RACGP

Royal Australian College *of* General Practitioners

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RACGP submission

Draft recommendations from the Primary Health Reform Steering Group

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1. Introduction

The Royal Australian College of General Practitioners (RACGP) welcomes the opportunity to provide a submission to the Primary Health Reform Steering Group on the Draft Recommendations for the Primary Health Care 10 Year Plan.

The RACGP is Australia's largest professional general practice organisation, representing over 41,000 members working in or toward a specialty career in general practice. The RACGP is responsible for:

- defining the nature and scope of the discipline
- setting the standards and curricula for training
- maintaining the standards for quality general practice
- supporting specialist general practitioners (GPs) in their pursuit of excellence in patient and community service

2. General comments

Australia's healthcare system is considered one of the best in the world.[1] However, rising rates of chronic disease, an ageing population, the COVID-19 pandemic, delayed preventive care due to the pandemic, and a looming mental health crisis, are putting increasing pressure on our healthcare system, resulting in poorer outcomes, ramping and long hospital wait times. Unless there is significant investment and reform, the system will fail.

General practice is the foundation of the Australian healthcare system. Australians see GPs more than any other health professional. In 2019-20, GPs and their teams provided over 160 million services, with almost nine in ten people consulting a GP.[2]

General practice is the most efficient and cost-effective part of the health system.[3,4] Despite this, general practice is in a state of crisis. Funding has stagnated, there are critical gaps in workforce supply, and the high-quality care GPs provide is at risk.

The Primary Health Care 10 Year Plan is a critical opportunity to improve the lives of all Australians through achievable and cost-effective reforms and investments in primary care. Many of the recommendations put forward by the Steering Group are a step in the right direction. However, the Steering Group must seize the opportunity to direct government to address the challenges facing the primary care sector and build a system that meets the needs of all Australians.

3. RACGP vision for primary care

The RACGP *Vision for general practice and a sustainable healthcare system* (the Vision) describes a sustainable model of high-quality, cost-effective and patient-centred care that aims to address many of Australia's healthcare challenges.

The Vision identifies that the future of our healthcare system can be protected by better supporting existing general practice services through:

- maintaining and modernising the Medicare fee-for-service system
- setting and indexing rebates that accurately reflect the cost of service provision by specialist GPs
- supporting the delivery of comprehensive general practice care
- increasing payments to practices to facilitate the employment of general practice team members
- facilitating genuine quality improvement activities in general practice
- increasing funding for GPs and practices to undertake teaching of medical students and GP registrars and introducing new funding to support teaching for all other members of the general practice team.

Innovative models of care in general practice and a sustainable general practice workforce can be facilitated by:

- supporting patients to be the central focus of the health system
- encouraging continuity of care for patients within their preferred practice via voluntary patient enrolment
- supporting GPs and their teams in coordinating care with hospitals and other health and social services
- recognising patient complexity through improved funding systems
- supporting general practice–based research and ensuring universities support academic general practice

- supporting the collection and appropriate use of general practice data to strengthen the evidence about the effectiveness of primary care, and to provide better population planning
- supporting better use of health resources through improved information-sharing and regional coordination.

4. Summary of submission

This submission has been developed based on the experience, insights and knowledge of RACGP members – GPs at the coalface – across Australia. The submission responds to the Primary Health Reform Steering Group recommendations and promotes the development of a sustainable model of high-quality, cost-effective and patient-centred primary care.

While many of the Steering Group recommendations align with the RACGP vision for primary care reform, significant revisions are also required to ensure:

- Support for measures that enable GP-led multidisciplinary primary care to better manage disease in the community setting, improve health outcomes, reduce hospital admissions and more efficiently use health resources.
- Funding models are in place to support the provision of high-quality care to all patients, including those with complex needs.
- The fee-for-service funding model is retained and modernised, with initial reforms including:
    - improved Medicare Benefits Schedule (MBS) rebates for longer consultations – to encourage shift of towards comprehensive service delivery within general practice
    - removal of rebate differentiation between MBS items based on provider status (eg standard consultations provided by a GP or other specialist)
    - focus MBS on the provision of holistic comprehensive care rather than single-disease MBS item numbers
- A Voluntary Patient Enrolment (VPE) model that supports improved continuity of care, clearer identification of a practice's population, and improved services enabled by the enrolment process.
- Additional funding to support GPs and their practices to provide comprehensive and coordinated care flowing from enrolment.
- A commitment for any savings generated through VPE to be transparently reinvested in general practice.
- GPs retain ultimate responsibility and oversight of patient care in general practice, allowing for comprehensive assessment, diagnosis, initiation of treatment and referral to appropriately qualified team members in accordance with their qualifications, areas of clinical expertise and levels of support.
- New funding models or mechanisms are trialled or implemented in a staggered approach to ensure proof of concept in the Australian healthcare system, and GPs are further consulted in the design of any new models of care or funding.
- The development of a sustainable permanent telehealth model that incorporates support for longer telephone consultations.
- Practical measures are implemented to attract and retain doctors in the general practice workforce, including the reinstatement of a Prevocational General Practice Placements Program.

5. Feedback on Steering Group recommendations

a. Person-centred health and care journey, focusing on one integrated system

Recommendation 1 (One system focus): Reshape Australia's health care system to enable one integrated system, including reorientation of secondary and tertiary systems to support primary health care to keep people well and out of hospital

1.1 Do you agree with this recommendation?

The RACGP strongly supports Recommendation 1.

This recommendation demonstrates clear alignment with the RACGP approach to primary health care reform outlined in the RACGP Vision.

International experience overwhelmingly supports better integrated and supported primary care as a solution to improving health outcomes and reducing pressure on hospital systems.[5] The RACGP strongly supports measures to enable GP-led multidisciplinary primary care to better manage disease in the community setting, improve health outcomes and reduce hospital admissions, and more efficiently use health resources.

A sustained increase in public funding is required to meet the growing and changing needs of our community and minimise costs to patients. Key funding priorities should be: improving the accessibility and capacity of primary care to promote health and wellbeing across the lifespan in a cost-effective way; supporting the increased demands for chronic disease care to be provided in the community; and integrating services across the health system to ensure comprehensive and coordinated care. The implementation of this recommendation requires support for high-quality GP-led multidisciplinary teams.[6,7]

Required reform:

The RACGP continues to advocate for specific measures to reduce preventable hospitalisations, including introducing support for GPs who see their patient within 7-days of an unplanned hospital admission or emergency department presentation. Dedicated time to see a GP following an unplanned hospital admission will help to reduce the chance of a readmission. Australian research shows that patients who see their GP within 7 days of an unplanned hospital admission have a significantly lower risk of readmission within 30 days.[6]

Conservatively it has been estimated that general practice can prevent at least 12% of hospital readmissions through implementing a dedicated follow up consultation, improving patient health outcomes, and saving the health system $69 million each year.[7]

1.2 What do you see as the challenges in implementing this recommendation?

The main challenge with this recommendation, and several others throughout the Discussion Paper, is inadequate detail as to whether the actions associated with this recommendation will refocus health system funding towards primary health care and health outcomes. More detail is required (for example, on how this system will integrate with other areas such as the National Disability Insurance Scheme and aged care) before all possible benefits and challenges can be determined.

A key challenge for the implementation of this recommendation is the divisions between Federal and State government funding. The dissonance between Federal and State approaches will make it difficult to develop one integrated system, although there is promise in the proposed shared commitments of the National Health Reform Agreement. An effective primary care system requires a collaborative approach from Federal and State governments. Rural and remote healthcare provision in particular needs integrated funding models, with agreed funding streams into a single entity. State government willingness to engage in shared resourcing and provision of community services is not enough to make this happen. Local health districts and hospital services need to have clear linkages and accountability to primary care if this one integrated system is to be achieved.

The RACGP agrees with the Steering Group that the current percentage of total health funds directed to primary care is significantly inadequate. As identified by the Steering Group, setting a minimum percentage is one way to address this. However, we firstly need agreement about what constitutes primary healthcare in Australia and introduce clearer reporting methods before we can determine what appropriate expenditure would be.[8,9] It is important that primary care funding retains flexibility in funding based on demand and can respond to future challenges. Designing and implementing funding systems which are responsive to new and emerging health system challenges is key to support the future of primary care.

In recent years there is a tendency for governments and aspiring governments in Australia to announce the dedication of considerable ad hoc funding towards specific and isolated health issues or services. These decisions and proposals increase fragmentation of care, resulting in wasted resources, and do not support an integrated and sustainable health system. It is important that Recommendation 1, and the broader Primary Health Care 10 Year Plan, are underpinned by a long-term commitment to substantive increases in investment for holistic long-term person-centred care.

Recommendation 2 (Single primary health care destination): Formalise and strengthen the relationship of individuals, families and carers with their chosen primary health care provider and practice

2.1. Do you agree with this recommendation?

The RACGP supports Recommendation 2 in-principle.

The impacts of this recommendation will depend heavily on the details of implementation. The RACGP is strongly opposed to any compulsory model of enrolment, any model that replaces fee-for-service, and any funding model that reduces the capacity to GPs to determine appropriate care in partnership with their patients.

General practice is the most accessible entry point to the healthcare system and GPs are the most appropriate partner in overseeing long-term patient care, navigating the system and safeguarding community health and wellbeing. Strengthening the relationship between patients and primary care providers via an appropriately funded Voluntary Patient Enrolment (VPE) model could produce meaningful benefits for patients, health system funders and providers of comprehensive holistic general practice care. These could include improved continuity of care, clearer identification of a practice's population, and improved services enabled by the enrolment process.[10,11] VPE could also allow for recognition and investment of the holistic care provided by general practice, in particular preventative care, that is currently unremunerated within Medicare.

Required reform:

The RACGP is cautiously supportive of the VPE model described, which links high value MBS items and access to telehealth items with registration. However, successful implementation of any VPE model must include:

- co-design of any model to be appropriate for Australian health system
- a commitment to fee-for-service remaining the core of Medicare/primary care funding
- additional funding to support GPs and their practices to provide comprehensive and coordinated care, for their enrolled patients, but in particular for those with chronic conditions
- funding for implementation of VPE until the process is normalised for both consumers and general practice
- an electronic registration system that is functional and interacts with clinical software
- commitment for any savings generated through VPE (including restriction of high value MBS items) to be transparently reinvested in general practice
- review and evaluation of impact of model on care and practice viability
- a commitment to adapting model based on clinician feedback

Without these measures, VPE will simply increase the administrative and bureaucratic burden in general practice. This could threaten the viability of the current model of general practice in Australia and is unacceptable. Further challenges in VPE implementation which must be resolved are discussed in more detail overleaf.

The RACGP has previously advocated for additional funding for GPs and their teams to manage patient transitions between general practice and other parts of the health system. The introduction of this type of coordination or navigation funding is critical to the successful implementation of this VPE model.

2.2. What do you see as the challenges in implementing this recommendation?

The challenges associated with VPE will be dependent on the method of implementation, including the following areas:

- **Mechanism for enrolment** – It is important that patient choice is supported through the mechanisms supporting enrolment. Patients should be able to sign up online and in-person. Enrolment must remain voluntary. Any new system for enrolment must not increase administration for practice staff, and link with existing services,

- **Compliance requirements** – The RACGP supports transparent compliance arrangements that result in minimal regulatory burden for general practice, while also ensuring high-quality care for all enrolled patients. The compliance measures underpinning VPE will depend on the data infrastructure provided by the Department of Health. An increased compliance burden will negate patient and provider benefits from this new system.

- **Patient mobility** – Ensuring patients can change their chosen primary health care provider and practice without significant administrative burden is important. Flexible options are needed for people travelling or away from their local practice, and groups that may face barriers to accessing a regular GP (eg people experiencing homelessness, Aboriginal and Torres Strait Islander people, and people with severe mental illness).

- **Patient incentives for enrolment** – Introducing incentives for patients to sign up for VPE could assist with reaching vulnerable populations and encouraging those who would not usually engage with a GP.

There are situations where it may be appropriate for a GP to provide care to an unknown patient (eg if the GP provides a highly specialised service) or to a patient who is not registered but is clearly known to the practice. It is important to ensure the introduction of VPE does not reduce access to care in these and other reasonable circumstances.

Integration of MyGP with other government systems, including Medicare, as well as GP clinical information systems, will be essential to allow for efficient information reporting systems and reduce the administrative burden for general practice.

2.3. Please provide any examples of best practice for implementation of this recommendation (from Australia or overseas).

Patient enrolment has been implemented in several other countries with various benefits and challenges. The RACGP recommends considering the models employed in New Zealand and Denmark for possible lessons around how best to implement patient enrolment programs. For example:

- Patient enrolment is voluntary for the whole population of Denmark, without a focus on any special group.[12] Patients register on the patient list of a general practitioner or a general practice. Patients can register at an alternate practice 3 months following registration. GPs are paid more for longer consultations with enrolled patients in order to encourage preventative and comprehensive care.

- All New Zealand citizens are eligible for primary care enrolment. Eligibility also extends to other groups, including individuals with a resident visa or a permanent resident visa, those with work visas and refugees.[13] In New Zealand, the Primary Health Organisations receive funding for administration as well as the services provided. They must report on their financial activity via budgets and annual reports and make these available to the public.[12]

Recommendation 3 (Funding reform): Deliver funding reform to support integration and a one system focus

3.1. Do you agree with this recommendation?

The RACGP supports Recommendation 3 and the underpinning actions in-principle, noting that further detail is required to determine how the recommended activities will integrate with the current Medicare system. The RACGP particularly welcomes the commitment to move the health system towards quality care with necessary investments over time, taking into account private business sustainability, as per Action 3.2.

Current MBS and funding structures do not adequately support the delivery of comprehensive general practice care, including high-quality chronic disease management, preventative care and care for people with complex needs.[14] This was recognised in the MBS Review and has been consistently raised as a key issue by the RACGP. Existing support for patient access to GPs and general practice teams also does not properly value general practice services nor reflect the true cost of providing effective general practice care. Notably, GPs report spending a considerable amount of non-billable time on providing integrated services and holistic care to patients.[15]

Required reform:

There is a need to modernise and simplify the fee-for-service system to reflect the cost of providing care, and incorporate funding systems that support longer consultations for more complex patients and high-quality care for all. The skills, training, responsibility, practice costs and effort of GPs must be valued equally with those of other medical specialties.

Reforms to the fee-for-service model should include:

- improved MBS patient rebates (with regular indexation) for service delivery within general practice
- improved MBS rebates for longer consultations – to encourage shift of towards comprehensive service delivery within general practice
- removal of any rebate differentiation between MBS items based on medical provider status (eg standard consultations provided by a GP or other medical specialist)
- focus MBS on the provision of holistic comprehensive care rather than single disease-MBS item numbers.

The RACGP supports the introduction of blended payment models, on top of fee for service, and welcomes more flexible approaches to funding general practice services in addition to the fee-for-service model. The RACGP does not support removing fee for service and re-badging the funding as 'new funding' and does not support any funding model that is solely focused on block or capitation payments. Such models do not align with the flexibility often required in general practice.

Required reform:

In alignment with the reforms to the fee-for-service funding system outlined above, the RACGP supports a blended funding model with the following features:

- increased fee for service patient rebates for longer GP consultations
- Practice Incentive Payments which recompense the costs of practice accreditation and labour time
- deprivation payments based on patient demographics or practice location
- implementation of service coordination payments (eg Service Incentive Payments (SIPs))

Further detail is required on how the flexible funding models highlighted in Action 3.1.1 will integrate with the existing fee-for-service model. More information is required on how these funding arrangements will support general practice to improve patient outcomes. It is critical the funding reform does not result in a reduction in funding that supports patients to access their GP or negatively impact the viability of general practice. Reform without a substantial increase in funding is just additional bureaucracy.

Any new funding models or mechanisms must be tested and evaluated. This could be through a staggered rollout to ensure proof of concept in the Australian healthcare system. The RACGP urges caution against universal introduction of untrialled and unproven new funding structures without evidence and consideration of the potential benefits and unintended impacts.

Funding models need to support the provision of high-quality care to patients with complex needs, including older people, community-based palliative care patients, people discharged from hospital, people presenting with mental health concerns and people with chronic disease.

Required reform:

The RACGP would support the introduction of new SIPs for high-needs patient groups, including the following:

- **Aged care:** Introducing a SIP for over 75s would support the provision of the continuous and complex care required by this group. It will also enhance the delivery of preventative health activities by GPs to keep older people healthier. This SIP could comprise a tiered set of payments for the delivery of comprehensive care for people over the aged of 75 and Aboriginal and Torres Strait Islander people aged 55 and over. Higher payments would be provided for more complex care, including home visits.

  For example – $100 per year based on the completion of a GP Management Plan or Health Assessment for over 75s, plus at least one review, a frailty assessment, and an in-practice or home visit.

- **Mental health:** The introduction of a SIP for mental health will support GPs to deliver continuous and regular care for those with complex needs and enhance access to medical services for people presenting with mental health issues. The SIP would be payable when a patient receives a GP mental health plan, at least one review per year of the mental health plan (MBS Items 2713 or 2715), and a physical health assessment (given the high incidence of physical health concerns associated with mental health).

Regarding Action 3.2.4, to reform Private Health Insurance funding to allow delivery of primary care by allied health professionals and nurses, the RACGP urges caution. There remain concerns that any private health insurance reforms may cause further inequity of healthcare provision between patients who have private health insurance and those that do not.

The RACGP does not support amendment of the *Private Health Insurance Act 2007* to allow private health insurers to fund services currently funded by Medicare or to cover gap payments, without further investigation of how this model could impact universal access to care. Services already being provided by a patient's usual GP, such as chronic disease management, should not be duplicated by private health insurance at this time, as this could lead to fragmentation and inefficient use of health resources.

3.2. What do you see as the challenges in implementing this recommendation?

As outlined in the response to Response to Recommendation 1 (Questions 1.2), there is inadequate detail to understand whether the actions associated with this recommendation will refocus health system funding towards primary health care and health outcomes. Several of the challenges outlined by RACGP in response to Question 1.2 also apply to this recommendation – including issues with fragmented, ad-hoc government spending, and the need for a commitment to long-term substantive increases in primary care investment.

It is critical that GPs are included and consulted in the design of any new payment models. The COVID-19 pandemic has shown the ability of general practice to adapt services rapidly (such as the introduction of MBS funded telehealth) and that incentive design care can rapidly reduce practice viability.[16] Without input from those delivering services, any proposed funding models could potentially further impair general practice business viability reduce access to appropriate care, leading to poorer outcomes for Australians. Further, the RACGP firmly cautions against using VPE to focus on reducing funding for certain elements of primary care.

There is little strong evidence about how to design bundled payments in primary care, or how to choose clinical outcomes which matter to patients and providers.[17,18,19] There are a range of practice structures in terms of ownership, staffing, billing practices and capacity to adapt to reform. The recommendations in this Discussion Paper do not recognise these differences and the impact they will on the differing capacity of practices to respond to funding models and incentives

Several Actions underpinning Recommendation 3 require cross sector collaboration and accountability. While the RACGP strongly supports increasing collaboration and integration across different sectors, collaboration is currently limited by several factors, including non-interoperable information systems, a lack of funding to support cross-sector collaboration, and the limited support for GPs to take time away from clinical caseload. Although the NHRA promises improved cross sectoral collaboration, these practical issues (and the need for local collaboration) need to be addressed throughout the 10-Year Primary Health Reform Plan.

As mentioned in the response to Question 2.2, with regard to information systems and digital tools, there is a need for a national enterprise-wide platform that is complaint to national (and global) standards for interoperability and benchmarks for quality of digital health apps and data. This will encourage the industry to build interoperable digital tools for health and managerial purposes. Part of the funding to support reform should be directed towards general practice staff oriented to digital health and information technology.

Recommendation 4 (Aboriginal and Torres Strait Islander health): Implementation of the National Agreement on Closing the Gap for Aboriginal and Torres Strait Islander peoples through structural reform of the primary health care systems

4.1. Do you agree with this recommendation?

The RACGP supports this recommendation.

The RACGP welcomes the commitment to support Aboriginal and Torres Strait Islander community-controlled organisations (ACCHO) and improve the health outcomes for Aboriginal and Torres Strait Islander people.

We strongly support the ACCHO model of comprehensive primary health care, including by supporting integration of non-prescribing pharmacists in ACCHOs, as well as efforts to develop and support the Aboriginal and Torres Strait Islander workforce. Growing the Aboriginal and Torres Strait Islander GP workforce is fundamental in closing the gap in life expectancy and health outcomes.

In addition to tailoring models to support ACCHO success, there is a need to directly support capacity building for tendering process within ACCHOs. ACCHOs have a major role in service delivery and Government agencies and Primary Health Networks (PHNs) must acknowledge that tendering processes need to be made more accessible.

4.2. What do you see as the challenges in implementing this recommendation?

This recommendation will need to be underpinned by substantial additional resources to effectively improve the health outcomes for Aboriginal and Torres Strait Islander people, and must have input from Aboriginal and Torres Strait Islander people and ACCHO representatives

Additionally, there remains a need to address responsibility in mainstream primary healthcare for Aboriginal and Torres Strait Islander Mental Health. The discussion paper does not sufficiently address cultural safety in mainstream primary healthcare. The current recommendations place minimal responsibility on mainstream services outside of employing more Aboriginal staff.

Cultural safety must form a critical component of any primary care reforms, incorporating support for changes throughout the system and meaningful involvement of Aboriginal and Torres Strait Islander people. As part of this, cultural safety training should be embedded throughout primary care and should include an understanding of context and a tailoring of practice with face-to-face training, and regular follow-up and refreshment of training.[20,21] Targeted funding for cultural safety training may be necessary.

The focus of Action 4.6, the increased employment of Aboriginal and Torres Strait Islander People in mainstream services, may already be addressed through current mechanisms ie the Workforce Incentive Payment. This should be factored into the implementation of this recommendation.

4.3. Please provide any examples of best practice for implementation of this recommendation.

The RACGP suggests the Steering Group consider some of the elements of the initial Close the Gap program. For example, the requirement that cultural safety training be undertaken to access certain elements of the Close the Gap funding.

Recommendation 5 (Local approaches to deliver coordinated care): Prioritise structural reform in rural and remote communities

5.1. Do you agree with this recommendation?

The RACGP supports the local approach outlined in Recommendation 5.

Australia's rural and remote communities have poorer health outcomes than communities in metropolitan areas.[22] Australians in rural and remote Australia have inequitable access to health funding and are more reliant on primary care to manage and coordinate their health needs. The primary care approach to rural and remote health must be broad and flexible enough to accommodate the challenges of distance and local availability of health services.

Ensuring GPs have access to facilities and can provide care to their patients in a range of settings help makes services more viable over the longer-term. The RACGP supports measures that align with this approach. Addressing key local challenges relies on establishing strong community partnerships and providing regional structures for these partnerships to grow. This is reflected in the actions underpinning Recommendation 5.

In particular, the RACGP supports the use of telehealth, electronic communications and virtual models of care in rural and remote areas as part of the integrated health system. This could involve directing State government funded hospitals and private specialists to prioritise the availability of telehealth services and electronic communications with a person's usual GP.

5.2. What do you see as the challenges in implementing this recommendation?

There are many challenges associated with delivering high-quality primary care to Australia's rural and remote communities. These include issues with access to health services, gaps in digital and physical infrastructure, workforce maldistribution, and the increased prevalence and burden of chronic disease.

Without increased funding to retain the rural and remote workforce, many rural and remote communities will see minimal benefits from other structural reforms. While GP distribution is addressed in Recommendation 14, this remains a key challenge that should be considered across the Primary Health Care 10 Year Plan.

Practical measures are needed to support rural GPs. This could include providing greater incentives, rebates, and scholarships for rural GPs to gain and maintain additional skills to benefit their community. Adequate renumeration for general practice is critical to the sustainability of rural general practice. The decline in general practice funding via MBS, through both the Medicare freeze and the failure to appropriately index MBS patient rebates over successive governments, has impacted the viability of rural general practices. Member feedback indicates many rural GPs are approaching retirement age with no replacements. Increased overall funding and targeted funding for rural general practice MBS items is therefore critical to the viability of rural general practice patient services.

The salary of a general practice registrar drops significantly compared to that of a hospital-based junior doctor once they commence training in rural general practice. The disparity between the average GP in training's income (at the time of commencing general practice training) and hospital-based positions (that would alternatively be available to them) is estimated by the RACGP to be approximately $30,000 per annum. Funding support needs to be provided via training organisations to ensure that junior doctors are not financially penalised for choosing general practice, especially rural general practice, and have salary that is equal to that of other junior doctors. Funding should also continue for rural generalist programs, including to support GPs with subspecialist skills.

Policy attention to remove the key barriers to integrated care is vital. Support for digital infrastructure to improve communication and engagement between services and clinicians is needed to facilitate optimal clinical pathways. This could include funded programs to hasten the roll-out of e-communication and telehealth use by medical specialists in private practice and in hospitals. Broader health system reform efforts to improve care for patients presenting with chronic and complex health needs (as outlined in Recommendation 2), will also benefit those in rural and remote areas.

Required reform:

The introduction of Medicare rebates for telehealth consultations throughout the pandemic have been critical to ensuring people in rural and remote areas can access primary healthcare. The removal of longer phone consultations from July 2021 posed a significant challenge to rural areas, as many rural and remote patients may not have access to reliable video technology. RACGP members have consistently raised concerns about how the removal of rebates for longer phone consultations has the potential to worsen health gaps for specific groups, including Aboriginal and Torres Strait Islander people and people living in rural and remote areas.

We urge the Steering Group to support longer telephone consultations as part of a permanent telehealth model for all Australians. Under this model, any consulting through communications technology should be included in the item numbers that generate the Standardised Whole Patient Equivalent (SWPE) value for incentive payments.

5.3. Please provide any examples of best practice for implementation of this recommendation (from Australia or overseas).

The current development of the Acacia Patient Medical Record system in the Northern Territory across primary, secondary and tertiary services may be a valuable example to consider in the implementation of this recommendation. While not yet evaluated, this system aims to improve patient and client outcomes by providing essential clinical information at the point of care.

b. Adding building blocks for future primary health care – better outcomes and care experience for all

Recommendation 6 (Empowering individuals, families, carers and communities): Support people and communities with the agency and knowledge to better self-care and manage their wellness and health within a system that allows people to make the choices that matter to them

6.1. Do you agree with this recommendation?

The RACGP supports this recommendation in-principle.

Supporting people to better self-care and manage their wellness and health is key to improving health outcomes for all. Health literacy allows individuals to access, understand and use information to negotiate the health system and support self-management. Low health literacy is associated with poorer health outcomes and lower utilisation of health services such as screening and preventive care.[23]

The RACGP recognises the central role that social determinants, such as safe and secure housing, access to education, opportunity for good nutrition and exercise, have as a foundation for good health and the ability to make choices about one's health. There must be recognition that many patients in certain populations do not have access to socioeconomic resources to enable to make healthier 'choices' that matter to them. The RACGP supports appropriate investment beyond the health system targeted at the social determinants of health.

6.2. What do you see as the challenges in implementing this recommendation?

The implementation of this recommendation will be limited without measures that support the growth of genuine multi-disciplinary team, who can educate within their area of expertise and coordinated care with appropriate social supports. As addressed throughout in this submission, high-functioning multidisciplinary teams require appropriate funding and staffing. This must be a key focus in each of the recommendations put forward by the Steering Group.

The RACGP appreciates the importance of supporting individual health literacy and agency. An important element of this is ensuring that clinicians, including GPs, can spend sufficient time with their patients. While short consultations provide support for everyday issues, evidence shows that longer consultations with a GP have significant advantages, including increased patient education, identification and management of complex issues, preventive health, early intervention, immunisation adherence, counselling, patient satisfaction and participation, and better use of medications.[24,25] Longer consultations can make an important contribution to ensuring individual health literacy and access to information for patients. As such, the draft recommendations must be amended to reflect the need for funding to support GPs to spend more time with their patients.

While the RACGP supports the collection of patient reported measures, as per Action 6.1, it is important this does not place added administrative burden on general practices. Data collection processes must be transparent, and the data applied to constructive improvements in service delivery. Making digital health tools affordable to low socioeconomic status populations can be a solution to data collection as well as use of the data to improve services to geographically and socioeconomically isolated citizens.

Cultural competence is critical to providing appropriate patient education to all communities. This is particularly important in working with Aboriginal and Torres Strait Islander communities.

6.3. Please provide any examples of best practice for implementation of this recommendation (from Australia or overseas).

The RACGP *Red Book* *Guidelines for preventative activities in general practice* includes a section on patient education and health literacy, which provides an overview of the evidence to support behaviour change, patient education and health inequity.[26]

Recommendation 7 (Comprehensive preventive care): Bolster expanded delivery of comprehensive preventive care through appropriate resourcing and support

7.1. Do you agree with this recommendation?

The RACGP supports this recommendation.

Preventive healthcare is an important activity in the primary care sector. The RACGP is strongly supportive of Action 7.1, to encourage general practices to implement preventative health care for their patients as per the RACGP Red Book. The partnership between GP and patient can help people reach their health goals. As per the response to Question 6.2, GPs require support to spend sufficient time with their patients to address preventative care issues.

Prevention of illness is the key to improving Australia's future health – both individually and collectively. About 32% of Australia's total burden of disease can be attributed to modifiable risk factors.[27] Preventive care is critical in addressing the health disparities faced by disadvantaged and vulnerable population groups. General practices also need to think about preventive healthcare needs beyond the individual patient, towards a practice population approach to primary prevention.

Required reform:

The RACGP supports funding directed to GP-led preventative health measures targeted at specific population groups. Enhancing preventive care for older people is critical to reducing hospitalisations and helping older people stay healthier at home for longer.

It is recommended the eligibility for the four time-based MBS health assessment items: 701 (brief), 703 (standard), 705 (long) and 707 (prolonged) be expanded to include all people aged 65 to 74. This will support the important preventative care GPs provide to this population and improve the health of older people in Australia.

Social prescribing, as mentioned in Recommendations 2 and 8, could provide a valuable addition to the existing range of preventative healthcare options in Australia.[28] Social prescribing should be incorporated into the Australian

Government's primary healthcare and preventive health strategies, and governments should consider adopting a wellness budget to deliver an integrated approach to social prescribing.

7.2. What do you see as the challenges in implementing this recommendation?

Regarding Action 7.4, the RACGP supports increasing preventative services for people with GP-assessed risk factors and to support mental health. However, the focus should be placed on enhancing GP-led team-based care models, as proposed in the RACGP Vision, rather than expanding other health professionals' scope of practice.

Moves to increase access to health services provided with no connection to a patient's general practice, such as vaccinations in the pharmacy setting and attributing equivalent levels of authority and autonomy to nurse practitioners, will undermine the quality and efficiency of our healthcare system. Failure to involve a patient's GP can lead to fragmented and inefficient care.

Expanding the scope of practice of healthcare professionals without the same level of training as GPs may lead to a second-class primary healthcare system where patients who cannot access GP services (for example, due to cost or geographic location) receive care from another professional without the same level of qualification as a GP. This has the potential to reduce equity of access to high-quality healthcare and increase health disparities for already disadvantaged communities.[29] To manage this challenge, the RACGP recommends introducing models of care that are linked to general practice. One option for this is to embed other health professionals within general practice, for example the non-dispensing pharmacist model trialled in New South Wales.[30]

GPs also indicate that staying up to date with the many different wellbeing services can be challenging – an issue which should be addressed through Action 7.6. Continued support of information systems such as HealthPathways, including for use by general practice and other allied health, can also facilitate up-to-date knowledge of local service pathways.

While the RACGP is supportive of Action 7.9, that voluntary patient registration data be used to enhance understanding of individual and community needs, this relies on integrated and accessible data systems. This is not reflective of the current data systems and infrastructure in primary care. Ensuring data systems are integrated and linked should be a critical priority for the sector. Facilitation of e-communication between general practice, state funded services and private services including allied health including pharmacy, physiotherapy, dieticians and psychologists is needed to enable integration and coordination.

Recommendation 8 (Improved access for people with poor access or at risk of poorer health outcomes): Support people to access equitable, sustainable and coordinated care that meets their needs

8.1. Do you agree with this recommendation?

The RACGP supports this recommendation in principle.

General practice provides the appropriate main entry point to the healthcare system and GPs are the ideal long-term partner in overseeing patient care, navigating the system and safeguarding community health and wellbeing.[31] As per the RACGP Vision, GPs and their teams have a crucial and trusted role in helping their patients navigate the wider private and public healthcare systems.

The RACGP supports Action 8.5, which sets out the trialling of coordination and navigation supports. It is important these trials are based in general practice. Locating this research in the general practice setting, including through trials of innovative models and approaches to care, will assist translation of research findings into relevant practice and ensure Australians can access evidence-based care

This recommendation should incorporate targeted measures to improve access to essential allied health services, including dental care, for all Australians, with particular focus on services for Aboriginal and Torres Strait Islander peoples.

8.2. What do you see as the challenges in implementing this recommendation?

The capacity of GPs to help their patients navigate the wider health sector is limited in the current funding system, which does not sufficiently value GP time and rewards shorter consultations. Despite this, in the 2020 Health of the Nation Report, have GPs indicated they are spending more time coordinating their patients' care than in the past, using the skills unique to general practice.[32]

This may be linked to the increasing prevalence of chronic and complex conditions in Australia, which require more complex care involving more services. As longer consultations are remunerated at a lower rate that standard consultations, this coordination work has impacted negatively on practice viability. This must be addressed through increasing MBS rebates for longer consultations.

There is a need to consider how the mechanisms for service delivery and funding outlined under Recommendations 1-3 can support access for people at risk of poorer health outcomes. As flagged in the response to Question 2.1, the RACGP would support the introduction of additional funding for GPs and their teams to manage patient transitions between their general practice and other parts of the health system and to support multidisciplinary team care in general practices. This should include funding for general practice nurses and measures to embed non-clinical workers in general practice.[33,34]

Care coordination also extends beyond primary care. It is important other health providers are required to engage meaningfully with this recommendation and the integrated one health system approach outlined in Recommendation 1. Critical to this is ensuring that there is continuity of information across general practice and other elements of the health system. This can be supported by ensuring IT systems and digital tools are interoperable, providing funding for GPs to lead and coordinate care, and encouraging other health professionals to liaise with GPs.

c. Leadership and culture

Recommendation 9 (Leadership): Foster cultural change by supporting ongoing leadership development in primary health care

9.1. Do you agree with this recommendation?

The RACGP supports this recommendation.

To be effectively implemented, this recommendation must include a definition of leadership and culture, with particular consideration of clinical leadership and the factors that enable it. Clinical leadership should not be confused with management practices.

The RACGP recommends the focus be on 'shared leadership', where leadership is not restricted to people who hold designated leadership roles, rather it is about enabling every clinician to be a leader. The *NHS Medical Leadership Competency Framework* is a valuable example of this approach and should be considered in the revision of this recommendation.

GPs may have multiple leadership roles within the practice, as patient advocates and for general practice within the broader healthcare system. High-performing practices have GP leaders who are engaged in and responsible for developing and leading the implementation of a practice's measurable goals and objectives. The upskilling of GPs and development of greater health leadership roles is essential to create a sustainable workforce and will increase the attractiveness of general practice as a career.

The RACGP recommends this recommendation include measures targeted towards research and development leadership, which is discussed further in the response to Recommendation 18.

9.2. What do you see as the challenges in implementing this recommendation?

Some of the barriers for GPs working to be clinical leaders are addressed in the King's Fund discussion paper on *The leadership challenge for general practice in England*. Much of this paper applies to GPs working in Australia.

Involvement in leadership activities and personal development removes GPs from clinical care, and this may have health and financial impacts on practices. It is important that appropriate funding is dedicated to supporting clinicians to develop leadership skills and participate in leadership activities. Government agencies and non-government agencies such as PHNs must recognise that general practice is funded on a different model than the hospital system. General practitioner involvement in program design and governance is critical and highly beneficial, but this involvement needs to be adequately renumerated.

The university sector should also support the development of academic leaders in general practice and primary care, including by funding senior academics and fostering research. Research in the primary care area is underfunded and funding agencies, including government and non-government agencies need to prioritise translational research involving primary care, including general practitioner researchers.[35]

9.3. What do you see as the areas of opportunity for leadership and cultural change?

Supporting GPs to undertake educational activities and leadership training is a key opportunity to build leadership and cultural change. This funding could be provided via PHNs to support local networks of GPs. The RACGP also supports the provision of continued funding for GP Liaison Officers in hospital systems. Practice based research networks (PBRNs) could also administer and evaluate leadership and learning opportunities. RACGP would welcome the opportunity to explore profession-led leadership development as an adjunct to GP training.

d. Primary care workforce development and innovation

Recommendation 10 (Building workforce capability and sustainability): Address Australia's population health needs with a well-supported and expanding primary health care team that is coordinated locally and nationally for a sustainable future primary health care workforce

10.1. Do you agree with this recommendation?

The development of a comprehensive workforce plan, including specific workforce strategies targeting elements of the primary care workforce, is supported by the RACGP.

Improved support for allied health, nursing (especially community nursing) and general practice is essential for integrated care across the sector. Ensuring these professions are attractive and appropriately remunerated should be incorporated into any approach to build workforce capability and sustainability.

The RACGP specifically welcomes Action 10.3.1, which is targeted towards attracting students and early career health professionals into the primary health care workforce, with increased exposure to primary health care during training and mentorship. General practice skills are the cornerstone of medicine. Junior doctors, regardless of intended specialty, will benefit from exposure to general practice. Early exposure will provide doctors with increased diagnostic skills for undifferentiated patients, advanced communication and consultation skills, and broad exposure to health issues affecting everyday Australians. This further benefits the non-primary care workforce, ensuring they comprehensively understand a GP's role in coordinating the patient's journey through the health system. Early exposure will also assist junior doctors in making informed career choices.

The RACGP recommends the Steering Group amend the recommendations to specifically support a general practice–based junior doctor placement program that provides exposure to general practice for postgraduate year (PGY) 1 and experience in general practice for PGY 2. The program would enable junior doctors to observe or provide patient consultations in the general practice setting as well as access clinical education and training opportunities. This recommendation is discussed further in the response to Question 14.1.

10.2. What do you see as the challenges in implementing this recommendation?

The main barrier to attracting junior doctors to general practice as a career is that remuneration for general practitioners is lower than for other specialist medical practitioners and all stages of their career and this gap has accelerated over the last 5 years. This is further discussed in the response to Questions 14.1 and 14.2.

There are a range of other challenges that may need to be addressed in the implementation of Recommendation 10, including:

- Increasing workforce training and capability is likely to be an issue, when many health practitioners have limited capacity for non-clinical activities due to the current funding model, for example, in rural areas with high workloads.
- Renumeration via the PIP for hosting medical students in general practice is minimal and may not cover the cost of infrastructure, such as rooms, and the time spend by general practitioners teaching. Updated economic analysis of cost of hosting medical students needs to be updated, and the PIP payment for hosting student adjusted and indexed.
- Renumeration via Medicare fee for service billing for general practice registrars may not cover salary, thus some practices lose funding by hosting registrars. Other models of providing adequate remuneration to registrars need to be explored
- Virtually connecting multidisciplinary teams, while strongly supported by the RACGP, is limited by the current digital infrastructure that exist in primary care.

Recommendation 11 (Allied health workforce): Support and expand the role of the allied health workforce in a well integrated and coordinated primary health care system underpinned by continuity of care

11.1. Do you agree with this recommendation?

The RACGP supports this recommendation in-principle.

The RACGP welcomes measures to better support the allied health workforce to work within an integrated, multidisciplinary team care environment. GPs and allied health professionals work closely to provide quality care for patients. This relationship is especially important in providing care for patients with chronic conditions and reducing preventable hospital admissions. The RACGP is pleased to note that the recommendation to enhance communication between allied health professionals and GPs through Action 11.4. This is critical to implementation of an integrated health system (as described in Recommendation 1) and should comprise support for delivering and recording both electronic and face-to-face communication.

11.2. What do you see as the challenges in implementing this recommendation?

Fragmentation of care can be a key challenge in implementing new models of care. Many of the recommendations outlined by the Primary Health Reform Steering Group propose an expansion of the role of allied health professionals in primary care. While the RACGP welcomes increased access to services for patients, it is essential that any mechanism aiming to increase access does not also fragment care and undermine continuity of care with a patient's usual GP.

When situated at the centre of their patients' care, GPs can provide continuity of care, reducing fragmentation and duplication of services. Patients whose care is continuous and coordinated have lower rates of hospitalisation and emergency department attendances, as well as lower mortality rates.[36] Continuity of care is enhanced by patients accessing one GP and one practice for all their health needs with referral to other services where required. All health policies should encourage patients to form an ongoing therapeutic relationship with their GP.[37]

Integrated care requires timely and secure electronic communication. While most general practices are capable of sending and receiving encrypted electronic communication, many private allied health (and most hospital allied health) practices cannot. A targeted scheme to enhance uptake and normalisation of this would increase care coordination. This could be in the form of additional incentives or requirements for communication with GP before Medicare subsidy can be raised. Funding to ensure uptake and normalisation of e-scripts would also enhance the health of the community.

Continued funding of HealthPathways, including allied health services, and involvement of allied health practitioners in Primary Health Networks is also critical to care integration.

Recommendation 12 (Nursing and midwifery workforce): Support the role of nursing and midwifery in an integrated Australian primary health care system

12.1. Do you agree with this recommendation?

The RACGP supports the involvement of nurses in GP-led multidisciplinary care teams, such as in the general practice setting. The general practice sector is the largest employer of practice nurses in Australia, with over 12,000 nurses employed in general practices across Australia.[38]

Patients and primary healthcare providers have benefited significantly from the contribution that nurses make to general practice. The integration of nursing professionals into general practice has been shown to contribute to healthier communities and more positive health outcomes, by proactively engaging members of the community with general practice initiatives.[39]

12.2. What do you see as the challenges in implementing this recommendation?

The RACGP notes Recommendation 12 incorporates several actions relating to the scope of practice for nursing and midwifery and would like to urge caution depending on the implementation of this recommendation.

It is critical that general practices remain the clear first point of contact for patients within the healthcare system, particularly in a system which is being reformed according to Recommendations 1-3 (one health system, practice registration, and increased primary health care focus). GPs retaining ultimate responsibility and oversight of patient care allows for comprehensive assessment, diagnosis, initiation of treatment, and referral to appropriately qualified team members (including nurse practitioners) in accordance with their qualifications, areas of clinical expertise and levels of support. VPE can act as a vehicle for funding support for nurses in general practice.

The RACGP only supports the provision of quality care delivered by suitably trained and qualified health professionals. As discussed in response to Recommendation 7, the RACGP does not believe that role and task substitution from GPs to less trained/skilled professionals is a solution to an undersized general practice workforce and unmet need for GPs.

Recommendation 13 (Broader primary health care workforce): Support and develop all appropriate workforces in primary health care to better support people, the existing health care workforce and achieve an integrated, coordinated primary health care system

13.1. Do you agree with this recommendation?

The RACGP supports this recommendation in principle.

13.2. What do you see as the challenges in implementing this recommendation?

Action 13.2, which encourages support for non-traditional and emerging workforces, should be implemented with caution. As flagged in the response to Question 12.2, the RACGP only supports the provision of quality care delivered by suitably trained and qualified health professionals. The RACGP disagrees with workforce solutions which result in role and task substitution from GPs to less trained/skilled professionals.

Recommendation 14 (Medical primary care workforce): Support, streamline and bolster the role of GPs (which includes Rural Generalists) in leading and coordinating care for people, while building and ensuring a sustainable and well supported medical primary care workforce

14.1. Do you agree with this recommendation?

The RACGP strongly supports measures to improve supply, distribution and retention of GPs.

The number of medical graduates choosing to enter GP training each year has stagnated. Eligible applications for GP training have dropped by 22% since 2015. Unfilled rural training places have increased from 10% (65 places) in 2018 to 30% (201 places) in 2020. Unfilled non-rural places have also increased over the same period to 2.15% (16 places) in 2020.[40] There has also been a significant shift toward specialisation of the medical workforce. For every new GP, there

are 10 new non-GP specialists; this gap between the number of non-GP specialists and GP specialists widened from 119 in 2009, to 4271 in 2017.[41]

Data also show that GP job satisfaction and positive perception of work–life balance have deteriorated since 2013, which will compound the current slow growth in GP numbers across the country and increase the difficulties in recruiting and retaining GPs in the future.[42] The financial losses suffered by general practices during the pandemic will likely further negatively affect the future desirability of general practice as a career option. It will become more difficult to convince young doctors to pursue a career in general practice if the profession continues to be undervalued in comparison to other medical specialties.

Feedback from our members also indicates increasing regulatory and punitive responses to compliance and workforce regulation are leading to stress and burnout in the GP workforce. These factors, combined with difficulty in competing with higher-earning specialties, may be contributing to general practice being perceived as a less attractive career option for medical graduates.

Required reform:

The RACGP recommends that Recommendation 14 be enhanced by incorporating the reintroduction of a training model that increases exposure to general practice, such as the Prevocational General Practice Placements Program (PGPPP). The PGPPP is a prevocational training program that enhances junior doctors' understanding of primary health care and encourages them to take up general practice as a career.

This program is critical to ensuring the robust future supply of GPs, as well as building critical general practice skills and understanding in the broader medical workforce. This program could incorporate a target for the proportion of graduates who take up general practice.

Measures to enhance the general practice training experience, including the introduction of longer rotations where feasible, are also supported by the RACGP. The RACGP further recommends an action to develop a system to support portability of junior doctor leave entitlements, as they transition from hospital-based training to community-based training, to ensure the sustainability of the future GP workforce.

Regarding the distribution of GPs, the RACGP has advocated for a range of approaches to address this issue. It is recommended the Steering Group seriously considers the following practical measures to support appropriate GP distribution:

- Increasing the number of rural-origin students in medical school.
- Increasing exposure to rural general practice in undergraduate and graduate medical courses.
- Increasing support for rural GP supervisors, including increased funding for compensation, and access to training and professional development.
- Increasing support for GPs training in rural communities, eg bursaries to train in rural communities, travel expenses, accommodation provision etc.
- Encouraging initiatives to support GPs to experience rural medicine, and to move to rural communities
- Undertaking an audit of rural clinical schools to determine best practice.

14.2. What do you see as the challenges in implementing this recommendation?

While the actions outlined under Recommendation 14 are strongly supported by the RACGP, there remains several challenges to address in the implementation of this recommendation. These include:

- As outlined in the response to Recommendation 10, the fundamental challenge in attracting, training and retaining an appropriately skilled workforce into general practice is the widening remuneration gap between GPs and other specialist medical practitioners. Implementation of the actions outlined under Recommendation 14 require a significant and ongoing commitment to increased funding for the GP workforce.

- Challenges remain around classifying the areas that require workforce support. RACGP members have raised concerns about the impact of the Distribution Priority Area classification system on the ability to sustain general practice in regional and outer metropolitan areas.
- Any actions relating to connectivity and digital engagement require significant investments to improve local and GP IT infrastructure. The RACGP proposes the inclusion of an additional action under Recommendation 14 which acknowledges the need for greater investment in digital health infrastructure for general practice.
- The need for Fly-In-Fly-Out (FIFO) support in rural and remote areas remain a key issue, and support for on the ground medical FIFO staff requires further consideration. There is a need to streamline credentialing processes so that it's easier for GPs from other areas to locum in rural communities to fill gaps.
- The attractiveness of general practice as a career may be limited by perceptions of minimal research capacity and funding in primary care. The issues around research in primary care are discussed in responses to Recommendations 17 and 18 in this submission.

e. Innovation and Technology

Recommendation 15 (Digital infrastructure): Develop digital infrastructure and clinical systems to better support providers to deliver safe and effective care

15.1. Do you agree with this recommendation?

The RACGP supports this recommendation and the underpinning actions.

The provision of contemporary healthcare involves patients interacting with multiple healthcare professionals in different locations and patients moving between difference health services. The exchange of patient information across the healthcare sector is therefore a requirement of modern healthcare provision. General practices should be able to receive, review and incorporate health information from other sources into their existing local health records efficiently and in a manner that supports patient confidentiality, quality clinical handover and effective continuity of care.

GPs are often the primary care coordinators for patients, and depend on other healthcare organisations to reliably provide additional details regarding diagnoses, treatments, investigations, management plans, and outcomes. It is expected that several of the actions underpinning this recommendation, in particular Action 15.5, will support communication and engagement between GPs, their teams and other healthcare organisations.

Digital infrastructure should go beyond the shared health record to include shared care planning, and the development of software and tools that support and prompt management processes.

15.2. What do you see as the challenges in implementing this recommendation?

While the RACGP strongly supports improvements in the use of technology across primary care, a move towards digital tools has the potential to create a divide in healthcare access for those with high digital literacy and good infrastructure access compared to those who do not/cannot use technology or do not have access to adequate infrastructure. This issue needs to be addressed to ensure the effective and equitable use of technology in general practice.

The current gaps in digital infrastructure represent a key challenge to implementing this recommendation. The majority of secondary/tertiary health services and government agencies do not use IT systems compatible with those used in primary care. Even those systems designed for use within general practice are often unable to link together to exchange or share data. As a result, general practice staff are required to manually transfer information both to and from clinical and administrative systems, by scanning and uploading letters, reports and requests; faxing and posting information to others; and entering details into online forms. These processes pose a number of problems and demonstrate the need for a national enterprise-wide platform that supports interoperability of hardware, software, data and services.

Any actions relating to connectivity and digital engagement may require significant improvements in local and GP infrastructure. As flagged in response to Question 14.2, the RACGP proposes a further action be included in the Primary Health Care 10 Year Plan to provide greater financial support for increased digital health infrastructure for general practice.

The RACGP has also prepared a report on minimum requirements for general practice clinical information systems to improve usability. We encourage the Steering Group to consider the issues raised in this report when revising recommendations and actions relating to digital infrastructure.

15.3. Please provide any examples of best practice for implementation of this recommendation (from Australia or overseas).

As flagged in the response to Question 5.3, the current development of the Acacia Patient Medical Record system in the NT across primary, secondary and tertiary services may be a valuable example to consider in the implementation of this recommendation.

Recommendation 16 (Care innovation): Enable a culture of innovation to improve care at the individual / population level, build 'systems' thinking and ensure application of cutting-edge knowledge and evidence

16.1. Do you agree with this recommendation?

The RACGP supports this recommendation in principle. This recommendation could contribute to the attractiveness of a career in general practice and could encourage more applicants to GP training. It is important that any 'innovation' genuinely supports improved patient care, as opposed to it being misused to reduce funding and/or create further red-tape.

16.2. What do you see as the challenges in implementing this recommendation?

Many of the challenges in implementing this recommendation are similar to those outlined for Question 15.2. This includes the lack of current digital infrastructure.

Another significant challenge is the lack of capacity of GPs to take time away from clinical service delivery due to the current reliance on fee for service payments. As general practice viability has worsened since the start of the COVID-19 pandemic, the capacity of general practices to adapt and innovate has further declined. As flagged in the response to Question 2.1, there is an urgent need to introduce additional funding for GPs and their teams to manage patient transitions between their general practice and other parts of the health system, and to support multidisciplinary team care in general practices.

The very low percentage of National Health and Medical Research Council (NHMRC) and Medical Research Future Fund (MRFF) funding that is dedicated to primary care is unacceptable and must be rectified. Primary care urgently needs investment and capacity building in order to answer the important research questions in primary care, including many proposed by the Steering Group. There is also an issue with fewer academic GPs in university leadership positions capable of leading research in these areas. PBRNs also may have a role in developing research capacity, and PHNs could be supported to better promote innovation and research across regional primary care communities.

16.3. Please provide any examples of best practice for implementation of this recommendation (from Australia or overseas).

To address general practice research workforce issues, a national program for research training in general practice is required. In Sweden, the successful National Research School in General Practice (funded by the Swedish Research Council) was developed to increase the amount of research and enhance research training in general practice, and to encourage a new generation of researchers in general practice.[43]

f. Research, data and continuous improvement of value to people, population, providers and the health system

Recommendation 17 (Data): Support a culture of continuous quality improvement with primary health care data collection, use and linkage

17.1. Do you agree with this recommendation?

The RACGP supports this recommendation, including the leadership of GPs in interpreting, understanding and designing responses to the trends and patterns identified in the data. The RACGP would welcome the opportunity to work with those implementing this recommendation to provide insights about data limitations, and advice on improvements in primary health data infrastructure, as well as linkages to broader health system data.

Many of the Steering Group recommendations refer to Quadruple Aim and moving from volume to value. The RACGP supports these frameworks in guiding reform but notes that primary care is disadvantaged in often not having evidence of direct impact of primary care interventions nor the capacity to generate such evidence because of a lack of funding. Notably, several high-quality longitudinal studies are no longer funded (ie BEACH, MABEL).

In the absence of strong clinical data – much primary reform is reduced to simple cost reductions. This reductionist approach is dangerous for the financial viability of primary care, and the long-term sustainability of attracting a primary care workforce to enact the vision within the Steering Group recommendations. It is important that clinical data is collected and analysed to understand general practice activity including preventative health care. There are few incentives for practices to collect this data.

GPs and practice teams should be encouraged and supported to reflect on their own performance and engage in quality improvement initiatives and activities. Quality improvement is an underlying feature of general practice care and is supported through practice accreditation and continuing professional development. In the context of primary care, data collection and Continuous Quality Improvement (CQI) should be profession managed and adequately financed to permit the highest standards of data governance. Data-linkage requires an overarching national process that is accessible and affordable to primary care researchers and other drivers of CQI.

Ongoing research is important to understand how to best implement CQI programs incorporating primary care data in practice, the cost and cost savings associated with such programs, and whether they are translating to patient, general practice and policy outcomes. As flagged in the response to Recommendation 15, there is a broader need for a funding model and mechanism for digital infrastructure funding in Australia.

Data needs to be collected for the purposed of local quality improvement (at a personal, practice or local level) as well as for the purposes of quality control. These dual purposes of data – local quality improvement, and central quality control – need to be clearly distinguished. Primary care providers need to be supported in doing the QI, while feeling secure that the quality control is restricted to ensuring patient safety and quality of care, and not an exercise in cost cutting. For many GPs, their main experience in understanding the impact of their data is through MBS compliance – often via data mining exercises with the goal of saving money rather than improving patient care.

17.2. What do you see as the challenges in implementing this recommendation?

The challenges and considerations in implementing this recommendation are:

- Difficulties in generating clear evidence include that primary care outcomes are often long term, unpredictable and difficult to attribute that identification of clear outcomes. This means that reform and funding incentives may be more difficult to design than in tertiary settings.
- Ensuring adequate support for primary care researchers by funding the development and support of these vital teams. This is discussed further in the response to Recommendation 18.
- Fragmentation and duplication of collection of primary health care data in Australia.
- Ethical considerations and data security.
- Collection of data by itself is not sufficient to facilitate quality improvement. This requires ongoing feedback of data to practices and funding to support quality improvement activities at the practice level.
- Primary care data linkages help to determine the impact of primary care interventions across the health system. However, there are challenges related to multiple data linkage keys being used in different datasets, timeliness of linkage, ability to link to state-based hospital data and costs associated with data linkage.
- The collection of patient reported measures have the potential to be used to facilitate clinical care as well as health services re-design. However, costs associated with collecting these measures (such as subscription to applications, secure messaging costs) need to be considered given that many general practices operate as small businesses and may have difficulty absorbing additional costs. These should be integrated within current

workflow, for instance incorporated into electronic health records, rather than developing separate bespoke dashboards, to facilitate easy access by health professionals and practice staff.

17.3. Please provide any examples of utilising primary health care data collection and linkages to support continuous quality improvement (from Australia or overseas).

The previously funded Primary Care Collaboratives were an excellent program upskilling general practice staff in the value of their data. Additionally, A/Prof Jan Radford's Churchill Fellowship report provides an overview of systems in England, Scotland and the Netherlands and a reflection on Australia's context as of late 2018.

See: Jan Radford, 'The Department of Health Churchill Fellowship to investigate how routinely collected GP electronic medical record data can be used to improve patient care'.

Other examples include:

1. NPS MedicineInsight
2. Outcomes Health POLAR program
3. NSW Health LUMOS program
4. University of Melbourne Data for Decisions and Future Health Today programs
5. University of New South Wales Electronic Practice Based Research Network (PRBN)
6. Gold Coast PHN Primary Sense

Recommendation 18 (Research): Empower and enable contextually relevant, translational and rapid research and evaluation in primary health care, addressing questions directly relevant to service delivery in localised context

18.1. Do you agree with this recommendation?

The RACGP supports this recommendation.

There is an urgent need for many of the proposed reforms within the Steering Group Recommendations to be supported by local evidence (from the impact of voluntary patient enrolment on continuity and quality of care, to the impact of expanded allied health provider/nursing scope on quality of care). Many of the important reforms of primary care are driven by Medicare funding and are neither evidence-based or evaluated. Even when evidence of effect of a new model of care is provided, it is not enacted because primary care evidence is not assessed or evaluated as highly as new 'innovations' such as pharmaceuticals. For example, GP-led counselling for smoking cessation is potentially more cost-effective than many recently added medicines to Pharmaceutical Benefits Scheme.

Critical to this recommendation is empowering the primary health care workforce and building long-term research capacity. Creating evidence to underpin clinical practice in primary care requires an intimate understanding of the primary care context and the involvement of GPs and other primary care clinicians in research in a variety of ways. The active participation of GPs and their practice teams is essential for successful research and research translation in the primary care setting.

The RACGP is motivated to increase research capacity across primary health care, in actively engaging GPs and other clinicians to better understanding their individual and practice population data, encouraging clinician researchers to engage in research, including through support of local PBRNs, and through upskilling in research techniques and competitive grant application.

There is an urgent need for a dedicated primary care research grant program to develop the evidence base about the efficacy and value of different primary care funding models and to better understanding what clinical outcomes are relevant and of value to clinicians and patients (as well as funders) in the Australian context. A network of aligned primary care researchers would be an appropriate to spread capacity building and research skills. This recommendation should include research to address relevant clinical problems, as well as workforce and healthcare services research.

The implementation of this recommendation could also assist in attracting an increasing number of medical graduates into the specialty of general practice.

18.2. What do you see as the challenges in implementing this recommendation?

The challenges and considerations in implementing this recommendation are:

- Ensuring adequate support for primary care researchers by funding the development and support of these vital teams. Primary care research has long been neglected. The Primary Health Care 10 Year Plan should have a section devoted to a structured funded program of work to enhance and further develop the teams that exist, especially those servicing populations at particular risk. It must be university-based though acknowledging key partnerships with entities like the RACGP, Australian College of Rural and Remote Medicine (ACRRM), other specialist medical and nursing colleges, National Aboriginal Community Controlled Health Organisation (NACCHO), health peak bodies and PHNs.
- There are significant funding, workforce and structural barriers to primary care research in terms of workforce and research participation. This should not be further complicated by requiring research to be facilitated through PHNs, which have variable experience in facilitating and conducting high quality research. Relationships between primary care academic researchers and primary care; in many cases through existing or developing PBRNs, should be a focus of development and funding.
- A significant barrier is a lack of support for infrastructure, eg through PBRNs and a streamlined approach to the collection and management of patient data in general practice. In addition, a recognition that most Australian general practices are small businesses is required and that remuneration is required to overcome barriers to participate in research. The RACGP PC4 guide provides an overview of appropriate budgets and resource for primary care practice-based research.
- There are currently significant gaps in the general practice research workforce, with no clear clinical research career pathways, and not enough GPs entering research. Ongoing career support for the research workforce is required.
- GPs typically have less opportunity for a lengthy research career. People experience gaps in salary funding at all career stages. People who have been supported early in their career often require further support as mid-career researchers to develop competitive track records, and more established researchers require support to continue to sustain themselves and build the field of expertise.
- Current funding allocated to primary care is inadequate to support PhDs and fellowships, given the broad range and proportion of healthcare professionals working in this space. Dedicated funding should also be made available to non-clinician researchers who work in primary care research.
- Development of PBRNs needs to be profession-led to ensure the specific challenges of primary care research are addressed. The RACGP, Australasian Association for Academic Primary Care and universities are well placed to work together to develop a practical proposal.
- There is a need to ensure that primary care researchers are embedded in grant review panels, and within the NHMRC and MRFF where funding allocation priorities are considered.

g. Emergency preparedness

Recommendation 19 (Primary health care in national and local emergency preparedness): Deliver nationally coordinated emergency preparedness and response, defining Commonwealth, State and Territory roles and boosting capacity in the primary health care sector

19.1. Do you agree with this recommendation?

The RACGP supports this recommendation.

GPs are essential in supporting individuals and communities before, during and in the aftermath of natural disasters and emergencies, such as the 2019-20 Australian bushfires and the ongoing COVID-19 pandemic. GPs, as frontline health providers, must therefore be adequately recognised, supported and included in national natural disaster and emergency preparedness arrangements including in planning, mitigation, response and recovery.

GPs have continuous relationships with their communities before, during and after disasters and emergencies and have opportunistic encounters with patients due to the high demand for primary care during and disaster situations. This should see general practice firmly embedded in emergency plans across the country, especially in rural areas.

19.2. What do you see as the challenges in implementing this recommendation?

The RACGP has consistently flagged issues with the lack of consistent information and communication during emergency responses. The overall and overwhelming experience of GPs and general practice teams working in or near bushfire affected areas during the 2019-2020 bushfire events was that there was a lack of consistent information, and more particularly, inconsistency of communication between jurisdictions. Efforts to embed GPs in the wider healthcare response to the fires were confused due to state/territory government management of emergency planning and Federal Government responsibility for general practice.

RACGP members have advised similar issues have arisen throughout the COVID-19 response.

19.3. What has worked best for you during disasters such as the COVID-19 pandemic, bushfires and other disasters?

The introduction of Medicare rebates for telehealth consultations throughout the pandemic have been critical to improving access primary healthcare at this time. RACGP members have consistently raised concerns about how the removal of rebates for longer phone consultations has the potential to worsen health gaps for specific groups, including Aboriginal and Torres Strait Islander people and people living in rural and remote areas. We urge the Steering Group to support the reintroduction of longer telephone consultations as part of a permanent telehealth model.

The RACGP applauds the productive actions often taken by its members in responding to emergency situations and highlights this as contributing significantly to any emergency response. In the 2019-2020 bushfire events, these actions included:

- GPs coordinating their practice teams and other medical and allied health staff working and living in affected areas to ensure provision of coordinated care to their communities during the response and immediate recovery period.
- GPs assisting other general practices in bushfire affected areas.
- GPs supporting vulnerable patients by undertaking home visits.

h. Implementation is integral to effective reform that delivers on the Quadruple Aim

Recommendation 20 (Implementation)

20.1. Do you agree with this Implementation Action Plan approach?

The RACGP supports the Implementation Action Plan approach. It is important the independent oversight group has sufficient representation from across the primary care sector. This must include a representative from the RACGP.

As discussed in the RACGP response to recommendations 17 and 18, there is an urgent need to develop evidence of many of the proposed reforms contained with the Steering Group recommendations. This requires a clear commitment to a primary care data and research infrastructure to develop Australian evidence.

20.2. Do you see any challenges in implementing primary health care reform?

There are many challenges associated with implementing primary health care reform. Importantly, primary health care reform must be underpinned by significant financial investment on top of what is already directed towards primary care. Additionally, the reform must be supported to be enacted in the long-term, beyond limited political cycles.

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