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Royal Australasian College of Physicians (RACP) 2026–27 Pre-Budget Submission to the Australian Treasury

November 2025

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 21,000 physicians and 9,000 trainee physicians, across Australia and Aotearoa New Zealand.

The RACP represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, infectious diseases medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine.

Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients and the community.

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We acknowledge and pay respect to the Traditional Custodians and Elders – past, present and emerging – of the lands and waters on which RACP members and staff live, learn and work. The RACP acknowledges Māori as tangata whenua and Te Tiriti o Waitangi partners in Aotearoa New Zealand.

Introduction

The Royal Australasian College of Physicians (RACP) provides this 2026–27 Pre-Budget Submission to the Australian Federal Treasury to call for immediate investment across the health system to meet the challenges facing the physician workforce in providing, and the community accessing, specialist health care.

The measures we propose are targeted, prioritised and respond directly to several pressing issues: increasing physician workforce maldistribution, workforce distress, burnout and retention challenges, patient access barriers; rising hospital demand driven by preventable disease; inefficiencies in medicines regulation; and the limitations of the Medicare system.

Each of our recommendations offer a practical, evidence-based solution to strengthen system performance, reduce avoidable costs, and ensure that reforms translate into better outcomes for communities.

Getting physicians to where communities need them

Access to physician care remains inequitable across Australia, particularly for people with complex chronic conditions, regional, rural and remote communities, Indigenous communities and other communities facing a shortage of physicians and physician trainees.

Access barriers to physicians build up pressures on overstretched GPs and hospitals, and in turn on the Commonwealth under its National Health Reform Agreement commitments.

In 2023-24, 28.6% of people reported waiting longer than they felt acceptable for a medical specialist appointment, more pronounced amongst females, young adults (25-34 years), people living in areas of most socio-economic disadvantage and patients with a long-term health condition.[1]

It is imperative that we facilitate physician care in communities and for patient groups that have urgent health care needs.

Pipelines for getting physicians and trainees into communities remain inadequate, particularly where there are high unmet needs and rising patient demand.

The lack of robust, centralised and up-to-date national physician workforce planning data continues to act as a barrier, limiting ability to identify the appropriate number, mix and distribution of physicians and trainees required to meet the health care needs of communities most at risk of complex disease.

We call on the Australian Government to:

- Fast-track supply and demand studies of RACP specialties critical to meeting unmet health care need in Indigenous communities, such as:
  - Nephrology
  - Endocrinology
  - Oncology.
- Strengthen the Specialist Training Program (STP):
  - Increase the number and flexibility of STP places, fund longer term contracts, and expand program investment in MMM areas 2–7
  - Expand posts outside hospital settings, particularly in Aboriginal Community Controlled Health Services and community practice settings (which offer important training opportunities not available in hospitals and supports increased access to care)
  - Expand existing loadings and allowances to further support supervisors and trainees in rural settings.
- Fund the RACP to develop enhanced support arrangements for Specialist International Medical Graduates (SIMGs), particularly those working in regional, rural and remote areas.

Supporting and growing rural physician care

Concerted, co-ordinated efforts are needed to improve access to physician care across regional, rural and remote communities.

The latest AIHW Rural and remote health report shows that the distribution of GP services and many other primary health providers increases with increasing rurality and remoteness, while physicians and medical specialists remain low outside major cities.[2]

Despite important increases in distribution of primary care services beyond our cities, statistics continue to reveal stubbornly worse health outcomes for the 28% of our population living in these areas, including higher rates of hospitalisation, preventable illnesses, death and injuries.[3]

In tandem with improved access to primary care, our rural, regional and remote communities also require expanded physician services to meet their health care needs..

The need for physicians and physician trainees beyond our cities is intensifying as the scope of practice for primary healthcare practitioners expands, including for Rural Generalists across paediatrics, internal medicine, and palliative care. While these developments strengthen local health care capability, they underscore the need for close, reliable access to specialist physician input, consultation pathways, and ongoing collegial support when and where needed. Physician input to rural health teams provides necessary support to GPs and rural generalists managing increasingly complex presentations.

Attracting and retaining physicians beyond our cities is a persistent challenge as high relocation costs, limited community supports, limited incentives, and fragmented national workforce planning act as deterrents. For trainee physicians, unpredictable placements, relocation burdens, and limited structured pathways that align training with community health care needs remain barriers.

The RACP *Rural, Regional and Remote Physician Strategy*[4] sets out what the College is doing to support training, recruitment, and retention of the physician workforce outside our cities to strengthen training pathways, foster local leadership, and build sustainable models of care.

Coordinated national investment which recognises the central role of the physician workforce in achieving rural health equity will help ensure all Australians can access expert health care, no matter where they live.

We call on the Australian Government to:

- Expand and sustain funding for the Support for Rural Specialists in Australia (SRSA) program by investing $3 million annually to enhance the capacity to meet demand.
- Provide comprehensive relocation support to assist physicians and physician trainees in regional, rural and remote areas by establishing a National Relocation and Retention Fund to cover key costs such as travel, housing (including bridging accommodation), childcare, partner employment support, community integration and long-term settlement.
- Reform remote area tax concessions, such as the Zone Tax Offset, so they reflect current living costs and workforce needs, to provide improved incentives to attract and retain the physician workforce, broadening them to include Modified Monash Model (MMM) 3+ locations where workforce shortages persist.
- Develop a national rural health workforce planning framework informed by robust data and community input to guide integrated and equitable workforce distribution, align training and funding with local needs, and support a sustainable rural health workforce.

Keeping physicians and trainees healthy

Data over recent years continues to show growing distress and burnout among physicians and trainees.

The 2025 Australian Salaried Medical Officers Federation (ASMOF) National Doctors Survey[5] found that only 1 in 4 hospital doctors reported being treated with respect, 75% felt unable to raise workplace concerns safely, and most indicated discrepancies in understandings of the causes of burnout in hospital administrative systems.

Similarly, the 2024 Medical Board of Australia and Ahpra Medical Training Survey[6] found one third of trainees (33%) reported having experienced or witnessed bullying, discrimination, harassment, sexual harassment or racism, spiking to 54% of Indigenous trainees and 44% of interns. Around 70% of trainees reported this impacted negatively on their training.

Despite these troubling trends, there is no consistent, co-ordinated national mechanism to monitor both physician and trainee physician wellbeing. No body currently provides comprehensive longitudinal data to inform physician workforce planning or targeted interventions. This evidence is essential to identify risks, prevent workforce loss and ensure sustainable hospital capacity.

We call on the Australian Government to:

- Fund an annual national survey and report on the wellbeing of all medical practitioners, delivered through an organisation such as Drs4Drs or Ahpra.

Enhancing medicine shortage monitoring and regulatory capacity

Australia's physicians and patients continue to be impacted by fragmented medicine data infrastructure, particularly constrained regulatory capacity for medicines surveillance, monitoring and supply prediction.

Systems that underpin safe, equitable, and efficient medicine prescription in medical practice have not kept pace with the increasingly complex care needs of patients and the information that physicians need.

We welcome recent upgrades to the TGA's Medicine Shortage Alert System[7] [8], enhancing timeliness and accessibility of information for physicians and patients. However, these welcome developments are just the beginning of what is needed to create an integrated, national system capable of predicting, mitigating and transparently managing medicine shortages before they disrupt health care delivery.

Urgent attention is also required to strengthen surveillance and data integration in prescribing practices, particularly in areas of rapid growth and increased risk, such as broadening stimulant prescribing for attention deficit hyperactivity disorder (ADHD) in primary care.

Our medicines surveillance and reporting systems must become capable of integrating national dashboards for prescribing trends, medicine demand, and supply integrity in real-time for continuity of care. This supports patient safety and equitable access to essential medicines across Australia.

We call on the Australian Government to:

- Fund National Real Time Prescription Monitoring data integration to support national evaluation of prescribing changes, e.g. GP stimulant prescribing for ADHD.
- Fund the TGA Medicines Shortage Reform Program[9] including:
  - Critical data and digital infrastructure improvements, data sharing systems for improved monitoring and prediction of potential medicine shortage, distribution and supply issues
  - Better access to shortages information for healthcare professionals
  - Better sponsor predictions on medicine demand and shortages.

Medicare to support complex and coordinated care

Medicare reform has advanced in recent years through Strengthening Medicare[9] and the Primary Health Care 10 Year Plan (2022-2032)[10] centred on general practice and allied health services. However, there is now a critical need to focus on Medicare reform to support patients accessing the physician care they need, particularly for increasingly complex, chronic conditions.

While Medicare recently introduced 60-minute (Level E) GP consultations, recognising the necessity of longer appointments to meet the needs of patients with complex presentations[11], the same need exists for patients seeing physicians who are seeing more patients with a wide range of complex conditions.

Medicare's current structure continues to constrain the time and multidisciplinary coordination that complex care requires.

An effectively designed Medicare system must enable support for patient consultations, but also liaison between physicians and others involved in the patient's care, even when the patient is not present.

For effective management of patients, coordination between physicians, GPs, allied health professionals, community services, schools, and workplaces is often required. This principle, already reflected in Medicare's Voluntary Patient Enrolment model, must be extended to physician care.

Physicians also face growing challenges in navigating Medicare in a time-sensitive quality-assured way while balancing the practicalities of patient care. The complexity of item specifications, coupled with inadequate and inconsistent guidance compounds compliance risk and puts unnecessary administrative strain on physicians.

This strain is felt acutely by new physicians learning the Medicare item and claiming process, for which they have often had limited or no education or preparation.

Physicians and physician trainees need support to confidently and efficiently use the Medicare system, particularly given increasing numbers of patients with high and complex health care needs.

We call on the Australian Government to:

- Introduce Medicare loadings for regional, rural and remote specialists to address workforce maldistribution and access barriers.
- Include physicians in costings frameworks and funding arrangements for the new MBS patient-end-support items to be introduced on 1 March 2026.
- Fund additional physician MBS items which reflect the additional time required to appropriately care for patients with multiple comorbidities or a complex condition, for example, children and their families.
- Amend MBS physician case conferencing items to allow necessary liaison with non-health practitioners (e.g. schools, workplaces, service support providers).
- Fund comprehensive MBS compliance and claiming tools for medical professionals and physicians in coordination with medical colleges:
  - Enhance AskMBS with interactive applications, decision support resources and case studies
  - Develop e-learning modules, webinars and seminars
  - Introduce point of claim software to help reduce misunderstandings about what can be claimed.
- Fund development of new collaborative models of care involving physicians, GPs and other health professionals and support expansion of successful models, e.g. Aboriginal Community Controlled Health Services models of care.

Investment in preventive healthcare is critical

There is a critical need for sustained investment in preventive healthcare in Australia, particularly for the growing prevalence of serious preventable health conditions.

This absence places onerous pressure on our hospitals and contributes to challenges in accessing health care from physicians and other healthcare providers in the community.

Investment in preventive healthcare support disease incidence reduction.

After years of delayed action on key national prevention strategies, immediate, sustained investment in prevention will prevent avoidable hospital admissions and support improved access to healthcare in the community.

This investment would deliver tangible benefits to communities and reduce government expenditure over the long-term.

We call on the Australian Government to:

- Fund the Productivity Commission recommended *Prevention Investment Framework*[12] to reduce the incidence of preventable disease in the community, overall pressure on our hospitals and other physician work settings.

Conclusion

The RACP welcomes this opportunity to provide the Australian Government with funding advice to advance practical, evidence-based measures that strengthen the healthcare system and support the wellbeing of physicians, trainee physicians and patients. The priorities outlined in our submission respond to urgent and emerging pressures on the nation's healthcare system, the physician workforce, the sustainability of hospital care, and the resilience of our prevention, medicines, and Medicare systems.

Our proposals aim to deliver measurable benefits for communities while reinforcing the Federal Government's broader health care reform and fiscal objectives. We warmly invite the Federal Government to engage with us as a willing and informed partner to refine, implement and evaluate these initiatives.

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References

[1] Australian Bureau of Statistics. *Patient Experiences, 2023-24 financial year*, November 2024 [online]; Patient Experiences, 2023-24 financial year | Australian Bureau of Statistics

[2] Australian Institute for Health and Welfare (AIHW), *Rural and Remote Health*, April 2024 [online]; Rural and remote health - Australian Institute of Health and Welfare

[3] *Ibid*

[4] Royal Australasian College of Physicians (2023), *Regional, Rural and Remote Physician Strategy*, June 2023 [online]; https://www.racp.edu.au/docs/default-source/about/college-council/regional-rural-and-remote-physician-strategy.pdf

[5] Australian Salaried Medical Officers Federation (ASMOF), *National Doctors Survey 2025: Key Findings* [online]; National Doctors Survey Confirms Widespread Dysfunction

[6] Medical Board of Australia and Ahpra, *Medical Training Survey 2024 Report* [online]; National report 2024

[7] Royal Australasian College of Physicians (2024, *Medicine shortages in Australia – Challenges and opportunities*, submission to the TGA, March 2024 [online]; racp-submission-to-the-tga-on-medicines-shortages-in-australia.pdf

[8] Therapeutic Goods Administration 2025, 'What's changed on the website?', October 2025 [online]; What's changed on the website | Therapeutic Goods Administration (TGA)

[9] Australian Department of Health, Disability & Ageing, 'About the Strengthening Medicare Measures', 2025 [online]; About the Strengthening Medicare measures | Australian Government Department of Health, Disability and Ageing

[10] Australian Department of Health, Disability & Ageing, *Future focused primary healthcare: Australia's Primary Health Care 10 Year Plan 2022-2032,* 2022 [online]; Australia's Primary Health Care 10 Year Plan 2022–2032 | Australian Government Department of Health, Disability and Ageing

[11] MBS Online, 'Introduction of new Level E consultation items lasting 60 minutes or mote', 13 October 2023 [online]; MBS Online - Introduction of new Level E consultation items lasting 60 minutes or more

[12] Services Australia, *Budget 2025-26,* March 2025 [online]; Strengthening Medicare