Pre-Budget Submission 2024-25

Royal Australian College of General Practitioners

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About the RACGP

The Royal Australian College of General Practitioners (RACGP) is the voice of general practitioners (GPs) in our growing cities and throughout rural and remote Australia. We are Australia's largest professional general practice organisation representing more than 40,000 members working in or toward a specialty career in general practice, including four out of five GPs in rural Australia. For more than 60 years, we've supported the backbone of Australia's health system by setting the standards for education and practice and advocating for better health and wellbeing for all Australians.

Introduction

The Royal Australian College of General Practitioners (RACGP) appreciates the opportunity to make a submission to the 2024-2025 Federal Budget and acknowledges the Albanese Government's focus on addressing the many challenges facing the primary care sector.

In 2023, the RACGP heralded the Government's $5.7 billion dollar investment in general practice as a game changer for general practitioners and the patients they support. The 2023-2024 Budget was a critical first step in rebuilding general practice and the primary care sector after a decade long rebate freeze.

However, one Budget can't fix everything. The RACGP's *Pre-budget Submission 2024*-25 prioritises further funding requests, in line with Strengthening Medicare Taskforce recommendations and building the GP workforce.

Amongst growing pressure on public hospitals and emergency departments, general practice remains the most efficient and cost-effective part of the healthcare system but needs more support. **For every $1 spent within the primary care system, $1.60 worth of healthcare system benefits was observed**.[1]

Australia's aging population, coupled with an epidemic of chronic disease, is placing increasing pressure on Australia's health system. The Albanese Government is currently undertaking significant and much-needed reforms. General practice remains highly utilised and accessible, with almost nine in 10 Australians visiting their GP each year. Its long-term viability is critical.

Australia is facing a looming shortage of GPs, with the shortfall expected to approach 11,000 by 2031. This is a result of fewer junior doctors choosing general practice as a speciality (13.1% down from 13.8% in 2021) and the fact that almost three in 10 GPs plan to retire within the next five years. It is essential Australia takes comprehensive steps to boost the prestige and viability of general practice to attract and retain the next generation of GPs. Without this workforce, the entire primary healthcare system is in jeopardy.

The Federal Government's *Strengthening Medicare* reforms will help ensure Australia has the primary healthcare system it needs to provide cost-effective, sustainable healthcare for Australians now and into the future. However, it is essential that any reform program is evidence-based and best practice. Without appropriate research and data, there is no way to track the success of reforms or guide policy modifications.

Developed in line with government priorities, including the Strengthening Medicare Taskforce Report, the RACGP 2024-2025 recommends three key priorities for the 2024-25 Federal budget:

- Ensuring Australia has enough GPs for the future
- Increasing access to primary care for all Australians
- Producing equitable health outcomes through research-informed preventive health and health care

Part A of this submission provides high-level summaries of the RACGP's recommended initiatives aligned to these priorities

Part B of the submission provides further detail on each initiative, the issue it seeks to address and the solutions RACGP's recommended initiatives provide.

We look forward to your positive consideration of the initiatives we have presented.

Should you wish to discuss further detail on any initiative, please contact RACGP Chief Advocacy Officer, Shayne Sutton on 0410 508 541 or Shayne.sutton@racgp.org.au.

Part A: Summary of budget initiatives and alignment with Federal Government priorities

Priority area 1 – Ensuring Australia has enough GPs for the future			
Budget initiative	***Rationale***	***Annual Investment ($)***	***Alignment with Federal Government priorities***
$74.22 million pa GP Attraction Initiative: a) GPT 1 incentive at a cost of $32,500 per registrar b) Parental leave at a cost of $35,830* per registrar c) Study leave at a cost of $5,118.68 per registrar	Increase the number of home-grown junior doctors choosing to specialise in general practice by improving working conditions and ensuring they are paid the same as those working in hospitals.	$43,875,000 $9,459,342 $20,889,333	**Measuring What Matters** *Healthy focus area: Equitable access to quality health and care services* • Proportion of people who at least once delayed or did not see a GP when needed due to cost • Proportion of people waiting longer than they felt acceptable for an appointment with a GP **National Medical Workforce Strategy 2021 – 2031** Priority Five: Build a flexible and responsive medical workforce. This will enable greater flexibility for doctors across their professional life and will build opportunities for lateral movement across sites and specialties through innovative employment models and practices, including portability and uniformity of benefits and employment arrangements.
$25.2 million pa GP Training Boost: 1) Support 500 participants train to be GPs via the RACGP's Fellowship Support Program 2) Support 600 participants in the Practice Experience Program Specialist Program	Train more GPs to address acute shortages of GPs in regional, rural and remote areas of Australia. These programs support Specialist International Medical Graduates (SIMGs); International Medical Graduates (IMG) and Foreign Graduates of an Accredited Medical School (FGAMS). Funding could be targeted to areas of greatest need.	$18 million $7.2 million	**Measuring What Matters** *Healthy focus area: Equitable access to quality health and care services* • Proportion of people who at least once delayed or did not see a GP when needed due to cost • Proportion of people waiting longer than they felt acceptable for an appointment with a GP **Five Year International Medical Graduates Recruitment Scheme** Objective: To provide incentives to attract appropriately qualified and experienced international medical graduates/ foreign graduates of accredited medical school (IMG/FGAMS) in general practice to overcome the current and future community needs for general practice medical services in rural and remote Australia. Objective: To increase the supply of appropriately qualified IMG/FGAMS in rural and remote Australia. Objective: To enhance the professional development, skills, and knowledge of IMG/FGAMS in Australia.

Priority area 2 – Strengthening Medicare: Increasing access to primary care for all Australians			
Budget initiative	***Rationale***	***Annual investment ($)***	***Alignment with Federal Government priorities***
Build General Practice Based Multidisciplinary Care Teams: Double the planned investment in the **Workforce Incentive Program** – Practice Stream to $890.2 million over five years	Increase support for collaborative, multidisciplinary care teams to deliver coordinated and continuous care to improve patient outcomes.	$178 million	**Measuring What Matters** *Healthy focus area: Equitable access to quality health and care services* • Proportion of people who at least once delayed or did not see a GP when needed due to cost • Proportion of people waiting longer than they felt acceptable for an appointment with a GP **Strengthening Medicare** **Taskforce Report recommendation:** *Increase investment in the Workforce Incentive Program to support multidisciplinary teams in general practice, improving responsiveness to local need, increasing accountability and empowering each team member to work to their full of scope of practice.*
New bundled payment to support coordination of care for non-indigenous patients aged 75 years and over with multiple comorbidities and all Aboriginal and Torres Strait Islander patients aged 55 years and over via MyMedicare	Optimal coordinated care for older Australians with complex care needs will improve health outcomes and reduce health system expenditure by eliminating fragmentation and duplication.	Year 1 – $1.3 billion Year 2 – $1.9 billion Year 3 – $2.1 billion	**Measuring What Matters** *Healthy focus area: Access to care and support services* • Proportion of people (aged 65 years or over) living in households, who were satisfied with the quality of assistance in the last six months **Strengthening Medicare** **Taskforce Report recommendation:** *Support better continuity of care, a strengthened relationship between the patient and their care team, and more integrated, person-centred care through introduction of voluntary patient registration.* **National Health Reform Agreement** The Commonwealth will continue to invest in programs designed to minimise the impact of potentially preventable hospital admissions arising from shortcomings in areas within its own direct policy control including investments in national implementation of co-ordination of care models for persons with complex, chronic conditions.

Expand eligibility for Medicare Health Assessment Items	Reduce readmissions to hospital through the provision of continuous care post-hospital discharge.	$63.4 million	**Measuring What Matters** *Healthy focus area: Healthy throughout life* • Proportion of people with one or more selected chronic health conditions *Healthy focus area: Equitable access to quality health and care services* • Proportion of people who at least once delayed or did not see a medical specialist when needed due to cost • Proportion of people waiting longer than they felt acceptable for an appointment with a medical specialist **Strengthening Medicare** **Taskforce Report recommendation:** *Support better continuity of care, a strengthened relationship between the patient and their care team, and more integrated, person-centred care through introduction of voluntary patient registration.* **National Health Reform Agreement** The Commonwealth will continue to invest in programs designed to minimise the impact of potentially preventable hospital admissions arising from shortcomings in areas within its own direct policy control including investments in national implementation of co-ordination of care models for persons with complex, chronic conditions.
20% increase to all Medicare rebates for Level C (20–40 minutes) and Level D (40-minutes plus) GP consultations with an additional increase applied to MMM 3-7	Longer consultations are essential to addressing, and reducing, Australia's burden of chronic disease.	$373.8 million	**Measuring What Matters** *Healthy focus area: Healthy throughout life* • Proportion of people with one or more selected chronic health conditions *Healthy focus area: Equitable access to quality health and care services* • Proportion of people who at least once delayed or did not see a GP when needed due to cost • Proportion of people waiting longer than they felt acceptable for an appointment with a GP **Strengthening Medicare**

			Taskforce Report recommendation: *Support general practice in management of complex chronic disease through blended funding models integrated with fee-for-service, with funding for longer consultations and incentives that better promote quality bundles of care for people who need it most.* **Taskforce Report recommendation:** *Strengthen funding to support more affordable care, ensuring Australians on low incomes can access primary care at no or low cost.*
20% increase to Medicare rebates for GP mental health items	The 2023 *General Practice: Health of the Nation* report found psychological issues to be the most common reason for patient presentations for the last seven years. Boosting funding for these consultations will improve health outcomes and substantially contribute to sustainability.	$59.2 million	**Measuring What Matters** *Healthy focus area: Healthy throughout life* • Proportion of people who experienced high or very high levels of psychological distress Key Government initiative identified as 'Strengthening the mental health and suicide prevention system, growing the workforce and laying the groundwork for future reform'.
Decoupling GP Focussed Psychological Strategy items from the Better Access Initiative	Increasing support for mental health care in general practice will improve health outcomes without impacting access to other mental health professionals.	$2.4 million	**Measuring What Matters** *Healthy focus area: Healthy throughout life* • Proportion of people who experienced high or very high levels of psychological distress Key Government initiative identified as 'Strengthening the mental health and suicide prevention system, growing the workforce and laying the groundwork for future reform'.
Universal Annual Child Health Checks – First 2000 days. Introduce funding to support universal annual child health checks during the first 2,000 days	Early detection, screening and surveillance can improve children's health and development during the formative years leading to improved lifelong outcomes.	$838 million	**Measuring What Matters** *Healthy focus area: Access to education, skills development and learning throughout life* • Proportion of children who are developmentally on track in all five domains of the Australian Early Development Census

			Child wellbeing highlighted in a one-off spotlight including a focus on child health and development, alongside development of the Early Years Strategy 2024-2034.

Priority area 3 – Strengthening Medicare: Equitable health outcomes through research-informed preventive health and health care			
Budget initiative	***Rationale***	***Annual investment ($)***	***Alignment with Federal Government priorities***
Establishment of a national practice-based research network	Generate high quality, general practice specific research to inform efficient and cost-effective policy and practice and help fill the gap left by the widely recognised Bettering the Evaluation and Care of Health (BEACH) program.	$2.4 million	**Strengthening Medicare Taskforce Report** **Recommendation:** *Learn from both international and local best practice, and invest in research that evaluates and identifies models of high value primary care excellence* **Recommendation:** *Invest in better health data for research and evaluation of models of care and to support health system planning. This includes ensuring patients can give informed consent and withdraw it, and ensuring sensitive health information is protected from breach or misuse.* **Australian Medical Research and Innovation Strategy 2021-2026.** Objective: Equitable health outcomes through research-informed preventive health and health care across the spectrum from primary to tertiary care. Objective: Health and economic benefits from transformative and innovative research through translation of outcomes into policy and practice, and commercialisation of new diagnostics, therapeutics, and preventive health interventions.
Invest in RACGP guidelines and initiatives that support prevention, chronic disease management and aged care	Support the development and use of clinical guidelines to provide effective and low-cost preventive and chronic disease health care in general practice.	$330,000	**National Preventive Health Strategy** Objective to 'build a sustainable prevention system for the future – building on previous success and momentum, addressing the increasing burden of disease, reducing health inequity and increasing preparedness for emerging health threats.'

Part B: Budget initiatives in detail

Priority area 1 – Ensuring Australia has enough GPs for the future

Australia is facing a looming shortage of GPs. The shortfall expected to approach 11,000 by 2031. Fewer medical graduates are choosing general practice as a speciality (13.1% down from 13.8% in 2021) and almost 3 in 10 GPs plan to retire within the next five years.

The Federal Government is undertaking significant reforms and making substantial investments in primary healthcare. These efforts will not succeed if there is not a GP workforce available to deliver essential care to all Australians. GPs are essential to reducing mortality, improving health outcomes and ensuring a sustainable healthcare system.[2]

The RACGP is calling for two budget initiatives to address workforce shortages in general practice and support reforms in primary healthcare.

- ***A $74.22 million pa GP Attraction Initiative:*** To incentivise more home grown junior doctors to choose to specialise in general practice by improving working conditions and ensuring they are paid the same as those working in hospitals.
- ***A $25.2 million pa GP Training Boost:*** To support additional international and Australian participants in the RACGP's Fellowship Support Program (FSP) and Practice Experience Program (PEP) Specialist Programs.

1.1 *GP Attraction Incentive Plan*

Issue:

Junior doctors make crucial decisions about their career based on a range of factors, including remuneration, available entitlements and their family and personal circumstances. GPs in training face a number of financial pressures when they transition from the hospital training environment to general practice in community settings.

The RACGP considers direct incentive, parental and study leave payments the most expeditious, effective and efficient pathway to improving registration conditions, preserving the direct relationships between registrars and practice owners and boosting the long-term GP workforce.

During the hospital year of training, GP registrars are eligible for $125,900 p.a. There is a perceived salary reduction from this placement to one in general practice where income drops to $93,471 p.a. in the first 12 months (excluding percentage of billings). The perceived $32,500 p.a. pay cut is one of the biggest disincentives to choosing a career in general practice and a motivator to remain in the hospital environment.

The loss of paid parental leave entitlements is also a significant barrier to attracting junior doctors out of the hospital environment and significantly delays entry of junior doctors into GP training. A registrar being paid under a medical officers award such as the Doctors in Training (Victorian Public Health Sector) would have access to 14 weeks paid parental leave. At a registrar Year 2 rate ($133,086 p.a. or $2,559.34 per week), this equates to a $35,830 shortfall for registrars during their community general practice terms.

Similarly, the loss of paid study leave entitlements is also a barrier to attracting junior doctors out of the hospital environment and significantly delays entry of junior doctors into GP training. Acute hospital employees traditionally have access to up to 10 days paid study leave per annum which is not matched for GPs in training.

For example:

A Year 3 Hospital Medical Officer (HMO) in the acute hospital environment within Victoria is salaried at $95,829 p.a. and is a reasonable pay comparison point at entry to GP training. GP registrar's minimum base salary (excluding their percentage of billings) begins at $84,888 p.a. in the first 6 months of training and increases to $102,055 p.a. in the second six months of training. Taken together the salary of a full-time year one GP Registrar is not less than $93,471 p.a. and once a percentage of billings or receipts is included the income a registrar can earn in general practice is competitive with the HMO base salaries.

However, a registrar in the acute hospital environment within Victoria has the following salary progression:

- *$125,900 p.a. in year 1*
- *$133,086 p.a. in year 2*
- *$138,157 p.a. in year 3.*

While each state and territory has variable arrangements for the remuneration of their public health staff, this Victorian example highlights the issue faced by the profession.

Solution:

Implementing an incentive payment and direct leave payments provides a soft landing for junior doctors to leave the hospital environment by providing equivalent salary and entitlements. This is immediately actionable via existing Nationally Consistent Payments Framework and Services Australia payment mechanisms. It would immediately alleviate the most significant barriers identified by junior doctors and registrars. It also creates a workforce distribution lever for the Government.

An appropriate commencement incentive would be a GPT1 payment of $32,500 in the first 6 months of community general practice training.* This would alleviate the significant reduction in salary experienced by registrars during this period and remove the perceived income reduction which prevents some junior doctors from entry into GP training.

The introduction of paid parental leave would support gender equity and workforce diversity. It is recommended that parental leave payments, equivalent to those available to junior doctors within existing Enterprise Agreements, are introduced. The implementation of up to 14 weeks paid parental leave paid at the equivalent base pay rates of a registrar in the acute environment would remove the barrier to choosing a career in general practice, or delaying entry to the profession until after a junior doctor has had children. As demonstrated in Health of the Nation 2023, the growth in the number of female GPs makes addressing the disparity in paid parental leave critical.[3]

Similarly, the introduction of paid study leave would improve registrar wellbeing and support their progression through training. Two weeks paid study leave paid at the equivalent base pay rates of a registrar in the acute environment would remove the perceived barrier of poorer conditions associated with a career in general practice.

The RACGP recommends:

- A new incentive payment for GP trainees in the form of direct payments via Nationally Consistent Payments Framework and paid via Services Australia.
- Parental leave for GP trainees in the form of direct payments via Nationally Consistent Payments Framework and paid via Services Australia.
- Study leave for GP trainees in the form of direct payments via Nationally Consistent Payments Framework and paid via Services Australia.

Measure	Estimated investment required, annually ($)
GPT 1 incentive at a cost of $32,500 per registrar	$43,875,000
Parental leave at a cost of $35,830† per registrar	$9,459,342
Study leave at a cost of $5,118.68 per registrar	$20,889,333
Total investment	**$74,223,675**

* Work to consider state-based variation to income barriers should be done to validate the incentive figure to ensure there are no unintended consequences.

† Figure based on registrars who took parental leave in term 1, 2023. All Calculations are based on the RACGPs Australian General Practice Training registrar cohort. It does not include the Australian College of Rural and Remote Medicine (ACRRM), Remote Vocational Training Scheme (RVTS) Program, Fellowship Support program or International Specialist Program (ISP).

1.2. GP Training Boost: *Targeted support for GP training*

Issue:

The Fellowship Support Program (FSP) is a crucial initiative providing an alternative to the Australian General Practice Training (AGPT) Program, creating opportunity for people who may be ineligible for the AGPT.

The FSP provides supervised and accredited education and training over two years and continues to support doctors in their approved placement location for up to three years whilst they are completing RACGP Fellowship requirements. FSP provides a medical workforce solution for regional and remote communities across Australia, particularly whilst doctors are meeting their moratorium requirements.

Under the previously funded Practice Experience Program (PEP), almost four in five (78%) standard participants worked outside major cities in Modified Monash Model (MMM) geographic areas 2–7, and almost nine in 10 (88%) of completed PEP standard participants reported they would like to continue to work in their current practice location.

The FSP is currently self-funded, creating an additional financial barrier for potential trainees. Under-subscription of this program could result in significant reduction to the medical workforce for regional and remote (MM2-7) areas. The FSP provides an estimated 500 places per year (two intakes of 250). The FSP also delivers a significant number of doctors to remote and rural areas, with 17% (67 doctors in the 2023 cohort) of all FSP applicants training in the most needful MMM5-7 regions.

The Practice Experience Program (PEP) Specialist Program recognises the skills and experience of Specialist International Medical Graduates (SIMGs). The SIMGs undertake a period of orientation, supervision and assessment to confirm they are at the level of an Australian new Fellow. Funding was previously available under the PEP but SIMGs have been self-funded since 2022. SIMGs work in MMM2-7 or MMM1 and Distribution Priority Area (DPA) and provide a valuable experienced workforce. In light of the Kruk report, *Independent review of Australia's regulatory settings relating to overseas health practitioners*, making it more attractive for overseas trained doctors to enter the country is a key priority.[4] However, in an internationally competitive market, migrating to Australia with the associated fees becomes less attractive than other locations.

Solution:

Funding to support participants in the FSP would enable more doctors to practice in regional and remote communities. Dedicated support would prevent under-subscription of the program and boost medical supply in MMM2-7 areas.

Funding to support the PEP Specialist Program would enable SIMGs to contribute to workforce solutions in regional and remote communities. This cohort already have a specialist general practice qualification and a desire to come to Australia. Reducing the financial barriers to migration would increase the attractiveness of the move. If well supported, they represent a rapid pathway to workforce supply in those areas at greatest need.

The RACGP recommends:

- Funding to support 500 participants in the Fellowship Support Program (FSP).
- Funding to support 600 participants in the Practice Experience Program (PEP) Specialist Program.

Measure	Estimated investment required, annually ($)
Support 500 participants in the Fellowship Support Program (FSP)	$18 million
Support 600 participants in the Practice Experience Program (PEP) Specialist Program‡	$7.2 million

‡ Program implementation is dependent on appropriate planning and resourcing.

Priority area 2 – Strengthening Medicare: Increasing access to primary care for all Australians

The Strengthening Medicare Taskforce Report highlights the importance of preserving Australia's world class health system, underpinned by primary care.[5] The Federal Budget 2023-24 prioritised the recommendations of the Taskforce and laid the groundwork for future investment in universal healthcare. Good progress has been made but there is more work to be done.

To meet current and future challenges the RACGP is calling for five budget initiatives to strengthen Medicare and support reforms in primary healthcare.

- Implement a top up increase to the Workforce Incentive Payment – Practice Stream of the Practice Incentives Program with a proportion of funds dedicated to the employment of a general practice based pharmacist.
- Introduce funding to support coordination of care by a patient's regular GP.
- Introduce funding to support GPs to see their patient within seven days of an unplanned hospital admission or Emergency Department presentation.
- Implement a 20% increase to Medicare rebates for all Level C (20–40 minutes) and Level D (40-minutes plus) GP consultations with an additional increase applied to MMM 3-7 (as per the distribution of the bulk billing incentive).
- Implement a 20% increase to Medicare rebates for GP mental health items.
- Implement universal annual child health checks via MyMedicare registration during the first 2,000 days to support optimal development.

2.1. Multidisciplinary care teams

Issue:

Evidence shows fragmentation of care increases health system costs and results in poorer health outcomes.

Australia's health system is fragmented, with patient care becoming more complex as the population ages and the prevalence of chronic disease increases.[6] Implementing best practice multidisciplinary care teams (MDCTs), which enable coordinated, continuous whole of person care, are essential to meeting these challenges. Different types of health professionals work in the primary care setting, all attending to the needs of their patients. Because of the way Medicare is funded these professionals often work independently of each other. The full benefits of multidisciplinary care can only be achieved within a primary care team - ensuring interventions are done by the most appropriate person, and the scope of care for the patient is enhanced, not fragmented.

MDCTs should include a GP working collaboratively with other health professionals such as nurses, nurse practitioners, pharmacists, Aboriginal and Torres Strait Islander Health Practitioners and other allied health practitioners to improve patient outcomes. These teams must be appropriately resourced to coordinate care for patients with complex needs and adaptable to local community needs.[7] As highlighted in Measuring What Matters: Australia's First Wellbeing Framework, this is a key government initiative designed to better support multidisciplinary care and expand equitable access to coordinated and comprehensive healthcare for all Australians.[8]

The quadruple aim of healthcare encompasses improved patient experience, improved population health, reduced healthcare costs and improved provider experience, which can be enhanced by team-delivered care allowing all providers to work to their full scope of practice.[7] The support of suitably qualified team members enables GPs to delegate more within the coordinated practice team, freeing up more time for complex or urgent care, resulting in improved access to general practice.

Solution:

Team-based care is widely recognised as best practice in the delivery of primary healthcare services. The Strengthening Medicare Taskforce Report encourages multidisciplinary team-based care, emphasising the importance of these practitioners working in a collaborative and coordinated manner with the patient at the centre.[5]

To achieve this model of care, significantly increased funding is required for general practices to employ, coordinate and provide oversight to a team of qualified health professionals, including nurses, nurse practitioners and pharmacists. Evidence shows that team-based care contributes to reduced hospital readmission rates and emergency department presentations.[9] More specifically, recent research showed teams which were predominantly made up of GPs and nurses were associated with a reduction in ED attendances.[10] This study also highlighted the role of general practice based

pharmacists, observing a higher prescribing quality and lowered prescribing costs in practices when more pharmacists were employed.[10]

The Workforce Incentive Program – Practice Stream (WIP-PS) facilitates patient-centred, multidisciplinary care within general practice. As part of the Federal Budget 2023-24, the Australian Government announced an investment of $445.1 million over five years to increase the WIP-PS. This commitment is valued and will enable more practices to invest in their care teams, however, further strengthening of this commitment is needed.

The RACGP recommends:

- Implement a top up increase to the Workforce Incentive Program – Practice Stream of the Practice Incentives Program with a proportion of funds dedicated to the employment of a general practice based pharmacist

Measure	Estimated investment required, annually ($)
Double the planned investment in the Workforce Incentive Program – Practice Stream to $890.2 million over five years	$178 million

2.2. Coordination of care

Issue:

Patients with complex health needs and/or chronic disease can face a significant burden when managing their care and interactions across various health and social services. GPs are uniquely placed to provide comprehensive, continuous and coordinated care to patients, bridging the gaps between primary, secondary and tertiary care and other health and social services, such as access to housing and financial support for patients in need of assistance. This coordination role relies on effective two-way communication and engagement across health and social services, including hospitals and other medical specialists.[11]

General practice can be a central point of coordination for patients with complex needs who are accessing care from multiple sources, reducing duplication across the health system and associated inefficiencies.[7] Prioritising coordinated care ensures valuable health resources are targeted to patients who would benefit most from services, such as patients with chronic conditions.[7] It also enables information sharing across providers, which ultimately improves communication and clinical decision making.[7]

GPs practice comprehensive and coordinated care every day, prioritising effective communication and shared clinical information to improve health outcomes for their patients and minimise fragmentation of care and wasted resources. This important role must be supported to ensure patients continue to receive care and advice as they navigate the complexities of the healthcare system. As patient presentations continue to become more complex greater support for coordinated care facilitated by GPs is essential.[6]

Solution:

Coordinated care must be better supported through Medicare. Innovative funding paid directly to assist GPs to coordinate the care of their patients, particularly those with complex needs, reduces fragmentation and duplication. The Lumos research study investigated the benefit to cost ratio of high connectivity general practices, defined as those where greater than 30% of patients visited at least 12 times in two years.[1] It found the benefits of coordinated care outweighed the additional costs associated with higher visitation. **More specifically, for every $1 spent within the primary care system, $1.60 worth of healthcare system benefits was observed**.[1]

Multidisciplinary care prioritises reliable and timely communication between the relevant health and social services. This benefits patients and funders alike through reduced unplanned hospitalisations and increased quality of life for the patient, their families and carers. A planned strategy would be needed to manage cases of chronic disease, emphasising the importance of the patient learning to assist in the management of their own care through a person-centred approach.

International research compared the delivery of coordinated care with usual care among patients who were frequent users of emergency departments, demonstrating a 19% lower risk of hospitalisation for those who received coordinated care, alongside cost savings for the health system.[12] Similarly, Australian research calculated an incremental cost

effectiveness ratio of $548 per Quality Adjusted Life Year (QALY) among children with a chronic condition who received care coordination, noting the average of $17 in additional costs to the health system resulted in an additional 0.031 QALYs over 12 months.[13]

The independent review of the Coordinated Veterans' Care (CVC) Program identified the benefits of an increased focus on coordination including improved quality of life and social connectedness, as well as avoided hospitalisations.[14] Additionally, participants reported improvements in their ability to navigate the healthcare system and self-manage, alongside related increases in health literacy.[14] The investment in general practice also built capability in the system through enhanced collaboration between GPs and their teams, and other providers.[14]

However, to avoid straining general practice, funding must not be accompanied by increased red tape and administrative burden for practices.

The RACGP recommends:

- Introduction of funding to support coordination of care by a patient's regular GP.

Measure	Estimated investment required ($)
New bundled payment to support coordination of care for non-indigenous patients aged 75 years and over with multiple comorbidities and all Aboriginal and Torres Strait Islander patients aged 55 years and over via MyMedicare	Year 1 – $1.3 billion (this is an estimated annual investment of $2,300 per eligible patient) Year 2 – $1.9 billion Year 3 – $2.1 billion

2.3. Reducing hospitalisations through general practice

Issue:

Public hospitals are experiencing high demand across Australia, resulting in significant delays for ambulance and Emergency Department (ED) services. The RACGP sees a significant opportunity to reduce the pressure on these services by addressing potentially preventable hospitalisations (PPHs). Annually, there are more than 748,000 PPHs in Australia, accounting for 6.6% of all hospital admissions and 9.8% of hospital bed days.[15] In remote and very remote areas, PPH rates were 2-3 times higher than in major cities as of 2021-22.[16]

Preventable hospital readmissions make up a significant proportion of these potentially preventable hospitalisations. Approximately 718,000 readmissions to hospital occur each year.[17] Unplanned or unexpected hospital readmissions may be required because of the need for hospital or as the result of a lack of appropriate post discharge care in the community, including appropriate and timely clinical handover.

Better support for, and use of, general practice is associated with reduced ED visits and hospital use, and decreased hospital readmission rates.[2, 18, 19] Patients who see their GP soon after discharge from hospital experience significantly fewer hospital readmissions. Dedicated time for seeing a GP following an unplanned hospital admission reduces a person's chance of readmission by up to 24%.[20] New South Wales data shows:

- a visit to the GP in the first week is followed by 7% fewer readmissions within 28 days
- a visit to the GP in the first 4 weeks is followed by 22% fewer readmissions over 1 to 3 months.[21]

Conservative estimates suggest a 12% reduction in hospital readmissions could save the health system a minimum of $69 million per year.[17] In addition to the savings, patients experience better health outcomes and pressure on the hospital system is reduced.

Solution:

Funding to support continuous and coordinated GP-led care post-hospital discharge will help address unsustainable hospital demand, reduce PPH's and improve outcomes for patients. Introducing targeted funding for GPs to see patients within seven days of an unplanned hospital admission or ED presentation will reduce readmissions and ensure people with complex needs do not get lost in the system, particularly those in rural and remote Australia. This must be supported by appropriate timely communication to the GP from the hospitals.

Additional funding for GP visits post hospitalisation will also allow practices to dedicate time for staff, including GP, nursing, employed pharmacists and allied health staff, to create short notice availability for assessment and review of relevant patients in a timely manner.

The RACGP recommends:

- Introduction of funding to support GPs to see their patient within seven days of an unplanned hospital admission or Emergency Department (ED) presentation.

Measure	Estimated investment required, annually ($)
Expand eligibility for Medicare Health Assessment Items to include 'Discharge within 7 days of hospital'	$63.4 million

2.4. Longer GP consultations (Level C and D)

Issue:

Rising rates of chronic disease and mental ill-health, as well as the ageing population, means more patients are presenting to general practice with increasingly complex needs.[6] In 2020-21, almost half (46.6%) of all Australians had at least one chronic medical condition.[8] These conditions are long term, and require early identification and care that can be provided in the community by GPs and their multidisciplinary teams.

Although short general practice consultations support straightforward issues, longer consultations are needed for chronic illnesses and complex health concerns.[22, 23] Longer consultations have significant advantages for patients, 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.

However, patient rebates are lower per minute for longer consultations, disadvantaging people who require more time with their GP. This can mean the sicker a person gets, the more they pay out of pocket to see their GP and the harder it is to get the extra time they need with a GP. Concerningly, there is a growing trend that patients seeking bulk billed care can only access shorter consultations, exacerbating access issues for those most in need.

More broadly, patients need an increase in their rebates to ensure they can still access the care they require. Without additional investment, inflation and other factors mean rebates are not keeping up with growing healthcare costs.

Solution:

Care for complex health issues must be better supported through Medicare to arrest the deterioration in the prevalence of chronic medical conditions.[8]. Longer consultations provide an opportunity to address major risk factors by allowing more time for preventive care and early intervention for chronic conditions.

Increasing funding for all standard general practice consultations longer than 20 minutes is a simple and effective way to build additional support for people with complex health needs, including for the elderly and the most vulnerable.

Better supporting longer consultations is also important for rural and remote communities, which are significantly more likely to report barriers to accessing GPs compared with other Australians.[16, 24] For this reason, increased investment is required to support GPs working in these communities (MMM3-7).

The RACGP recommends:

- A 20% increase to all Medicare rebates for Level C (20–40 minutes) and Level D (40-minutes plus) GP consultations with an additional increase applied to MMM 3-7 (as per the distribution of the bulk billing incentive)

Measure	Estimated investment required, annually ($)
20% increase to all Medicare rebates for Level C (20–40 minutes) and Level D (40-minutes plus) GP consultations with an additional increase applied to MMM3-7	$373.8 million

2.5. Mental health consultations

Issue:

GPs play a crucial role in Australia's mental health system as an entry point and deliverer of care. GPs receive education in treating mental health conditions throughout their 10+ years of training, and 90% of GPs have undertaken Mental Health Skills Training to be eligible to provide GP Mental Health Plans under the MBS.[25]

Over half of all Australians require support with their mental health and 37% of them are most likely to access support through their GP.[26] GPs have reported psychological issues to be the most common reason for patient presentations for the last seven years.[3] GPs are the most accessible part of Australia's mental health system.[27-31] For patients who face financial disadvantages or live in rural or remote areas, their GP may be the only mental health professional they can access.

The current structure of the MBS incentivises short consultations, rewarding GPs for seeing as many patients as possible. Short consultations do not suit the provision of mental healthcare. This funding structure makes it financially difficult for GPs to provide their patients with adequate care without charging gap payments that can then be a barrier to care.[§]

The structure of the Better Access Initiative currently discourages GPs from providing Focused Psychological Strategies (FPS) services to their patients, leaving GPs as an underutilised mental health resource. Currently under the Better Access Initiative an FPS session with a GP counts towards the 10 sessions per year a patient can utilise and which could be used to subsidise an appointment with a dedicated mental health professional. For this reason some GPs do not provide FPS services so they can ensure patients don't lose out on access to other mental health professionals.[9] This means GPs with FPS training are underutilised. It also discourages other GPs from pursuing FPS training.

Solution:

The application of a 20% increase to GP mental health MBS items would significantly increase the viability for GPs to provide these services to patients, ensuring they receive the clinical time they require. This increase would have a significant positive impact for the thousands of Australians struggling with mental health challenges. It would have its biggest impact on patients who have difficulty accessing care anywhere other than their GP.

Australia's mental health system is being pushed to breaking point. We need to ensure every element of our mental health workforce is utilised for the benefit of patients. FPS services provided by GPs must be uncoupled from the Better Access initiative so GPs can provide FPS services without compromising access to other mental health professionals. This measure will create a vital opportunity for care to continue once a patient's 10 sessions under the Better Access Initiative have been exhausted. It will allow an FPS trained GP to provide higher quality care for these patients until additional sessions become available in the following calendar year.

The RACGP recommends:

- A 20% increase to Medicare rebates for GP mental health MBS items.
- GP FPS items to be decoupled from the Better Access Initiative.

Measure	Estimated investment required, annually ($)
20% increase to Medicare rebates for GP mental health items[**]	$59.2 million
Decoupling GP FPS items from the Better Access Initiative	$2.4 million

[§] This issue is worsened by MBS item 2713 (attendance related to a mental disorder >20 minutes) having a lower rebate than MBS item 36 (standard attendance 20-40 minutes). This distinction also makes MBS billing data unreliable. Many GPs will opt to bill an MBS item 36 rather than the 2713 to access the higher rebate but making the prevalence of mental health attendances in general practice appear lower than they are.

[**] Based on a 20% increase to 2022-23 billing rates of MBS items 2700, 2701, 2715, 2717, 2712, 2713, 92112, 92113, 92116, 92117, 92114, 92115, 92126, 92127, 2721, 2723, 2725, 2727, 2739, 2741, 2743, 2745, 91818, 91819, 91859, 91861, 91842, 91843, 91864, 91865, 90250, 90251, 90252, 90253, 90264, 92146, 92147, 92148, 92149, 92170, 92176, 90271, 90272, 90273, 90274, 92182, 92184, 92194 and 92196.

2.6. Universal annual child health checks

Issue:

Evidence indicates the first 2,000 days of life are a critical period. Interventions during this time can result in significant improvements to children's early life experiences, health and development.[32] Good health in childhood also has a long term impact, as problems that become more apparent in adulthood often have their origins in childhood.[33] Early detection, screening and surveillance facilitated by a family's GP during these years leads to better outcomes and early intervention to give children a better chance at achieving normal ranges of development.[34]

General practice plays a significant role in providing ongoing care to women, children and their families during pregnancy and the early childhood years, along with providing the support, information and referrals to services needed to thrive.[34] GPs provide holistic family centred care pivotal to the child's long-term health and wellbeing. While all states and territories include wellbeing milestones in their early childhood health checks, there is no nationally consistent approach.[32]

The final Working together to deliver the NDIS report from the National Disability Insurance Scheme (NDIS) review states that all Australian governments should agree as a matter of priority to expand universally available child development checks, to ensure the early identification of children with developmental concerns and disability and enable early intervention. The report also recommends this approach should be implemented by mainstream services working with children including maternal child health, early childhood education and care and general practice.[35]

Measuring What Matters: Australia's First Wellbeing Framework highlights the importance of child development as a key determinant of future health, wellbeing and prosperity.[8] There is an opportunity for GPs to positively influence a child's life during this critical period, if adequately supported, to improve health and development in the formative years when intervention is most consequential.

Solution:

A universal, annual children's health check accessible via MyMedicare registration could support consistency, enable early identification of any emerging challenges children are experiencing, and support GPs to provide timely support and advice to families. The First 2,000 Days Implementation Strategy 2020-2025 provides recommendations that could form the foundation for universal children's health checks to ensure a seamless transition from maternity to child and family health services as facilitated by their GP and to encourage every family to have a consistent relationship with a general practice that works closely with maternity and child and family health services.[34]

Prevention and health promotion in the early years, from conception to 5 years of age, is critical for an individual's lifelong health and wellbeing.[36] It may also be an opportunity to redress health inequalities.[37] Support for universal, annual health checks could incentivise GPs to screen the child's functional development, capacity, independence, and participation in daily activities, along with developing early intervention goals, if needed, in collaboration with the child's family.[38] Incentivising the early childhood approach will enable best practice care to support children and their families.

The RACGP recommends:

- Implement universal annual child health checks via MyMedicare registration during the first 2,000 days to support optimal development.

Measure	Estimated investment required, annually ($)
Introduce funding to support universal annual child health checks††	$838 million

†† Based on the MBS 705 – Long health assessment at 80% of rebate ($167.56), for the (approx.) 5 million children under the age of 5 years in Australia at the time of submission.

Priority area 3 – Strengthening Medicare: Equitable health outcomes through research-informed preventive health and health care

The Federal Government's Strengthening Medicare reforms will help ensure Australia has the primary healthcare system it needs to provide cost-effective, sustainable healthcare for Australians now and into the future. However, it is essential reforms are evidence-based and best practice. Without appropriate research and data, there is no way to track the success of reforms or guide policy modifications. Additionally, practice-based research will help improve the image of general practice as a specialty and contribute to shoring up the future GP workforce.

The RACGP is calling for two budget initiatives to support guidelines and data that will underpin successful reform.

- Allocate funding and support to establish a national practice-based research network.
- Invest in the RACGP guidelines over the next three years to make these 'living guidelines' and to encourage implementation.

3.1. Practice-based research network

Issue:

Funding, infrastructure and capacity for research has been progressively moved away from general practice and primary care. Currently the bulk of research underway is irrelevant to primary care. While general practice sees over 90% of the Australian population each year, only 18% of the activity is underpinned by research carried out in general practice.

High quality, relevant evidence is needed to inform efficient and cost-effective policy and practice for general practice. A significant barrier to generating high quality evidence, or evaluating policy effectiveness in general practice, is the lack of a national practice-based research network (PBRN).

It is also critical to shorten the time lag between generating evidence and changing clinical practice. By engaging general practices nationally in research, and translating that research into practice, we create a system that ultimately provides efficiency, engagement and better outcomes for the health and wellbeing of the community.

Creation of a national primary care PBRN is critical to the success of:

- The evaluation and future refinement of the proposed changes in models of care and funding arrangements arising from the *Strengthening Medicare Taskforce Report*.
- The proposed Centre for Disease Control to improve the responses to public health emergencies would be supported by a national PBRN for testing policy decisions and providing an evidence-base for decisions.
- Providing national general practice data to inform current and future government frameworks and strategy such as the recent *Measuring what matters: Australia's first wellbeing framework*.

A national practice-based research network is critical to the future of general practice as a thriving specialty and attraction of our future workforce. "PBRNs are the missing link between professional and research institutions and the general practices that are partnering in that research, and an indispensable component of the future of general practice in Australia".[39]

Solution:

A national PBRN will build general practice research capacity to address important research questions and increase Australia's clinical trials capacity which will generate income, increase job satisfaction and improve health outcomes. This network will create collaboration opportunities with commercial entities developing novel pharmaceuticals, diagnostics and devices in their target populations in the community.

Importantly, establishing this network is critical to support the re-establishment of a national general practice dataset which enables capture and interrogation of GP encounter-level data. This level of data and reporting is essential to understanding GP consultation activity, inform policy and decision-making, as well as contributing to the evaluation of general practice reforms. This will fill the gap left by the previous Bettering the Evaluation and Care of Health (BEACH) data, which was the national study of general practice clinical activity, including GP encounter-level data from 1998 to 2016.[40] The BEACH study significantly contributed to quality patient care, health system performance, and the work of the RACGP. It is important that the next iteration of data collection and reporting is a collaborative endeavour including RACGP and universities across Australia, and that it leverages off advances in technology making it fit for purpose in the current and future general practice context.

Building a national PBRN will have a direct positive impact on GP workforce issues. The GP academic workforce is vital to sustain general practice in medical schools, where GP academics are needed to lead and contribute to teaching and inspire the next generation of medical students to a career in general practice. A strong GP academic workforce and research culture will have a direct impact on the number of medical students choosing general practice by raising the status of the discipline.

A national PBRN will:

- Establish critical infrastructure that can address important policy and research questions at scale including evaluating new models of care in general practice.
- Upskill the primary care workforce to support and translate research into practice and create academic career opportunities in general practice.
- Provide access to linkable general practice data for disease surveillance, vaccine effectiveness and pandemic preparedness.
- Provide access to the methodological and technical expertise to analyse and interpret linked general practice data, led by primary care researchers in collaboration with the RACGP and its members.

We propose the government allocate funding for development of a national PBRN model via the Medical Research Future Fund (MRFF), or other relevant agency, for the general practice sector to submit proposals for government selection and funding.

The RACGP recommends:

- Allocate funding and support to establish a national practice-based research network (PBRN).

Measure	Estimated investment required, annually ($)
Establishment of a national practice-based research network (PBRN) at $12 million over five years	$2.4 million

3.2. Preventive health guidelines

Issue:

Preventive health is the key to achieving a healthier Australia. The leading causes of death and disability in Australia are preventable or able to be delayed by early treatment and intervention. About 38% of Australia's total burden of disease can be attributed to modifiable risk factors.[41]

Preventive healthcare aims to prevent illness and assist in the early detection of specific diseases whilst encouraging the promotion and maintenance of good health. The benefits are system-wide with decreased disease burden leading to reduced pressure on our health and aged care systems and a healthier population. General practice is pivotal to the delivery of evidence-based preventive healthcare.

Guidelines are critical pieces of health infrastructure needed to support the delivery of evidence-based care. The RACGP has traditionally produced a range of preventative health and chronic disease management guidelines but this is becoming increasingly challenging. Evidence informing guidelines rapidly changes and existing recommendations become outdated. Medical knowledge currently doubles every 73 days.[42] This expansion means healthcare practitioners will constantly struggle to keep abreast of new information, impacting patient care. As such, evidence needs to be regularly reviewed and captured to ensure prevention efforts are achieved.

The cost of producing guidelines to contemporary standards is rising. As a result, guidelines are not updated as frequently as they should and the RACGP has been constrained in its ability to promote and support their implementation.

Solution:

General practice is in a pivotal position to deliver preventive healthcare. The partnership between GP and patient can help people reach their health goals. Preventive care is also critical in addressing the health disparities faced by disadvantaged and vulnerable population groups.

GPs and their teams use our guidelines to provide effective and low-cost preventive and chronic disease health care, and deliver sustainable, equitable, high-value healthcare, benefiting patients, providers and funders. Therefore, investing in RACGP guidelines would support the Government achieve aims in these areas and demonstrate commitment to support general practice care.

In 2017, the Productivity Commission conservatively estimated that improvement to the health of people in fair or poor health could provide a boost to GDP of $4 billion per annum.[43] Investment in guidelines supporting preventive care is critical to realising the benefits of improved health across the population.

We propose investment in the following RACGP guidelines over the next three years to make these 'living guidelines' and to encourage implementation:

- Guidelines for Preventive Activities in General Practice (Red Book)
- Green book - Putting prevention into practice
- Handbook of Non-Drug Interventions
- First do no Harm: A guide to choosing wisely in general practice
- Prevention and chronic disease management – Management of type 2 diabetes: a handbook for general practice

The RACGP recommends:

- Investment in the RACGP guidelines over the next three years to make these 'living guidelines' and to encourage implementation.

Measure	Estimated investment required, annually ($)
Investment in RACGP guidelines	$330,000

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