RACGP

Dr Ramya Raman

Responses to member questions received in advance of the member Q&A webinar as at 20 August 2026

Question	Dr Ramya Raman'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.	One of my five priorities is to reorient the College and spend member fees wisely. I will push for a disciplined review of overheads, duplication and administrative inefficiency. If elected as President, I will call for any increase in RACGP membership fees to be capped at the same indexation rate applied to MBS rebates. The savings must be redirected to member-facing services, including stronger advocacy, faster responses to emerging issues and better practical support for GPs.
Are you familiar with RACGP climate change and health position statement? How will you address it?	Please refer to my Climate & Environmental Position.
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?	I reject the idea that government should define the 'highest end' of general practice by transferring core GP work to other professions and leaving GPs with only the most complex cases. Our work must be defined by our training, professional standards and community needs, not workforce shortcuts or commercial lobbying. If elected as President, I will: • Reorient the RACGP to proactively address the scope of specialist general practice. • Oppose substitution of GP diagnosis and prescribing without strong evidence of safety, continuity and patient benefit. • Push for Medicare rebates that properly supports long consultations, complexity, mental health and preventive care. • Protect opportunities for GPs to maintain procedural, hospital, aged-care and rural skills. • Support GP-led multidisciplinary teams responsibilities, records and clinical accountability are clear. Working to full scope should expand GP capability not remove it.
Do you have any plan to strengthen the role of the RACGP against Medicare?	The RACGP should not be against Medicare. It should be stronger in shaping it. I support Medicare, but not an underfunded system or wholesale capitation that shifts financial risk to GPs.

Do you support formation of a medical / GP lobby group (that is allowed to make political donations to get action).	A separate, voluntary and transparent GP advocacy body could be considered, but it must remain independent of the College, with strong governance and safeguards against commercial influence. I support stronger and more organised proactive political advocacy, but the RACGP is a registered charity and cannot make political donations. Changing the College's legal structure would be costly, complex and divert valuable member resources at the very time we need stronger advocacy. Our influence should come from evidence, member mobilisation, trusted political relationships and sustained pressure across all parties. My priority is to make the RACGP itself earlier, sharper and more politically effective.
How are you going advocate for better recognition and remuneration for GP Supervisors?	If elected as President, I will treat GP supervision as essential workforce infrastructure, not goodwill. Supervisors carry teaching, assessment, clinical oversight and administration, yet payments do not consistently cover their time or lost consulting income, particularly outside protected teaching and in later terms. I will press government for independently costed, indexed teaching and practice payments that reflect workload, complexity and rurality. Within the College, I will cut accreditation and reporting burdens, consult supervisors before introducing new assessments, strengthen professional development and create meaningful recognition through College leadership and career pathways. I will work with GPSA, practices, registrars and other stakeholders to ensure funding reaches those doing the work and supports protected teaching time. Without supported supervisors, there is no sustainable GP workforce.
How are you going to help with Medicare billing and allied health prescribing?	If elected, I will: • Demand appropriate indexation across all MBS items. The most recent indexation took general practice backwards – 2.6% vs 4.5% CPI. • Immediately call for a 40% increase to Level C and D rebates to reduce the financial penalty for providing longer, more complex care. • Push for an urgent successor to the BEACH program. Without reliable data, government controls the narrative. • I oppose pharmacy prescribing – it weakens patient safety, and it weakens general practice. Where other allied health professions argue to prescribe we must look at through the lens of evidence, patient safety and strengthening general practice – that is a tall bar for alternate professions to pass
How are you going to improve the reputation of GP services in the community? How are you going to make GP training popular?	I will lead a national campaign to rebuild the respect for general practice and make our value impossible to ignore. It will present GPs clearly as specialist doctors, using television, radio, print and digital media to show the complexity, continuity and preventive care we deliver. RACGP and FRACGP should be visible in every participating practice, backed by a rapid public response that I will lead from the College whenever our profession is diminished or misrepresented.

	To strengthen GP training, I will lead the case to government for proper funding of the FSP and PEP pathways, alongside sustained support for AGPT. I will push for better funding for supervisors and teaching practices, stronger rural and remote pathways including funded remote supervision and greater flexibility across training programs. We must also reduce unnecessary administrative burden, simplify pathway requirements and better support IMG doctors progressing toward Fellowship. Respect the profession, fund the pathways and remove the barriers.
How do you understand the challenges for a membership organisation to promote quality care in general practice?	A membership organisation should do two things at once: defend its members and uphold the standards that earn public trust. Those responsibilities are complementary, but the balance must be handled carefully. Quality care cannot be promoted through standards alone. The College must understand the realities in which GPs work: rising complexity, workforce shortages, inadequate funding, administrative burden and very different rural, regional and metropolitan settings. Expectations that are not practical, funded or developed with members will not improve care; they will simply add pressure. The RACGP should set clear evidence-based standards, support GPs to meet them, and advocate for the funding, workforce and systems required to deliver them. It must also listen to members, measure the impact of its policies and avoid becoming an extension of government regulation. Quality improves when GPs are trusted, supported and properly resourced.
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"?	I would push for a public scorecard with clear targets, timelines and named responsibilities across the Commonwealth, states, PHNs and other funded organisations. The College also has a role. We should track progress, report honestly to members and call out the gap between government announcements and what GPs and patients are experiencing. Where commitments are missed, there should be parliamentary scrutiny and independent review.
How will you represent our most remote and marginalised practices caring for vulnerable and underserviced populations?	If elected President, I will ensure remote and marginalised practices are not consulted as an afterthought they will have a direct voice in the College's priorities, advocacy and decision-making. I will establish stronger, regular engagement through the Rural, Aboriginal and Torres Strait Islander Health, state and territory faculties, with clear pathways for frontline concerns to reach the Board and advocacy teams. Just as importantly, members must be informed what action has resulted from their feedback. I will advocate for funding and workforce policies that recognise the higher costs, complexity and professional isolation involved in caring for vulnerable and underserviced communities. I will also ensure culturally safe care is embedded across the College and that Aboriginal and Torres Strait Islander doctors are supported to lead and shape its decisions. This reflects my record. As a state faculty chair, I travelled to remote and marginalised practices, listened directly to grassroots GPs and carried their

	concerns into state and federal advocacy. That work contributed to grant and funding support for practices. As President, I will take the same approach nationally: listen personally, advocate directly and deliver measurable outcomes.
How would you propose to lift the morale of RACGP members to build pride in the profession of general practice?	One of my five priorities is Back Every GP. Morale will rise when general practice is respected, properly funded and placed at the centre of Australia's healthcare system. I am proud to be a specialist GP, and as President I will lead a national campaign that clearly communicates who we are: highly trained specialist doctors providing continuity and keeping patients well and out of hospital. I will promote this message through mainstream media, community education, patient stories and stronger RACGP responses. Respect must also be reflected in policy. I will advocate for funding that properly values GP time, longer consultations, preventive care and continuity not models that reward volume or fragment care. I will challenge policies that diminish our expertise, undermine professional autonomy or substitute disconnected care for comprehensive general practice. My record demonstrates this approach. I have consistently represented general practice in the media, advocated directly to governments, secured practical funding support and promoted the value of GPs across rural, metropolitan and marginalised communities. Pride grows when our profession is visible, valued and influential. I will ensure the RACGP speaks with authority, defends its members and makes general practice impossible to ignore.
Is the RACGP considering any future plans to help or absorb experienced GPs who are unable to achieve Fellowship?	If elected as President, I will push for a clearer and more supportive pathway for experienced GPs who have not achieved Fellowship. The College must maintain the standard required for independent specialist general practice, but it should not abandon doctors who have served communities for many years. I will review where experienced GPs are falling out of existing pathways, strengthen individual mentoring, remediation and exam support, and ensure prior experience is properly recognised. I will advocate for case-managed pathways through the College with peer support.
The GP workforce depend heavily on IMGs but there's little reciprocal support from the College.	Backing Every GP is one of my priorities, and that includes supporting and advocating for IMGs colleagues. If elected, I will: • Strengthen practical support through clearer pathways, mentorship and exam preparation. • Reduce unnecessary duplication, delays and administrative barriers. • Advocate for fair recognition of overseas training and experience. • Increase and involve IMG representation in College decision-making. • Ensure rural and regional IMGs receive proper supervision and professional support. • Review the value of College services for IMGs.
What are your policies on sustainability in general practice ie reducing practices carbon footprint, climate advocacy?	I support the Climate policies in the RACGP's Advocacy Plan, particularly the full funding of the National Health & Climate Strategy, because it underpins how general practice can optimise its carbon footprint. I also know change adds pressure to practices and must be supported through appropriate incentives.

	One area consideration is the likely net-increase in scope 3 emissions due to explosive growth of AI. I have detailed my approach for with this in my Climate & Environmental Position
What are your programs/plans to IMGs settling in Australia?	Backing Every GP which is one of my priorities includes supporting IMGs to build successful careers in Australia. I advocated in the College for and helped establish the RACGP's National IMG Committee. If elected, I will strengthen the committee with greater resourcing, clearer access to the Board and advocacy teams, and a defined work program focused on practical outcomes. This will include orientation to Medicare, regulation and Australian general practice; expanded mentoring and peer support; simpler and more transparent training and Fellowship pathways; and better access to supervisors, exam preparation and pastoral support. I will also work with state, territory and rural faculties to establish or strengthen local IMG committees and networks, so support is available where doctors live and work, particularly in rural and regional communities. The College's responsibility must extend beyond registration. It should help IMGs achieve Fellowship, build professional networks, develop as leaders and feel fully connected to our profession.
What can you do at the political level to help influence health department decisions which benefit general practice?	If elected as President, I will draw on more than a decade of professional relationships with government, the crossbench and opposition to influence decisions before they are locked in. I will present government with clear solutions supported by general practice data, economic evidence and the real experiences of GPs and patients. I will identify the consequences of poor policy and propose workable alternatives. I will scale that influence by mobilising RACGP members who have trusted relationships and the ability to shift opinion where appropriate. I will also build community momentum. Patients and the public can be our greatest advocates when they understand how decisions affect access, continuity and safety. Finally, I will equip every willing GP to advocate locally through practical training, evidence and campaign resources. The RACGP is a registered charity. That allows member funds to be used efficiently, but it also means the College cannot make political donations. I have addressed separately the considerations and implications of an independent lobby body.
What is your position on Rural Generalism? Should it include GPs practicing in urban settings (MMM2) with a special interest?	I strongly support Rural Generalism as a distinct pathway combining general practice with advanced skills needed by local communities. GPs in MMM2 should be eligible where they have recognised advanced training and use those skills to meet local service gaps. Rural Generalist recognition should reflect accredited training, the work actually performed, community need and ongoing maintenance of skills.
What steps are you taking to address the discrepancy of Medicare rebate per minute decreasing for longer consultations?	If elected, I will: • Demand appropriate indexation across all MBS items. The most recent indexation took general practice backwards – 2.6% vs 4.5 CPI. • Immediately call for a 40% increase to Level C and D rebates to reduce the financial penalty for providing longer, more complex care.

	• Push for an urgent successor to the BEACH program. Without reliable data, government controls the narrative. Please read more: https://ramyaraman.com.au/articles/value-gp-care-fixing-long-consults-and-keeping-pricing-honest/ https://ramyaraman.com.au/articles/general-practice-funding-position/
Where do you see the college in 5-10 years, and how will you help steer it in that direction?	If elected as President, I see the RACGP becoming the profession's strongest advocate, trusted standard-setter and practical partner for every GP and their practice. The College's current strategy and advocacy plan already commit us to fairer funding, workforce growth, culturally safe care, less red tape, better technology and stronger research. My role would be to turn those plans into visible results and report progress honestly to members, and navigate challenges that arise. Digital health and AI will bring significant change to how we operate in the next 5-10 years. The College must lead, not react. I will ensure we shape government policy, regulation, standards and funding before decisions are locked in, while protecting GP clinical authority and patient trust. I want my legacy to be a stronger foundation that future leaders can build on as both known and unforeseen challenges and opportunities emerge over the next five to ten years.
Will you commit to holding a Plebiscite of members to halve the time for Level C cons to 10-20min and double the rebate?	My priority is to keep more money in general practice. First by fighting for MBS rebates to be indexed at actual CPI which provides better patient care across the board. Second, at least increasing long consults by 40% to better reflect the cost of complex care, and; Third, call for an independent pricing authority that levels up rebate with the true cost of care. Since this takes time, the first two are designed for immediate results for general practice. I am also supportive of members communicating their key funding priorities – such as your suggestion for evaluation.
Would you be willing to review and address a case(s) of ineligibility for vocational registration?	Yes. I would be willing to review the circumstances of individual cases and determine whether they reveal a broader problem with the pathway. While the RACGP President cannot overturn a registration decision, I would ensure affected GPs are heard, seek greater transparency around decisions and advocate for fair review processes. Where capable doctors are being excluded by inconsistent, outdated or unnecessarily rigid criteria, I will push for those barriers to be addressed.
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?	This is fundamentally why I am running for president. My 5 priorities came about to address these concerns. 1. **Value GP Care**

	• Fighting for **MBS Item Indexation with CPI** so money is kept in general practice and we do not go backwards. • An increase to patient rebates for Level C and D consults of at least 40% because complex care requires it. • Advocating for an **Independent Pricing Authority** so that MBS patient rebate are set accurately to reflect the true cost of care. This includes demanding a modern replacement for BEACH, because Government does not have useful data about general practice consults in Australia (even though it exists commercially) and without it, Government does get away with decisions that hurt our patients and our profession. 2. **Back Every GP** I recognise GPs are at different stages of their career and they bring diverse clinical experience from rural GPs, IMG GPs, Aboriginal and Torre Strait Islander GPs, Supervisors and experienced clinicians. Yet I hear time and time again their past and future paths have plenty of red tape. I will remove that – both within the College and within government or adjacent departments. 3. **Protect Continuity** Every GP knows the power and influence (see below) of the pharmacy lobby group and how commercial interests outweigh patient safety and continuity – to the extend that political leaders that represent our communities are bypassing processes, reviews and even partaking in advertisements in way that underpins general practice and health care. I will fight to stop pharmacy scope expansion – this is not new to me, I have moderated the full impact with the backing of the college, and I will strengthen our proactive response – both in front of; and behind the scenes. 4. **Build Influence** Our college has a strong advocacy program – on paper, and we must sharpen it. That means resourcing advocacy for the new age, leveraging deep relationships our members have with decision makers, and better requiring members that want to contribute. Our legal structure does not permitted political donations but as a college with tens of thousands of members we cannot be easily ignored either. 5. **Focus the College** This means spending your member fees wisely on things that matter. By the time you read this more information will be available on how I will reorient the college
How does each candidate plan to address the issue of infringement on GP scope of practice by pharmacists?	Opposition after a government announcement is already too late. We must stop treating pharmacy prescribing as isolated state debates and run a coordinated strategy that changes the political calculation. I would intervene earlier, engaging ministers, advisers, MPs and departments before proposals reach Cabinet. I would mobilise GPs in key electorates, because trusted local relationships can carry more weight than a media release. I support pharmacists using their expertise as part of collaborative healthcare teams. But substituting a retail transaction for comprehensive medical assessment is not health reform, it is fragmentation. I will demand independent evidence, national safety standards, mandatory information-sharing and clear protections against commercial conflicts. At the same time, I will advocate for

	properly funded same-day, after-hours and rural general practice support so patients receive accessible care without sacrificing continuity, diagnosis or safety. A major issue is government bypassing their own checks and balances when it comes to pushing through pharmacy scope expansion. I will be the public face that calls this out and holds them to account.
What are the candidates' responsibilities as president? Why a candidate wants to be president of RACGP?	The President's responsibility is to represent members, be a strong national voice for general practice and bring the realities facing GPs into the College's strategy and decisions. It is not a personal platform. The President must listen, unite the profession, work constructively with the Board and CEO, and hold governments and decision-makers to account. I want to be President because general practice is at a turning point. Funding, pharmacy prescribing, workforce pressures and digital disruption will shape our profession for years. I am standing to value GP care, protect continuity, back every GP, build our influence and focus the College on what matters most to members. I want to see our profession and College flourish.
How can we improve funding and staffing for community health which services marginalised people?	I will call for local faculties to engage more often, create clearer channels for feedback and show members what action the College is taking. This includes identifying the highest value areas for funding (e.g. housing for staff in regional areas, sponsoring training to enhance culturally safe care). Community health services care for people with some of the greatest health needs, yet too often operate with short-term funding. Funding must follow patient need and complexity; not simply service volume. I will advocate for: • Needs-based funding loadings for services caring for people experiencing homelessness, disability, family violence, cultural or language barriers, and socioeconomic disadvantage. • Dedicated workforce grants to employ/contract GPs, nurses, allied health professionals, interpreters, care coordinators and community health workers. • Funding for longer consultations, outreach, care coordination and non-face-to-face work, which conventional fee-for-service funding often fails to support adequately. Knowledge from practices and communities on the ground must shape funding decisions.
As President, what will you do to secure single employer models that attract junior doctors into general practice?	I support single employer models that provide GPs in Training with portable entitlements and employment certainty. However, the proposed models need refinement. If elected, I will advocate for: • Practice and supervisor autonomy in registrar selection and training. • Proper funding for supervision, administration and infrastructure. • Flexibility across rural, community and private practice settings. • Clear measures of recruitment, retention and training quality.

	We should secure the benefits of single employer models without weakening the practices and supervisors who train our future GPs.
How would you advance RACGP's Advocacy Plan priorities relating the impacts of climate change on general practice and health?	Please refer to my Climate & Environmental Position.
New question and responses content posted on 14 August 2026	
As RACGP members and an experienced IMG GP couple from Iran, we would genuinely value hearing your position on one of the major barriers preventing skilled doctors from entering Australian general practice: the Level 1 supervision bottleneck. My wife and I each have eight years of GP experience and previously supervised many junior doctors ourselves. We have passed the requirements and PESCI as well with excellent feedback, and all our documents are ready for registration. We are willing to relocate and commit long term to any rural or regional community in Australia, yet we remain unable to enter the workforce because of the severe shortage of Level 1 supervisors. This is not only our story. Many experienced IMGs are ready to serve communities facing critical GP shortages but remain locked outside the system by the same barrier. **If elected RACGP President, what practical action would you take to expand Level 1 supervision capacity and better support supervisors? Australia does not lack skilled and committed doctors—it lacks a workable pathway for them to enter the workforce. A clear commitment on this issue would mean a great deal to many IMG members and doctors following this election.**	Thank you for raising this. Supporting supervisors is one of my campaign priorities. If elected, I would: • Immediately commence work with stakeholders and advocate for properly funded Level 1 supervision, including payment for supervisor time, administration, training and backfill. • Reduce duplicated paperwork and approvals across the College and relevant programs. • Support team-based supervision, with principal supervisors, co-supervisors and backup arrangements where safe. • Push for timely, competency-based progression. The RACGP cannot change Medical Board requirements on its own, and patient safety must remain central. But we can lead stronger advocacy with government and regulators, support supervisors properly and make the pathway far more workable.
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 do not support payroll tax being applied to tenant GPs. These are not traditional employer-employee relationships, and agencies should not use creative interpretations of existing legislation, or change legislation, to make them so. Doing this is in no one's interest. It threatens already fragile practice viability, increases costs for patients and places greater pressure on hospitals and the broader health system. I understand this as a practice owner. In WA, I secured written confirmation that payroll tax would not apply to tenant GPs and that there was no intention to change the legislation. As President, I would take that case directly to State Treasurers, Health Ministers and Revenue Offices nationally. Success means clear, written

	protections across jurisdictions, no retrospective liabilities, and general practices remaining viable.
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?	My concern is when new government-funded services are introduced without first understanding whether existing community practices could meet that need if they were properly supported. Urgent Care Clinics and government-supported bulk-billing clinics have a role, but poorly targeted intervention can distort the local workforce, weaken the services communities already rely on. Investment should therefore be guided by local need, evidence and consultation with existing practices. If elected as President, I will advocate for government to identify genuine service gaps first, strengthen existing general practice wherever possible (including calling on funding for after-hours care and review of the after-hours MBS item numbers), and ensure new services integrate with local GPs rather than unnecessarily duplicating or competing with them.
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 of care, and the central role of the GP as coordinator of care?	I support multidisciplinary care, but changes to prescribing, investigation ordering or diagnostic responsibility must be driven by evidence, patient safety and continuity, not commercial lobby group pressure. https://www.ausdoc.com.au/opinion/pharmacist-prescribing-yes-access-matters-but-safety-must-always-come-first/ https://www.ausdoc.com.au/opinion/the-pill-is-rarely-just-the-pill-pharmacist-prescribing-risks-patient-safety/ https://ramyaraman.com.au/wp-content/uploads/2026/07/Pharmacy-Prescribing-with-Ramya-Raman-on-ABC-Drive-May-2026.mp4 https://ramyaraman.com.au/articles/pharmacy-ownership-rules-for-rural-health/ Nurse practitioners can have an important role, particularly in rural and remote communities. But the workforce pressures affecting general practice also affect nursing, pharmacy and allied health. Expanding scope alone will not fix the underlying workforce problem. I do not support parallel systems that fragment records, accountability or continuity with the patient's GP. If elected as President, I will mandate for independent evaluation of scope reforms, nationally consistent safety standards, clear clinical responsibility and interoperable information sharing. We should address the causes of workforce shortages while not compromising patient care.
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	The most significant taxation challenge I see is uncertainty. Payroll tax demonstrated how changes in interpretation can suddenly create substantial liabilities and threaten otherwise viable practices. I have demonstrated in WA that strong, proactive engagement with government can deliver the certainty general practice needs. Nationally, I would call for

burdens? What advocacy priorities would you pursue to address these challenges at both state and federal levels?	clearer and more consistent payroll-tax treatment across jurisdictions and resist taxation approaches that undermine established contractor models. It is not just the additional tax, but the administrative burden it creates around how clinics collect fees and manage compliance. At the federal level, I would advocate for tax settings that encourage investment, ownership and succession in general practice, including exploring targeted CGT incentives or concessions that could support investment in practices as essential community infrastructure and an important economic asset. More broadly, tax and regulatory policy should strengthen practice viability, reduce unnecessary compliance burden and avoid increasing costs that ultimately flow through to patients.
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?	My long-term vision starts with a simple priority: keep more money in general practice so practices remain viable, invest in their teams and continue providing comprehensive care. That means indexation of Medicare patient rebates, properly valuing longer and complex consultations, reducing unfunded work and regulatory burden, and ensuring new government policies strengthen rather than bypass existing practices. We also need to make general practice attractive to the next generation by supporting supervisors, registrars and practice owners, reducing unnecessary training friction, and creating conditions that encourage ownership, succession and investment. Today, only around 5% of Australia's total health expenditure goes to unreferred medical services, predominantly general practice. That needs to change. If elected as President, I will fight to bring a greater share of health funding back into general practice. We need investment that strengthens Medicare, supports longer and more complex care, builds our workforce and gives practices the financial capacity to invest, innovate and grow. I want a funding system that strengthens practices rather than increasing government control over how GPs deliver care. General practice should remain the enduring foundation of Australian primary care, not be gradually displaced by fragmented or externally controlled models.
Can you please tell us about your past and current associations with industry and pharmaceutical companies?	I have no current formal employment, board or advisory roles with pharmaceutical companies. I have had previous adhoc educational presentation/ facilitation roles as a GP. My professional associations are primarily with general practice, medical education, universities, government and not-for-profit organisations. I am a practice owner, hold academic and RACGP leadership roles, and sit on a number of health and government advisory groups/committee. I am also a committee member of the MDA Western Cases Committee. My research and grant activity has been through universities, the RACGP, Cancer Council WA and government or community organisations.

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?	Expanding GP involvement in ADHD diagnosis and management is an important step for our profession. It recognises specialist GP capability and can improve access and continuity of care, particularly because ADHD rarely exists in isolation. GPs are well placed to manage the associated anxiety, depression, sleep problems, substance use, autism and other physical and mental health comorbidities across a patient's life. I have been directly involved in achieving this reform in WA, working with government to expand GP diagnosis and prescribing and secure implementation funding. If elected as President, I would ensure the RACGP supports GPs with practical, evidence-based resources and education, not simply new responsibilities. I would bring together the RACGP ADHD, ASD and Neurodiversity Specific Interests group, other relevant Specific Interests groups, colleges, consumers and key stakeholders to develop education sessions, clinical guidance and practical tools covering both ADHD and its common comorbidities. I would also advocate for nationally consistent prescribing frameworks, access to non-GP specialist advice and shared-care pathways, mentoring and peer support, and appropriate funding for the longer, complex consultations this care requires.
What changes can be made to remunerate the long hours GPs take doing non-clinical paperwork e.g. result checking?	GPs spend significant hours outside consultations reviewing results, managing correspondence, following up abnormalities, coordinating care and completing necessary paperwork. Much of this work carries clinical responsibility and liability, yet it is largely unpaid. If elected as President I will fight for Medicare to properly recognise necessary work performed outside face-to-face consultations, including appropriately designed non-face-to-face items. I will also call for an independent pricing authority to calculate the real cost of delivering comprehensive general practice, including the substantial workload that occurs between consultations. At the same time, unnecessary administrative burden must be reduced, and I would push for a no unfunded transfer rule so when hospitals or governments shift work into general practice, funding follows the work.
How will you unite the fragmented group of General Practitioners so we have a unified voice advocating for the profession?	My campaign priority is to **Back Every GP**. That means bringing together GPs across career stages, practice models, geographies and backgrounds around the issues we share. A unified voice does not mean every GP must hold the same view. It means the College must listen better, identify common ground and advocate earlier and clearer where our collective interests align. If elected as President, I would strengthen engagement through faculties, rural and regional networks, GPs in training, supervisors, practice owners, IMGs and

	frontline members, then turn that input into clear national priorities. I want governments to hear a profession that is organised, confident and difficult to ignore. My job will be to turn the strength of our diversity into collective influence, and that influence into better outcomes for every GP
What is your opinion on lobbying versus advocacy?	We need both advocacy and lobbying. Advocacy builds the evidence, public case and member support. Lobbying takes that case directly to the people with the power to act. Lobbying is not simply about political donations. The RACGP's registered charity status limits that option, and changing the structure would consume significant time, money and focus. Effective lobbying means engaging governments, oppositions, crossbenchers, departments and advisers early. It also means identifying and supporting willing RACGP members who already have deep, trusted and ethical relationships with key stakeholders, and harnessing those relationships strategically. As President, I would strengthen both advocacy and lobbying, using the full reach of our membership (and patients) to turn influence into measurable outcomes for GPs.
[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?**	1. Advocacy plan: I will move the College from reactive advocacy to a deliberate, outcomes-driven strategy: identify threats and opportunities early, engage government before decisions are locked in (e.g. secured written confirmation that payroll tax would not apply to tenant GPs and that there was no intention to change the legislation in WA) , put credible alternatives on the table, and mobilise grassroots members and members with trusted relationships across government, health and the community. In my first 100 days, I will set clear priorities, timelines and accountable leads, with quarterly progress reporting and a 12-month assessment. KPIs must measure outcomes: funding secured, policy changed or stopped, commitments delivered and measurable benefit for members. 2. Different from previous leadership: The difference will be earlier intervention, stronger mobilisation of our membership and clearer accountability for results. Meetings, submissions and media are tools, not measures of success. Members should know what we are fighting for, how we are pursuing it and what has actually changed. 3. Medicare rebate and consult funding: My priority is to keep more money in general practice through full CPI indexation, increasing rebates for longer and complex consultations, restored mental-health funding and an independent pricing authority. I will build the economic and clinical case, engage Treasury, Health and political decision-makers early, mobilise members and patients, and maintain coordinated public and political pressure until funding better reflects the real cost of quality general practice.
What do you think about funding for mental healthcare? Does it need a revamp?	Yes it needs a revamp. The removal of dedicated mental-health item numbers was absolutely detrimental to general practice and needs to be reinstated.

	GPs provide a significant proportion of mental healthcare in Australia, often managing mental health alongside chronic disease, medications, family circumstances and social complexity. That work takes time, continuity and clinical judgement, yet the funding model increasingly fails to recognise it. I will advocate strongly for restoring and strengthening appropriately funded mental-health consultation items, particularly for longer and complex care. Funding should support ongoing GP-delivered mental healthcare, not just plans, referrals or fragmented programs. Mental-health reform must recognise the GP's role across the whole patient journey and ensure patients can afford the time with their GP that good mental healthcare requires.
New question and responses content posted on 20 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?** **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.**	**For supervisors:** GP supervisors are fundamental to the future of our profession, but too much of their teaching, mentoring and responsibility is still undervalued. As President, I would advocate for properly funded supervision that reflects the real time and responsibility involved, reduce unnecessary administrative burden, and strengthen practical support for supervisors and teaching practices. We also need to expand supervisor capacity, particularly in rural and regional areas, without compromising training quality. Supporting supervisors is not an optional extra. It is workforce policy, and it is essential if we want to train and retain the next generation of GPs. **For RACGP culture:** As President, I would expect a College that is respectful, transparent, accountable and genuinely responsive to members and staff. That means listening when concerns are raised, acting early when problems emerge, and ensuring there are clear and trusted pathways for people to speak up – staff surveys and team building at faculty levels *across* the country would be an essential component for this to be successful. I would also push for stronger transparency around decision-making and clearer accountability for outcomes. Members should feel that the RACGP belongs to them, that their concerns are heard, and that the College is focused on supporting them. **For Medicare:** advocate for CPI indexation, substantially better rebates for longer and complex consultations, reinstatement of the mental health item numbers an independent MBS pricing authority, and simpler billing rules that reduce unnecessary administration. **For recognition:** Absolutely. We need to do much more to reinforce that GPs are specialist doctors and elevate the standing of general practice in the community. At the 2025 RACGP Convocation, branding and elevating the profession was upvoted by members. As President, I will ensure that this is

	actively championed and translated into meaningful action. At this critical time for general practice, we need to see that work succeed. That means consistently promoting the role and expertise of Specialist GPs to governments, the health system and the public. I would also support an open, member-led discussion about terminology such as 'Family Physician' and whether it could strengthen recognition of our specialist role. Ultimately, we need more than a title change. We need general practice to be recognised, respected and funded as specialist medical care.
How will you push government to increase Medicare rebates and stop the cutting of funding for general practice?	If elected as President, I will take a clear, persistent and evidence-based case directly to government for a real increase in patient MBS rebates, not temporary incentives that disguise an inadequate baseline. That means putting specific funding asks in front of the Health Minister, Treasury and government before and throughout each Budget cycle, backed by evidence on practice costs, patient access and the downstream cost of underfunding general practice. I will advocate for CPI indexation across consultation items, with additional uplift for longer and more complex care, and actively oppose funding changes that simply shift money away from core general practice. I will also use the strength of the College, our members and our public voice to make the consequences of underfunding visible. We need government to understand that cutting general practice funding does not save money, it shifts costs into hospitals and urgent care. will push for an independent MBS pricing authority so rebates reflect the real cost of providing high-quality care and are less dependent on election-cycle politics. My approach: clear asks, strong evidence, direct negotiation and sustained public advocacy until general practice is funded like the essential health infrastructure it is
We face rising temperatures, climate change, rising inequality and genocides continue. Will you speak up for us?	Yes – see my responses to the RACGP Climate and Environment Medicine SIG https://ramyaraman.com.au/wp-content/uploads/2026/07/Dr-Ramya-Raman-Climate-Position.pdf
What would you do for IMG recruitment, job security, training (FSP) which should have been done much earlier?	IMG colleagues are essential to Australia's general practice workforce, particularly in communities that have struggled to recruit and retain doctors. I agree, we should have acted earlier. If elected as President, I will call for simpler, faster and more consistent pathways into Australian general practice, reducing unnecessary duplication while maintaining high professional standards. I will push for proper government funding of FSP, with PEP pathways also appropriately supported, so IMGs are not carrying excessive training costs and supervisors and practices are properly resourced.

	Recruitment alone is not enough. I will promote greater certainty and stability through training and Fellowship, with clearer progression, fewer administrative cliff-edges and better support for both doctors and practices. We need to recruit, train and retain IMGs as valued, long-term members of Australian general practice.
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?	My strategy is clear: protect the role of the specialist GP and keep general practice at the centre of patient care. I will oppose policies that substitute GP care with isolated or commercially driven services, and I will challenge governments when scope expansion fragments care, weakens continuity or creates unclear clinical responsibility. I will push for any new models of care to be evidence-based, independently evaluated and integrated with general practice, with shared records, clear accountability and proper communication back to the patient's GP. At the same time, I will fight for properly funded multidisciplinary teams within general practice, so pharmacists, nurses and allied health professionals can work to full scope as part of a coordinated GP-led team. And I will challenge the underlying policy failure: governments cannot underfund general practice, create workforce shortages, and then use those shortages to justify replacing GP care. I have taken on difficult scope and workforce battles before. If elected President, I will take that fight nationally: protect GP-led care, challenge fragmentation and make governments accountable for the consequences of their decisions.
RACGP is so disconnected from the common members, what will the candidates do to change this and make all members involved?	I agree, and I have heard this directly from members across Australia. That is why, during this campaign, I made a deliberate effort to travel to every state and territory, meeting grassroots GPs, GPs in training and members in metropolitan, regional and rural communities. If we want a College that represents members, we have to go to them and listen. My approach is Back Every GP. As President, I will strengthen local faculties, create more direct access to College leadership, and take consultation out to members rather than expecting busy GPs to always come to us. I will also push for a much stronger feedback loop. When members raise an issue, they should know what the College did, what changed, and where we still need to keep fighting. Most importantly, member engagement must influence decisions, not simply be consultation after the fact. The RACGP should feel like your College, wherever you practise. My job as President will be to make sure members are heard, represented and connected to the decisions that affect them.
Is now the time to address and publicise the failure of Medicare as a health finance system?	Yes. Now is the time to have that conversation. Medicare remains fundamental, but the way it finances general practice has failed to keep pace with the cost and complexity of modern care.

	A decade of underinvestment has made GP funding a political football, with major announcements too often tied to election cycles rather than the real cost of providing care. We need to make the consequences visible: higher out-of-pocket costs, pressure on practices, shorter consultations and greater downstream hospital expenditure. If elected as President, I will call for a substantial uplift in patient MBS rebates and promote an independent MBS pricing authority to set rebates transparently, based on the actual cost, time and complexity of delivering high-quality general practice. We cannot remove politics from health funding, but we can reduce its dependence on the election cycle and build a more sustainable funding system.
Do you believe the RACGP's current charitable / constitutional structure limits our political influence? (Eg via donations).	Yes, the RACGP's charitable structure creates some limits, but I don't believe those are the limits holding us back most. Once influence becomes about who can donate the most, we enter an arms race with organisations and industries with much deeper pockets. I would need to see a compelling benefit before committing significant member time and resources to changing the College's structure. Our bigger opportunity is the influence we already have within our membership. Many GPs have strong, trusted relationships across government, business and the community. If elected as President, I will call on members willing to use that influence, and push for earlier engagement in the policy cycle. Our strength is our credibility, relationships and collective voice, not the biggest cheque.
What would you prioritise as President to make GP-led aged care (both in RACH & at home) clinically and financially sustainable?	GP-centred aged care needs continuity, complexity recognised, and funding that follows the work GPs actually do. If elected as President, I will prioritise funding that properly pays for longer consultations, RACH and home visits, travel time, care coordination, case conferencing and after-hours care. GPs should not be expected to subsidise complex aged care through unpaid work. I will also protect continuity with a patient's usual GP and promote multidisciplinary models that support that relationship rather than fragment it. For people ageing at home, we need viable funding for home visits and stronger links between general practice, community services and aged-care providers. GP-centred aged care is clinically sustainable when continuity is protected, and financially sustainable when the work required to provide that continuity is properly funded.

What is your plan to facilitate the Fellowship steps for IMGs? with lack of supervisors and capacity problems?	I would tackle the bottleneck at both ends. First, fund more FSP and PEP placements, so experienced IMGs are not being asked to carry tens of thousands of dollars in training costs themselves. Second, expand supervisor capacity by paying supervisors for adequately, reducing the administrative burden around supervision, and making it easier for experienced GPs and practices to become accredited supervisors. Third, improve placement matching, particularly in areas of workforce need, with earlier intervention when a placement is not working. And finally, streamline College processes so recognition, assessment and progression are clear, timely and consistent. We need to make Fellowship rigorous, but not unnecessarily expensive, slow or difficult to navigate.
Team based care is beneficial. How do you expect GP clinics to fund it given our overheads are costlier than allied health clinics?	Team-based care works, but GP practices cannot be expected to carry the cost themselves. If government wants multidisciplinary care, it should fund it within general practice, including the infrastructure, coordination and practice costs that make those teams work. There is also a bigger economic argument. GP-delivered multidisciplinary care is prevention in action. It helps us manage chronic disease earlier, keep people healthier and prevent avoidable hospital admissions. For government, prevention is one of the best investments it can make. It is far better to fund care early in general practice than pay many times more when a patient ends up in hospital (https://www.medicalrepublic.com.au/prevention-should-be-seen-as-an-investment-in-economic-productivity/127396
How will you contribute to the robust raising of quality in general practice, reducing variability of patient experience?	I strongly believe quality cannot be separated from how we fund and design general practice. As President, I will contribute by pushing for an MBS that gives GPs the time to provide quality, particularly for longer, complex and preventive care, rather than driving volume through underfunded models. I will advocate for multidisciplinary teams centred in general practice and led by the patient's GP, so care is coordinated rather than fragmented and the patient experience remains continuous. I will also ensure GPs are at the centre of digital health design, standards and governance, because poor systems introduced at scale can rapidly amplify poor patient experiences. And I will use the College's education, standards and data capability to help practices identify unwarranted variation and improve.

What is your plan to: **1) help government take primary care seriously** **2) see an increase in baseline Medicare rebate.**	Primary care needs to be treated as core health infrastructure, with general practice at its centre. Preventive care is not always politically exciting. There is no ribbon to cut when a heart attack is avoided or a patient stays out of hospital. But that is exactly why government must take general practice seriously. If elected as President, I will make that clinical and economic case directly to government: underfund general practice and you pay hospital prices downstream https://www.medicalrepublic.com.au/prevention-should-be-seen-as-an-investment-in-economic-productivity/127396 https://www.medicalrepublic.com.au/australia-is-paying-hospital-prices-for-failures-in-primary-care/128089 On Medicare, I will call for a real increase in baseline patient MBS rebates, followed by ongoing CPI indexation so they do not fall behind again, with a greater uplift for longer and more complex consultations. I will also promote an independent MBS pricing authority so rebates reflect the real cost of providing high-quality general practice care.
What will you do to strengthen the unity in GPs, increase RACGP member numbers and not being separated based on PB/UBB/UCC?	As President, I would bring together GPs from private billing, bulk billing, UCCs, rural, corporate and independent practices around the issues we actually share: professional value, autonomy, viability and continuity of care. I would strengthen Faculty and member networks, create more regular direct forums with members, and deliberately include GPs from different practice models in policy development before positions are set. I would also make membership more valuable through stronger advocacy, practical support and clearer accountability for how member fees are spent. We will not grow membership by asking GPs to join. We grow it by making the RACGP a College every GP can see themselves in.
How will you ensure the adequate funding of quality mental health care in addition to complex condition management in the MBS?	I would make this a specific, costed MBS reform agenda, not simply ask government for more funding. First, I would push to restore dedicated GP mental health items and properly fund the longer consultations, care coordination and follow-up that mental health care requires (evidence driven from membership and an economic costing/savings) Second, I would take a costed proposal for higher Level C, D to the Minister, Department and Treasury, using real practice data on consultation time, complexity and delivery costs.

	Third, I would advocate for an independent MBS pricing authority so rebates are reviewed regularly against the actual cost of providing quality care, rather than being determined politically. And I would publish our progress, so members can see exactly what we have asked for and what government has delivered.
Please provide, with evidence, your personal contribution to General Practice in Australia, with focus on Government workforce policy.	My contribution has been turning frontline GP concerns into government action. In WA, I led advocacy that secured written State Government confirmation protecting independent GPs and practices from a changed payroll tax approach, removing a major threat to practice viability. I helped drive ADHD workforce reform, resulting in a funded $1.3 million program enabling specialist GPs to diagnose and treat ADHD, initially training 65 GPs, including rural clinicians. And after meeting GPs in Albany, I advocated directly for continuation of its GP after-hours service; government funding was subsequently reinstated. These are examples of how I work: listen to GPs, take the case to government, and pursue a tangible outcome. Please refer to my track record for more/further details: https://ramyaraman.com.au/track-record/
How can we improve quality of GP training?	Over the past few weeks, travelling across Australia, I've heard a very consistent message. Supervisors tell me they need to be better valued and fairly remunerated for the time, expertise and responsibility involved in training. Practices tell me they need flexibility and autonomy to make training work locally, and that new employment models must not come at the expense of that. GPs in training tell me some placements are not working for them, and they need the College to listen and respond earlier. When supervisors, practices or GPs in training are unhappy, training suffers. If elected as President, I will push for fair remuneration, protect autonomy, support portable employment benefits and ensure the College listens earlier and acts faster.