RACGP

Dr Gavin Colthart

Reponses to member questions received in advance of the member Q&A webinar as at 14 August 2026

Questions	Dr Gavin Colthart's response
Are you familiar with RACGP climate change and health position statement? How will you address it? **What are your policies on sustainability in general practice ie reducing practices carbon footprint, climate advocacy?** **How would you advance RACGP's Advocacy Plan priorities relating the impacts of climate change on general practice and health?**	The environment and climate are undergoing rapid, potentially catastrophic and almost certainly human-induced degradation and instability. As GP's we will be frontline in treating the health impacts of this, which puts us in a strong position to demand action. I fully support the RACGP Advocacy Plan, which pushes for net zero, phasing out fossil fuel production, reducing pollution, and increasing renewables. But the agenda being played out in real time by governments and powerful corporations is to abandon any commitments to net zero, expand fossil fuel production, weaken or remove environmental regulations, and undermine renewables. What can the College do? A good start would be a clear statement of opposition to this agenda. And I hope we can go further. But because I support (and would extend) existing suggestions for bringing more members into the heart of College advocacy, it should be members who decide how far into action the advocacy develops.
The GP workforce depend heavily on IMGs but there's little reciprocal support from the College. **What are your programs/plans to IMGs settling in Australia?** **What is your next plan for the new international, more than one qualification specifically for those with high experience?**	As an IMG myself, and someone who works in the more remote and rural parts of Australia, I'm well aware of how IMGs continue to support critical workforce gaps in General Practice and contribute as skilled new Australian's to the richness and diversity which is a fundamental part of this country. As a Kiwi graduate and UK GP Fellow, my own IMG journey was heavy on paperwork but light on restrictions, and I haven't faced any racism beyond obligatory sheep jokes. Other IMG colleagues have not been so lucky. I believe the College does its best to support IMGs but can always do better. The urgent challenge now is how to support IMGs who are from groups being targeted for dehumanisation by those who should know better. This has already crossed what should be a College red line and I would be looking for reiteration of support for all IMG's, their families and all those who Australia has welcomed and now wishes to reject.
Would you be willing to review and address a case(s) of ineligibility for vocational registration?	It is understandably upsetting to be turned down for vocational registration but the president's role in this area is very limited. If there are widespread concerns among members and applicants about the VR process or decisions then this would be a suitable issue for the president to take up, but their involvement in individual registration decisions would undermine the impartiality and professionalism of the registration team. Supporting that impartiality and professionalism is an ongoing task for both the College and the president.

Is the RACGP considering any future plans to help or absorb experienced GPs who are unable to achieve Fellowship?	Have you explored the existing pathways for experienced GPs seeking Fellowship? Your local RACGP faculty may be able to help advise on the best option and there is further information under “Becoming a GP” on the RACGP website.
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 president, quite rightly, does not set membership fees, which are a matter for the Board as a whole. Also, while it is always good to keep an eye on costs and efficiencies, the real question is about what you get for your money and whether now is the time to focus on cost reductions (and the ensuing chaos this often brings to organisations) rather than increasing GP support and advocacy.
Do you support formation of a medical / GP lobby group (that is allowed to make political donations to get action).	The use of political donations to gain political influence seems to be part of the reason for the erosion of our democracy, which is threatening to overturn the commitment to universal healthcare on which our profession is based and funded. So, not keen on the College endorsing that approach. But there is nothing stopping anyone from forming a lobby group. Funding it to the multi-million-dollar extent of most of the powerful existing groups is another question.
How are you going to improve the reputation of GP services in the community? How are you going to make GP training popular?	Our strength as GP’s lies in our commitment to provide our patients with the highest quality of primary care. We each see hundreds to thousands of patients every year. Being an awesome GP and an awesome practice for them is better than any College PR campaign. GP’s already have a great reputation as trusted advisors, although we can sometimes feel those in power don’t share this view. The College’s role is to support us to be better and to celebrate and amplify the stories which show us at our best. The College also provides an opportunity for us to supervise trainees, which is in itself both a great advertisement for our commitment to quality but also gives us a reason to up our own game and remember why we chose to be a GP.
How would you propose to lift the morale of RACGP members to build pride in the profession of general practice?	
How do you understand the challenges for a membership organisation to promote quality care in general practice?	
Where do you see the college in 5-10 years, and how will you help steer it in that direction?	They say a week is a long time in politics and at the current rate of change in politics and public governance it feels impossible to look as far ahead as 5 years with any clarity. I’ve outlined elsewhere my priorities for the College to be a more powerful voice for advocacy on issues both within and outside the medical world and to continue to believe in and support an ethically based and thriving profession of general practice. My hope is that it can also become more democratic by involving more members more directly in formulating policy and strategy. Without concerted efforts on these fronts I wonder if there will be a profession called General Practice in 5 years, let alone a College to support it.
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 have received a lot of questions about scope of practice, the Medicare maze, and general GP funding. The College should clearly continue to argue that we are best placed to deliver the core of primary care, that Medicare is a monster that needs taming, and that GP’s need funding which doesn’t drive them out of business or into dodgy revenue generation.
Do you have any plan to strengthen the role of the RACGP against Medicare?	But we are not in Kansas anymore. The far right politics sweeping over us at unprecedented speed does not value universal healthcare, sees a strong public service ethic as “woke”, and

How are you going to help with Medicare billing and allied health prescribing? **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"?** **What can you do at the political level to help influence health department decisions which benefit general practice?** **What steps are you taking to address the discrepancy of Medicare rebate per minute decreasing for longer consultations?** **Will you commit to holding a Plebiscite of members to halve the time for Level C cons to 10-20min and double the rebate?** **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?** **How does each candidate plan to address the issue of infringement on GP scope of practice by pharmacists?** **How can we improve funding and staffing for community health which services marginalised people?**	regards scientific evidence as a nuisance. Yet we are a profession dominantly funded by taxpayers, with core ethical principles of equity and justice, and a strong tradition of scientific enquiry and careful reasoning. Resisting the marginalisation of our profession will require us to defend all health professions, stand up for universal healthcare, support an independent public service, and advocate for a politics based on evidence and considered judgement. We have much in common with pharmacists, nurses and nurse practitioners, health service managers, and those politicians who are appalled at the tidal wave of tyranny ahead. Our College is already trying to build alliances but it needs to go further, and as GP's we may need to consider whether attacks on potential friends are in our best interests.
What are the candidates' responsibilities as president? Why a candidate wants to be president of RACGP?	The RACGP website has an excellent page on the elections and the presidential role, and this has links to the candidate statements and other material provided by candidates. You will note that the President has no authority over the Board and although elected by members is required to act "in accordance with Board-approved policy and strategy". My motivation in standing for president is to try to make the world a better place and encourage GP's to use their moral authority to do the same.
How will you represent our most remote and marginalised practices caring for vulnerable and underserviced populations?	I am currently based in an MMM5 area and have recently started occasional work in other remote locations in Far north Queensland, so I have some understanding of the challenges faced in these areas. Advocating for better support for those working in more challenging settings should be (and is) part of the core identity of the College. We should also be advocating for those supporting the marginalised and vulnerable in our cities and suburbs.
What is your position on Rural Generalism? Should it include GPs practicing in urban settings (MMM2) with a special interest?	I currently work in a rural generalist role and think it is a fantastic style of practice that matches well with the needs of communities outside the major urban/suburban areas, which have often struggled to recruit and retain GP's with the necessary skills and motivation. Any future review of the RG pathway could usefully include how it might be expanded to include those working in less remote settings with expanded scope, or whether this would more effectively be dealt with separately through the Recognition of Extended Skills (RES-FRACGP) scheme.

As President, what will you do to secure single employer models that attract junior doctors into general practice?	Pushing for an appropriately structured and managed SEM is an ongoing and successful part of RACGP advocacy. We can also attract junior doctors by being awesome GP's who aren't afraid of standing up to powerful forces which will harm our patients, using our financial and social privileges for good, and providing excellent and evidence-based care.
How are you going advocate for better recognition and remuneration for GP Supervisors?	Helping to teach GPs has always felt like a privilege and often forced me to improve my own knowledge and skills. However, it is important to ensure that supervision is adequately resourced and recognised. I'm aware that there are ongoing issues with the complexities of medical school placements with different Universities involved and that the separation of RACGP and ACCRM training has in some cases led to confusion and duplication of paperwork. I believe the College is motivated to improve the experience of supervisors and I would encourage supervisors to advocate via GPSA or directly with their College training team.

New question and responses content posted on 14 August 2026

Having received another batch of member questions via the RACGP website, many asking for very detailed policies and advocacy priorities, particularly around tax, profitability and role encroachment, I have a few thoughts which clump together answers to several of the questions:

1. The President's has no power to create policy or advocate outside Board approval. Although elected by members (around 20% of us actually vote) the president is subject to oversight by the Board (a mix of directly elected and appointed members). The role description states that the president will "serve as the principal public representative and spokesperson of the RACGP in line with Board-approved policy and strategy." So, any election promise by any candidate is subject to convincing the Board it is a good idea.

2. The Board already advocates against unfair taxes, role encroachment, ill-conceived government-funded clinics, and over-zealous regulation. I support this fully and am confident they will continue to do so whoever is elected President.

3. We might not wish to forget that however we spin it, GP's (and almost all healthcare in Australia) is either directly or indirectly funded via taxation. While we have valid reasons to reject taxes which produce an unfair burden on GP's, we are always nibbling on the hand that feeds us – if we are taxed less the tax we rely on to support us will need to come from elsewhere. Where should we cut? Or which other taxes should be increased?

4. A common concern is retention of our independence as GP's, and the perceived threat to this is government intervention. This is a real concern. But practices are increasingly being sold to insurance companies or private equity (perhaps around 15% currently) – can we say these are independent practices anymore? Are the non-owner GPs in these practices independent? Might the larger threat to independence not be the government after all?

Some more specific questions were also sent in:

What is your long-term vision for preserving and strengthening independent, community-based general practice in Australia?	My approach to this is that we should do more of what we do best – awesome primary care provided by GPs who are able to make the wellbeing of patients their main concern, free from political or financial interference, accessible to all, and likely funded via taxation. Our biggest threats are coming from corporatisation (profit-driven medicine has little or no place for primary care as we know it – see, for example, the USA), a political wind blowing strongly against provision of universal healthcare, plus imported agendas to demonise anyone who opposes tyranny but who we should be supporting as doctors with a clear ethical duty (including, but not limited to, those advocating for women's health, first nations rights, stopping or preventing murderous armed conflicts/assaults, or environmental sanity).
Can you please tell us about your past and current associations with industry and pharmaceutical companies?	In the 1980's or thereabouts I worked for a company which made its money from selling research to pharmaceutical companies, and in this job I also edited some publications which relied on pharmaceutical advertising. Since then I haven't knowingly attended events sponsored by pharmaceutical companies, eaten any lunches paid for by pharmaceutical companies, accepted meetings with pharmaceutical sales reps, taken any branded items from pharmaceutical companies, or received speaking fees or travel/accommodation from pharmaceutical companies. And I've still managed to attend CPD, feed myself, outfit my office, and take holidays. I wouldn't feel comfortable if one of my patients were sitting with me as I accepted offers which were designed to influence my impartiality.

What is your opinion on lobbying versus advocacy?	Lobbying as currently practiced seems to involve using money to gain more access to elected or appointed officials to encourage them to support/reject legislation or implement/ignore regulations which will provide material or political benefit to the lobbying organisation. It's a huge and expensive business which bypasses democracy and uses techniques often indistinguishable from bribery and corruption. Should we join the fray? How does this sit with being an ethically led profession? If we join in, will this leave us unable to argue against those who outspend us without looking hypocritical? Can we afford the millions of dollars we would need? Advocacy isn't tightly defined but I believe it arises from an ethical foundation – these are the ideas we believe in, our members embody these, we are respected to give impartial advice on what's best and not just argue for our own professional or financial interests. I believe the examples of good care and impartial advice we give every year to millions of patients, plus the College's reputation for impartial comment on key medical issues are worth more than any amount of lobbying.
Apologies again for clumping all this together, and apologies for not answering the specific questions on ADHD, mental health and aged care – these are existing advocacy priorities, with which experienced and dedicated members are engaged (with significant success to date). I wouldn't presume to do anything other than ensure they continue to be supported and celebrated.	