RACGP

Dr Anita Muñoz

Reponses to member questions received in advance of the member Q&A webinar as at 18 August 2026

Question	Dr Anita Muñoz's response
Can I please ask the presidential candidates if they can commit to a freeze / reduction of RACGP membership fees and what they will be doing to reduce costs / improve efficiency within the RACGP.	The reaction of members to the recent fee increase must be respected and heeded. Fee changes do need to reasonably reflect the costs of doing business but should not increase by more than CPI. In simplifying the number of member categories (formerly 10+) we have lost flexibility for fees to reflect the hours members work. Fee structures must ensure RACGP does not return to operating deficit, but we must demonstrate transparently what members' fee are spent on, where our efficiencies are (and there have significant improvements in costs/spending in the last 3 years) and ask what members want to see added to their membership that delivers greater value to them. The President is one voice on the board and cannot commit the organisation to a promise single handedly. I do commit to advocating for the 2027 fees to • Ensure categories fairly reflect what members can reasonable pay based on income • The percentage increase is only the percentage required to reflect 2 years of CPI MINUS the increase from this current year
Are you familiar with RACGP climate change and health position statement? How will you address it?	Yes. I will use the Presidential access to media to speak on climate change as issues emerge or become topical, using subject matter expert advice to ensure our commentary is accurate, intelligent and well-informed. I asked the RACGP to become a member of CEDA, and that organisation has a priority focus on climate impacts that will be helpful to the College because for government, we need to speak in terms of economic impacts, not only health to get greater cut through. I will underline the impact climate change has on health, the disproportionate impacts it has on vulnerable people, rural communities, Aboriginal and Torres Strait Islander persons. We must recognise that healthcare leaves significant carbon footprints and we must reduce those impacts. The biggest impacts come from hospitals, but general practice can contribute to sustainability in meaningful ways. I see the launch of the 6th Standards for General Practice as a key opportunity in this space.
Can you comment on Butler's infamous stance on making us work at the 'highest end of our scope' which seems to define for us?	Unfortunately, this stance has not translated into a workable reality for GPs. This has resulted in GPs working more for less remuneration, sure, but it has not resulted in GPs being able to prescribe oral isotretinoin for example. In fact, we

	have had to push back on more PBAC limitations (like drops for dry eye) on GP prescribing while watching pharmacist scope expanding. I am going to fight hard for GPs to be given the funding and authority to do what we are capable of. I am also going to encourage our members to unshackle themselves from MBS item number when they decide what procedures to do. We do not need an item number for joint injections. We do need to be prepared to charge what our procedural skills are worth, however.
Do you have any plan to strengthen the role of the RACGP against Medicare?	Yes. I have a strong appetite for a public discussion about the incremental ways Medicare has eroded funding for general practice. We have gone from 8% of the health budget down to 5.5% and it is increasingly difficult to access funds through red tape and fear of compliance. I will do everything within my power to advocate for respect and recognition, including financial recognition, of our role as expert generalists in Australia's healthcare system.
Do you support formation of a medical / GP lobby group (that is allowed to make political donations to get action).	Yes, with caveats. The college cannot be that lobby group: it cannot given its charity status. I have spoken to many people on this issue and have had access to a poll of GPs that indicate while 60% of GPs would support a lobby group, only 30% would contribute financially. I will commit to exploring this further. To be successful, donating GPs would need to accept that it may be years of donating before meaningful impacts occur. The Guild has lobbied since 1923 and spends 2.5 million dollars every 5 years. The group would also need to manage tension between lobbying for practice owners and contractors alike, if both donate. Finally, an appropriate organisation would need to be established. We don't want to cannibalise our current groups in making yet another one, so we must ask if an existing group could take on the role.
How are you going advocate for better recognition and remuneration for GP Supervisors?	Absolutely. This is a huge and urgent priority and is an absolute necessity for securing training and the future of the profession. Supervisors should be remunerated in accordance with their expertise and enormous value.
How are you going to help with Medicare billing and allied health prescribing?	I will be indefatigable in my advocacy for greater remuneration for long consults, return of mental health item numbers and procedural numbers, doubling of WIP payments. I will adamantly oppose policies that mandate bulk billing to access payments such as WIPs, PIPs and other grants/payments. I will use coalitions of patient peak bodies and other medical organisations to make our demands for better remuneration difficult to ignore. We must continue to insist upon an independent pricing authority to remove the political uncertainty that plagues general practice funding and replace it with fair remuneration that reflects the costs of providing care. The push back against unsafe prescribing by under-trained practitioners requires a combination of demonstrating the lack of evidence for this policy (which RACGP has already commissioned), continuing to demonstrate instances of harm, and to pivot to demonstrating the economic issues this causes- including increased costs to the health system, delayed and missed diagnosis and poorer patient outcomes.

	We will need to use the voices of patients to get cut through on this now.
How are you going to improve the reputation of GP services in the community? How are you going to make GP training popular?	The RACGP must commit to a professional, public, orchestrated and striking media campaign to promote the value and skills of expert generalism. For practices struggling to stay open, the way for them to uplift what they can offer their patients, they need better funding. Encouraging single-issue and fast through-put medicine with perverse incentives drives patient dissatisfaction in the end. We must stop the trend of funding systems that impede GPs' capacity and then criticises them when the inevitable reduction in services occurs. GP training had a huge uplift with the GP registrar training grant- the first version of which came directly from my advocacy in Victoria, and which was made a standing national policy. Fair payment is a huge incentive. High quality training practices, well remunerated supervisors and helping registrars feel welcomed into their practice communities is essential in raising the profile of training. This trend is already occurring and can be built upon.
How do you understand the challenges for a membership organisation to promote quality care in general practice?	There is a perpetual tension between high quality standards and the costs of maintaining those standards to practices. If we fail to publish quality standards, we risk having those standards taken from the college and executed by other organisations. We must also recognise that each layer of regulation brings the onus of compliance and oftentimes, costs. RACGP must listen to feedback when its standards are genuinely too onerous and do not clearly improve safety or quality. It must support practices with education and change management principles when new requirements are implemented. We must also seek supporting grants for practices to comply with standards from PHNs and other organisations.
How is the government (and other players) to be held to account for the progressive implementation of "Australia's Primary Health Care 10-year Plan 2022-2032"?	This type of advocacy requires a coalition. We must work with other colleges, the AMA, CPMC, patient representation peak bodies, the media to hold government to account. We must use patient stories as the most effective way of painting a picture politically.
How will you represent our most remote and marginalised practices caring for vulnerable and underserviced populations?	I feel strongly about this and have proven my commitment to this in my very strong advocacy for CoHealth in Victoria. I know that the MBS in no way reflects the needs and the work done by GPs to serve vulnerable populations. Funding mechanisms for these populations and practices must be co-designed by GPs who are expert in these areas. It is imperative that new resourcing models put more money on the table, not more complex ways of accessing the same funds. The practices must retain both their clinical and practice autonomy in the implementation. I follow Prof Fran Baum's thinking on this and know that vulnerable populations require specific funding and care environments beyond over simplified fee-for-

	service models. I vehemently support community health and ACCHO models and will defend them and their vital role in Australia.
How would you propose to lift the morale of RACGP members to build pride in the profession of general practice?	A key focus for me is regaining respect and recognition for our profession. Member has told me this is a matter of high priority for them. A targeted, proactive and public campaign in all forms of media must be delivered by the College in the next 2 years espousing our value, skills and knowledge as expert generalists; one that underlines the fact that no other clinician can do what we do. I also want RACGP members to experience belonging, pride and satisfaction in being part of our college.
Is the RACGP considering any future plans to help or absorb experienced GPs who are unable to achieve Fellowship?	The College cannot provide Fellowship status to candidates who have not met the requirements of Fellowship. For those wanting to attain Fellowship, exam and learning support is an important part of our role as an academic college, and I am in favour of working to help people pass their requirements. The RACGP can be a valuable CPD home for hospital medical officers who do not have a CPD home and who seek a sophisticated environment for their ongoing learning.
The GP workforce depend heavily on IMGs but there's little reciprocal support from the College.	Australia's healthcare system would have collapsed decades ago were it not for our IMG workforce. I feel very strongly about shifting the negative narrative in some sectors towards IMGs to one of celebration and recognition of their roles in general practice. I will advocate to external organisations to remove unnecessary barriers to IMGs achieving accreditation and fellowship. Elements of AMC, immigration and AHPRA requirements and College policies clash in a way that causes some IMGs to get stuck in a loop or returned to the beginning of their journeys which is devastating. I believe IMGs should receive more support, not less at a government and college level and we need to hear from IMGs themselves where things are going wrong so we can determine where to act and reform policies that don't work.
What are your policies on sustainability in general practice ie reducing practices carbon footprint, climate advocacy?	Climate stewardship is every person and business's responsibility. The biggest climate impacts from health come from hospitals and pharmaceutical industry but general practice can contribute to sustainability in meaningful ways. I see the launch of the 6th Standards for General Practice as a key opportunity in this space. We can support practices to build their portfolio of actions to reduce carbon footprints, from managing waste and use of energy etc within practice to encouraging GPs and their patients to advocate politically about the impact climate change has on health.
What are your programs/plans to IMGs settling in Australia?	I will advocate to external organisations to remove unnecessary barriers to IMGs achieving accreditation and fellowship. Elements of AMC, immigration and AHPRA requirements and College policies clash in a way that causes some IMGs to get stuck in a loop or returned to the beginning of their journeys which is devastating. I believe IMGs should receive more support, not less at a government and college level and we need to hear from IMGs themselves where things are going wrong so we can determine where to act and reform policies that don't work.

What can you do at the political level to help influence health department decisions which benefit general practice?	Advocacy inside of departments of health requires the establishment of trusted relationships and frank and respectful feedback, a willingness to accept that change takes time, repeated conversations and engagement, collaboration and compromise and the capacity to understand the views and motivation of government to influence and work inside of their agendas. I have approached the Victorian Department of Health and SaferCare Victora in this way and as a result, RACGP Victoria and I are now sought out on all government health reform projects and initiatives. I intend to replicate that success federally.
What is your next plan for the new international, more than one qualification specifically for those with high experience?	The issue of additional recognition of mastery of general practice has been discussed with me by several parties. The intent here as I understand it is to recognise that following a period of time, a fellowed GP achieves a level of skill, experience and knowledge beyond the level required to attain fellowship. I have consulted some other senior GPs on this matter. I am open to starting a discussion and a SWOT analysis and deep dive into the benefits and risks of this approach. The idea is that this signals the significant value of expert generalists as separate from other primary care providers. I do not want to see fellowed GPs charged large sums of money to complete a Masters of General Practice. But there may be a role for recognising mastery and the awarding of a Laureate Fellowship title. The framework for this would require consultation with academic experts. I am happy to be curious about this but recognise that this idea will not rest in the hands of the President alone and would take time to explore appropriately.
What is your position on Rural Generalism? Should it include GPs practicing in urban settings (MMM2) with a special interest?	I am fully supportive of rural generalism. I support the Collingrove Agreement vision for RGs as the bridge between hospital and community medicine, by way of their advanced skills and authoritative presence in both places within a rural community. To become an RG, a GP must do RG training with the required advanced skill. It is not awarded via the acquisition of a specific interest. If an RG lives in an MMM2 area, it would be ideal for them to use their advanced skill in the local/regional hospital rather than give that skill up. I have championed the role of GPs in hospitals in Victoria and will do so nationally.
What steps are you taking to address the discrepancy of Medicare rebate per minute decreasing for longer consultations?	This remains a disastrous policy embedded in Medicare and recently reinforced by bulk billing incentives. It punishes GPs for doing thorough medicine and spending quality time with patients. I will never give up calling for fair remuneration for GP time and recognition for the value they bring to patients by being thorough. We must use patients themselves to help us demand higher long consult rebates.
Where do you see the college in 5-10 years, and how will you help steer it in that direction?	I see the College as key authority on general practice, trusted and respected advisor to government, the setter of standards and the custodian of a world-class general practice training program, training 3,000 GPs a year and continuing to deliver over 90% of Australia's rural generalists.

	RACGP will be the key authority in general practice internationally through associations with myriad countries by helping them establish general practice training and standards. Our membership numbers will approach or surpass 70,000 as we attract, train and retain GPs and RGs. We will be the source of truth, learning and support on matters beyond clinical medicine, including practice ownership, clinical governance, AI tools used in practice, multidisciplinary team structures, practice management, sustainability. We will be a key co-designer of the healthcare system of the future. We will esteemed as highly effective advocates for our profession.
Will you commit to holding a Plebiscite of members to halve the time for Level C cons to 10-20min and double the rebate?	I think there may well be a role for a plebiscite in the future of the college to gauge the members' appetite for advocacy actions. The urgent need for higher rebates and fairer ways of timing GP consults is already well established, and prosecuting the need for rebate reform will remain a priority. I do foresee more working groups on how best to sue for item number reform. That may produce more sophisticated options to put to government than a single question plebiscite where members can only answer yes or no.
Would you be willing to review and address a case(s) of ineligibility for vocational registration?	I have reviewed many cases in my role as Chair of Victoria where candidates had run aground on regulatory systems that clash, with competing deadlines and requirements that can strand people in a regulatory limbo. I cannot promise to change regulations as they are set by the AMC, AHPRA, Australian Government Dept of Immigration etc as the President does not have jurisdiction there, but we do have an important role in advocating for and influencing policies to remove clashes between systems that unfairly disadvantage candidates and unnecessary red tape. The standards that are set for Fellowship are not under the control of the President. The Council of Censors and Academic Committee of the College cannot be overridden by any single board member. We are very prepared to review cases individually and ensure every possible avenue to Fellowship has been offered to our candidates.
General Practice in its true sense is gone. Without true MBS Reform of base item numbers, it can't be a desirable career nor respected. Can you please discuss?	General practice has changed in the last 20 years and will continue to change. If it fails to, it will die or be replaced by non-GP coalitions of the willing. We must embrace modernisation, but we must retain what matters. Our skills, knowledge, human engagement, empathy and humanity. The single most urgent issue to achieve is respect and recognition for our profession. That recognition must be expressed financially, and not in tokenism.
How does each candidate plan to address the issue of infringement on GP scope of practice by pharmacists?	We must use patient voices and stories to get the attention of the media, public and government. The media is interested in this. That will work alongside the already established approaches of demonstrating a total lack of evidence for safety and quality in independent retail pharmacy prescribing and collecting and recording instances of harm.

What are the candidates' responsibilities as president? Why a candidate wants to be president of RACGP?	The President is the members' representative to all external stakeholders at a national and federal level and on the board of the RACGP. The President has the same weight as any other director on the board, but it is a position of significant influence and carries the mandate of the members' voice and endorsement. The President sets the political tone and much of the appetite for political engagement and stakeholder relationship management on behalf of the organisation. That person is also tasked with guiding the board and college about threats and opportunities facing our profession. I want to be President because I know we need a very strong and courageous voice leading our profession in the next two years. I have the fight and the stomach for that and will not shy away from difficult conversations. I am not seeking this role for exposure, internet presence, prestige or a title. I am doing it because I am worried our profession is going to die and the time to be assertive has come.
How can we improve funding and staffing for community health which services marginalised people?	I feel strongly about funding for CHCs and have proven my commitment to this in my very strong advocacy for CoHealth in Victoria. I know that the MBS in no way reflects the needs and the work done by GPs to serve vulnerable populations. Funding mechanisms for these populations and practices must be co-designed by GPs who are expert in these areas. It is imperative that new resourcing models put more money on the table, not more complex ways of accessing the same funds. The practices must retain both their clinical and practice autonomy in the implementation. I follow Prof Fran Baum's thinking on this and know that vulnerable populations require specific funding and care environments beyond over simplified fee-for-service models. I vehemently support community health and ACCHO models and will defend them and their vital role in Australia.
As President, what will you do to secure single employer models that attract junior doctors into general practice?	I have already championed SEM in Victoria and have seen SEM work very well in other jurisdictions. Having attended the SEM Conference in Devonport this year, I know that the model can work well, but it is highly dependent on factors such as the state/state government approach to funding, local hospital networks, hospital preparedness to give RGs work after fellowship in their advanced skill. SEM is likely to pass from pilot to business as usual in many rural areas and I support that. It is imperative that registrars and RGs work in and remain in community practice, alongside work in hospital environments, exactly as the Collingrove Agreement intended.
How would you advance RACGP's Advocacy Plan priorities relating the impacts of climate change on general practice and health?	I will use the Presidential access to media to speak on climate change as issues emerge or become topical, using subject matter expert advice to ensure our commentary is accurate, intelligent and well-informed. I asked the RACGP to become a member of CEDA, and that organisation has a priority focus on climate impacts that will be helpful to the College because for government, we need to speak in terms of economic impacts, not only health to get greater cut through. I will underline the impact climate change has on health, the disproportionate impacts it has on vulnerable people, rural communities, Aboriginal and Torres Strait Islander persons. We must recognise that healthcare leaves significant carbon footprints and we must reduce those impacts. The biggest impacts come

	from hospitals, but general practice can contribute to sustainability in meaningful ways. I see the launch of the 6th Standards for General Practice as a key opportunity in this space.
New question and responses content posted on 14 August 2026	
Payroll Tax and Tenant GPs: **What is your position on the application of payroll tax to tenant general practitioners, and what specific actions would you take to advocate with State Revenue Offices and state governments to protect the viability of independent general practice businesses?** **Follow-up: How would you measure success in this area during your term as RACGP President?**	I have dedicated 5 years to this issue in Victoria. I created a coalition of 4 peak bodies, The Four Peaks, being RACGP Victoria, AMA Victoria, AGPA and PCBC to tackle this advocacy head on. We met numerous times with the Victorian SRO, Revenue Commissioner, Minister for Health and Treasurer over 3 years. The result of this advocacy was an amnesty on 5-year retrospective tax bills threatening (and already) closing practices, and an agreement not to tax income on bulkbilled consults. The key November 2026 Election priority of my faculty is a state-wide exemption for general practice from payroll tax on tenant doctor income. I have secured a promise from the Liberal/National parties for this to occur should they be elected. I continue to apply pressure on the Labor Party. I will take the same capacity for advocacy and approach to the federal level for national harmonisation on this matter.
Government Intervention in the General Practice Market: What are your views on direct government involvement in the primary care market, including the establishment of Urgent Care Clinics and government-supported bulk-billing clinics? How would you ensure that these initiatives complement rather than compete with existing community general practices?	The government has a social contract to ensure that vulnerable populations have access to care that reflects the complexity of their needs. I strongly support a more robust, well-funded and geographically Australia-wide network of CHC and ACCHOs within which block funding dominates. The funding must be more than what is currently available. Fee-for-service can still apply beyond chronic care delivery, and urgent care should be rebated as described below. CHCs should be focussed on treating vulnerable communities. Outside of ACCHOs/CHC clinics/GPs should be monetarily rewarded for treating vulnerable populations with significant injections of funding not merely bulkbilling incentives. The funding offered to UCCs should be available to every general practice. Any clinic delivering urgent care should receive the same funding for the same work. All general practices can then determine the extent to which they offer and run urgent services. Any urgent treatment that prevents a hospital presentation is hugely valuable- irrespective of which building the service is delivered in. No clinic should operate at a loss because of using their procedure room. Clinics should not be disadvantaged for having mixed billing and must retain autonomy over their businesses. All clinics should have access to increased WIPS and PIPs and capacity to create multi-disciplinary teams without financial losses. The overall spend on general practice must return to 8% of the health budget. Gap fee payments should be decoupled from MBS rebates so that patients can pay the gap only, removing a significant barrier to care.
Scope of Practice Expansion: What is your position on expanding prescribing rights for pharmacists and nurses, and on allowing allied health professionals to directly order diagnostic imaging and other investigations? How would you balance workforce pressures and access to care while maintaining patient safety, continuity	I am in favour of general practice as the centre of community-based or nursing home-based multi-disciplinary care, within which allied health clinicians can increase their scope. The key here is that the clinical governance is robust, expert generalist/s are the clinical leads and there is continuity of care within a single clinical entity. This maintains the safety of the apprenticeship model with quality and safety monitoring.

of care, and the central role of the GP as coordinator of care?	GPs should continue to see their own patients and not be relegated to authorising agent for others alone. They must be paid for the governance role. I do not support prescribing in retail environments. I have enormous respect for nurse practitioners but maintain that an expert generalist must be available as the clinical and governance lead within such a service. Unrestricted access to imaging and investigations will result in enormous unnecessary expenditure in our system as it has done overseas and the potential for harm if conducted by clinicians untrained in clinical decision making and synthesis.
Taxation and Financial Sustainability of General Practice: What do you see as the most significant taxation challenges facing general practice today, including payroll tax, GST-related issues, capital gains tax implications, and other regulatory burdens? What advocacy priorities would you pursue to address these challenges at both state and federal levels?	Victorian businesses are the most taxed in the country- with 33 different taxes and levies to comply with. In 2024-25, the state closed 129,000 businesses in a year, or 350 per day. Payroll tax exemptions are an absolute priority. Land tax has raised rents significantly and remains a huge state priority. In preparation for the Victorian election, I have already established relationships with peaks like the Small Business Council of Victoria and the Victorian Chamber of Industry and Commerce. CGT is now disincentivising business ownership. The country is being taxed into oblivion and so is general practice. I asked the College to become a member of CEDA (Centre Economic Development Australia) as I recognise that we will need allies in economics and industry to prosecute our state and federal business agendas.
Vision for Independent General Practice: Many GPs are concerned about increasing regulatory requirements, workforce shortages, declining practice profitability, and government policy changes affecting primary care. What is your long-term vision for preserving and strengthening independent, community-based general practice in Australia?	It is imperative that significant funding enter our sector, from 5.5% of the health budget currently to 8% as it was formerly, around 2003. Clinical, billing and business autonomy must be maintained at all costs, and we must not allow an NHS-style system to be implemented by stealth. Respect ad recognition for us as expert generalists must be wrested back from government, the media, non-GP specialists and the public. We must not be compelled to apologise for seeking to thrive as a profession and in business by fallacious narratives about greedy and fraudulent doctor behaviours.
Can you please tell us about your past and current associations with industry and pharmaceutical companies?	I have been involved in medical education and medical advisory work for many years. I have received honoraria for teaching via unencumbered grants from a variety of pharmaceutical companies. Medicines Australia applies a very strict code of conduct to companies sponsoring medical education- trade names cannot be used and, in any instance where therapeutics are mentioned, a balanced representation of all available options must be demonstrated so that the education is unbiased and reflects current guidelines and evidence bases. I have sat on several pharmaceutical advisory boards on topics of vaccination, cardiovascular disease, sarcopenia and diabetes, providing the general practice perspective on treating various conditions. I have also engaged in unpaid public education campaigns on vaccine-preventable illness.

	In accordance with the requirements of Medicines Australia, all my honoraria are disclosed on the public record. Obviously, if elected President, this educational activity will be suspended for the duration of the presidency.
How will the RACGP support its members as they become more involved in the Diagnosis and Management of patients with ADHD and the Comorbidities that frequently accompany it?	The lost mental health item numbers must be restored as a matter of urgency. Long consult rebates must also be increased. NSW has led the way with fees to support ADHD consultations. Advocacy for MBS GP neurodiversity assessments items is logical on the back of this win. In Victoria, we have created a high-quality 2-day workshop for GPs to train in ADHD assessments with comorbidities in adults and children. That IP belongs to the College, and we will use it to train more GPs over time. We have also achieved a reduction in the permit requirements for GPs treating ADHD patients ongoing to reduce the regulatory red tape regarding stimulant prescribing and that will be advocated in other jurisdictions where similar rules apply.
What changes can be made to remunerate the long hours GPs take doing non-clinical paperwork e.g. result checking?	The realistic options that exist to address this vexed issue include: MBS Funded: 1. A remuneration framework for GPs to be recognised as clinicians within the NDIS 2. Block funding options for patients with chronic and complex illness that remunerates care coordination beyond the fee-for-service model 3. Appropriately using telehealth item numbers to advise patients of abnormal results if clinically indicated Private Options: 1. Use asynchronous care delivery software to charge for issuing repeat scripts and referrals 2. Charge reasonable fees for filling in insurance paperwork, letters etc Almost all professionals will do a degree of work outside of their traditional remunerated hours. We will need to manage the tension between doing some of our paperwork unpaid (checking results and emails, which the government will never fund us for) and establishing mechanisms to reduce that to an acceptable level.
How will you unite the fragmented group of General Practitioners so we have a unified voice advocating for the profession?	This is an age-old challenge. Our membership has as many views, political persuasions, priorities and challenges as there are members. I aspire to lift the thinking of the profession as much as possible to the strategic need to get back respect and recognition for our craft. I do not think total unity is possible with such a disparate group. But I do hope to create a critical mass that is enough to generate meaningful influence on government thinking. Part of this will be creating alliances with other colleges and peak bodies.
What is your opinion on lobbying versus advocacy?	I have spoken to many people on this issue and have had access to a poll of GPs that indicate while 60% of GPs would support a lobby group, only 30% would contribute financially. I will commit to exploring this further. The college cannot be that lobby group given its charity status.

	To be successful, donating GPs would need to accept that it may be years of donating before meaningful impacts occur. The Guild has lobbied since 1923 and spends 2.5 million dollars every 5 years. The group would also need to manage tension between lobbying for practice owners and contractors alike, if both donate. Finally, an appropriate organisation would need to be established. We don't want to cannibalise our current groups in making yet another one, so we must ask if an existing group could take on the role.
[What are your plans / views on]: **1. Advocacy plan (strategy, timeline, KPIs)?** **2. How different from previous RACGP leadership?** **3. Medicare rebate & consult funding plan?**	I support the current RACGP Strategic Plan as I am a member of the board that drafted and endorsed it. We have an outstanding CEO whom I know will deliver that plan and who is open and flexible to refining it as circumstances require. Each President builds on the work of those that came before. I acknowledge the huge work and contribution of the former Presidents. I will bring my own style, which is forthright, resolute, courageous, determined and politically aware. RACGP is already fighting for the return of mental health item numbers, longer consultations, an independent pricing authority. I will continue that fight but not suggest that I am the only person or President doing that work. We must get general practice funding back to 8% of the federal health budget, restore item numbers for procedures and get funding for the complexity of our work.
What do you think about funding for mental healthcare? Does it need a revamp?	It is imperative we get back funding for mental health consulting. While the loss of those numbers was a blow, we must never let ourselves be paralysed by despair. Every threat is also an opportunity. In getting back funding for mental health consulting, we have an opportunity for calling for the funding to be done better than before and that is what our focus must be on.
What practical strategies would you introduce to strengthen GP involvement in aged care, particularly by attracting and training more GP registrars, improving the efficiency and financial viability of providing care in residential aged care facilities, and supporting GPs to improve their knowledge and quality of care for older people?	General practice services in aged care have been woefully treated by governments and funding systems as long as I have held my licence to practise. New funding ideas come embedded in a quicksand of compliance requirements. Aged care needs better funding and less red tape. That is irrefutable. We must put a sophisticated model on the table for government; not respond to the ideas that they generate. That will need input from GP experts in the sector. We must also bolster training opportunities in aged care and teach GPs and trainees how to make aged care rewarding from a business and remuneration point of view.
New question and responses content posted on 18 August 2026	
1. What will you do to improve recognition, support and remuneration for GP supervisors? **2. RACGP Culture & Accountability: What will you do to improve workplace culture, accountability and member support within the RACGP?**	1. This is an urgent priority and is an absolute necessity for securing training and the future of the profession. Supervisors should be remunerated in accordance with their expertise and enormous value. This work is already underway. 2. RACGP culture is already transforming significantly. I have been a very vocal board member on this for 6 years. I continue to make culture a key priority for our employees and within member experience. 3. Please see this link for a fulsome answer: https://dranitamunoz.com.au/from-vision-to-action-strengthening-general-practice/

3. Medicare & Billing: What practical changes will you advocate for to improve Medicare rebates and simplify GP billing? **4. Recognition of GPs as Specialists: What will you do to improve the community's perception of GPs as medical specialists? Would you support exploring the title "Family Physician" to better reflect our specialist role and improve recognition of general practice.**	4. I outline the actions I will take on this priority here: https://dranitamunoz.com.au/from-vision-to-action-protecting-gp-led-care/ I have sought counsel from many people on the issue of a name change. This issue divides the membership very quickly and would take immensely valuable time and resources away from the urgent and existential matters before us in the next 2 years. I would approach respect and recognition with very strong campaigns in the media, government, public sphere, social media firs, making it clear what our value as expert generalists is. RACGP is now a household name and brand. Giving that up would come at a cost to our influence at this time.
How will you push government to increase Medicare rebates and stop the cutting of funding for general practice?	I will be indefatigable in my advocacy for greater remuneration for long consults, return of mental health item numbers and procedural numbers, doubling of WIP payments. I will adamantly oppose policies that mandate bulk billing to access payments such as WIPs, PIPs and other grants/payments. I will use coalitions of patient peak bodies and other medical organisations to make our demands for better remuneration difficult to ignore. We must continue to insist upon an independent pricing authority to remove the political uncertainty that plagues general practice funding and replace it with fair remuneration that reflects the costs of providing care. I have a strong appetite for a public discussion about the incremental ways Medicare has eroded funding for general practice. We have gone from 8% of the health budget down to 5.5% and it is increasingly difficult to access funds through red tape and fear of compliance.
We face rising temperatures, climate change, rising inequality and genocides continue. Will you speak up for us?	Yes absolutely I will. I will underline the impact climate change has on health, the disproportionate impacts it has on vulnerable people, rural communities, Aboriginal and Torres Strait Islander persons. We must recognise that healthcare leaves significant carbon footprints and we must reduce those impacts. The biggest impacts come from hospitals, but general practice can contribute to sustainability in meaningful ways. I see the launch of the 6th Standards for General Practice as a key opportunity in this space. I have been active in promoting the rights of vulnerable populations in my work with community health care centres, Street Side Medics and as an advocate in the Children in Out of Home Care for over a decade. I will continue that work federally. I agree with the WHO framework for seeing armed conflict as a public health emergency.
What would you do for IMG recruitment, job security, training (FSP) which should have been done much earlier?	I will work with the various Australian workforce agencies and with the College accreditation teams to find, train and support new practices and supervisors to support IMGs on various levels of supervision including level 1 and 2 and FSP. I believe we need to challenge the requirements set out by the medical board and AMC and ensure that they are evidence-based, fit-for-purpose, fair and achieve their intended aims.

	Where requirements are unfairly preventing clinicians from working or where various agencies' policies clash and cause barriers to completion of training or registration, we must be prepared to call those out and remove those impediments. This does not reduce safety and quality of standards, but removal of and unnecessary barriers.
With the increasing expansion of non-GP providers into GP-led areas, what's your strategy to protect GP's role and prevent fragmentation of Primary Care?	I will make the case to government, media, and the public, that GPs are expert generalists whose skills and clinical judgement cannot be replaced by a less-qualified substitute. • Mobilise mainstream and medical media to assert the real value of expert generalism • Build a coalition with peak bodies**,** patient groups, and specialist colleagues to strengthen our voice • Work with CEDA and other respected organisations to demonstrate the economic value of expert generalism and GP-led care. Make the case that only an expert generalist can safely lead a multidisciplinary care team
RACGP is so disconnected from the common members, what will the candidates do to change this and make all members involved?	My goal is to enable those members who wish to engage to do so easily and with high levels of satisfaction. That may not be all 50,000 members. I also seek to make engaging much more attractive and desirable by our members. Re-establishing Divisions of General Practice within the College structure is an excellent way to build places of belonging, advocacy, peer learning, networking and socialising. Karen Price tried to establish these entities as College Clusters, but the project was thwarted by COVID during her presidency. I believe such geographically placed clusters in each state would lend to a regular and local calendar of opportunities to participate in college life.
Is now the time to address and publicise the failure of Medicare as a health finance system?	The coming two years are of vital importance to our profession because of the 2028 federal election and that time must not be squandered. Yes, we can appropriately call out and criticise what is not working or serving the good of our patients, the health system or our incredibly hardworking GPs. When we suggest things aren't working, we must put a viable solution on the table in its place and not wait for that to be designed for us and potentially without us.
Do you believe the RACGP's current charitable / constitutional structure limits our political influence? (Eg via donations).	Being a charity means the RACGP cannot make political donations. The RACGP has never intended to purchase political time and favour monetarily. The College has significant influence as the representative of 50,000 members and 90% of the general practice workforce. The best thing we could do as a collective is join together and apply pressure on the government and its MPs directly. It has been historically very difficult to have all of our members unite on political matters. I have spoken to many people on the issue of lobbying and have had access to a poll of GPs that indicate while 60% of GPs would support a lobby group, only 30% would contribute financially.

	I will commit to exploring this further. To be successful, donating GPs would need to accept that it may be years of donating before meaningful impacts occur. The Guild has lobbied since 1923 and spends 2.5 million dollars every 5 years. The group would also need to manage tension between lobbying for practice owners and contractors alike, if both donate. Finally, an appropriate organisation would need to be established. We don't want to cannibalise our current groups in making yet another one, so we must ask if an existing group could take on the role.
What would you prioritise as President to make GP-led aged care (both in RACH & at home) clinically and financially sustainable?	General practice services in aged care have been woefully treated by governments and funding systems as long as I have held my licence to practise. New funding ideas come embedded in a quicksand of compliance requirements. Aged care needs better funding and less red tape. That is irrefutable. We must put a sophisticated model on the table for government; not respond to the ideas that they generate. That will need input from GP experts in the sector. What is required is remuneration that values this work, means of accessing funding that is not onerous, mechanisms for clinical documentation that does not waste GP time and incentives for GPs to work in aged care. We must also bolster training opportunities in aged care and teach GPs and trainees how to make aged care rewarding from a business and remuneration point of view.
What is your plan to facilitate the Fellowship steps for IMGs? with lack of supervisors and capacity problems?	Australia's healthcare system would have collapsed decades ago were it not for our IMG workforce. I feel very strongly about shifting the negative narrative in some sectors towards IMGs to one of celebration and recognition of their roles in general practice. I will advocate to external organisations to remove unnecessary barriers to IMGs achieving accreditation and fellowship. Elements of AMC, immigration and AHPRA requirements and College policies clash in a way that causes some IMGs to get stuck in a loop or returned to the beginning of their journeys which is devastating. I believe IMGs should receive more support, not less at a government and College level and we need to hear from IMGs themselves where things are going wrong so we can determine where to act and reform policies that don't work. The College is already working very hard to stand up more training sites and supervisors to accommodate the large number of trainees in our programs.
Team based care is beneficial. How do you expect GP clinics to fund it given our overheads are costlier than allied health clinics?	General practices are private businesses that deliver an essential public service. I intend to: • Protect practice owners' right to clinical and billing autonomy. • Ensure funding models support general practice without forcing practices into a single business model. • Preserve flexibility so practices can invest funding where it delivers the greatest benefit for their communities. • Support GPs to prescribe oral isotretinoin independently, reducing unnecessary barriers to patient care.

	• Remove unnecessary PBS Authority interactions. • Ensure Assignment of Benefits changes do not disadvantage vulnerable patients. • Reform MyMedicare to remove barriers to care and appropriate remuneration. • Make the case that only an expert generalist can safely lead a multidisciplinary care team • Restore investment in general practice to 8% of the federal health budget. • Increase PIP and WIP funding to support sustainable multidisciplinary care. • Restore item numbers that properly recognise complexity, beginning with mental health. • Ensure procedures performed in general practice are appropriately remunerated. • Establish an independent pricing authority to provide fair, transparent and evidence-based remuneration. • Properly recognise GP supervisors for the expertise they provide in training the next generation. Ensure GPs are appropriately remunerated for care provided within the NDIS.
How will you contribute to the robust raising of quality in general practice, reducing variability of patient experience?	There is a perpetual tension between high quality standards and the costs of maintaining those standards to practices. If we fail to publish quality standards, we risk having those standards taken from the college and executed by other organisations. We must also recognise that each layer of regulation brings the onus of compliance and oftentimes, costs. I have a strong relationship with the organisation that owns HealthPathways and I am aware that there is an opportunity to make HealthPathways national and endorsed by the federal government. That tool can be a means of establishing less variation in clinical care in Australia. It must be used with appropriate caveats and must protect the clinical autonomy, experience and decision making of GPs.
What is your plan to: **1) help government take primary care seriously** **2) see an increase in baseline Medicare rebate.**	I will make the case to government, media, and the public, that GPs are expert generalists whose skills and clinical judgement cannot be replaced by a less-qualified substitute. I will build a coalition with peak bodies, patient groups, and specialist colleagues to strengthen our voice and work with CEDA and other respected organisations to demonstrate the economic value of expert generalism and GP-led care. I will make the case that only an expert generalist can safely lead a multidisciplinary care team I will advocate for general practice funding to be restored to a level that reflects its true value to the health system, and I will fight to keep GPs in control of how they practise. I will p**ush for long consults**, mental health care, and after-hours/urgent care to be funded fairly, closing the gap between GPs and Urgent Care Clinics. I will c**hampion an independent pricing authority** as the mechanism government uses to rebuild trust with general practice. And o**ppose any capitation model** that strips away billing autonomy or clinical independence — new funding must mean more funding, not more complexity for the same spend.
What will you do to strengthen the unity in GPs, increase RACGP member numbers and not being separated based on PB/UBB/UCC?	This is an age-old challenge. Our membership has as many views, political persuasions, priorities and challenges as there are members.

	I aspire to lift the thinking of the profession as much as possible to the strategic need to get back respect and recognition for our craft. I do not think total unity is possible with such a disparate group. But I do hope to create a critical mass that is enough to generate meaningful influence on government thinking. Part of this will be creating alliances with other colleges and peak bodies. I see RACGP's future including very strong international alliances and supporting neighbours in our region to set up strong general practice training programs and systems. This will increase our international membership and make our standing as the undisputed authority on general practice certain in the eyes of our own government and those abroad.
How will you ensure the adequate funding of quality mental health care in addition to complex condition management in the MBS?	It is imperative we get back funding for mental health consulting. RACGP is already fighting for the return of mental health item numbers, longer consultations, an independent pricing authority. In getting back funding for mental health consulting, we have an opportunity for calling for the funding to be done better than before and that is what our focus must be on.
Please provide, with evidence, your personal contribution to General Practice in Australia, with focus on Government workforce policy.	Please see my CV via the following link as my response exceeds the work limit for this question: https://dranitamunoz.com.au/wp-content/uploads/2026/08/dr-anita-munoz-experience-qualifications-racgp-president-candidate.pdf
How can we improve quality of GP training?	I believe that training has significantly improved since returning to the College and I acknowledge the huge work of the teams involved. I also understand that there are ways to continue improving. In my extensive discussions with registrars, I have formed the view that the following are priorities • Removing bureaucratic processes internally that do not improve safety and quality of training • Transparency or and access to flexible funds • Advocating externally to resolve clashes between regulatory body requirements that impede GPiT journeys towards fellowship, especially for IMGs • Standardised minimum training quality for all registrars to remove "good" versus "bad" practice stigma • Returning the clinical exam to a face-to-face experience • Returning procedural and hands-on clinical skills to the curriculum • Teach the business of general practice to registrars to empower them as contractor GPs or practice owners • Mediating proactively to help GPiT resolve issues with training sites