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Delivering Quality Care More Efficiently

Royal Australasian College of Physicians submission to the Productivity Commission
June 2025

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 23,200 physicians and 8,700 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. The drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients, the medical profession and the community.

Delivering efficient, accessible quality physician care is a core priority of the RACP.

Contact Peter Lalli, Senior Policy & Advocacy Officer, via policy@racp.edu.au for submission inquiries.

Introduction

Our clinical expertise across a wide range of medical specialties and settings makes us well-placed to guide the Productivity Commission on where the current system works, and where it must improve to meet future health needs. We particularly welcome the focus on regulatory reform, integration of services, and the role of prevention and early intervention in lifting care quality while improving efficiency. We look forward to contributing to a shared reform agenda that places patients, communities, and clinicians at the centre of care, and ensures physicians are empowered to deliver the best possible outcomes.

Reform of quality and safety regulation to support a more cohesive care economy

To what extent do differences in quality and safety regulation make it costly or complex to provide or access care services and for what reasons?

To a great extent.

My Health Record

Quality care relies on health professionals having the right information at the right time.
The interoperability and adaptability of My Health Record to specialist practice continues to be a problem. In 2023, 33% of people who accessed a Medicare service (8.6 million) were referred to see a specialist from a GP. Unlike General Practitioners and their practices, physicians have not received any funding to support MHR use.

There is a need to implement Strengthening Medicare recommendation to “modernise My Health Record to significantly increase the health information available to individuals and their health care professionals”, including:

- Incentives for physicians to support ‘Sharing by Default’ requirements.
- Support for interoperability between MHR and other different digital health systems.
- Improve the usefulness of MHR information
- Streamlining MHR uploading processes to reduce administrative burdens.

Medicines regulations

Australia is largely dependent on imported medicines and is facing ongoing and severe shortages of many medicines. This impacts continuity of patient care and outcomes, and increases workloads for prescribers seeking viable substitutes for patients.

Concerted regulatory reforms are needed to improve our domestic capacity to prescribe and distribute medicines for the increasing number of complex patients. Regulatory barriers that can exacerbate shortages and slow the pace of patients getting access to the medicines they need or viable substitutes, including:

- Accessing unapproved or international alternatives can be slowed by the complex Special Access Scheme (SAS), preventing timely substitution of unavailable medications and disrupting continuity of care.
- Lack of streamlined regulatory approval processes for medicines approved for use by a competent overseas authority, but not yet approved in Australia.
- No regulated list of critical, life-sustaining medications for which stockpiles must be preserved by Governments and pharmaceutical companies.
- Restricted regulatory powers of the TGA to coordinate medicine redistribution and prioritise vulnerable patients.
- PBS pricing rules which can result in the delisting of older but essential medications.

To what extent should quality and safety regulations be more aligned across the different care service sectors and jurisdictions and for what reasons?

To a great extent.

Doctor wellbeing and workforce sustainability

Patient safety and quality care are inseparable from ensuring the health and wellbeing of doctors and other health professionals. Hospitals and other healthcare worksites present significant, risks of ongoing burnout and other psychosocial hazards through increasing workloads, services over-capacity and increasing complexity of care. Having the right framework in place to address these issues is critical for ensuring the best outcomes for people receiving care and ensuring workforce sustainability. We do not currently have standardised tools or centralised data gauging medical practitioner wellbeing beyond the Australian Health Regulation Agency (Ahpra) / Medical Board of Australia Medical Training Survey (MTS) specifically for medical trainees. There is a need for:

- A Chief Wellness Officer in the Department of Health, Disability and Ageing to champion and coordinate wellbeing initiatives for physicians, trainees and other health professionals.
- Investing in Chief Wellness Officers in healthcare settings across the country – these are paid clinical positions with health and wellbeing responsibilities.
- Funding Ahpra to implement a national survey of wellbeing for all medical practitioners.
- Funding Safe Work Australia to:
    - Enhance tools and frameworks to support safety in hospitals.
    - Produce an annual national review of overall safety in hospitals across the country.
    - Establish a National Centre for Workplace Mental Health and Wellbeing.
    - Fund re-establishment of occupational health and safety units in hospitals incorporating occupational and environmental physicians.

Specialist International Medical Graduates (SIMG)

Australia's reliance on international medical graduates is growing, especially in underserved areas. The RACP and other specialist colleges play a vital role in maintaining standards and providing oversight for SIMGs. The newly introduced Ahpra 'fast track' pathway for SIMGs, independent of medical colleges, marks a significant shift in credentialing regulation. While this aims to reduce bottlenecks, it also raises concerns about consistency in quality and support as well as patient care experience and outcomes.

To safeguard care standards by supporting SIMGs, an evaluation of the new fast-track program is needed. There is also an urgent need for dedicated support systems for SIMGs: bridging programs for SIMGs needing additional preparation, funding for remote supervision models, and online and in-person communities of practice. These measures, recommended in the Working Better for Medicare Review, are essential to ensure SIMGs are not only clinically competent but also culturally and professionally supported in their transition into the Australian health system.

Artificial intelligence in healthcare

AI tools are being used on a growing scale in healthcare. Regulation of AI needs to occur in a consistent, safe and standardised manner. We do not currently have standardised regulations for certification and accountability of AI systems.

Healthcare providers and patients need to understand how AI tools arrive at their outputs to ensure safe and effective care. Transparency and explainability are crucial. Differences in regulations regarding transparency requirements can complicate the integration of AI into healthcare services, potentially leading to inconsistencies in care quality and increased training and/or compliance costs. Harmonised regulations are needed to maintain high-quality patient care.

Our 2024 submission to the Safe and Responsible Artificial Intelligence in Health Care – Legislation and Regulation Review identifies a range of relevant recommendations.

Reducing low value care

We support our members to reduce and minimise low value and unnecessary practice through our Evolve Program. It seeks to phase out low-value tests, treatments and procedures, provide high-value care to patients based on evidence and influence the best use of health resources, reduce wasted expenditure and the carbon footprint of the healthcare system.
These lists provide a source for busy practitioners in pressured environments and would greatly complement the work of the Australian Commission on Safety and Quality in Health Care (ACSQHC) to provide a fuller

picture of detailed optimal and value reduced practice. The Evolve Program can strengthen quality clinical practice promotion, education and regulation as part of a range of tools and resources for practitioner support and governance. There is a need to:

- Expand funding to initiatives minimising low value, unnecessary healthcare, such as the RACP's Evolve Program.
- Evaluate programs such as RACP Evolve to assess their impact on reducing low-value care, climate mitigation, and resource stewardship.

Embed collaborative commissioning to increase the integration of care services

What is your experience with collaborative commissioning?

The RACP has long supported collaborative commissioning to overcome the fragmentation of healthcare, limitations of fee-for-service-models and increasing chronic and complex nature of Australian healthcare needs. These increasingly require interdisciplinary collaboration and are placing escalating strain on our hospitals.

There is a strong need for Government support of interdisciplinary models of care involving physicians for patients with complex and chronic health conditions across primary and tertiary settings. The RACP's Model of Chronic Care Management is a collaborative commissioning model developed by physicians, with coordinated processes tailored to the current design of our health care system. It allows patients to be taken into, flow through and exit in a seamless way from primary or secondary care points with the support of a care coordinator who helps to facilitate collaborative commissioning for enrolled patients, drawing resources and funding from primary health networks and local hospital networks in pooled funding arrangements. It promotes coordinated team-based care that aligns specialist and primary care services around the needs of the patient. It would bridge jurisdictional and sectoral divides, supporting more efficient use of health system resources.

What are the benefits of pursuing greater collaborative commissioning?

Collaborative commissioning can significantly improve the Australian healthcare system by promoting service integration, reducing duplication, and better addressing the needs of patients with complex health conditions—especially in rural, remote, and underserved communities. Specific priority populations and patient demographics would be better serviced by collaborative commissioning, with expanded opportunities to tailor care, involving PHNs, LHNs, ACCHOs, and other community organisations in planning and funding decisions. This results in more culturally appropriate, responsive and engaging care, especially for Aboriginal and Torres Strait Islander communities. Joint accountability would also be encouraged through blended funding.

There is a need to improve the integration of healthcare delivery, enhance the quality and safety of services, and overcome inequities in health. Integrated service delivery structures are needed to better support accessible, more patient-centred health services offered closer to home for diverse populations, compared to the hospital-centric and siloed services into which our services have evolved. Reorienting our way of delivering services is a sensible approach to addressing the challenges Australia shares along with many countries with an ageing population, increasing numbers of people with chronic and multiple conditions, and uneven service distribution.

Although excellent examples of integrated care can be seen in Australia, these often work despite the system, and are not widely translated into the broader system as standard best practice.

Fundamental to effective integrated models of care is a cross-disciplinary, cross- organisational approach; especially for patients who need care for multiple, chronic and often complex health issues. In Australia that will require strong cross-jurisdictional collaboration and cooperation and new ways of funding. Regional planning, reporting, commissioning and organising are likely to come to the fore, providing challenges but also opportunities to drive a more patient-centred and connected health system. There can be no single model or approach to integrated care that will meet the needs of all patients. The RACP is particularly cognisant of this due to the wide and varied range of specialties it represents. We need to be future-focused and move to service delivery environments where physicians and other clinicians can be more collaborative (multidisciplinary team-based care) and supported to practice more in ambulatory and community settings.

Experience to date shows that while integrated care has significant support, it is not easy to deliver within the context of a complex healthcare system. The potential benefits of integrated care have made it an important policy priority for the RACP. There is potential for integrated and patient centred care to:

- Improve the timely provision of appropriate care.
- Reduce unnecessary or inefficient appointments or referrals made for patients.
- Improve the patient experience.
- Increase patient attendance and lead to fewer patients lost to lack of follow-up.
- Reduce the incidence or potential impact of conflicting clinical advice or management (for example, medication interactions).
- Lead to higher levels of professional job satisfaction.
- Assist in reducing unnecessary hospitalisations.
- Reduce waste of other professional services (unnecessary use of services) within the health system.

What are the barriers to collaborative commissioning, and do you have any suggestions for solutions that would lead to better collaboration in the commissioning of care services?

To best enable interdisciplinary care through collaborative commissioning, the Federal Government together with state and territory governments must:

- Establish joint funding pools across Commonwealth and state/territory levels to support integrated care initiatives, including a mandate for shared planning between PHNs, LHNs, and ACCHOs.
- Implement shared governance structures that include clinicians, community representatives, and Aboriginal and Torres Strait Islander leadership, ensuring that all partners have an equal voice in planning and oversight.
- Invest in data infrastructure that allows providers to securely share relevant clinical and population health data, enabling coordinated care and outcomes-based planning.
- Provide funding and technical support to community-controlled and smaller providers so they can engage equitably in commissioning partnerships.
- Align commissioning frameworks with clinically informed models such as the RACP's Model of Chronic Care Management, which provides a structure for integrated, team- based care that can guide local implementation.

A national framework to support government investment in prevention

What are the main barriers to governments investing in evidence-based prevention programs across the care economy?

The RACP has long urged all levels of government to prioritise investment in prevention.

Prevention is crucial to reducing pressure on our health system, acute services, and delivering a sustainable healthcare economy. It addresses the social determinants of health (i.e. the conditions in which people grow, live, work and age) that are contributing to illness and disease, which are disproportionately high in priority communities.

Key issues limiting the beneficial impacts of prevention include lack of funding continuity within and between government funding cycles, varied levels of jurisdictional commitment, diffusion of responsibility between levels of government and a lack of real-time integrated national surveillance and data sharing. Multiple primary prevention strategies exist that are awaiting effective funding. This is not sustainable.

We also remain a long way from pandemic preparedness, understanding the public health workforce distribution and size required for prevention initiatives, and capturing centralised national data we need to plan and rollout targeted and successful prevention programs.

There is a need to:

- Fully fund and implement the National Preventive Health Strategy, which requires that 5% of total health expenditure be dedicated to prevention by 2030.

- Fully fund our existing national strategies for obesity, tobacco, diabetes, lung conditions and dust diseases.
- Finalise establishment of the Australian Centre for Disease Control (CDC), particularly to enhance its risk assessment and communication capabilities, with initial focus on:
    - Antimicrobial resistance and interpersonal micro bacterial transmission
    - Key transmissible diseases
    - Interface of key communicable diseases with non-communicable diseases, environmental, social and occupational drivers.
- Support the CDC to develop an open data policy framework to support disease surveillance.
- Fund the CDC to develop a national public health workforce strategy and training program.

With preventable complex diseases increasing, a valuable role exists for secondary prevention in reducing subsequent or co-occurring morbidities.

We have warmly welcomed recent efforts of the Federal Government to capture secondary prevention issues in parliamentary inquiries, such as the 2024 Inquiry on Diabetes. We now urge key recommendations to be funded so that our health services can keep pace with the escalating associated co-occurring morbidities. This includes:

- A best practice framework to address increased obesity risks.
- Medicare access to longer appointments for people with diabetes and obesity.
- Expanding Continuous Glucose Monitors for Type 2 diabetes requiring regular insulin.
- Improved access to bariatric surgery within the public system.
- Support access to GLP-1 agonist medications patients with complex obesity.
- Fund increased research into diabetes and obesity, which has decreased in real terms.
- Broaden access to cardiac magnetic resonance imaging to patients with coronary disease.

What are some examples of successful prevention programs (this could include discontinued programs)?

Below are five specialist-integrated secondary prevention services that exemplify the innovative ways physicians can support early detection, surveillance and screening. They focus on priority populations and key chronic diseases, offering community engagement, interdisciplinary integration, and innovative diagnostics.

Example 1: Indigenous Cardiac Outreach Program[1] [2] [3]

The Indigenous Cardiac Outreach Program (ICOP) in Queensland is an example of a hub and spoke model of care involving various sites to provide specialist services to remote communities.

It is achieving good secondary prevention outcomes with its innovative multidisciplinary community-driven and culturally sensitive tertiary specialist program which seeks to improve cardiac care in remote and rural Indigenous communities by building the capacity of the Indigenous Health Workers to manage cardiac care and reconnect clients to visiting specialists.

Fundamental to ICOP's responsiveness is the ability of Indigenous Health Workers to make direct referrals to the specialist service, without the time and travel constraints of requiring referral by primary care providers. Direct access to the cardiac specialty outreach service has established strong relationships between the community and specialty services.

Initial consultation with Indigenous Health Care Workers helped to inform the program and develop a sense of community ownership. Indigenous Health Care Workers were engaged in screening training and education to understand indicators for direct referral to the cardiac outreach program. A locally customised assessment tool was created and educational sessions on applying the tool followed.

[1] Muthana Abdul Halim, Diabetes control in rural and remote communities in Queensland: A snapshot look into Indigenous Cardiac Outreach program cohort, March 2022 [online]; https://www.clinicalexcellence.qld.gov.au/improvement-exchange/diabetes- control-in-rural-and-remote-communities-in-queensland-a-snapshot-look-into- indigenous-cardiac-outreach-program-cohort

[2] Schmidt B, Smith D J, Battye K. Strategies for implementing best practice primary and secondary preventative interventions in chronic disease in remote Australia. Sydney: ACSQHC; 2017

[3] Tibby D, Corpus R, Walters DL. Establishment of an innovative specialist cardiac indigenous outreach service in rural and remote Queensland. Heart Lung Circ. 2010 May-Jun;19(5-6):361-6. doi: 10.1016/j.hlc.2010.02.023. Epub 2010 Apr 8. PMID: 20381420

The partnering cardiac service team initially included a cardiologist and sonographer (rostered from the tertiary referral hospitals) to visit each site. More recently this has included a general medicine advanced trainee and a chronic disease nurse practitioner.

The sites are often within Community Health Centres to establish a sense of community ownership. The Team travels with a portable echocardiography machine, ECG, point of care technology (lipid profile, blood sugar, HbA1C and renal function) and vital signs monitor.

Patients are seen by the team, with each person receiving an ECG, various point of care tests, an ECHO and blood analysis. The specialist is then able to assess individual response to treatment and determine a management plan to provide the best outcomes. The specialist also provides a patient care letter, which is sent to the Indigenous Health Workers.

A key part of the service is to undertake secondary prevention of ischaemic and rheumatic heart disease by optimising medical therapy, instituting penicillin prophylaxis and providing advice on risk factor modification.

Its key secondary preventive care outcomes have included beneficial changes in the lipid profiles of patients with established atherosclerotic disease comparable to levels in developed countries (57 per cent achieved target LDL of less than 1.8 mmol/L). The model has shown to support relatively effective diabetes control in rural and remote Indigenous communities.

Example 2 - The One Stop-Liver Shop[4] [5]

The One Stop Liver Shop in the Northern Territory is a mobile care delivery initiative for people with chronic hepatitis B in a remote community that provides person-centred care in local community languages.

The initiative was developed in conjunction with the Galiwin'ku community to encourage regular follow up, antiviral treatment and screenings in a responsive manner outside of far-away tertiary care settings.

Central to the model is coordination between a community based Aboriginal Health Practitioner who coordinates visits and patients with a specialist doctor, accompanied by a broader team including a sonographer and a clinical nurse specialist. Portable ultrasound scan (USS) and a transient elastography (FibroScan®) technologies are used, as well as mobile devices to educate patients using an app custom created for the One-Stop-Liver-Shop. The app provides chronic hepatitis B related education in various community languages. The Aboriginal Health Practitioner and community-based educators have been trained to deliver education using the app to assure cultural safety.

The One-Stop-Liver-Shop has supported the ongoing connection between patients and specialists for health surveillance, early health promotion and intervention.

An overwhelming majority of patients in a surveillance study were found to have up-to date liver scans, tests and viral load monitoring. One key documented outcome of the One-Stop-Liver- Shop has been its engagement in care of 88% of patients aware of their chronic hepatitis B diagnosis, above the national average.

Example 3 - Pilot integrated diabetes service for remote First Nations communities[6]

Several RACP Fellows evaluated an integrated specialist diabetes outreach service across several rural and remote First Nations communities that showed promising results for the secondary prevention of diabetes complications.

The outreach team comprised a team of endocrinologists and diabetes nurse educators, established to support remote primary health care services to deliver diabetes care to eleven remote Indigenous communities. The team visited community clinics routinely, with three-to- four visits by the nurse and two by an endocrinologist to consult with patients referred by the local primary health care team or identified through regional primary health care information systems.

Key components of the pilot that enabled it to be responsive to patient need included:

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[4] Hla, T.K., Bukulatjpi, S.M., Binks, P. et al. A "one stop liver shop" approach improves the cascade-of-care for Aboriginal and Torres Strait Islander Australians living with chronic hepatitis B in the Northern Territory of Australia: results of a novel care delivery model. Int J Equity Health 19, 64 (2020). https://doi.org/10.1186/s12939-020-01180-w

[5] Productivity Commission 2021, Innovations in Care for Chronic Health Conditions, Productivity Reform Case Study, Canberra

[6] Hotu C, Rémond M, Maguire G, Ekinci E, Cohen N. Impact of an integrated diabetes service involving specialist outreach and primary health care on risk factors for micro- and macrovascular diabetes complications in remote Indigenous communities in Australia. Aust J Rural Health. 2018 Dec;26(6):394-399. doi: 10.1111/ajr.12426. Epub 2018 Jun 4

- A clinical classification system to prioritise delivery of care to patients with poorly controlled diabetes and those with diabetes complications and link them with an appropriate amount and mix of outreach interactions.
- A collaborative approach to clinical advice and clinical risk management: at each visit, patients were reviewed and the outreach team provided clinical advice, including diabetes treatment recommendations to the patients, the remote medical practitioners, Aboriginal health workers and remote area nurses.
- Care plans were formed in partnership and implemented by the primary health care team, who provided patients with diabetes care between specialist outreach visits.
- End-to-end engagement: education and up-skilling in diabetes care was frequently provided by the outreach team to primary health care staff during the outreach visits and the latter received clinical support from the outreach team between visits.

The pilot was associated with an improvement in glycosylated haemoglobin and total cholesterol, both important risk factors, respectively, for micro- and macrovascular diabetes complications. Over the 12-month pilot, the patient cohort had a significant reduction in median (interquartile range) glycosylated haemoglobin from the baseline. Median (interquartile range) total cholesterol was also reduced. The number of patients prescribed insulin, glucagon-like peptide-1 analogues and dipeptidyl peptidase-4 inhibitors increased over the twelve months.

Example 4 - Strengthening Care for Children Project in Victoria and NSW [7] [8] [9]

The Strengthening Care for Children Project in Victoria and NSW is delivered in partnership by the Royal Children's Hospital, Murdoch Children's Research Institute and North- Western Melbourne Primary Health Network (NWMPHN). It involves a paediatrician being placed in a general practice once weekly to fortnightly for paediatrician-GP co-consultation sessions at the general practice, monthly case discussions and telephone or email clinical support for GPs to upskill and increase their confidence in caring for children.

The Strengthening Care for Children Project has 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.

This patient-centred model presents two key benefits for children and their families: they are able to access paediatric support at their regular general practice and it reduces the burden of having to find, wait for, travel to and pay for a private specialist.

An evaluation of the Strengthening Care for Children Project in Victoria involving 896 families reveals that it decreased referrals to private paediatricians after the intervention (from 34% to 20%) and emergency departments (from 19% to 12%). While cost estimates were $172 above usual care per child seen in the co-consultations, this was offset by a reduction in more costly episodes of hospitalisation.

Example 5 - Geriatrician in the Practice (GIP) program[10] [11]

The GIP program aimed to "provide patients with dementia timely assessment in a familiar location, to improve the skills in primary care for the diagnosis and management of dementia and build improved relationships between the primary health and hospital sectors." It focused on delivering a patient-centred shared care approach between the General Practitioner and geriatrician including:

- 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

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[7] Hiscock H, O Loughlin R, Pelly R, Laird C, Holman J, Dalziel K, Lei S, Boyle D, Freed G. Strengthening care for children: pilot of an integrated general practitioner-paediatrician model of primary care in Victoria, Australia. Aust Health Rev. 2020 Aug;44(4):569-575

[8] Murdoch Children's Research Institute, 'New paediatric care model produces positive results' [online] available via this link: https://www.mcri.edu.au/news-stories/new-paediatric-care-model- produces-positive-results

[9] Strengthening Care for Children Project - North Western Melbourne Primary Health Network (nwmphn.org.au) – Available via this link: https://nwmphn.org.au/news/strengthening- care-for-children-inside-a-participating-practice/

[10] Christley, Jeremy and Tabitha Hartwell, Geriatrician in the Practice Model of Care, International Journal of Integrated Care. October 2017

[11] NSW Government, Illawarra Shoalhaven Local Health District, Coordinare, South Eastern NSW PHN, Geriatrician in Practice Program. 2018. Available via this link: https://www.coordinare.org.au/assets/Uploads/COORDINARE-case-studies/deeaab56e0/GIP- project-Case-Study-October-2018.pdf

- 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”. Participants “were less likely to have planned reviews, actual reviews and emergency department presentations than patients who did not take part in the program.” In addition, “GPs and practice nurses expressed increased confidence in and knowledge of dementia assessment and management.”

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.

How can governments better support investment in prevention activities that have broad and long-term benefits for the Australian community?

There is a need to recognise prevention as a core component of the healthcare system which is

essential to reducing the burden of chronic disease, improving equity, and building a more resilient population.

A foundational step is embedding prevention into the health system’s funding architecture. This means dedicating a fixed proportion of health budgets to preventive activities, in line with the Australian Government National Preventive Health Strategy 2021-2030 which calls for 5% of total health expenditure being dedicated to preventive health by 2030 across Commonwealth, state and territory governments.

Governments should also strengthen support for integrated, person-centred care that addresses the physical, mental, and social dimensions of health across the life course. Investing in models that address the social determinants of health—such as safe housing, access to nutritious food, and stable employment—is critical. These investments are especially impactful for people experiencing disadvantage or marginalisation, and can prevent the escalation of chronic conditions that are more costly and complex to manage later.

Building a robust and well-supported public health workforce is another essential pillar. This includes expanding training and retention of specialists in public health medicine, general practitioners, and allied health professionals working in prevention.

Long-term planning, monitoring, and evaluation are essential to ensure that prevention efforts are effective and accountable. Investments in data infrastructure are needed to measure outcomes and track equity impacts, and independent evaluation should be embedded in all programs to ensure public funding delivers value and evidence-based improvement.

Climate change must be recognised and addressed as a core public health issue. Climate change poses a growing threat to health, particularly for priority populations. Addressing climate impacts on health must be integrated as a key part of prevention. Governments must invest in making health systems climate resilience and environmentally sustainable, and support policy actions that deliver co-benefits for health and the environment. Governments must also invest in building healthy and climate resilient communities by mobilising sectors outside of the health system to address the wider determinants of health. Our 2025 Federal Election Statement calls on the Federal Government to:

- Establish a Climate Friendly Health System Innovation Fund to provide grants to local health services for climate resilient emissions reduction and environmental sustainability initiatives.
- Establish a National Climate Change and Health Resilience Research Fund to identify resilience strategies.
- Build healthcare system climate resilience, including a strong, sustainable medical workforce.
- Commit to, and deliver on-track progress towards, net zero healthcare emissions by 2040.
- Prevent harms from fossil fuel developments to human health and the environment.
- Require fossil fuel extraction projects to undertake a full, independent Health Impact Assessment.
- Develop and implement a just, equitable, effective, and feasible transition plan for a whole-of government transition to renewable energy.

Action on transitioning away from fossil fuels and decarbonising transport and improving housing are a crucial part of prevention. These matters are also covered in Pillar 5 of the Productivity Commission’s suite of five current productivity inquiries – “Investing in cheaper, cleaner energy and the net zero transformation”. While the RACP has not provided a separate submission to that inquiry, we support policies that can facilitate an urgent transition to zero emission renewable energy across all economic sectors. Any such policy actions must provide support to affected communities and prioritise Indigenous equity and leadership, and health equity.

Housing and transport are key aspects of our climate change and health advocacy. Homes must be energy efficient to protect and promote health. Governments must facilitate construction of buildings to high health and environmental standards. Reducing emissions from transport must focus on increasing public transport, particularly to inadequately serviced areas. Governments must also invest in active transport use and safety, including for example funding for construction of bicycle and pedestrian paths.

Further information on the RACP's positions on fossil fuel combustion and extraction, transport, and housing can be found in our Health Benefits of Mitigating Climate Change Position Statement.

Conclusion

We thank the Productivity Commission for the opportunity to contribute to this important inquiry. We believe this submission offers constructive insights grounded in clinical expertise and a strong commitment to improving health outcomes across Australia. We welcome continued engagement with the Commission as it progresses its work and would be pleased to provide further input. We look forward to collaborating on practical reforms that support high-quality, efficient, and equitable healthcare delivery for all Australians.

Please contact Peter Lalli, RACP Senior Policy & Advocacy Officer by email: policy@racp.edu.au for further engagement.