About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of 20,449 physicians and 9,480 trainee physicians, across Australia and 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.

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) welcomes the opportunity to provide a submission to inform the Mid-term Review of the National Health Reform Agreement (NHRA) Addendum 2020-2025 (the Review). We are also thankful for the opportunity to provide input to the Review via an interview. This written submission complements the feedback provided during the interview.

RACP members are physicians who work in hospitals, private practice and in the community. They play an essential part in delivering high quality hospital and community care and are trained to care and treat patients with complex illnesses and presentations in collaboration with general practitioners, nurses and allied health professionals.

As outlined by the Minister for Health and Aged Care, The Hon Mark Butler MP, when he announced the Review, the NHRA governs the funding and delivery of public hospital services in Australia. The NHRA is an agreement between state and territory governments with the Commonwealth which runs from 2020 to 2025 and this Review is independent and has been commissioned by all Australian Health Ministers.

The Review presents an important opportunity to assess whether the objectives set out in the NHRA Addendum to “improve health outcomes, access and innovation – are being met and, in particular, whether the Addendum’s health funding, planning and governance architecture is fit-for-purpose, given emerging priorities for better integrated care and more seamless interfaces between health and primary care, mental health, aged care and disability systems.”

Importantly, the NHRA Addendum also sets out some long-term health care reform principles that state and territory governments and the Commonwealth have agreed to. This submission focuses on the principles of improving efficiency, ensuring financial stability, prioritising prevention and helping people manage their health.

Feedback on the NHRA Addendum
The RACP supports the objectives and long-term health care reform principles outlined in the NHRA Addendum to improve the health of all Australians. These align broadly with the RACP’s own recommendations to Government to enhance the health and wellbeing of all Australians. However, we are concerned that in its current form, the NHRA is not well equipped to meet its ambitious objectives because it lacks detail on governance and accountability, the best ways to fund and prioritise prevention and to deliver innovative funding and care models.

The Australian health care system faces pressing challenges which require significant commitment and investments from all levels of government.

Sustained, strategic and appropriately resourced system-wide reform of the health and social care sectors has been at the centre of ongoing attempts to address the persistent challenges in delivering high-quality healthcare and bring about more effective and efficient care that meets the needs of the Australian community. Whilst the challenges to achieving such outcomes are well known, the implementation of potential responses has been lagging. These pressing challenges include:

- Increasing demand for health services: Australia’s population is growing and ageing, which is leading to increased demand for health services. This is placing pressure on the health system, particularly in areas such as aged care and chronic disease management.
- Rising healthcare costs: healthcare costs are rising due to factors such as rising practice costs, advances in medical technology, an ageing population and an increase in chronic disease. This is putting pressure on the sustainability of the health system and increasing costs for patients.
- Health workforce shortages: there are shortages of healthcare professionals in certain areas and certain specialties, particularly in rural and remote areas of the country. This can lead to reduced access to healthcare services for some Australians.
- Health inequalities: there are significant health inequalities in Australia, with some groups experiencing poorer health outcomes than others. This includes firsts Australians, people living in socioeconomically disadvantaged areas and those with a disability.

3 Correspondence from Independent Reviewers, Rosemary Huxtable PSM and Michael Walsh PSM to the RACP.
• Fragmented care: the Australian health system is fragmented, with different levels of government responsible for different aspects of healthcare. This can lead to gaps in care and a lack of coordination between different providers.

Health reform and system integration can be conceptualised in a range of ways, but it is broadly agreed that their essential elements are:\(^5\)

- Patient-centeredness, including change in provider, funder and policy maker mindset; improved health literacy; access to relevant information and high-quality services and choice; self-management and shared decision making.
- Seamless lifetime care delivered through strong linkages across the health care system and beyond; a team ethos across clinical and administrative domains; incentivising efficient, patient-centered quality care; access and effective use of data; clear governance and accountability arrangements and appropriate allocation of funding, time and staff.
- Dynamic efficiency underpinned by innovation, including through enhanced use of technological enablers; data-driven learning systems to guide targeted policies and interventions and embedding evidence-based practice across the system.

Successfully implemented, these elements are likely to result in improved healthy life expectancy for all Australians, effective prevention and management of disease, better and more equitable patient outcomes from interventions, patient empowerment and positive patient experience, as well as value for money.

**The NHRA must include a clear accountability mechanism.**

To truly fulfil its objectives, the NHRA needs clear guidelines and a set of guiding principles to enable effective communication between national, state and local level.

We recommend that the NHRA Addendum provides a clear written framework for the responsibilities of each of the national, state and local levels. This is the only way to ensure effective and accountable governance and to make certain that each entity is fulfilling its complete responsibilities. Medical professionals and consumers need to be involved in developing this framework and it is essential that this process be made transparent to all stakeholders.

The framework development process needs to ensure that health professionals and patients are involved and consulted from the beginning as they have ‘hands on’ experience of the healthcare system. Surveying patients regularly, particularly those in underserved First Nations and rural communities, would be beneficial. It would be also prudent to undertake regular workforce surveys and account for their findings in policy-making decisions.

**Governments at all levels need to make prevention and health equity a priority by funding and implementing the National Preventive Health Strategy 2021-2030.**

As stated in the introduction, the NHRA’s key purpose is to govern the funding and delivery of public hospital services in Australia. Given this focus on hospital services, it could be argued that it is not the most appropriate mechanism to achieve one of its key long term-health care reform principle: *Prioritising prevention and helping people manage their health across their lifetime, including long-term reforms in empowering people through health literacy and prevention and wellbeing.*

While the NHRA acknowledges prevention as a key pillar to improve the health of all Australians, it continues to be significantly underfunded at all levels of government.

In 2022, Australians lost 5.5 million years of healthy life from chronic illness or dying prematurely; disability free adjusted life years were reduced on a national level for the first time. The non-fatal burden of disease has now overtaken the fatal burden as the largest contributor to the overall burden of disease.\(^6\) Around 38% of all disease in Australia is preventable through modifiable risk factors, with alcohol consumption, smoking, overweight and obesity the top long standing drivers of preventable disease.\(^7\) Approximately $38 billion per year is spent by governments in Australia for management of preventable diseases, adding to an

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\(^5\) Productivity Commission Supporting Paper No. 5: Integrated Care, 2017

\(^6\) Australian Burden of Disease Study 2022 (aihw.gov.au)

\(^7\) Australian Burden of Disease Study 2018: Interactive data on risk factor burden, About - Australian Institute of Health and Welfare (aihw.gov.au)
estimated annual economic productivity loss of $40 billion. Higher avoidable morbidity and mortality rates exist in First Nations communities, rural, regional and remote communities, as well as among lower income households. Colonisation, racism and discrimination have had catastrophic effects for First Nations communities, with these communities having shorter life expectancy, higher overall rates of morbidity, infant mortality, chronic illness, and lower levels of education and employment, as well as unacceptably high rates of youth and adult incarceration.

First Nations children born between 2015-2017 are expected to live 71.6 years (male) and 75.6 years (female) compared to 80.5 years (males) and 84.6 years (females) per the national average. First Nations communities also live less years in full health. Prioritising prevention is thus a key tool to addressing the inequities that persist in the Australian health system and beyond.

To do so, the Australian Government and jurisdictions need to fully fund and implement the National Preventive Health Strategy and the design and implementation of a sustainable and well-funded upcoming Centre for Disease Control (CDC) which will have a significant role to play in prevention and addressing the social determinants of health. We welcome the Australian Government’s commitment to establish a CDC which takes an all-hazards approach to disease control, addresses the social and wider determinants of health and climate change and health, takes the One Health approach to controlling disease and has a clear focus on equity. Each of these principles have long informed the RACP’s policy and advocacy work.

For Australians to enjoy the highest possible standard of health and wellbeing, allocation of health resources must be prioritised according to the principles of equity and need, delivered through a well-designed and funded, responsive, culturally safe health system. We welcome the Australian Government’s recent commitments to improve First Nations health and develop the First Nations health workforce, expand child health and education, and care for elderly Australians and people living with a disability, all well aligned with the RACP’s longstanding advocacy goals.

However, in the interest of progressing the goals of health equity and prevention we express concern for the lack of progress against most Closing the Gap health and wellbeing targets. The RACP stands prepared to work with governments to implement the National Aboriginal and Torres Strait Islander Health Plan 2021-2031, noting that preconditions to its implementation include sufficient funding, fit-for-purpose MBS items for chronic disease management in First Nations communities and an adequately sized and distributed First Nations health workforce. For a full list of prevention and equity-related recommendations included in our recent pre-Budget statement, please see Pathways to wellbeing: enhancing the health and wellbeing of all Australians.

At this stage of the review it remains unclear whether the NHRA Addendum which governs the funding and delivery of public hospitals in Australia is the most appropriate framework to ensure prevention is prioritised.

Well-designed funding and care delivery models will drive best practice multidisciplinary care. As outlined in the RACP Discussion Paper titled Integrated Care – Physicians supporting better patient outcomes, appropriate funding and payment models must be used to support models of team-based integrated care. Innovative approaches to funding and payment emphasise managing patient populations and overall health, compared with methods of the past that have been based more on transactions for distinct episodes of care and focused solely on the direct interaction between the patient and clinician.

Whilst the fee-for-service payment model is very effective to support patient access to an important range of health care services, it is primarily best suited to care that is acute, clearly defined and time-limited. However, where the health need is ongoing, complex, multi-faceted and changing, then a pay-for-performance or value-based funding approach can offer advantages, whether in addition to or replacing the fee-for-service model.

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8 Crosland et al, the economic cost of preventable chronic disease in Australia: a systematic review of estimates and methods, Australian and New Zealand Journal of Public Health, 43 (5), 2019
8 Deaths in Australia. Variations between population groups - Australian Institute of Health and Welfare (aihw.gov.au)
9 Indigenous health and wellbeing - Australian Institute of Health and Welfare (aihw.gov.au)
10 3302.0.55.001 - Life Tables, States, Territories and Australia, 2015-2017 (abs.gov.au)
11 Indigenous health and wellbeing - Australian Institute of Health and Welfare (aihw.gov.au)
To enable more healthcare services to be provided in community-based settings and to support multidisciplinary teams and enable effective shared patient care, there is a need for Australia to move away from the current dominance of fee-for-service in funding healthcare.

The RACP has consistently raised limitations with fee-for-service payment systems that restrict more integrated multidisciplinary care; for example, fee-for-service payments can be deficient in cases where patients have complex or long-term chronic issues. There is clear scope to better incentivise responses to changing patient needs by reorienting the MBS to better support ongoing, coordinated care provided by a multidisciplinary health care team.\textsuperscript{14}

Future Funding and payment structures should enable individual practitioners and organisations to adopt and drive new integrated models of team-based care. These funding structures also need to facilitate those activities necessary for good care that do not require the patient being present; for example, supporting the conversation between two clinicians to coordinate patient services or treatment, conducting pre-consultation exchanges, or recording and sending patient information to another clinician to support their clinical decision making. In summary, fit-for-purpose reimbursement models for physician services in multidisciplinary care systems need to be explored and introduced.

A system which blends different payment options – one that recognises that different care models and levels of care are needed and that supports varying operational settings and contexts – is likely to be most effective. Within such a blended funding system, it should be expected that fee-for-service payments would remain the most effective option for a certain range of services – perhaps a significant number and type of services, but not the default mechanism.\textsuperscript{15}

As such, the review might consider the adoption of a funding model centred on the four principles outlined in a recent Grattan Institute report on reforming Medicare:\textsuperscript{16}

1. Blended – Giving clinics more flexible funding to support enrolled patients to manage chronic disease over time, while keeping appointment fees to encourage throughput.
2. Needs-based – Making funding proportional to patient need, so that resources are concentrated and targeted at the points of the system where they are needed.
3. Accessible – Ensuring universal access to care.
4. Rewarding what matters – Sustained and carefully designed incentives for what matters most – improving health outcomes.

Innovative funding and care models to be implemented under the NHRA need to be grounded in an agreed national approach to multidisciplinary care that is underpinned by effective governance arrangements. Clear connections and accountability structures between organisations that commission and deliver care are fundamental to effective integrated care models. Governance structures that have been used in integrated care include joint boards, formal or informal overarching governance bodies, or legislation-based governance. Whichever is adopted, it is important that leadership be defined along with clear roles and responsibilities, areas and levels of accountability, decision making processes, funding mechanisms and outcome measures.

Digital health technologies are essential to an interconnected healthcare system and can be used to promote more effective, personalised and precise medicine and more efficient healthcare delivery. Examples of digital health developments are telemedicine, telephone and web-based triage, remote monitoring, web messaging, electronic patient records, decision support capabilities for providers, e-referrals and discharges, and use of e-ordering for pathology tests and diagnostics. Importantly, digital platforms can help ease some of medical staff shortages. Integrated care can be supported by positioning services out of centralised hospitals into more community settings and also virtually via technological platforms. Through digital platforms, patients and consumers can be supported and empowered in managing their own health, which is central to patient


centred care. New technologies are emerging fast and the NHRA needs to facilitate their timely and judicial adoption and best practice use across the health system.17

**We need a decisive move towards a truly integrated health system.**
The division of funding structures by place of service delivery (public hospital versus private practice) leads to disconnections and fragmentation in the way consultant physician services are accessed – by both GPs and other health professionals, for advice and diagnosis, and patients navigating the health care system. For patients with chronic conditions, who comprise a growing number of the population, it is essential to have GPs and physicians enabled to work collaboratively from the same care plan and to access more consultant physician healthcare from within the ambulatory care sector.

To improve health care and health outcomes, health care workers (specialists, nurses, general practitioners, allied health practitioners) need to be enabled to work collaboratively to share knowledge and expertise to make the entire health care system more effective and efficient and most importantly, to provide high quality to all Australians.

Improving collaboration between GPs and medical specialists provides a range of benefits including increased provider and patient satisfaction, improved health condition-specific outcomes and a reduction in fragmentation of care.18 We present some practical examples below of models of care which include medical specialists to achieve these outcomes. Whilst many of these models of care show promising outcomes for patients and medical professionals, their implementation remains ad-hoc and time-limited as they lack a dedicated funding source.19

Systemic reforms to integrate medical specialists into innovative blended funding models as part of the ongoing Medicare reforms need to:

- provide funding support for GPs to seek advice from medical specialists in difficult cases
- break down the place of service delivery (public hospital versus private practice) funding barrier for patients with chronic conditions to ensure GPs and physicians can work collaboratively from the same care plan
- include medical specialists in the Australian Government’s future ‘My Medicare’ initiative to support team-based routine care for chronic patients
- appropriately index Medicare rebates so they are sustainably aligned with inflation.

A care pathway for medical specialists to support team-based care for patients with chronic diseases would support GPs to have real-time access to specialist medical advice for more complex patients, avoiding the need for lengthy delays between referral and consultation. What is needed to achieve this is innovation in the funding of medical care.

The RACP is not requesting that specialists take over the coordination of care for patients who can be managed by a GP. Rather, we are seeking to build better linkages between the patient, GPs and other members of the care team so that care planning and monitoring of the patient’s progress can include the advice and support of medical specialists where that is needed, without triggering a lengthy referral process.

The National Health Reform Agreement 2020-2025 prioritises healthcare value and outcomes, joined-up service delivery and joint planning, funding at a local level and financial sustainability. The Agreement recognises that the activity-based or fee-for-service model alone is not fit for purpose for rising co- and multimorbidity rates where clinicians routinely coordinate the direct and indirect aspects of care for complex and chronic patients to avoid hospital admission or escalation. New funding and delivery models are needed to promote cost-effective multidisciplinary teamwork, provide timely, quality care in place and improve patient convenience and experience.

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Our innovative work on integrated care and the RACP Model of Chronic Care Management (see more detail below) offers an evidence-based template for coordinating services and delivering value-based care for complex patients. In addition, the RACP encourages the Government to invest in expanding multidisciplinary ambulatory care services and outreach programs and to consider providing funding for bulk billed services for specialties underrepresented in publicly funded clinics.

Hospital systems across Australia are under extreme strain, with the pandemic and declining rates of bulk billing in General Practices amplifying these pressures. Consultant physicians and paediatricians have leadership roles in our hospitals as educators, mentors, clinical supervisors, and leaders of multidisciplinary teams. As such, they have been experiencing increasing fatigue, stress and burnout.

The rural, remote and regional specialist workforce is especially overtaxed. Although 28% of Australians live in rural, regional or remote areas, only 11% of specialists practice in these areas; there are seven times fewer specialists than in metropolitan cities despite a higher burden of chronic disease, risky behaviours, patient hospitalisations, mortality, injury, and poorer access to and use of primary health care services.

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An enhanced and targeted investment in specialist physicians is needed for our rural, regional and remote communities to promote equitable access to healthcare. The RACP recognises the scale of the issues facing our health care systems, physicians and patients. We have developed a range of workforce strategies and policies to expand access to generalist and other specialist services outside metropolitan areas and are investigating ways to optimise the overseas trained physician pathway and expand generalist specialty credentials.

The RACP is also working to bolster its organisational response to member burnout. However, we strongly believe that the real response to the pervasive problem of burnout lies at the systemic level, where all parties involved in the health sector need to work together to appropriately design, fund and implement workforce planning and distribution strategies.

Census surveys of hospital bed use based on validated appropriateness criteria in Australia and Canada indicate 70% of acute hospital bed-days are inappropriate as a result of impaired access to residential care, palliative care, rehabilitation services, domiciliary care, community services and family support. Specialist physicians and paediatricians support and enhance care management pathways that do not require hospitalisation or emergency department visits, reducing the pressure on our overtaxed hospital system.

To drive the NHRA’s reform agenda, there is a strong imperative to improve linkages and communication between the health, aged care, disability and social services sectors, including access to appropriate specialist disability, aged care management and rehabilitation services, discharge planning from hospital, disability training for physicians and other healthcare professionals. Models delivering sub-acute and rehabilitation care, out-of-hospital care and support transition to appropriate housing must also be prioritised, as are the efforts to provide enough aged care and NDIS services and workers to deal with the hospital logjam crisis.

Effective models of multidisciplinary care involving specialists already exist.

Strengthening Care for Children Project across Victoria and New South Wales
The Strengthening Care for Children Project runs across Victoria and New South Wales and is a multidisciplinary care trial with three aims: (1) strengthening the paediatric care skills of GPs; (2) increasing knowledge of child health and management in general practice and (3) reducing the need for referrals to hospital services. It involves a paediatrician being placed in a General Practice once a week for half a day where they see children together with the GP and monthly case discussions to upskill GPs and increase their confidence in caring for children. This model enables continuity and streamlining of care through the family’s usual GP when a child is seeing multiple specialists. It also frees up paediatricians who we know are in short supply to see new patients as the trialled model reduces the number of appointments overall. As there are no Medicare items available for GP-paediatrician co-consultations alone at present, the GPs involved in the project bill Medicare and participating hospitals pay for the paediatricians’ time. The lack of a dedicated funding stream limits innovative models of care, such as this, from becoming the norm, and leaves Australia stuck in a model of care that is not fit-for-purpose for the health needs of the population. A similar program of

integrated GP-paediatrician care in England reduced secondary care usage amongst participants including a reduction in admissions and a decrease in attendance to Emergency Departments.\(^\text{22}\)

The trial is delivered in partnership by the Royal Children’s Hospital, Murdoch Children’s Research Institute and North Western Melbourne Primary Health Network (NWMPHN).\(^\text{23}\) It follows the expansion of a project that was successfully piloted with general practices in NWMPHN catchment between 2017-2019 and is centred on an integrated GP-paediatrician model.\(^\text{24}\)

**Geriatrician in the Practice (GIP) program in rural New South Wales**

The GIP program focused on delivering a shared care approach including:\(^\text{25}\)

- joint clinic appointments with the patient and carer, GP and geriatrician, practice nurse and clinical nurse consultant
- on the job mentoring, coaching and training for both the GP and practice nurse
- diagnosis and interpretation of neuroimaging at the point of care
- development of an agreed patient management plan.

A recently published evaluation of the GIP program concluded that “it was well received by most patients, GPs and practice nurses” and that “almost 90% of patients found it easier to see the specialist at their General Practice” and “were less likely to have planned reviews, actual reviews and emergency department presentations than patients who did not take part in the program.”\(^\text{26}\) In addition, “GPs and practice nurses expressed increased confidence in and knowledge of dementia assessment and management.”\(^\text{27}\)

This GIP program was delivered in the rural section of the Illawarra Shoalhaven Local Health District in New South Wales from November 2015 to August 2018. It was funded by the NSW Ministry of Health Integrated Care Planning and Innovation Fund and focused on dementia assessment and management.

**The RACP Model of Chronic Care Management**

The RACP has developed a Model of Chronic Care Management for people with co-morbidities at an ‘intermediate’ level of care to make multidisciplinary team care more accessible and patient-centred. The target population are those with cardiovascular related multi-morbidities at high risk of hospitalisation and therefore requiring both a general practitioner and consultant physician to prevent exacerbation of their conditions, rather than patients who can be appropriately serviced mainly by GPs. It excludes patients who make frequent presentations to the hospital and who are so ‘high risk’ that no significant improvements can be made in reducing their level of future hospitalisations. Patients meeting risk assessed criteria would have their care delivered and managed by a core multidisciplinary team of clinicians.

This is a non-fee for-service model that has two pathways to the integrated care program for multi-morbidities: from primary care or from secondary care.

We envisage that this model would be funded by pooling funding from Commonwealth and State governments into funds at the local hospital network area which would be jointly managed by their associated local hospital network (LHN) and primary health network (PHN), and Aboriginal Community Controlled Health Organisations (ACCHOs). One possible source of funds could be a modest share of current Activity Based Funding of public hospitals contributed by both tiers of government. Other sources that could be considered include current MBS payments for Chronic Disease Management items and

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\(^{23}\) For further information about this project, please refer to: Khano, Sonia, et al. "Strengthening Care for Children (SC4C): protocol for a stepped wedge cluster randomised controlled trial of an integrated general practitioner-paediatrician model of primary care." *BMJ open* 12.9 (2022): e063449. [https://bmjopen.bmj.com/content/12/9/e063449.abstract](https://bmjopen.bmj.com/content/12/9/e063449.abstract)


practice nurse incentive payments to fund the specialist nurses that may be required in the model.

**Concluding remarks**

Significant system reforms are required to strengthen the health system, provide more options for patients to receive the care they need beyond the hospital and improve the responsiveness of care. Hospital reform is a component of a much-needed whole-of-system reform and must be closely aligned and connected to work on prevention through the full implementation and funding of the National Prevention Strategy, strengthening primary healthcare and improving integrated care across all levels of the health sector.

To quote Professor John Dwyer, “Redesigning and implementing a new health care system that is “fit-for-purpose” first and foremost requires a politically acceptable instrument to integrate and fund the current health programs run by States and the Commonwealth while exploring new models of care. In recent times, Labor and Liberal State Premiers have urged their federal colleagues to embrace the idea. It is impossible to integrate patient focussed health care efficiently and economically with the current divisions. 

The RACP is looking forward to working with all Ministers of Health and departments of health to support their efforts at achieving the goals of the NHRA Addendum.

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