Policy Document

Primary Healthcare

Executive Summary

World Health Organisation - Primary Healthcare Definition

The Australian Medical Student Association (AMSA) believes that access to quality Primary Healthcare (PHC) is a fundamental right. PHC is defined by the World Health Organisation (WHO) as a "whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution" through a healthcare system that encompasses the guiding principles of comprehensiveness, accessibility, quality of care, person centredness and coordination.

AMSA calls upon relevant stakeholders to adhere to the fundamental principles of general practice as defined by the WHO: comprehensiveness, accessibility, quality of care, person centredness and coordination. Furthermore, Medical Speciality Colleges must strive to uphold these principles in the teaching and training of the Primary Care workforce.

Australian Primary Healthcare 10 Year Plan 2022-2032

Presently, the "Australian Primary Healthcare 10 Year Plan 2022–2032" provides the framework for reform of the PHC system over the course of the next decade. With the government committing $632.8 million in the 2022-23 Budget, this plan details seven guiding principles which aim to support equitable access, closing the gap in health outcomes for Aboriginal and Torres Strait Islander people, keeping people well, supporting continuity of care, integrating PHC systems, embracing new technologies, and improving safety and quality of all services. The 10 Year Plan has three streams of targeted change: (1) focus on integrating telehealth into the Medicare Benefits Schedule (MBS); (2) formalising the patient-GP relationship through the MyMedicare platform; and (3) integration of health services through planning and collaboration.

AMSA calls upon relevant stakeholders to pursue the Primary Healthcare 10 Year Plan and continuously monitor and update for the changing needs of Primary Healthcare as determined by the changing health needs of Australian society. The 10 Year Plan must be continuously updated, including to include the

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recommendations put forward by the RACGP in "The Vision for general practice and a sustainable healthcare system".

Primary Healthcare Funding

The financing of the PHC system in Australia is a large contributor to both its successes and its shortcomings. Currently, the system is funded primarily through the Medicare Benefits Schedule (MBS), which subsidises citizens and permanent residents of Australia to access PHC as well as specialist consults, diagnostic tests, and public hospital care. General Practice operates on a fee-for-service model whereby clinics may bulk bill (cost is covered by the MBS) or require out of pocket expenses. The 10 Year Plan proposes the MyMedicare platform which seeks to move away from the fee-for-service model and towards payments that are linked to quality and outcomes measures. The RACGP has also provided recommendations for PHC funding change in "The Vision for general practice and a sustainable healthcare system". This Vision presents a framework for addressing issues confronting General Practice and the PHC system as a whole.

AMSA calls upon the Australian Federal Government to review the fee structure in the MBS, aiming for fairer remuneration for PHC providers, including but not limited to covering the costs of running a practice, conducting consults and equipment for procedures. AMSA also calls upon Australian State and Territory Governments to work with Primary Health Networks to effectively coordinate resource allocation and ensure community representatives are able to have influence on decisions.

Primary Healthcare Workforce

Workforce is another challenge in the contemporary PHC space. This is a longstanding issue that will soon be exacerbated in the setting of the General Practice Health of the Nation 2023 report findings that 29% of GPs intend to retire in the next five years in addition to seven in 10 GPs reporting feelings of burnout. AMSA therefore calls upon many different institutions to contribute to tackling the PHC workforce challenges.

AMSA calls upon the relevant stakeholders, especially the Federal Government, RACGP and ACRRM, to offer incentives to students and junior doctors seeking to specialise in GP. Furthermore, competitive salaries and improved working conditions must be offered to retain existing GPs and attract new GPs. A focus on areas of need, including regional, rural and remote settings, should be made by the RACGP and ACRRM.

Evolving Needs of the Australian Population in Accessing Primary Healthcare

The importance of access to PHC is well established; however, the ever changing and evolving needs of the Australian population and therefore the changing barriers to access are important to consider and review. The PHC system needs to continue taking into consideration these ever-changing needs, particularly in the setting of the Australian ageing population. Culturally and linguistically diverse groups, Aboriginal and Torres Strait Islander people, members of the LGBTQIASB+ community, regional and remote communities, and people with a lived experience of mental health are all important groups to consider in ensuring equitable PHC access.

AMSA calls upon the Australian Federal Government to ensure PHC structures recognise the diversity of the Australian populations and the changing and evolving health needs. AMSA also calls on relevant Specialty Colleges to equip medical professionals training in the General Practice pathway to be knowledgeable and informed of the vastly changing and evolving landscape of PHC.

Policy Points

AMSA calls upon:

1. The Australian Federal Government to:
    a. Strive to uphold throughout government policy the WHO principles of Primary Healthcare including comprehensiveness, accessibility, quality of care, person centredness and coordination;
    b. Adhere to the guidelines laid out in the Primary Healthcare 10 Year Plan and continuously monitor and update for the changing needs of Primary Healthcare as determined by the changing health needs of Australian society;
    c. Update the Primary Health 10 Year Plan to include the recommendations put forward by the RACGP in "The Vision for general practice and a sustainable healthcare system;
        i. Support Primary Healthcare services to manage low-urgency presentations that would otherwise go to the emergency department;
        ii. Invest in the primary management of common conditions that result in preventable hospital admissions;
        iii. Restructure the billing system to allow for focus on chronic conditions and mental health consults by incorporating a "complexity loading payment;
        iv. Appropriately reflect the cost of service and accurate indexation in the Medicare rebate fees;
        v. Explicitly recognise general practitioners as medical specialists
    d. Ensure Primary Healthcare structures recognise the diversity of the Australian populations and the changing and evolving health needs ;
    e. Review the fee structure in the MBS, aiming for better remuneration for Primary Healthcare providers to cover the costs of running a practice, conducting consults and equipment for procedures;
    f. Achieve pay parity for doctors working in General Practice compared to hospital-based medical practitioners by:
        i. Increasing PIP payments for General Practitioners and explore the benefits of extending these payments to General Practice Registrars;
        ii. Continue to review and research the efficacy of the 'Single Employer Model' and differentiate its effectiveness based on rural and metropolitan environments;
    g. Enable bolstering of the GP workforce through:
        i. Investing in teaching and training capacity through proposed strategies including the GPRN 'Future GP peer initiative';

ii. Investing funding into infrastructure to enable GPs to provide gold standard teaching including parallel consulting;

h. Conduct regular independent reviews monitoring the effectiveness of their PHC strategies, and in doing so allow:
    i. Strategies that are proven to be effective to be implemented more broadly;
    ii. Strategies that are unsuccessful to be reconsidered and adapted or replaced;

i. Provide information pamphlets about new reforms such as "Australia's Primary Healthcare 10 Year Plan 2022–2032" and MyMedicare (voluntary patient registration system) in multiple languages to increase accessibility to Australians with English as a second language;

j. Invest into advertisement for new reforms such as MyMedicare to increase public awareness about the service and its benefits. Especially as success of useful data collection depends on population involvement;

2. All Australian State and Territory Governments to:
    a. Strive to uphold through legislation policy the WHO principles of Primary Healthcare;
    b. Offer competitive salaries and improve working conditions to retain existing GPs and attract new GPs with particularly focus on areas of need including regional, rural and remote settings;
    c. Insure adequate funding and resources are allocated to members of the multidisciplinary Primary Healthcare team to ensure effective coordination of holistic patient care;
    d. Work with Primary Health Networks to effectively coordinate resource allocation and ensure community representatives are able to have influence on decisions;
    e. Work with Primary Health Networks to enhance coordination between hospitals and general practices, including in the delivery of discharge summaries;
    f. Ensure Primary Health Networks are regularly consulting Aboriginal Community Controlled Health Organisations (ACCHOs) for effective allocation of resources;
    g. Offer incentives for GPs to practise in less served urban or rural areas:
        i. Increase regional infrastructure to encourage healthcare worker's families to move there;
        ii. Offering higher wages to GPs in these regions;
        iii. Offering flexible working hours to help GPs achieve better work-life balance ;

h. Offer legislation reforms to streamline the path to becoming a GP;
i. Effectively coordinate and attract locum practitioners to areas experiencing staffing shortages as immediate, short-term relief;
j. Secure funding for positions within the social prescribing framework to liaise with health practitioners for the purpose of referring patients to community services.

3. Royal Australian College of General Practitioners and Australian College of Rural and Remote Medicine to:
    a. Strive to uphold, in the teaching and training of the Primary Healthcare workforce, the WHO principles of Primary Healthcare;
    b. Offer education surrounding the Australian PHC system which highlights the importance of collaborative, holistic and future focussed care;
    c. Implement and increase accessibility of training pathways in General Practice and Rural Generalism in regional and remote areas;
    d. Aim to promote training pathways for general practice in all regions of Australia, particularly those with GP shortages;
    e. Equip medical professionals training in the General Practice pathway to be knowledgeable and informed of the vastly changing and evolving landscape of Primary Healthcare by educating GP trainees in:
        i. Mental Health provision of care in the Primary Healthcare space;
        ii. Treating patients from a Culturally and Linguistically Diverse background;
        iii. Treating Aboriginal and Torres Strait Islander patients in a culturally safe manner;
        iv. Treating patients who identify as LGBTQIASB+;
        v. Recognising the effect of climate change of Primary Healthcare practice and understanding of General Practice as the forteer of education and healthcare provision on the matter;
    f. Enhance the training programs and incentives for medical students and junior doctors to choose general practice as a career.
4. Australian Medical Schools to:
    a. Encourage more students to pursue general practice throughout the curriculum through strategies including:
        i. Focused teaching of Primary Healthcare and common patient presentations, offered throughout the curriculum;

ii. Early structured mentorship programs designed to connect medical students with GP mentors early in their education to foster positive perceptions and interest in general practice;
iii. Ensuring high-quality GP placements through measures including but not limited to increasing funding for practices to offer diverse, enriching experiences in the Primary Healthcare setting; and
iv. Supporting additional external opportunities and leave for students;

b. Increase GP placement and early exposure for all medical student;
c. Increase exposure to "specialist" GPs who have trained in an interest area;
d. Recognise the need for regular adjustment and updating of the curriculum surrounding Healthcare as technology and regulations continue evolving;
e. Ensure that the portrayal of future pathways in all specialty training is taught equally with an aim of destigmatising General Practice as a specialty;

5. Australian Medical student bodies to:
    a. Provide continuous support towards Primary Healthcare interest groups such as the General Practice Student Network (GPSN), who will promote and advocate for general practice as a career;
    b. Promote education and awareness around the major issues which surround Primary Healthcare in Australia:
        i. Finance;
        ii. Accessibility;
        iii. Workforce;
6. Australian Healthcare practitioners to:
    a. Incorporate culturally sensitive care to reduce inequities in healthcare received by vulnerable groups;
    b. Educate themselves and implement care in a way that targets the future needs of the population, rather than simply focusing on current healthcare problems;
    c. Engage in interdisciplinary communication and collaboration with other aspects of the healthcare system, ensuring a holistic approach to healthcare is utilised.

Background

1.0 Principles of Primary Healthcare

1.1 World Health Organisation definitions

The World Health Organisation (WHO) definition asserts that Primary Healthcare (PHC) "is a whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people's needs and as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment."(1)

This definition focuses on the importance of equity, preventative medicine and overall well-being in the everyday lives of people across the world.(2) It is important to note that the definition of PHC varies across the world and amongst different institutions.(3) A key aspect that the WHO highlights as essential is the integration of care into the daily lives of people from different walks of life, while ensuring their individual needs are met throughout their lifetimes, with patient-centred care.(2) The importance of equipping patients with the education and resources necessary to have agency over their own health is also central to the WHO definition of PHC.(2) Moreover, a fundamental part of the WHO approach to PHC is the focus on addressing the wider structural, social, political and economic issues which threaten quality of life and care for many people.(2)

Five categories which encompass the facets of PHC are outlined by the WHO.(4) These include:

1. **Comprehensiveness**

The ability of PHC to address a wide range of issues that a person may face. It encompasses "the scope, breadth, and depth of primary care, including the competence to address health issues throughout the life course" (4), and focuses on maximising the effectiveness of systems and their resource allocation. This could include training of healthcare workers to offer mental and social support along with physical care.

2. **Accessibility and Coverage**

The equitable distribution of care in a way that maximises effective coverage to provide people with the best possible opportunities to access healthcare from a range of sources, taking into account their own personal circumstances which may make access more difficult. This could involve utilising mobile clinics to improve range of coverage or government-funded schemes which subsidise healthcare costs for financially disadvantaged individuals.

3. **Quality of care**

The safe and effective administration of healthcare services for a population, providing care in line with the principles of healthcare, and delivered in a timely fashion, to ensure patients receive the highest quality support available. This could include implementing regular reviews and audits of healthcare strategies, and making evidence-based information about best practice readily available to healthcare practitioners.

4. **Person-centredness**

The effort dedicated towards ensuring that care for people is not only equitable, but also tailored to the specific needs of individuals across the world, both from a clinical perspective and in a broader sense, wherein "the full physical, mental, and social circumstances [of individuals are considered] rather than focusing on a specific organ, stage of life, or subpopulation".(4) This could include making use of culturally centred healthcare services which acknowledge an individual's beliefs and values when providing care.

5. **Coordination**

The quality and reliability of "service delivery across the whole spectrum of health and social care services" (4), which encompasses communication and collaboration between a range of disciplines and services, along the transitions between types of healthcare facilities and systems. This may involve information sharing through electronic healthcare as well as direct communication between multidisciplinary teams.

The WHO definition has evolved over time, but the current form was constructed in hopes of reducing confusion about the meaning of PHC (4), and reflects the Sustainable Development Goals set forth by the WHO to help ensure people's fundamental right to the "highest attainable standard of physical and mental health".(5) The WHO aims to offer a broad framework through which decisions about PHC can be made with clear principles and goals in mind. Thus, the wide-spanning definition has potential to be applied in a range of ways through individual systems and structures as required.(2)

1.2 Primary Healthcare principles as a Structure of Healthcare

The WHO states that "PHC enables health systems to support a person's health needs" (2), which reflects the integral importance of healthcare structures applying the principles outlined by the WHO to best support the people whose care they supervise. The goals for PHC which the WHO provides are able to guide decision making on healthcare policy, while also offering a basis for the structures and systems. This can manifest in countries which employ different explicit definitions

of PHC, but heavily integrate WHO principles into the PHC related structures of their respective systems.(4)

Indeed, Australia's definition of PHC, rather than the overarching principles provided by the WHO, refers to "those services in the community that people go to first for healthcare".(1) The Australian Government's 10 Year Plan for Primary Healthcare, for example, expressly outlines its intentions to "consider [Australian PHC services] in the broader context of the WHO/UNICEF definition of PHC" (3), allowing for a multifaceted approach which takes into account both the nation's own unique situation, along with the wider principles that underpin equitable, accessible and effective care.(1)

2.0 Primary Healthcare in Australia

2.1 The WHO Categories of Primary Healthcare in the Australian Context

Comprehensiveness:

Australian PHC does involve an extensive array of services, all of which collectively aim to identify social determinants of health (SDoH), as well as manage acute and chronic diseases, mental health concerns, cancer, sexual health and medication safety.(6)

There are still limitations in the comprehensiveness of PHC. For example, the economic costs and geographic barriers associated with PHC delivery in more remote parts of Australia can prevent individuals from already disadvantaged communities from attaining a complete range of services.(6)

Accessibility and Coverage:

Although access to PHC services (including preventive care) is improving, the current system still faces difficulty in achieving access and coverage for particular sub-populations.(6) These include low socioeconomic individuals, those facing geographic barriers and those at risk of harmful health behaviours.(6) It should also be noted that lack of cultural respect (in terms of communication issues and racial discrimination) contributes to reduced access.(7) Note that further information regarding specific subpopulations' interactions with the Australian healthcare system are detailed in sections 5.1 and 6.0.

Quality of care:

The implementation of Primary Health Networks (PHNs) is a contributing factor to the healthcare system's ability to address patient needs.(6) These are local-level organisations that assess gaps in their respective communities and then commission and/or coordinate service providers to facilitate those resources.(8)

PHNs are independent, local-level organisations which receive funding from the government to assess gaps in their respective communities and then commission and/or coordinate service providers to facilitate those resources.(8) PHNs are expected to provide services in line with the 7 key priority areas determined by the government, including mental health, Aboriginal and Torres Strait Islander health, population health, health workforce, digital health, aged care, alcohol and other drugs.(9) To achieve these goals, PHNs receive input from key stakeholders within local regions through GP-led Clinical Councils comprised of individuals from diverse health backgrounds, skills-based boards with experts across different disciplines and community advisory committees. Each of the 31 PHNs receive performance reviews every 12 months to ensure health is being improved in their region.(9)

It is also noted that PHC settings do engage in implementing evidence-based practice and knowledge translation to guide clinical practice. However, quality of care continues to suffer from high staff turnover, low levels of continuity of care and the discrimination faced by marginalised groups.(6) Discrimination includes lack of cultural safety, where there is inadequate engagement, inadequate understanding of power differentials and/or prejudice and stereotyping.(10) Furthermore, an emerging challenge is the progressively increasing complexity of chronic conditions and comorbidities.(9) Note that although PHNs occupy the role of mediating authorities that link resources to need, this policy explores ways to bolster those additional supports by discussing multidisciplinary care and social prescribing in sections 4.4 and 4.5.

Person-centredness:

Australian PHC is experiencing a transition over the last two decades where patient-centredness is being discussed and integrated into the guiding principles of different services and organisations of the healthcare system.(11) The goal is to form a system that appreciates the risk factors and personal context associated with each unique patient more than it does currently.(6)There is also a body of evidence supporting the health benefits of person-centredness guiding that transition. Persistent challenges to empowering the patient in a person-centred healthcare model include some healthcare providers being culturally incompetent.(6) Also, a low level of health literacy among patients in terms of health promotion and prevention as well as disease management which can hinder the process of sharing decision-making with the patient.(6)

Coordination:

Distance to the service provider and financial costs are some of the barriers to achieving effective referrals.(6) There are also deficiencies in referring patients to manage the risk factors that contribute to their chronic condition. Another

dimension to the coordination aspect of PHC is the role of multidisciplinary teams. These teams consist of various healthcare professionals (see details in section 4.3) who communicate with each other to deliver care for the same patient. This model is gaining success in Australia, with one large study of more than 100 000 patients measuring approximately 23% less emergency room visits and 10% less hospital readmissions for patients receiving care under a multidisciplinary (integrated) model compared to a traditional model.(12)

Multiple Principles:

An obstacle in the provision of comprehensive care, accessibility and quality of care is the shortage of staff and physical resources.(6) This is especially problematic because it is self-reinforcing, with lack of resources creating stress and dissatisfaction among current staff, exacerbating staff turnover and the tendency of graduates to not enter PHC.(7)

2.2 The benefits of prevention over treatment

PHC forms the backbone of preventative medicine in Australia. Integrated within communities, PHC services often represent a first point of contact between an individual and the health system. With roles extending from health promotion and prevention to treatment and management, PHC is integral to lessening the burden on other downstream medical services. A major aspect of this is through continuity of care, whereby an ongoing relationship can be formed between practitioner and patient.(13) This facilitates increased levels of shared decision-making and greater quality of care.(13) In general practice specifically, having a regular GP is furthermore associated with greater patient satisfaction and an increased likelihood of adhering to medication.(14)

PHC also has the ability to reduce strain on downstream healthcare services. In recent years, emergency use is increasing at a rate exceeding population growth, growing from 330 presentations per 1,000 people in 2018-19 to 334 per 1,000 in 2022-23.(15) Despite wait times and duration spent in the emergency department increasing compared to previous years, the number of patients designated as lower urgency remains constant.(15,16) Adequate access to quality PHC services could be part of the solution in reducing the number of lower-urgency presentations.(16) This is supported by studies evidencing that regular use of a GP was associated with reduced 'high use' hospitalisations.(17,18)

In addition to minimising the burden placed on downstream health services, proper PHC utilisation is associated with reduced economic expenditure and even increased GDP.(19,20) In its current state, a significant proportion of Australia's

annual healthcare expenditure is centred on modifiable risk factors including obesity, alcohol consumption and physical inactivity.(19) This is accompanied by significant downstream non-health-care related costs, such as funding for law enforcement dealings with substance abuse.(19) Likewise, significant gross domestic product is lost due to reduced work productivity and early retirement resulting from ill health.(20) By targeting disease before it develops, PHC therefore has the potential to be more economically advantageous for the government, businesses, individuals and communities than focusing on treatment alone.(20)

2.3 "General Practice Health of the Nation 2023" - Annual insight into general practise by the RACGP

"General Practice Health of the Nation 2023" is the only annual report that provides insights into the state of general practice in Australia, collated by the RACGP. The report incorporates data from a nationwide survey of GPs across Australia. The 2023 topic of the report is the 'attraction and retention of the general practice workforce'.(21)

Some main points of interest the "General Practice Health of the Nation 2023"(21) report found are:

- GPs remain highly accessible medical professionals, delivering 179 million services in the last year
- Fewer than 1% of people reported they were unable to see a GP when they needed to in 2021–22
- GPs are spending more time with their patients than ever
- Patients accessing PHC services are facing increasing costs for their care
    - In the space of one year, the proportion of GPs bulk billing all of their patients halved from 24% in 2022 to just 12% in 2023.
    - General practice represents only 6.5% of total government health spending in 2021-22 and has decreased from an average of above 7% in all previous years between 2016 and 2021
- The profession as a whole has concerns about workload, burnout, and fragmentation of care
    - More than seven in 10 GPs (71%) reported feelings of burnout in 2023.
    - GPs report their overall job satisfaction has decreased from 70% in 2022 to 66% in 2023.
- There is waning interest in the profession among both medical students and working GPs.
    - In 2023, just under four in 10 practising GPs indicated they would recommend their profession to their junior colleagues.
- Workforce issues are worsening, with increasing numbers of GPs intending to retire or cease practising over the next 10 years.
    - 29% of GPs intend to retire in the next five years

2.4 "Australia's Primary Healthcare 10 Year Plan 2022–2032"

"Australia's Primary Healthcare 10 Year Plan 2022–2032" (henceforth referred to as 'the Plan') is a publication by the Australian Government in 2022 to provide an agenda for PHC reform from 2022 to 2032.(3) This plan, together with $632.8 million in new investment in the 2022-23 Budget, delivers on the Australian Government's continuing commitment to stronger PHC.(3)

Below are the objectives of the plan quoted directly from the organisation.(3)

> *The objectives of the plan are:*
> - *Access: Support equitable access to the best available* PHC *services.*
> - *Close the Gap: Reach parity in health outcomes for Aboriginal and Torres Strait Islander people.*
> - *Keep people well: Manage health and wellbeing in the community.*
> - *Continuity of care: Support continuity of care across the healthcare system.*
> - *Integration: Support care system integration and sustainability.*
> - *Future focus: Embrace new technologies and methods.*
> - *Safety and quality: Support safety and quality improvement.*

To achieve these objectives, the Plan concentrates on three streams of work as core agenda items for the next decade: future focused healthcare; person-centred PHC supported by funding reform; and integrated care, locally delivered.(3)

Stream 1 describes a focus on integrating telehealth and video communications into the MBS as part of creating a healthcare system that is future focused.(3)

Stream 2 proposes a new platform for voluntary patient registration (VPR) that formalises the relationship between patients and GPs that ultimately seeks to encourage patients to return to the same GP and for GP practises to overtime have a database of information to better understand their patient populations to achieve quality personalised care for the patients.(3) This platform (previously named MyGP, now renamed MyMedicare) would also support practice incentives such as PIPs (practice incentive program) and WIPs (workforce incentive program). A platform to give funding to GPs and GP practices based on their patient population (formalised by the VPR system) and increase incentive to look after disadvantaged populations.(3) More detailed information about the VPR program - MyMedicare is provided in section 3.3.

Stream 3 outlines delivery of integrated and local health service models through joint planning and collaborative commissioning at regional and state-wide levels.(3)

The Plan is a vague agenda document outlining aims, objectives, reasons behind agenda items and the current state of the Australian PHC system.(3) The document

does not provide quantified measurements of success, nor does it provide a plan of quantified funding the Australian Government can promise to invest into the action items proposed in the Plan.(3)

2.5 Training pathways for General Practice

Currently, fellowships in general practice are provided by two Australian Medical Council (AMC) accredited medical colleges, the Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of General Practitioners (RACGP).(22,23) The RACGP offers fellowship training for specialist general practice across urban and rural settings. It furthermore provides clinical resources, current news and education around general practice.(23) Alternatively, the ACRRM delivers fellowship training in preparation for a rural generalist model of practice. Rural generalists operate in an extended scope of practice to best suit the needs of rural, remote, and Aboriginal and Torres Strait Islander communities. This involves having skills in general practice, emergency care and hospital care.(22)

3.0 Funding and Finance

3.1 Primary Healthcare Funding Model

How is Primary Healthcare financed?

Healthcare in Australia receives funding from federal, state and territory governments, which contributes to a universal, public healthcare system funded by tax-payer money.(24) Approximately 10% of governmental support for general practice derives from quality and outcome payments via programs like the Practice Incentives Program (PIP), the Workforce Incentive Program (WIP), and the Indigenous Australians Health Program (IAHP). The remaining 90% is disbursed through Medicare, primarily through the Medicare Benefits Schedule (MBS), which is based on a fee-for-service model.(3) Public health services can be supplemented with finance from private health insurance, accident compensation schemes or out-of-pocket consumer payments.(25)

What is Medicare?

Medicare is Australia's universal public healthcare system, seeking to provide affordable, accessible and quality care.(27) It allows services to be free or subsidised to all citizens and permanent residents.(24) Medicare encompasses subsidies for GP and specialist consults, diagnostic tests and in- and out-patient care in public hospitals.(27,28)

Service users can choose to purchase private health insurance to cover hospital services or other services that Medicare doesn't cover, for instance dental care.(24)

Under Australian Medicare, doctors can set their own prices – many following suggested fee guidelines from the Australian Medical Association. If there is a gap between their set price and the Medicare rebate, it leaves a gap payment out of pocket for patients.(24)

What is bulk billing?

PHC funding is allocated based on appointment fees. This 'fee-for-service' model dictates healthcare provider reimbursement from the public system on the number of services or consults provided, and each service rate is set by the Medicare Benefits Schedule (MBS). If a service is covered completely by the MBS this is termed "bulk billing", where there is no out-of-pocket expense to the patient. Out-of-pocket or gap payments can be claimed by clinics in addition to the rate set by the MBS.(29) Bulk billing provides an opportunity for patients from lower socioeconomic backgrounds such as concession card holders or young people to be seen at no personal cost, as Medicare will directly pay the service fee to the providing doctor and, in so doing, minimise barriers to accessing healthcare to vulnerable populations.(29)

Service use

From 2021 to 2022, approximately 270 million PHC services were subsidised by Medicare in Australia, such as 189 million GP attendances, 25 million allied health attendances and 4.1 million services provided by nurses, midwives and Aboriginal health workers.(30) According to the Australian Bureau of Statistics, between 2020-2021, one third of the health budget was expended on PHC, at $73.4 billion.(30) This spending was broken into $13.2 billion on unreferred medical services, predominantly general practice consults and $12.5- and $12.2 billion respectively on subsidised and non-subsidised medications.(30) Despite this, in 2021-2022 there was a rise in the percentage of individuals, 3.5%, who either postponed or didn't consult a GP due to financial constraints, compared to 2.4% the previous year. Regarding those with chronic health conditions, 3.9% faced barriers accessing GP services due to costs, exceeding the percentage among those with more acute conditions (3.0%). Moreover, the proportion was higher in remote regional areas, at 5%, as opposed to metropolitan, at 3.1%.(30)

Examples of recent funding commitments

In 2019 and 2020 respectively, the PIP and WIP programs were adapted to incentivise data-driven quality enhancement endeavours within general practice settings and to support the involvement of nursing staff in clinics along with various other allied health practitioners. Each program also incorporates rural loadings to assist in bolstering the recruitment and retention of general practice workforces in rural regions.(3)

The 2022-23 budget committed $2.9 billion to revamping the PHC system in Australia.(8)

- $220 million to establish the Strengthening Medicare GP Grants Program, seeking to offer further resources and facilities to PHC clinics.
- $235 million to institute 50 Medicare Urgent Care Clinics.
- $750 million across three years' duration as investment in strengthening and bolstering the current Medicare system.

3.2 The cost-efficiency of General Practice and suggested changes to the current system

"The Vision for general practice and a sustainable healthcare system" (The Vision) is a model of care introduced by the Royal Australian College of General Practitioners (RACGP) which presents their suggested framework for addressing the issues and pressures confronting general practice, and provides evidence-based solutions to a sustainable and equitable healthcare system for patients, providers and funders.(31)

The Vision proposes significantly increased cost-effectiveness for the healthcare system by implementing strategies to reduce secondary healthcare use, focus on disease prevention and enhance economic productivity of citizens.(32) In terms of cost-effectiveness, The Vision estimates that more than $4.5 billion can be saved per annum if general practitioners are adequately supported in their roles.(32) According to their research on decreasing secondary healthcare use, $1.5 billion per year can be spared if GPs were better equipped to manage "low-urgency" cases that otherwise present to emergency departments, and $3 billion per year spared if better resourced to manage the prevalent conditions that escalate to otherwise preventable in-patient admissions.(32) Moreover, increased economic productivity of society as a whole is an objective outcome of preventative care and reduced illness within the population.

To further elucidate the cost-efficiency of general practice relative to the rest of the healthcare system, the government will spend $375 per person per year on general practice, compared to $2606 on hospital care, almost seven times less.(33) Ultimately, improved support and efficiency within general practice will lead to substantially reduced expenses incurred in the broader healthcare system, as pressure on costly secondary care will be minimised. It will also enhance the nation's gross productivity by promoting good health and active engagement in society.(33)

Some of the barriers preventing Medicare from functioning optimally can be divided into:

a. the type of care required; whereby Australia has an ageing population with increasing prevalence of chronic conditions and complex comorbidities, yet its existing system incentivises acute treatments and expensive hospital admissions over managing chronic conditions or promoting prevention.(33) The current system prioritises quantity over quality of care, incentivising the volume of patients seen rather than focusing on individual need.(34) As illustrated previously in Section 3.2, there is significant cost-effectiveness achieved by investing in preventative care and management of complex conditions, which is unfortunately not prioritised in the current Medicare rebate structure.
b. the structure of the system; whereby the costs of receiving and providing care are increasing faster than the rate of inflation and rebate payments have not reflected appropriate indexation.(33) Moreover, the regulation of Medicare itself requires modification, for instance in the case of patients having to await reimbursements of the rebate, and practices having to conduct additional administrative work in order to process these.(32) GPs are also worried about appearing to 'over-bill' their patients and accidents in navigating this complex system can lead to being flagged by Medicare for fraud. This leaves GPs likely to "under-bill because of the fear that Medicare will come knocking on your door".(34) The MBS must also recognise general practitioners as medical specialists to reflect how this field has developed since the MBS was established in 1984. Ultimately, The Vision supports that the 'fee-for-service' MBS model should remain the structure for funding PHC, however that the service rebates must be reviewed and increased to sustain the additional complexity and time required to achieve safe practice.

Below is an excerpt taken from the executive summary of The Vision, detailing its suggested solutions.(33)

Upon consulting the suggested changes stipulated by RACGP in The Vision, PwC modelled that, over the next five years, their implementation would result in an economic benefit of $5.6 billion for the Australian Government. Moreover, these changes would conservatively result in a gain of 520,000 quality-adjusted life years during this time, representing an invaluable social return on investment beyond the health-dollars saved.(35)

Existing general practice services must be better supported through:

- *maintaining and modernising the fee-for-service system*
- *setting rebates that accurately reflect the cost of service provision by GPs and ensuring appropriate and regular indexation of rebates*
- *appropriately supporting the delivery of comprehensive general practice care*
- *increasing payments to practices to facilitate team-based general practice care*
- *facilitating genuine high-quality improvement activities in general practice*
- *increasing funding for GPs and practices to undertake teaching of medical students and general practice registrars, and introducing new funding to support teaching for all other members of the general practice team.*

General practice can be further strengthened by:

- *encouraging continuity of care for patients within their preferred practice via voluntary patient enrolment*
- *supporting the role of GPs and their teams in coordinating care with hospitals and other health and social services*
- *recognising increasing patient complexity by introducing a complexity loading payment to GPs and practices*
- *supporting general practice–based research*
- *supporting the collection and appropriate use of general practice data to strengthen the evidence about the effectiveness of* PHC*, and to provide better population planning*
- *supporting better use of health resources through improved information-sharing and regional coordination.*

State and territory governments also have a role in supporting high-quality general practice and the quadruple aim through:

- *supporting coordinated care between general practice and state or territory-funded programs and services*
- *supporting integrated care initiatives that improve the interface between general practice, hospitals and other health services.*

3.3 New initiatives and ideas to improve the funding of Primary Healthcare system

Funding reform proposed by "Australia's Primary Healthcare 10 Year Plan 2022–2032"

Within "Australia's Primary Healthcare 10 Year Plan 2022–2032" (the Plan), a funding reform is proposed to occur over the decade to better facilitate "outcome focused and multidisciplinary care" and to address the challenges faced by population cohorts who face barriers to accessing appropriate care.(3) Details of the proposed new funding model are outlined under objective A ("incentivise person-centred care through funding reform") of reform Stream 2 ("person-centred PHC, supported by funding reform").(3)

Below is a summary of the funding reform proposed by the Plan (3):

- A new "system of voluntary patient registration" established with the public to be the future platform to coordinate GP funding. This was named MyGP and allocated $50.7 million in the 2021-22 Budget, recently the system has been renamed MyMedicare. This is still a service in development. "In future Budget updates, the Government will consider opening the MyGP system for enrolments to specific cohorts of the population and eventually to the whole of the population." As of the writing of this policy, MyMedicare is open to all holders of an Australian Medicare card to register.
- The Government plans to continue to invest in the Practice Incentives Program (PIP), the Workforce Incentive Program (WIP), with a series of reviews and adjustments of individual incentives being considered in consultation with stakeholders. (e.g. Indigenous health, Aged care).
- In 7-10 years the vision is for all general practice payments to be linked to VPR for "people will receive better care". "Payments linked to quality and outcomes measures, rather than fee for service, will contribute up to 40% of the blended payment mix."

Essentially the Plan outlines the future of PHC funding to be coordinated through a new platform of "voluntary patient registration (VPR)", in order to centralise and congregate information about PHC services and thus collate data regarding patient populations for each GP practice.(3) Through VPR data collection and investigations into known inequities in health, the government plans on further implementing PIP and WIP programs to compensate general practice services based on quality of care. Eventually in 10 years time, the vision is for 60% of payment for the service to come from the Medicare Benefits Schedule (MBS) as a baseline and 40% of payment to come from PIP and WIPs. The 10 Year Plan reasons that having 40% of payment to come from PIP and WIPs, this will lead to more personalised care.(3)

There are criticisms of the Funding Model proposed in the Plan. From a 2022 article published on the RACGP website, past RACGP college President Adjunct Clinical Professor Karen Price raises her concerns regarding a lack of funding in the federal budget to support the Plan. (31) Chair of the RACGP Expert Committee – Funding and Health System Reform (REC–FHSR), Dr Michael Wright also points out he has doubts about aspects of the plan, for example, as a part of moving towards a part digitised healthcare provision as the future "We need to remember that there are patients who do not have the skills nor access to the technology required for video consultations."(36)

More about MyMedicare

MyMedicare is a system connected with the current Medicare online portal. Patients can enrol with a general practice registered with MyMedicare. Enrolment will give practices more comprehensive information about their regular patients.(37) Through the MyMedicare system, the Australian government will gradually roll out additional funding packages. The first of such packages is planned to be released mid 2024, it will be a lump sum "capitation" payment given to practices for each patient registered with MyMedicare who have more than 10 hospital admissions a year, to support complex care needs, however at this point in time further details are yet to be confirmed.(37)

There are 3 ways for patients to register with their GP on the MyMedicaresystem, in all cases the practice needs to be registered first on MyMedicare. Patients can initiate the process through their Medicare Online Portal (which is integrated in the MyGov Portal) or Express App. The practice can initiate the process and ask patients to complete their registration on the Medicare Online Portal. Alternatively, patients can fill out a physical registration form and provide it to their practice for the practice to complete the registration.(37)

Another core goal of the establishment of the VPR system is to increase continuity of care.(38) Patients are more likely to visit the same GP they have voluntarily acknowledged to register with. Looking to the future, as more funding programs roll out, theoretically practices will be incentivised to encourage patients to register on the MyMedicare system in order to be remunerated for more complex care and care to vulnerable populations.(38) Additionally practices may improve care and become more welcoming to disadvantaged populations identified by funding packages to incentivise patients staying with the practice.(38)

MyMedicare is a new system without data to judge its effectiveness. This system like the rest of Australian healthcare requires ongoing dedication of the government budget.(38) Its success in meeting the established goals outlined in the 10 year Plan, such as continuity of care, improving access for disadvantaged populations and rewarding quality over quantity of care, is dependent on continuous accurate and effective identifications of priority populations for care as well as effective determination of the amount of funding. It also requires spread of awareness to increase general practice and patient participation.(38)

A robust PHC system should be built of multi-source funding options, it is important to have a mix of MBS funding and VPR based funding packages based on patient populations.(39) This new funding system should not excuse stagnated MBS

funding for GP appointments. This policy strongly urges the authority bodies to have ongoing review and improvement of this new system of funding.(37)

4.0 Workforce

4.1 Who makes up the workforce

In Australia, the PHC workforce is diverse and includes general practitioners (GPs), nurses, allied health professionals, and support staff.(40)

4.2 What are the issues with workforce shortages

Currently, one of the issues with workforce shortage is geographic maldistribution, with rural and remote areas facing more significant shortages and these areas most likely to have worsened shortages in the coming years. An issue is also raised due to the ageing workforce which precipitates higher retirements while at the same time increasing the demand for health services.(41) Additionally, there is current reliance on International Medical Graduates (IMGs) and there is a real need for a shift towards national self-sufficiency. This issue has been emphasised by both the Royal Australian College of General Practitioners (RACGP) and the Australian Medical Association (AMA).(42,43) Finally, there are negative perceptions of general practice, limited opportunities for GP skills development in medical school, disparity in remuneration, and inflexible training conditions.(42)

4.3 Strategies and initiatives for promoting General Practice specialisation

One of the ways that GP specialisation could be promoted is through enhanced training programs and incentives for medical students and junior doctors to choose general practice as a career. Government plays an important role here by enacting policies or legislative reforms that would support the expansion of the healthcare workforce.(36) An example of one country that has made the efforts to attract more doctors into GP through initiatives like GP induction and Refresher scheme that would make it easier for students to enter GP specialty is the UK. Government could also invest in healthcare infrastructure and create policies that support health workforce sustainability. This could also involve multi-step strategy that aims to in the short-term make better use of IMGs while in the long-term shift towards national self-sufficiency might be well-served. This could include policies that would facilitate the accreditation and employment of IMGs.(44)

An important step in supporting junior doctors to enter GP specialisation is striving towards pay parity for GP registrars and their hospital specialty-based counterparts. New analysis performed by the General Practitioner Registrars Australia (GPRA) has revealed that GP registrars take a 12 percent pay cut when transitioning from their

hospital-based training.(45) This is widely recognised as one of the significant contributors to the workforce challenges facing the GP sector.(45)

One strategy aimed at bolstering the GP workforce and achieving pay parity, particularly within the rural setting, is the proposal of a 'Single Employer Model'.(46) The principles of this initiative, as stated in the AMA's plan to modernise Medicare, strive to promote GP training by providing equitable remuneration and employment conditions relative to other speciality fields.(46) This is done by placing the employment of general practitioner trainees under a single-employer, allowing ease in transfer been practices without loss of entitlements. Pilot programs of this program have been implemented and undergone review across sights in Tasmania and New South Wales.(47,48) Research and review of these strategies continue to occur, particularly as the program moves from regional settings to tests within metropolitan areas.

Another proposed idea is the 'Future GP Peer initiative', which was put forward by the GPRA in the 2024 budget submission.(49) With the aim to attract future medical workforce for the GP speciality as well as build upon the strengths of the current workforce, this strategy would provide additional support to the future workforce through peer-to-peer framework.(50) The proposed plan to achieve this is through 'Peer Hubs', which would be established across metro and rural settings to help facilitate linking GPs to trainees and medical students and provide positive peer learning experiences, professional development, and take steps to overcome the stigma and misconceptions surrounding General Practice. In time, these Hubs would aim to become Centres for General Practice Excellence.(50)

4.4 The Multidisciplinary Team

A multidisciplinary team (MDT) approach in the workforce, particularly within the PHC setting, plays a crucial role in delivering comprehensive and efficient services.(40) Within General Practices and the broader community, there are multiple clinicians and healthcare providers that will make up the multidisciplinary team that plays a role in the care of patients. Members of this team include general practitioners, nurses, physiotherapists, social workers, dietitians, psychiatrists, psychologists, pharmacists, administrative staff, clinic managers, and many other allied health professionals.(40) The MDT framework aims to bring these professionals from various disciplines together in a coordinated manner to provide holistic and effective care for patients.(51) Invaluable elements to the success of a MDT includes effective communication facilitated through infrastructure and technology, respect and trust within the team, solid implementation strategies, and transparency.(52)

4.5 Social prescribing as a strategy to address the social determinants of health (SDoH)

Social prescribing is a developing feature of PHC that has had success in other parts of the world, including the United Kingdom.(53) Social prescribing is the process of linking those community members with non-clinical health needs to community services that can provide reliable opportunities to meet those needs. This approach requires the cohesive integration of existing community services with the healthcare sector.(53) Therefore, referrals may be made from sites of PHC to organisations that provide a wide range of services (e.g. housing and financial support). The result is a population that is empowered to address the SDoH that contribute to the burden of disease.(53)

It should be noted that although this method calls on the healthcare system to harness pre-existing services, those community services still likely require additional funding and staff to be effective in Australia. A centralised government authority could be responsible for the allocation and redistribution of funds to areas lacking regularly available and appropriate community services.(53)

5.0 Factors Affecting Primary Healthcare Access

5.1 Existing and Changing Healthcare Needs of the Australian Population Informing the Changing Demands on Primary Healthcare

With the third highest global life expectancy rates, Australia is a country that is currently undergoing immense population-level changes on the basis of not only ethnicity or locality but also age.(54) With current growth rates, by 2066, those over 65 years of age within our population will comprise approximately 20% of our communities.(54) This shift in population demographics cannot purely be attributed to increasing life expectancies, a by-product of a relatively efficient healthcare system, but also to rapidly declining fertility rates which are not adequately bolstered by migration.(54,55) In lieu of the effects of such previously unseen population shifts, the PHC workforce and systems need to adapt to meet the changing needs of the Australian population.

The accessibility of PHC in Australia, particularly for disadvantaged groups such as Aboriginal and Torres Strait Islander people, refugees, low socio-economic status individuals, and the ageing population, is a critical issue that has been addressed through various policies and studies.(6) These groups often face barriers to accessing PHC services, including cultural, physical, and language barriers, as well as unmet health service needs.(6)

Australia has achieved universal health insurance since 1975, which was a significant step towards increasing access to PHC. However, challenges persist, including inequity in healthcare access.(6) There is evidence of persisting socio-economic inequalities for individuals with disabilities.(56) Women with disabilities in Australia have identified systemic barriers such as financial resources and accessibility issues that hinder their ability to achieve health and relationship goals.(57) Additionally, there is a focus on integrating primary health and social care to better serve vulnerable older people in the community.(58)

Culturally and Linguistically Diverse Communities

As a nation, Australia has a vastly complex, multicultural society, with some of the highest rates of immigration in the Western world. With these rates of immigration come new challenges, especially to a PHC system that was founded to meet the needs of the Australian population of the 1980s.(59) For the purposes of this analysis, people who were born overseas or those who speak a language other than English will be termed as culturally and linguistically diverse [CALD] individuals [i.e. migrants]. In general, in the initial years post-migration, most migrants experience better physical health ["healthy migrant effect"], however, a smaller subset of this group, namely asylum seekers and refugees, face immense challenges within foreign healthcare structures.(60)

These challenges are further compounded due to complicating factors such as language barriers, relatively lower health literacy levels, lower socioeconomic status and poorer baseline health, especially with regards to preventative care [i.e. vaccine, dental care, diet education] at first contact.(44) Language barriers can prevent CALD communities from effectively accessing and utilising health services. The study examining CALD communities in Logan, Queensland, found that even long-standing communities were unfamiliar with health services and experienced difficulties due to language barriers.(61) Ease of access to PHC services within this demographic is also affected by financial difficulties, cultural beliefs surrounding mental healthcare, lack of trust within healthcare professionals from differing backgrounds, lack of continuity of care [which aids in developing trust to breach initial barriers in communicating psychological needs] and fears surrounding confidentiality.(60)

In order to address these barriers, PHC should aim to target this innate inequality through education and the utilisation of appropriate resources.(59) Recent studies have shown that the uptake of such services are affected by the accessibility of health services to those living in ethnic enclaves with high proportions of refugee populations, access of patients and families to entry-level jobs] and support network systems in place within these communities. More importantly, the cultural

competence of healthcare workers also plays an integral role in encouraging engagement with new healthcare structures.(59,60) Hiring multicultural practitioners or establishing cultural specific roles to better communication and health education, implementing education sessions around different cultural backgrounds and incorporating cultural beliefs into treatment plans for individuals all work to increase uptake of the services already afforded to these vulnerable populations.(60)

Aboriginal and Torres Strait Islander Communities

Finally, the immense barriers to healthcare faced by the Australian Indigenous community must be explored as well.(62) As of 2022, five key closing-the-gap targets are not on track to be met by 2031, or have not been met by 2018 [halfway point]:

- halve child mortality rates within the Indigenous population [2018 target],
- halving the gap for Indigenous children in reading, writing and numeracy within a decade [2018 target],
- closing the gap in school attendance [2018],
- halving the gap in employment outcomes between Indigenous and Non-Indigenous Australians; and
- closing the gap in life expectancy [2031].

These unmet targets imply significant flaws within the PHC system to meet these goals, whether in theory, practice or in some structural manner [i.e., funding, uptake by population].(62) A 2018 study of disease burden in Australia found that Indigenous Australians lost approximately 240,000 years of healthy life due to ill-health and premature death, with the five leading disease groups contributing to this cause consisting of: mental and substance use disorders, injuries, cardiovascular disease, cancer and other neoplasms as well as musculoskeletal disorders.(63) Of note, respiratory conditions also contributed substantially to the non-fatal burden.(63)

To primarily target these barriers to achieving optimal health, the targeted lowering of risk factors for chronic disease [i.e. obesity, smoking, drug use, alcohol reliance] through the promotion of access to support PHC services that work to educate communities, along with improving overall health literacy will aid in bridging the gap between Indigenous and Non-Indigenous healthcare outcomes.(64,65) Additionally, further education of healthcare providers regarding the specific challenges, both in terms of physical health and overall wellbeing, faced by this demographic, will improve overall access to healthcare for these communities and ensure that any recommended interventions will have maximal impact, rather than simply being simplistic, uniform recommendations for all individuals, regardless of their personal circumstances and unique backgrounds.(62–65)

While Australia has made significant strides in providing universal health coverage and addressing some aspects of PHC accessibility, there is still a need for targeted policies and interventions to improve cultural, physical, and language accessibility for disadvantaged groups. Efforts must continue to address the unmet health service needs of these populations to achieve health equity.

5.2 Climate Change

Climate change poses significant risks to physical health through extreme weather events, changes in disease patterns, and impacts on food and water security. In Australia, the prevalence of climate change-induced natural disasters such as floods, hurricanes, wildfires, and heatwaves has been linked to worsening physical health outcomes.(66) These events not only cause immediate injuries and fatalities but also have long-term health implications due to the disruption of healthcare services, contamination of water supplies, and food scarcity.(67) PHC professionals, especially GPs, are on the frontline, dealing with the immediate and chronic health issues arising from these events.

The mental health impacts of climate change are profound, with a significant burden placed on individuals and communities. Vulnerable populations, including those with low socioeconomic backgrounds, young individuals, and communities with close cultural and working relationships with the environment, are at higher risk.(66) The prevalence of mental health issues related to climate change, such as eco-anxiety, PTSD, and pre-traumatic stress, is notable in Australia.(68) GPs are crucial in addressing these mental health concerns but face challenges due to the increasing complexity and volume of cases, contributing to burnout.(69)

Evidence suggests that PHC professionals can play a pivotal role in changing patient perspectives on global health and climate change. By engaging in conversations about the health impacts of climate change, GPs can raise awareness and encourage lifestyle changes that contribute to mitigation efforts.(66) This approach not only addresses individual health concerns but also contributes to broader public health goals by fostering a more informed and health-conscious population.(66)

Given the increasing demands placed on GPs due to climate change, there is a need for targeted support to enable them to effectively manage the health impacts. This includes providing GPs with access to resources and training on climate-related health issues, enhancing mental health support services, and implementing initiatives to reduce burnout among healthcare professionals.(68,70) Additionally, fostering interprofessional collaboration and integrating climate change into the PHC curriculum can empower GPs to address these challenges more effectively.(66)

6.0 Relevant Associated AMSA Policies

Refer to these policies within the policy base for more detailed explorations AMSAs position on the following:

Racial Discrimination and Cultural Diversity Policy:
This policy discusses the specific barriers that refugees face in accessing PHC, such as language barriers, cultural differences, lack of understanding of the healthcare system, and trauma-related issues. Emphasis is placed on the importance of healthcare providers being culturally competent when treating refugee populations, including understanding their cultural beliefs, practices, and experiences that may impact their health. The policy advocates for training programs that educate healthcare professionals on effective care for these populations, proposes implementing systematic auditing to tackle institutional racism and encourages collaboration with refugee communities to better understand and address their specific health needs.

Aboriginal and Torres Strait Islander Health Policy:
The Aboriginal and Torres Strait Islander Health Policy addresses the barriers faced by Aboriginal and Torres Strait Islander people in accessing PHC services. It highlights that these communities face challenges such as geographical remoteness, the effects of the Stolen Generations and intergenerational trauma, and a lack of cultural safety in healthcare settings. These barriers result in reduced presentation to healthcare services and poorer physical, psychological, and cultural health outcomes for Aboriginal and Torres Strait Islander people. The policy emphasises the importance of recognising and respecting the diverse needs and strengths of these communities and leveraging their strong connection to community, Country, and culture in promoting healthy lifestyles. Additionally, it discusses the effectiveness of community-led healthcare initiatives, such as Aboriginal Community Controlled Health Organisations (ACCHOs), in improving healthcare provision and engagement in Aboriginal and Torres Strait Islander communities.

LGBTQIASB+ Health Policy:
The policy addresses the challenges faced by LGBTQIASB+ people in accessing quality PHC, particularly in regional and rural areas. It highlights that discrimination, marginalisation, and oppression within healthcare systems can lead to delays in seeking care and poorer healthcare outcomes for LGBTQIASB+ individuals. Negative experiences, stigmatisation, biological essentialism, and misgendering by healthcare workers can impact engagement with the healthcare system.

Additionally, the policy emphasises the importance of finding safe practitioners for LGBTQIASB+ individuals.

Regional, Rural and Remote Health Policy:

The policy addresses several key issues related to access to PHC for Regional, Rural, and Remote communities. It highlights the disparities in healthcare resources and funding between rural areas and metropolitan areas, leading to poorer patient outcomes and limited care options for doctors. Overall, the policy underscores the importance of addressing workforce shortages, improving resources and technology, and providing incentives to healthcare professionals to enhance access to PHC services in Regional, Rural, and Remote communities.

Unemployment and Health Policy:

The policy highlights the disparities and challenges lower SES face in obtaining quality healthcare services. It discusses how individuals with lower SES often experience barriers to accessing healthcare due to financial constraints, lack of health insurance, and limited availability of bulk-billed medical services. One key aspect mentioned in the policy is the provision of low-income healthcare cards for people with a low income, which offers benefits such as reduced Medicare Safety Net thresholds and cheaper medications in order to alleviate some of the financial burdens of accessing healthcare. This policy advocates for initiatives that promote equitable access to PHC services for this vulnerable population.

Social Prescribing Policy:

The policy on Social Prescribing advocates for a biopsychosocial model of health, focusing on holistic patient well-being and disease prevention. It calls for the piloting and evaluation of social prescribing programs in Australia to integrate them into PHC. The policy emphasises the importance of involving various stakeholders in the implementation of social prescribing, ensuring accessibility for diverse populations, educating medical students on social prescribing, and collaborating with different organisations to promote social prescribing practices. The policy also highlights the need for research, training programs, and collaboration with local councils to expand existing community services for inclusion in systemic social prescribing plans.

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