, such as child removals from family, and the lack of cultural safety in health services. People living in rural and remote Australia experience higher rates of poverty than those who live in metropolitan areas, and have the challenges of geographic distance, workforce shortages, and limited infrastructure and resource availability to contend with.[5]

Refugees and asylum seekers have often experienced significant trauma, from which they have fled, and may not speak or understand English. Many people who have been in prison are also in poverty, and have their own challenges in contact with the justice system. Many people with disabilities live in poverty, caught between inadequate benefits, and work opportunities limited by systems and stigma.

The particular circumstances of all these groups must be taken into account, and solutions should be considerate of specific community needs.

5. RACGP response to Interim Report recommendations

5.1 Draft recommendation 1.1: The Australian Government should pursue greater alignment in quality and safety regulation of the care economy to improve efficiency and outcomes for care users

The RACGP supports this recommendation in principle. A fractured approach to strategies and plans across health service systems has led to uncoordinated efforts and gaps in responsibility not just between agencies but the broader primary care system, including general practice.

An example of this is the lack of collaboration between general practice and the disability sector, including through the NDIS, where GPs are not formally or appropriately acknowledged as a medical specialists who coordinate the total healthcare of patients with disabilities who are also supported by the NDIS. GPs could improve the NDIS and patient outcomes if they could:

- coordinate, review and discuss a patient's initial and ongoing NDIS plans with the patient and provide expert advice to NDIS planners for consideration prior to finalisation
- automatically receive a copy of a patient's NDIS plan as well as reports generated by NDIS support providers (with patient consent)
- contact NDIS providers directly (with patient consent) to advise of issues a patient may be experiencing and the need to amend a plan.

More positively, the RACGP is very supportive of the Coordinated Veterans' Care model of care in the way it systematises complex care for patients, and encourages multidisciplinary team care, and improved care coordination. Further, the RACGP considers it to be a key example of a successful GP-led care coordination program, and the College has highlighted the successful features of this model to other health funders, including Medicare, and would support its expansion to other at-risk patient cohorts including for aged care and those living with disability.

Broader regulatory landscape recommendations

The broad range of high-level measures proposed in the interim report to align the **broader regulatory landscape** across the aged care, NDIS and veterans' care sectors listed under Recommendation 1.1 in the Interim report summary are noted and have merit.

i. With regard to the establishment of a standardised quality and safety reporting framework and data repository to reduce reporting burden and enable more consistent reporting the RACGP recommends:
   - Further consultation to develop a common set of indicators to ensure data collection is meaningful but not onerous
   - Aboriginal and Torres Strait Islander data sovereignty be embedded in any framework to ensure the right of Indigenous peoples to control data about them and align with the principle of self-determination and improving health outcomes.

ii. The RACGP supports the recommendation for a consistent approach to the regulation of artificial intelligence (AI). AI has great potential but as these technologies become more advanced, the risks that they pose must be carefully mitigated. The RACGP:
   - Requests that GPs be involved in the development and integration of AI-based solutions in the sectors they work within, including aged care, NDIS and veterans care, to ensure solutions are fit-for-purpose

- argues that efforts to ensure the sector is appropriately regulated include post-market surveillance systems and
- is committed to support GPs to develop the skills needed to work with AI as required.

iii. With regard to exploring the suitability of a singular regulator across the aged care, NDIS and veterans' care sector, this must be structured and resourced to be free of racism, culturally safe, and able to support well-trained health professionals who are able to respond to the needs of Aboriginal and Torres Strait Islander people.

The RACGP offers the following further initiatives from a general practice perspective that would improve productivity and deliver quality care more efficiently:

Investment in interoperability of clinical information systems (CISs) across the health sector

Lack of interoperability between CISs across the health sector and government significantly impacts sector productivity. Efforts to align quality and regulatory systems across sectors must prioritise improvements to CIS interoperability. A major contributor to the administrative burden placed upon GPs is the need to interact with different CIS across the three target sectors and beyond. There is a critical need to address the lack of interoperability to support the sharing and exchange of patient data. The use of fax and paper letters to share information is outdated and does not support the efficient delivery of care. The RACGP's position statement on interoperability and useability requirements for general practice CISs outlines key information on this topic, issues and recommendations.

Reducing administrative and regulatory burden

Maximising the time GPs spend caring for patients or otherwise facilitating that care, particularly for patients located within the aged care, disability and veterans care sectors must be a priority. A productive and well-functioning primary care system depends on the ability of health practitioners to devote their time and expertise to direct patient care. Low value compliance activities take time away from patient care and inhibit the quality of services doctors can offer their patients.

Reducing the administrative and regulatory burden on general practices will improve productivity by freeing up more time for patient care and could be achieved by:

- streamlining the online Pharmaceutical Benefits Schedule (PBS) authority system as per RACGP recommendations, which includes full integration with general practice clinical information systems to enable more efficient prescribing processes. One in three GPs rate applying for PBS authority approvals as their greatest administrative burden.
- reforming Medicare claiming processes, such as the 90-day Pay Doctor via Cheque Scheme (PDVC), to reduce delays and errors and improve cash flow for practices. Delayed payments and rejected claims create financial stress and impact bulk billing viability.
- simplifying the Medicare Benefits Schedule (MBS) by limiting the introduction of new disease-specific item numbers and clarifying rules around co-claiming (ie when multiple MBS items are billed by a practitioner during a single consultation).
- ensuring government agencies are able to share and receive information through secure means of digital communication that integrate with GP clinical and practice software (eg the National Disability Insurance Scheme Access Request Form).
- enabling Medicare claiming channels to instantly reject claims that are non-compliant, alleviating stress and worry for GPs. This must be approached cautiously to avoid any delays in payments for compliant services.

Recommendations

- GPs be formally and appropriately acknowledged as a medical specialists across the various funding mechanisms, sectors and responsible agencies.
- Standardised quality and safety reporting framework requires consultation to develop a common set of indicators and ensure Aboriginal and Torres Strait data sovereignty is embedded.
- To achieve a consistent response to regulation of artificial intelligence, GPs must be involved in development and post market surveillance systems must be included.

Further opportunities and recommendations

- Prioritise work to improve interoperability between government and clinical information systems across the care sector.
- Additional initiatives that reduce administrative and regulatory burdens on health practitioners should be identified and progress to improve productivity and free up more time for patient care

5.2 Draft recommendation 2.1: Governments should embed collaborative commissioning, with an initial focus on reducing fragmentation in health care to foster innovation, improve care outcomes and generate savings

Overall, the RACGP welcomes measures to remove fragmentation in the healthcare system. Many current measures (eg role substitution, urgent care) increase fragmentation with no evidence these measures will improve care quality or efficiency, and instead, will likely worsen quality of care and efficiency.[6]

Collaborative commissioning

The RACGP agrees in principle with the report's recommendation to embed collaborative commissioning into the governance and funding arrangements for LHNs, PHNs and ACCHOs. The RACGP has previously recommended PHNs collaborate with LHNs and ACCHOs when completing their needs assessments in its submission to the review of the PHN business model and mental health flexible funding model and we continue to support this position.

The RACGP agrees collaboration and joint initiatives between PHNs, LHNs and ACCHOs will reduce service duplication and fragmentation, enabling more streamlined and effective services. Closer collaboration between these organisations will provide greater visibility and accountability across the sector at a regional level. The Closing the Gap Priority Reform commitments must guide how this collaboration happens.

RACGP advocates for policies that support Aboriginal and Torres Strait Islander people to make decisions about, and take responsibility for, their own health and wellbeing – this includes financial and political support for Aboriginal and Torres Strait Islander–led initiatives, and evidence-based engagement and consultation practices (https://www.racgp.org.au/FSDEDEV/media/documents/RACGP/Position%20statements/Working-together-to-improve-the-health-and-wellbeing.pdf)

PHNs can provide effective support to GPs though identifying community needs and service delivery gaps; and for the brokering of mutually supportive relationships between practices, local community, government and non-government agencies and services, the experiences of GPs across Australia with PHNs varies substantially. An RACGP newsGP poll found more than 50% of respondents classified their PHN as poor or very poor.

The RACGP has also made numerous other recommendations concerning PHN operations and governance in previous submissions, listed below:

- RACGP submission to the Review of Primary Health Network Business Model and Mental Health Flexible Funding Model.
- RACGP submission to the Effectiveness of Dept of Health & Aged Care's performance management of Primary Health Network program audit.

Overall, we are optimistic that greater collaboration with ACCHOs and LHNs would encourage underperforming PHNs to improve.

GP involvement in collaborative commissioning efforts

GPs are often a patient's first point of contact in the health system and need to have a significant voice in collaborative commissioning efforts. Involving GPs with current clinical experience will provide vital expertise into the design, implementation and evaluation of collaborative commissioning projects. GPs and practices will require the appropriate tools and training to effectively engage and participate in collaborative commissioning. For example, training and support in business/project/change management, data insights/reporting tools, legal/governance support, administration/workforce capacity.

Seeking specific feedback from GPs working in ACCHOs and those working in lower socio-economic areas will be important to ensure the complexity and challenges of the communities they support are understood and taken into account.

Empower ACCHOs, PHNs and LHNs (along with local GPs) to determine areas of greatest funding need within their jurisdictions.

The RACGP recognises that PHNs are diverse and their relationships with the ACCHO sector and its peak bodies are inconsistent, and in some cases there is resistance to meaningful engagement.[7]

We also note PHNs are increasingly required to locally implement policies that have been designed at a federal level. PHNs have limited capacity to adapt these programs to the local context. While there are circumstances where a national approach is ideal, the focus of PHNs should be on regional health priorities. If PHNs have the capacity to address regional needs as their clear focus and priority while also implementing national programs, this will result in increased trust and goodwill between PHNs and general practices.

PHNs and LHNs should be able to address social determinants of health at their local level, using a similar model to ACCHOs. There will be differing health needs according to each area, and these groups are best placed to act on and address local issues like housing, health justice and social prescribing.

A stronger foundation and structure that embeds cultural safety, shared decision making and accountability is needed to ensure effective long-term outcomes for individuals and communities.

This will also provide opportunities for PHNs and LHNs to directly address workforce difficulties in the local area. For example, by employing GPs to work across practices in deprived areas or remote towns or employing allied health professionals (eg general practice pharmacists, nurses, or social workers), to work from some of the general practices.

Team-based care improves health outcomes for patients and reduces GP workload, supporting business viability. GPs must be involved in the governance of these measures. Recent initiatives to address gaps in GP services have often created competition for GP workforce with no net benefit for communities. Some urgent care clinics, and previously, GP superclinics, have effectively 'poached' GPs from the local area leading to re-distribution rather than increase in services. Other initiatives have cherry picked tiny components of GP services to deliver in other settings with very limited evidence of efficiency or effectiveness. Expensive examples include nurse practitioner emergency clinics in ACT and community pharmacy pilots in Queensland. Greater investment in existing GP services would achieve much more than standalone narrowly focused services.

The RACGP offers the following further initiatives from a general practice perspective that would improve productivity and deliver quality care more efficiently:

Data sharing governance

Data-sharing agreements and formal governance arrangements are important if GPs are to engage positively in joint commissioning of services. The RACGP agrees with the need for stronger requirements for formal joint collaborative commissioning committees. This should include dedicated funding and the development of data-sharing arrangements to underpin joint needs assessments and evaluation of outcomes to ensure GPs engage in the process.

Support for robust governance structures and flexibility in funding

The RACGP outlined its support for the pooling of hospital and PHN funding as well as greater flexibility in how PHNs are allowed to use funding and commission services in its submission to the Review of Primary Health Network Business Model and Mental Health Flexible Funding Model.

Greater flexibility is necessary for PHNs to adapt services to meet the needs of their regions. Pooling of funds is a straightforward way to reduce service duplication and fund larger services which can take advantage of economies of scale and greater resourcing without increasing the funding burden on government. The RACGP supports additional resourcing of LHNs, PHNs and ACCHOs to undertake comprehensive joint governance. A criticism the RACGP has had of the existing PHN model is inconsistent governance structures. Support for more robust governance structures will support collaborative commissioning and translate to improved governance of PHNs.

As discussed in the interim report, the Health Alliance is an excellent example of LHNs and PHNs collaborating in care to significantly improve outcomes for some of the most vulnerable patients in the Brisbane area.

Long-term funding certainty for general practices is essential, especially in rural and underserved areas. Unpredictable funding cycles and short-term grants undermine continuity of patient care, as well as business planning and workforce retention.

The RACGP's position statement on funding priorities calls on Australian Governments to:

- Prioritise health spending which supports:
  - Equitable access to person-centred, comprehensive, continuous and coordinated primary healthcare
  - Integration and collaboration between the primary, secondary and tertiary healthcare systems, as well as related health and social services, such as aged care
- Significantly increase expenditure on health, in relative and per capita terms
- Utilise evidence to guide investment, program development and service planning

Improve integration between hospitals and primary care

General practice is currently poorly integrated with state hospital systems leading to increased complexity and worse outcomes for patients. While e-referrals are improving integration in some states, referring patients to hospital often remains administratively burdensome for GPs. Many hospitals still use hospital specific templates and may reject a referral for unclear administrative reasons, resulting in GPs spending time resolving these issues rather than seeing patients.

The lack of timely discharge summaries is a consistent hindrance to GPs providing effective care after a hospitalisation. Many discharge summaries are received more than 48 hours after patient discharge, if they arrive at all. In many cases, the GP is only made aware that a patient was hospitalised when the patient presents for a follow-up consultation, expecting the hospital to have briefed the GP about what care the patient needs next.

Lumos data from New South Wales has shown visiting a GP within 2 days after an unplanned hospital admission can reduce readmissions by up to 32%. The RACGP advocates for hospitals to always provide discharge summaries to the patient's regular GP within 48 hours to enable high quality post-discharge care. Governance standards for private hospitals and emergency departments should align so GPs can make referrals and receive information in a consistent format.

Recommendations

- The RACGP's previous recommendations concerning PHN operations and governance in previous submissions be revisited when considering collaborative commissioning
- GPs must be involved in collaborative commissioning and supported to do so.
- Closing the Gap reform commitments be utilized as a guide.
- PHNs and LHNs should be able to act locally on social determinants of health, using a similar model to ACCHOs.

Further opportunities and recommendations

- Data-sharing agreements and formal governance arrangements are important if GPs are to engage positively in joint commissioning
- Data sharing must align with RACGP's key principles for the secondary use of general practice data by third parties. Secondary use of data must not compromise GP and patient trust.
- Embed Indigenous data governance and sovereignty principles.
- pool hospital and PHN funding and allow greater flexibility in how PHNs are allowed to use funding and commission services.
- referral, discharge summaries and information sharing should be standardised so GPs can make referrals and receive information in a consistent format.

5.3 Draft recommendation 3.1: Establish a National Prevention Investment Framework to support investment in prevention, improving outcomes and slowing the escalating growth in government care expenditure

The RACGP welcomes the establishment of a National Prevention Investment Framework. As a key aspect of defining scope and planning implementation, the Framework should identify which type of prevention will be the key focus (for example, primordial, primary, secondary, tertiary and/or quaternary). As the main provider of primary and secondary

prevention advice to Australians in the community, GP expertise and input will be critical in understanding the clinical inclusions and design and potential utility of the Framework.

Prevention Framework Advisory Board

GP, Aboriginal and Torres Strait Islander representation on the proposed Prevention Framework Advisory Board is essential to shape and harness our sector's involvement in prevention. The RACGP would be pleased to assist in finding a suitable GP representative. The RACGP's Representative and Endorsements Coordinator will be able to arrange a GP representative and can be contacted at: repsandendorsements@racgp.org.au.

The RACGP offers the following further initiatives from a general practice perspective:

Culturally safe preventive healthcare for Aboriginal and Torres Strait Islander people.

The National Aboriginal and Torres Strait Islander health plan 2021-2031 recognises that prevention and early intervention are central to health, and that preventive health programs foster positive health and wellbeing outcomes for Aboriginal and Torres Strait Islander people. This requires investment in a responsive healthcare system that is structured and resourced to be free of racism, culturally safe and staffed by well-trained health professionals who are able to respond to the needs of Aboriginal and Torres Strait Islander people.

It is imperative that the four priority reform areas under Closing the Gap drive design of policy and establishment of any preventive health initiatives:

- Formal Partnerships and Shared Decision Making
- Building the Community Controlled Sector
- Transforming Government Organisations
- Shared access to Data and Information at a Regional Level

It is the particular responsibility of the Australian Government to ensure this commitment is sustained with effective, collaborative leadership and coordination with state and territory governments.

Existing commitments from the National Aboriginal and Torres Strait Islander health plan 2021-2031 and the National Aboriginal and Torres Strait Islander health workforce strategic framework and implementation plan 2021-2031 and recommendations from key Aboriginal and Torres Strait Islander led initiatives such as Yoorrook Justice Commission's recommendations for health are paramount.

Areas of disadvantage

The health consequences of poverty and adverse social determinants of health limit the choices and agency that people have over their own lives, and through reduced access to health services through a range of reasons. There are multiple determinants of health, as acknowledged in the Department of Health's National Preventive Health Strategy 2021–2030, including environmental, structural, economic, cultural, biomedical, commercial and digital factors, which frequently act adversely on people living in poverty.

People in disadvantaged communities have more chronic disease, more mental health problems, more multimorbidity at a younger age, and often live in social circumstances that result in worse health.[8] They also have less access to healthy food, nature, and clean air. Critically, access to healthcare is often worse for these groups.[9]

The Framework should focus at several levels:

- Federal and/or state policy level – for example, policies relating to welfare, housing, health screening, immunisation and public health (such as alcohol pricing or tobacco control).
- Local level action on social determinants of health – this is currently being done well by ACCHOs, and could also be done by PHNs (including supporting local infrastructure for social prescribing as well as developing programs in their regions that support access to appropriate housing, health food and community activities).[10]
- General practice level – this is the level where preventive measures can be best implemented as GPs have direct contact with people. Evidence demonstrates that decisions to participate in screening and vaccination, are often influenced by a conversation with a GP. People trust the information and advice from their GP because they have developed trust and rapport.[11] The Patient-Reported Indicator Survey (PaRIS) found that 94% of Australian patients rated the medical care they received in the past 12 months as good to excellent.

Factors like having an ongoing relationship with a GP, reduced cost and travel barriers, and increased awareness and usage of digital services were linked with more positive experiences of quality of care.[11]

Enabling Preventive Healthcare through MBS health assessment item numbers

MBS Health assessments provide a valuable opportunity for GPs to do preventive health and comprehensively examine physical, psychological and social needs and review risk reduction measures. The funding also allows practice nurses, Aboriginal health workers and Aboriginal Torres Strait Islander health practitioners to assist with health assessments, utilising skills within a multidisciplinary care team and allowing patients to receive wraparound care from a range of healthcare professionals.

Currently, health assessments are very limited to specific groups. Ideally, regular evidence-based health assessments should be available to patients of all ages, with recommended intervals varying depending on healthcare need (as an example, older people would receive an assessment more frequently than young adults). This is preferable to singling out specific conditions upon which to base eligibility, which creates a hierarchy of diseases and is open to debate.

Expanding the patient cohorts eligible for health assessments should be deemed an investment in more affordable and accessible preventive care for patients. These health assessments should be evidence-based, using the RACGP's Guidelines for preventive activities in general practice (the Red Book) to guide appropriate preventive activities to undertake for each individual patient. Guidelines are critical pieces of health infrastructure needed to support the delivery of high quality, evidence-based care. We call for government investment in RACGP guidelines to be continuously updated in as new evidence becomes available, to support preventive care, as an important step in improving health outcomes across the population.

GPs must remain central to the delivery of health assessments and coordination of follow-up services, with support from multidisciplinary teams in general practice. Health systems with a strong foundation in general practice will deliver better health outcomes.

A healthy society is a productive society. Poor health is associated with absenteeism and lower productivity at work.[12] Labour force participation rates are consistently and considerably lower for people with a health condition, and lower still for people with multiple health conditions.[12] Carers' participation in work may also be impacted, as they may need to take time away from their jobs to care for ill or injured family members.

If Australians are supported to visit their GP earlier, they will be more likely to receive appropriate preventive care, early diagnosis and early treatment for health conditions. This will improve workforce participation and economic productivity.

Evidence-based preventive care and high-quality acute and chronic disease management provided through general practice will:

- help people to live healthier lives and age well in the community
- reduce disease complications and prevalence of preventable hospital presentations and admissions
- reduce healthcare expenditure for government
- reduce future out-of-pocket costs for patients
- address health disparities and inequities experience increase the overall economic productivity of society.

Governments pay more for a single patient hospital admission than the cost of that same patient visiting their GP twice a week for an entire year.

Enabling preventative health care through social prescribing

Social prescribing could provide a valuable addition to the existing range of healthcare options in Australia. However, to date, the adoption of social prescribing as an organised program of support has been limited.

Social prescribing is 'a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services'.

The Preventative Health Investment Framework should support a systematic, nationally scaled and locally implemented approach to social prescribing in Australia could lead to:

- improved prevention and management of physical and mental illness

- a shift in the focus from illness to wellness
- increased consumer enablement and self-management
- a more comprehensive approach to service delivery
- decreased demand for health services • greater value care, and greater access to care and support
- reduced siloing of health and community services
- increased wellness and decreased helplessness for both providers and patients
- decreased social isolation and loneliness
- stronger communities.

In response to Interim Report Recommendation 3.1

- GP and Aboriginal and Torres Strait Islander perspectives must be well represented on the Prevention Framework Advisory Board.
- The Preventive Health Investment Framework must:
  - consider the four priority reform areas of Closing the Gap in the establishment of any preventive health initiatives
  - honour the existing commitments from the National Aboriginal and Torres Strait Islander health plan 2021-2031 and the National Aboriginal and Torres Strait Islander health workforce strategic framework and implementation plan 2021-2031
  - incorporate recommendations from key Aboriginal and Torres Strait Islander led initiatives such as Yoorrook Justice Commission's recommendations for health
  - focus at several levels including federal and state policy; local responses and within general practice
  - should focus on investing more resources into areas of disadvantage.
- The Preventive Health Investment Framework should also:
  - specify types of prevention to be targeted
  - support a systematic, nationally scaled and locally implemented approach to social prescribing in Australia
  - support investment more resources into areas of disadvantage
  - support investment in clinical guidelines that support preventive care.

Further opportunities and recommendations

Health assessments should be available to patients of all ages to improve healthy equity and ensure all Australians have access to appropriate resources and supports to live longer, healthier and more productive lives.

6. Conclusion

Overall, the interim report contains many of the Productivity Commission's recommendations are welcome and supportive particularly the proposals for collaborative commissioning partnerships and a National Prevention Investment Framework.

We are hopeful our submission has emphasised the foundational role of specialist general practitioners in the provision of effective and efficient care, particularly for at-risk communities and stressed the need for productivity reforms to embed cultural safety provisions from the outset and strive for improved health equity.

We thank the Productivity Commission again for the opportunity to provide comment on the *Delivering quality care more efficiently – interim report.* If you have any questions regarding our submission please contact Ms Shayne Sutton, Chief Advocacy Officer, at Shayne.sutton@racgp.org.au.

7. References

[1] NSW Health. Lumos GP activity insight. Sydney, NSW Health: 2021. Available at: https://www.health.nsw.gov.au/lumos/Pages/gp-activity-insight.aspx
[2] Sandvik H, Hetlevik Ø, Blinkenberg J, Hunskaar S. Continuity in general practice as predictor of mortality, acute hospitalisation, and use of out-of-hours care: a registry-based observational study in Norway. Br J Gen Pract. 2022 Jan 27;72(715):e84-e90. doi: 10.3399/BJGP.2021.0340. PMID: 34607797; PMCID: PMC8510690.
[3] Australian Institute of Health and Welfare (AIHW). Health Across socioeconomic groups 2022. Canberra, AIHW: 2022. Available at: https://www.aihw.gov.au/reports/australias-health/health-across-socioeconomic-groups
[4] Freeman Toby, Baum Fran, Lawless Angela, Jolley Gwyn, Labonte Ronald, Bentley Michael, Boffa John. 2011. Reaching those with the greatest need: how Australian primary health care service managers, practitioners and funders understand and respond to health inequity. Australian Journal of Primary Health 17, 355-361. https://doi.org/10.1071/PY11033
[5] National Rural Health Alliance. Poverty in Rural & Remote Australia Factsheet 2017. Available at: https://www.ruralhealth.org.au/sites/default/files/publications/nrha-factsheet-povertynov2017.pdf
[6] Australian Institute of Health and Welfare. General practice, allied health and other primary care services [Internet]. Canberra: AIHW: 2025. Available at: https://www.aihw.gov.au/reports/primary-health-care/general-practice-allied-health-primary-care
[7] Coombs D. Primary Health Networks' impact on Aboriginal Community Controlled Health Services. Aust J Publ Admin 2018;77(S1):S37–S46
[8] Australian Institute of Health and Welfare. Chronic conditions [Internet]. Canberra, AIHW: 2024. Available from: https://www.aihw.gov.au/reports/australias-health/chronic-conditions
[9] Australian Institute of Health and Welfare. General practice, allied health and other primary care services [Internet]. Canberra, AIHW, 2025. Available at: https://www.aihw.gov.au/reports/primary-health-care/general-practice-allied-health-primary-care
[10] Senior, T M. 2023 Churchill Fellowship to investigate how to provide high quality primary care to disadvantaged communities in Australia. Available at: https://churchilltrust.my.salesforce-sites.com/api/services/apexrest/v1/image/?Id=069RF00000IRSneYAH&forceDownload=Yes
[11] Australian Commission on Safety and Quality in Health Care. OECD Patient-Reported Indicator Surveys (PaRIS) Australian National Report 2025. Sydney, NSW. Available at: https://www.safetyandquality.gov.au/publications-and-resources/resource-library/paris-survey-australian-national-report-2025
[12] The Royal Australian College of General Practitioners. Vision for general practice and a sustainable healthcare system. East Melbourne, Vic: RACGP, 2019. Available at: https://www.racgp.org.au/advocacy/advocacy-resources/the-vision-for-general-practice