RACGP submission to the Effectiveness of the Department of Health and Aged Care's performance management of the Primary Health Network program audit

Australian National Audit Office (ANAO)

RACGP

About the RACGP

The Royal Australian College of General Practitioners (RACGP) is the voice of general practitioners (GPs) in our growing cities and throughout rural and remote Australia. We are Australia's largest professional general practice organisation representing more than 40,000 urban and rural general practitioner members. For more than 60 years, we've supported the backbone of Australia's health system by setting the standards for education and practice and advocating for better health and well-being for all Australians.

The RACGP has a long and proud history of keeping general practice at the forefront of the quality healthcare agenda, supporting our members in their pursuit of excellence in patient care and community service and, supporting efforts aimed at collaboration and integration to improve quality and safety across the health system.

Key observations

- Primary Health Networks (PHNs) have received insufficient performance management to date, resulting in potentially inefficient spending of taxpayer funds allocated for primary healthcare. Such inefficiency is unacceptable when general practice is experiencing some of the most significant challenges in its history and struggling to remain financially sustainable.
- The Performance Management Framework (PMF) has been overly focused on the provision of services rather than ensuring these services reflect the needs of stakeholders and are delivering outcomes that are important to stakeholders. Patients deserve services that are not just accessible but also deliver substantial improvements to their health.
- The Department of Health and Aged Care (DoHAC) has not provided sufficient oversight of PHNs resulting in systemic governance issues and poorly managed conflicts of interest in some PHNs. Patients expect and deserve health services that have been commissioned based on best practice principles with their needs considered first, not the needs of those who profit from these services.

Recommendations

1. The PMF must move to indicators based on the delivery of outcomes rather than the provision of services. The community and primary care stakeholders of PHNs need to be involved in determining these indicators to ensure outcomes are meaningful.
2. PHNs need to be bound to mandatory governance processes and organisational structures to ensure consistent approaches to governance issues including conflicts of interest.
3. PHNs need to be regularly audited by government-appointed auditors to review services and ensure they are reflective of community needs and are meeting the PMF indicators.
4. Amend indicator O3 to require greater disclosure of specific advice provided by committees and how it was considered by the Board.
5. Amend the PHN Needs Assessment Completion Guide so PHNs are required to consult with the respective RACGP faculty and other relevant peak bodies when conducting a PHN Needs Assessment. This consultation must be based on the prevalence of health conditions and the presence of vulnerable demographics as indicated by population data. Consultation during the development of a PHN Needs Assessment must also foster better collaboration with hospital planning teams that often conduct separate Local Area Needs Assessments.
6. Amend indicator P4 to require at least one instance of high or moderate support being provided to general practice in the PHN's region. PHNs must be able to demonstrate how their support to general practice is based on the needs of local GP practices.
7. Amend indicator P9 to include all MBS items related to team care arrangements and case conferences to ensure high-quality multidisciplinary care for all patients, as coordinated by their GP.
8. Develop a new indicator to record increases in GPs credentialed to deliver focused psychological strategies to drive workforce capacity improvements for mental health treatment.

9. Develop a new indicator measuring the rate of hospital discharge summaries made available to GPs within 48 hours of their patient's discharge or adapt indicator P11 to measure this as well to promote better discharge processes after admitted and non-admitted care episodes (including outpatient care, emergency department care and day surgery) of public and private hospital services.
10. Develop a new indicator assessing measures taken by the PHN to improve the interface between primary and secondary healthcare with the aim of reducing potentially preventable hospitalisations and improving the flow of data and communications.
11. Amend O14 to include a requirement for formalised partnerships between PHNs, general practice representatives and hospital services to better guide local needs assessments, service prioritisation & planning, data sharing, transfer of care, clinical handover and integrated care initiatives. This also includes sharing key insights and evaluations of programs, including robust reasons for program extensions.
12. Include a mechanism in the PMF by which Aboriginal and Torres Strait Islander people confirm that services claimed to be culturally appropriate and/or safe actually are. Also, ensure consistent terminology in these indicators is established with cultural safety being the best term to use rather than cultural appropriateness.
13. Move beyond optional guidelines on how PHNs and ACCHOs work together and create mandatory standards for Aboriginal consultation and equitable involvement in commissioning.
14. An additional indicator should be created to measure how many practices in PHN's region have updated their details on the National Health Services Directory (NHSD) in the last 12 months.

RACGP feedback to ANAO consultation questions

Has DoHAC established a fit-for-purpose PMF for the PHN program?

While PHNs remain young institutions, the indicators they are currently required to meet set the bar too low and do not sufficiently drive or measure outcomes as per the quadruple aim.

A number of the current indicators in the PMF focus on measuring the number or rate of services being delivered by PHNs rather than the outcomes, both in the short and longer term, of these services. While the accessibility of services is important so patients do receive care, unless these services deliver clinically significant improvements in outcomes for patients, health practitioners and the health system more broadly, the funding could be better spent elsewhere. A risk in measuring service provision rather than the outcomes of services is that the target will incentivise low-value or ineffective services. Low-value services can often be implemented faster and at a lower cost than more complex high-value services, while still meeting the outlined requirements for service provision. As PHN funding does not roll over year to year, there can be pressure to roll out these sorts of rapidly commissioned services when approaching the end of the financial year to ensure allocated funding is spent rather than lost and government requirements are met. PHN programs also tend to be funded around short funding cycles. On the ground, GPs are frustrated by short two-year funding cycles. These short funding cycles make it hard to follow what services are active to refer patients to and participants often finish the program without sufficient time in the program to see results.

PHNs were established in 2015 and should now have moved beyond the stage where initiating and implementing programs is challenging. PHNs should now be sufficiently mature that they can be expected to initiate and implement complex programs without being driven by performance management. Instead, the focus of the PMF should shift to outcomes within PHN jurisdictions. A focus on outcome-based indicators would disincentivise low-value or inefficient services and incentivise funding towards services with the greatest likelihood to contribute to real-world outcomes. These outcomes should reflect the needs of the communities and primary care providers PHNs have been established to support. For example, Indicator P11 (Rate of discharge summaries uploaded to My Health Record) does not sufficiently reflect the type of outcomes GPs are seeking regarding hospital discharges.[1] The clinical handover from hospital to GP is a more complex process than the uploading of a document and greater reforms are needed to improve this process (being mindful that My Health Record does not have notification functionality and therefore is not a trigger for action).

GPs are much more concerned about the timeliness and reliability with which a discharge summary is provided, rather than whether it is uploaded to My Health Record. The timeliness of follow-up care after a hospitalisation can have a significant impact on patient outcomes. Patients who see their GP within 7 days of an unexpected hospitalisation are less likely to be readmitted within 30 days.[2] A preferred indicator would be "*Rate of discharge summaries provided to patient GPs within 48 hours*". This indicator would incentivise more timely and improved discharge processes allowing GPs to see discharged patients sooner with all necessary information for follow-up care.

Indicators are often too vague to appropriately hold PHNs to account. They are too easy to achieve and give significant flexibility for PHNs to portray their services as meeting the indicators. Indicator P4 (Support provided to general practices and other health care providers) is an example of an indicator that is too ambiguous.[1] The range of support categories in this indicator are broad enough to involve both high-level intensive support as well as cheap, low-level support such as running a workshop. This risks allowing PHNs to deliver more low-value or ineffective services to meet this indicator without delivering significant benefits to patients or GPs. Patients require a range of low and high-intensity services to support their health conditions and outcomes. GPs similarly require a range of support in their practices as different conditions or challenges require lower and higher levels of intervention, support and care coordination. When the PMF's indicators are reviewed, communities and primary care stakeholders need to be involved in these reviews to ensure revised indicators address their needs and priorities and will provide meaningful benefits. PHNs should also be required to demonstrate at least one instance of high or moderate support being provided to general practice in the PHN's region.

The areas PHNs support in indicator P4 are also extremely broad. This can force PHNs to divide their funding across so many different initiatives that the impact on primary healthcare services, and their patients in each initiative is limited or diluted. Allowing PHNs to focus on select areas that are closely associated with community needs could allow PHNs to have a greater impact on patient and service outcomes. To ensure accountability and ensure needs are addressed with the best available advice, PHNs should be required to seek advice from peak bodies relevant to the prevalent conditions and significant demographics in their region. Affected healthcare providers should also be given the opportunity to provide feedback on both the level and nature of support being provided and if it is having a meaningful impact on their work. Clinic-reported outcome measures could be an effective way to quantify this impact. PHNs should also be required to consult with the respective RACGP faculty and other peak bodies when they are conducting a PHN needs assessment which can be used to determine the PHN's approach to meeting this indicator. This requirement should be reflected in amendments made to the PHN Needs Assessment Completion Guide.

There are elements of the PMF that do not record and therefore identify GPs providing higher levels of care to patients who need it resulting in GPs not being recognised for their work by PHNs. Indicator P9 (Rate of GP team care arrangements/case conferences) only records a limited range of MBS numbers for team care arrangements and case conferences. These are mainly shorter items that may be inappropriate for patients with high levels of complexity or where more than three practitioners are involved. This indicator needs to be amended to include all MBS items related to case conferencing including new mental health case conferencing items to properly record levels of multidisciplinary practice in primary care.

PHNs have significant scope within a number of indicators to self-report their performance which could lead to biased portrayals of the services being delivered. PHNs have a strong interest in portraying their services in the best possible light rather than a more objective portrayal as their continued funding depends on meeting these indicators. Many of these indicators also lack external assessment. To ensure value for money, PHNs and their services must be regularly audited by government-appointed auditors to understand whether they are providing helpful support to health services and contributing to the PNH objectives. Without an objective and balanced assessment against appropriate indicators, it is impossible for the government to understand the actual performance and impact of PHNs. While using indicators that limit the potential for biased reporting such as patient/clinic-reported outcome measures, will be useful, the most effective solution is likely to be external, government-appointed auditing or assessment which will improve the independence and objectivity of performance management.

The current PMF has a range of indicators specific to Aboriginal and Torres Strait Islander health outcomes that are required to be culturally appropriate and culturally safe. Cultural safety is a matter of utmost importance for Aboriginal and Torres Strait patients and primary healthcare professionals. Culturally unsafe environments are directly tied to poor engagement with health services by Aboriginal and Torres Strait Islander people and high turnover of Aboriginal and

Torres Strait Islander staff.[3] The current PMF does not have a mechanism by which Aboriginal and Torres Strait Islander people confirm that services claimed to be culturally appropriate and/or safe actually are. Cultural appropriateness and safety are defined by the person receiving the services and specific cultural protocols are likely to vary between Aboriginal and Torres Strait Islander communities.[4] Confirming cultural appropriateness and/or safety cannot be standardised and can only be confirmed by Aboriginal and Torres Strait Islander people themselves. Any future PMF needs to provide a mechanism for Aboriginal and Torres Strait Islander people to be involved in the assessment of cultural safety and appropriateness whilst also ensuring data sovereignty and reciprocity while conducting these evaluations. The RACGP would also recommend consistent terminology in these indicators and would advise cultural safety is the best term to use rather than cultural appropriateness.

Has DoHAC effectively monitored and enforced compliance with PHN grant terms and conditions?

In recent years, the public perceptions of PHNs have been mired in controversy due to perceived conflicts of interest and poor governance. The North Queensland PHN faced public criticism and the resignations of two GPs from its Board after it was revealed that the North Queensland PHN's chair co-owned multiple pharmacies and stood to benefit as a result of the North Queensland Community Pharmacy Scope of Practice Pilot which the PHN had voted to participate in without being aware of this conflict of interest.[5] While an audit of the North Queensland PNH was conducted, the RACGP is disappointed that only a summary of the review has been released. A Gippsland PHN has also faced scrutiny after a $100,000 contract to provide after-hours health services to the bushfire-affected town of Mallacoota was awarded to a Sydney-based company to provide telehealth-only services rather than the town's own general practice.[6] To date, the affected communities have received insufficient transparency and assurances that conflicts of interest are being appropriately managed and decisions are being made with the community's interests at heart.

Those providing tenders to PHN commissioning processes receive insufficient information about why tenders are rejected and why successful tenders are rewarded. This is contributing to a culture of mistrust between GPs and PHNs who struggle to reconcile the role of PHNs in supporting GPs while continually finding their tenders rejected in favour of non-GP services. This mistrust has also grown because of a lack of accountability around the tendering process. Members of the RACGP have reported instances of their tender application being deleted without assessment with insufficient follow-up resulting in them being unable to submit a tender that was assessed and not knowing why their initial application was deleted. RACGP members have also reported some PHN boards are hostile towards GPs and are disinterested in engaging with them. GPs are also frustrated when staff changes result in changes to measures and requirements for existing projects making these relationships feel unpredictable. These cultural issues are difficult to quantify but present a significant challenge to the relationship between GPs and PHNs into the future.

Some of these conflicts of interest are inherent to the PHN model and will be particularly hard to resolve, especially in rural and remote areas. PHN membership is made up of representatives from health services within the PHN catchment and this membership elects the Board of a PHN. The health services these representatives work in are eligible to bid for contracts commissioned by PHNs, creating conflicts of interest amongst Board members representing these organisations. This risk is potentially manageable, similar issues are managed by many organisations in a variety of contexts. However, it becomes a risk that is difficult to manage when the member organisation is genuinely one of the few, or the only organisations in the area capable of running the service being commissioned to a sufficient standard as can be the case in rural and remote areas. PHNs have often been left to develop their own constitutions and governance processes, meaning there is no consistency in how this issue is being addressed. Reform is necessary to ensure PHNs are transparent in their decision-making processes and conflicts of interest are appropriately managed. To ensure consistency across PHNs, they should be bound to mandatory governance processes and organisational structures to ensure consistent approaches to governance issues, including conflicts of interest.

There is significant scope to improve the transparency of PHN performance and decision-making. While these are independent not-for-profit organisations, their decisions are made with the money of Australian taxpayers and seek to address government priorities. As such, the public has a right to know how their money is being spent and whether their government is appropriately responding to the needs and concerns of the public. The government does not release adequate levels of data on PHN performance which has contributed to widespread confusion and mistrust around the

role of PHNs and their performance. The government must make PHN performance data public to give patients trust that health funding is being spent appropriately.

The current PMF allows PHNs to self-report how they have complied with many of the indicators. This gives PHNs significant scope to frame their services and performance in the best light and to meet indicator targets. There are few external mechanisms by which PHNs are independently assessed or audited to gain an independent perspective. While Community Advisory Councils provide an opportunity for communities and stakeholders to provide feedback regarding PHN commissioned services, their role and influence within PHNs vary within each PHN's individual structure. The future PMF needs to ensure a more independent assessment of PHNs. Rather than allow self-reporting, there are additional opportunities for communities and stakeholders to provide feedback on a PHN directly to government and independent assessors. The role of Community Advisory Councils must also be more consistent across PHNs, with PHNs being required to show how they have acted or not acted on Community Advisory Council advice. One measure to begin to address this issue would be to bring greater scrutiny to Indicator O3 (PHN Board considers input from committees). Currently, to meet this requirement, each PHN only needs to provide a list of the PHN committees and a short statement explaining how the Board considers input from them. This indicator needs to be amended to require much greater disclosure of discussions between PHN committees and the Board and how the Board's work has responded. Requiring the production of both the committee and Board meeting minutes along with process feedback from advisory committees/councils would go a long way in revealing whether the opinions from committees had been properly considered in Board decision-making.

Has DoHAC demonstrated that the PHN program is meeting its objectives?

Improved coordination of care is an objective of the PHN program but it is an area in which the Australian health system continues to experience significant fragmentation and poor communication. Hospitals routinely provide inadequate discharge summaries which often take longer than 5 working days to be provided to a GP (and many hospital discharges still occur without any clinical handover documentation to the GP).[7] Many GPs face bureaucratic hurdles when they refer patients to hospitals through named referrals and hospital-specific templates.[8] While multidisciplinary care is often seen as best practice, it is rarely achieved effectively on the ground. Patients still must navigate the various health services themselves with little communication or coordination between them despite the best efforts of their regular GP. Even services commissioned by PHNs are reported to poorly communicate with the GPs of participating patients. These practices are continuing almost 10 years into the operation of PHNs.

PHNs need to capitalise on opportunities to improve the flow of data between hospitals and general practice and help the health system move towards a 'one patient, one chart' model. PHNs need to better leverage their position as an intermediary between primary and secondary health stakeholders to reduce bureaucratic hurdles for GPs when referring and establish discharge processes that provide adequate information to GPs faster so they can take over care once their patient is discharged from acute care settings. This includes discharges and clinical handover after admitted care but also after non-admitted hospital care. Analysis of GP referral patterns would be useful to facilitate better-targeted health service delivery and general practice support. The RACGP recommends this be driven by a new indicator in the PMF assessing how the PHN is working to improve the interface between primary and secondary healthcare. Collaboration and integration cannot occur optimally without a formalised partnership which includes agreement about shared goals and co-designed/co-commissioned initiatives based on local area needs. At present there is no requirement for coordination with state hospital and health services, or requirements to strengthen the governance framework across the primary and secondary care interface, progress with regard to care integration has been disappointingly slow over the past decade. Improving this governance framework could be incentivised through amendments being made to O14 and P2 to become more 'outcome-oriented'. An area of interface improvement not discussed in the PMF is the maintenance of the NHSD. This Directory is a key resource for hospitals and other areas of the health system in coordinating the care of patients. Out-of-date details in the NHSD can be a significant driver of missed discharge summaries and other interface difficulties. An additional indicator should be created to measure how many practices in PHN's region have updated their details on the NHSD in the last 12 months.

Better collaboration between PHNs and GPs has significant potential to deliver on the objectives of PHNs. Australians see GPs more than any other health profession - 80% of Australians have a usual GP and 90% have a usual practice.[9]

GPs treat a patient's whole being across their lifespan and provide cost-effective care that keeps people out of the hospital. GPs are the backbone of Australia's primary health system. Significant reforms to primary care cannot be achieved without closely working with GPs. Despite this, many PHNs have had a poor relationship with their region's GPs which has impacted their ability to meet the objectives of the PHN program. Insufficient funding has been provided to PHNs for GP engagement, making it difficult for PHNs to have a meaningful impact on general practice. This limited funding is often spread thin by PHNs trying to address numerous government priorities and community needs with limited resources. Additional funding needs to be provided to achieve meaningful engagement with GPs. This funding must also be tied to clear KPIs to ensure efficiency and limit how diluted this funding becomes. The RACGP argues PHNs need to be required to consult with the RACGP faculty for their state or territory when conducting a needs assessment for their region to ensure the needs of general practice are given a voice. Hospitals frequently conduct their own local area needs assessments, often with limited collaboration between hospitals, PHNs and general practice. This is another area of opportunity to improve collaboration between PHNs and hospitals and reduce duplication.

PHNs deliver a range of services and programs every year, often seeking to address government priorities but rarely in cooperation or synergy with government programs. The provision of so many different programs seeking to address the same issues leads to inefficiencies and duplication which could be reduced if PHN services become better aligned with government programs. The incoming MyMedicare program will be seeking to target frequent hospital users to deliver better and more coordinated primary care to prevent these patients from returning to the hospital. This also aligns with the PHN's priority to reduce potentially preventable hospitalisations. Synergy could be achieved by using practices receiving MyMedicare Frequent Hospital User Incentive payments as a PHN indicator to drive PHNs to promote the scheme and support its implementation across general practice.

Members of the RACGP who have been involved with PHN-run services have expressed concerns about the ability of DoHAC to effectively manage changing PHN contracts in a timely, efficient and effective manner. This leads to the commissioning of services and providing the associated contracts are often short-term in nature, often only lasting around 24 months. The short-term nature of these contracts is made more complex by the delays of the DoHAC to renew and re-contract (either by tender or variation) and the changing priorities that influence what these short-term contracts are funding. These changing priorities are rarely determined by community needs. Much more often they are the result of changing strategic and political priorities within DoHAC and the federal government. This leads to the specific services offered by PHNs, including the commissioning of services and the needs services are expected to address, changing so frequently that GPs cannot keep track and disengage from PHNs. GPs on the ground are frustrated by PHNs being obligated to work to the strategic and political whims of the federal government rather than the needs of local GPs. Bureaucracy within the DoHAC around changing contracts is also inefficient and ineffective in delivering better outcomes for the commissioned services. Short funding cycles further compound the issue requiring bureaucracy around contracts be facilitated frequently, the services operate with uncertainty with flow-on effects to the workforce and patient outcomes.

Aboriginal and Torres Strait Islander people are identified as a priority area for targeted work by PHNs to improve the efficiency and effectiveness of medical services. Aboriginal Community Controlled Health Organisations (ACCHOs) have a long track record of being effective and the preferred providers of health services by Aboriginal and Torres Strait Islander people.[10,11] Their unique structure has been described as a best practice example of the implementation of the right of indigenous peoples to self-determination which has implications for Aboriginal and Torres Strait Islander health, social and emotional wellbeing and reconciliation.[12] PNHs have been found by ACCHOs to insufficiently consult and collaborate with them and have failed to provide them with adequate resourcing to serve their Aboriginal and Torres Strait Islander populations.[13] The PHN model also functions hierarchically, with PHNs being placed above ACCHOs as ACCHOs must apply to the PHN for funding who take their direction from the government, thereby undermining the self-determination of Aboriginal and Torres Strait Islander communities.[13] The government must move beyond optional guidelines on how PHNs and ACCHOs work together and create mandatory standards for Aboriginal consultation and equitable involvement in commissioning.

The RACGP acknowledges the diversity of performance amongst the 31 PHNs. While some PHNs have come under scrutiny and remain the subject of criticism, there are also PHNs who perform exceptionally well and drive quality and efficiency improvements in primary health. The RACGP also acknowledges the limitations faced by PHNs where state governments and other stakeholders may be reluctant to engage with PHNs or primary care more broadly. The DoHAC

needs to bring in requirements for partnerships and funding arrangements with other health jurisdictions that they collaborate and work with PHNs to start relationships that can become self-sustaining in time.

Further comments on primary care funding

The PHN program was founded on the sound theory that people working closer to where healthcare is delivered are in the best position to decide how health funding should be spent. Such a model is important when primary care is funded federally, and decision-makers can be far removed from the local general practices their funding decisions affect.

Every layer of bureaucracy between federal funding and the on-the-ground recipients is an additional layer of complexity that costs money to operate, delays funds reaching on-the-ground services and risks still not delivering what patients and GPs inherently need. When PHNs are obligated to meet targets based on government priorities, this forces them to focus on those priorities rather than what patients in their region may be seeking, resulting in funding and services that aren't patient centred. PHNs are best placed to facilitate collaboration and integration between health stakeholders rather than solely facilitating funding. To maximise funding available for services and streamline the process of funding provisions, it is the RACGP's preference that funding be provided directly to GPs and general practices wherever possible rather, than through intermediaries like PHNs. While short-term funding has its role, more funding arrangements should be moved to the medium to long term to provide stability for patients and GPs.

It is worth considering how PHNs are addressing the issues that their predecessors, Divisions of General Practice, were established to address, namely:

- A lack of voice in planning.
- A lack of structure to involve GPs at a local level.
- Poor links between GPs and other health care providers.
- A diminished role in hospitals.
- Urban oversupply and rural shortages.
- Inappropriate financing mechanisms, particularly the lack of financial support for GP involvement in preventive care, health promotion, teaching, and quality assurance activities.

Despite over $1 billion currently being spent on PHNs annually and the previous operation of Divisions of General Practice, Medicare Locals and PHNs over the course of 30 years, these issues remain substantively unaddressed.[14,15] Surveys of GP's attitudes towards PHNs vary significantly between regions. Some GPs regard them as intrusive and unhelpful, while others find their work to be invaluable, with some still having no relationship with their PHN and being unsure of their role and what services they provide.[16] Many GPs find their PHN has little understanding of the business elements involved in running a general practice, resulting in their programs ineffectively supporting general practice. GPs are reluctant to make such opinions public as they fear PHNs may stop providing funding for their service. Currently, 40% of GPs list maintaining their income as one of their three biggest challenges.[17] The RACGP argues that addressing these issues requires working with GPs at a local level. To progress work in this area, considerations need to be made regarding whether the core model of these organisations has delivered value for money. Any review or evaluation of the PHN model should consider significant structural changes that could deliver a greater impact on these issues with increased value for money and better outcomes for the patients that PHNs serve.

Additional opportunities exist to drive upskilling of the general practice profession through PHNs. For the last six years,-- GPs have reported mental health issues as the most common reason for patient appointments with an estimated 38% of all consultations having some mental health component.[18] Mental health is also a priority area for the PHN program.[1] Once they meet the credentialing requirements, GPs are able to deliver a range of effective therapeutic interventions for anxiety, depression and post-traumatic stress disorder, for example through Focused Psychological Strategies (FPS) including cognitive-behavioural therapy, relaxation strategies and Eye-Movement Desensitisation Reprocessing. Currently, only 3.5% of GPs are accredited in FPS.[18] Improving the skills of GPs in the management of mental health conditions and their treatment would improve outcomes of a significant number of GP consultations while increasing access to treatment for mental health conditions. The RACGP recommends creating a new indicator to record the number of GPs who are credentialed to deliver focused psychological strategies in a PHN's region to drive upskilling and improved delivery of essential mental health care.

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