Investing in Comprehensive Primary Care

Proposal for establishing health equity as a core element in general practice funding models

By The Health Equity Coalition – Brisbane, March 2025

Contents

Executive Summary....2
Origin Statement....4
Guiding Principles/ Proposed Models....5
Background and Case for Change....7
Part 1: The Economics for Change....10
Principle 1: Equalise funding....10
Principle 2: Address rising health inequality....13
Principle 3: Reform MBS incentives....16
Part 2: The Case for Teamwork....20
Principle 4: Recognise the value of patient-centred care....20
Principle 5: Prioritise continuity of care....21
Principle 6: Avoid overloading stretched primary care....22
Principle 7: Fund nursing roles adequately....23
Principle 8: Accelerate team-based care....29
Principle 9: Resource larger, multidisciplinary teams....33
Part 3: Funding What matters....34
Principle 10: Implement patient enrolment models....34
Principle 11: Introduce incentivised salaried roles....42
Principle 12: Fund acute care clinics....46
Principle 13: Design clinical spaces to support team-based, flexible models of care....48
Part 4: Addressing Need and Scale....50
Principle 14: Support access to capital for charitable practices....50
Principle 15: Partner with innovative practices....51
Principle 16: Recognise infrastructure costs....54
Principle 17: Use real-world costing data....55
Section 5: Governance and Capacity Growth....57
Principle 18: Incentivise student placements....57
Principle 19: Invest in clinical governance....59
Principle 20: Fund corporate governance capacity....60
Principle 21: Create flexible funding pools....62
Conclusion....69
Table of Figures....72
References and Footnotes....73

Executive Summary

Context:

Australia has rapidly rising population, escalating ageing amongst residents, increasing rates of multi-morbidity and polypharmacy, falling hospital bed to population ratios and a tightening health workforce. With such cost and workforce constraints, new solutions are required to deal with pressure points so evident across the health sector. These challenges are most prevalent in populations of disadvantage. Serving their more frequent and complex presentations requires a dedicated team who knows the patient and offers comprehensive care in accessible and affordable ways.

Working with the most disadvantaged and marginalised often falls on the not-for-profit sector. In primary care this is no different. In indigenous communities, aboriginal medical services have pioneered team-based solutions which are culturally appropriate and targeted at addressing the trauma and social determinants in those populations. In rural areas, organisations like the Royal Flying Doctor Service and Check Up fill the gaps in service provision which are so evident when there is no market to provide care for small populations. Each of these types of provider receives block grants to enable ongoing care in recognition of the needs of their client groups. In some instances, they can combine that with access to fee for service (Medicare Item billing).

In metropolitan locations, there are many hard to serve populations. Those who are experiencing homelessness, people with problematic substance use and dependence issues, people from LGBTIQ+ communities, those of multi-cultural backgrounds with a history of trauma and those from backgrounds of intergenerational poverty often find access to healthcare a real challenge.

Proposal:

The Health Equity Coalition proposes a *blended funding model* for primary care that makes health equity a core outcome of funding. Under this model, Medicare fee-for-service would cover direct doctor-patient care. The majority of funding to practices would come through block payments and incentives to support a multidisciplinary care team inclusive of time spent by General Practitioners and Nurse Practitioners into case management and clinical governance. This approach would be scaled in not-for-profit general practices whose mission is to serve marginalized and high-need groups. These practices require a different staffing mix (more nurses, allied health and support workers relative to doctors) and more time to build trust, health literacy and care coordination for their patients. The blended funding model will allow comprehensive, team-based care focused on preventive health and *keeping patients well and out of hospitals*.

Key Recommendations:

- **Implement a Blended Funding Model:** Establish a program for not-for-profit general practices in disadvantaged communities, combining standard Medicare billings with substantial incentive payments or grants reflecting their patient cohort.
- **Support Multidisciplinary Teams:** Fund an expanded care team (e.g. nurses, allied health, peer support, health workers) in these practices so that care can address complex physical, mental, and social needs holistically and foster wellness not just reactive care to acute sickness.
- **Embed Urgent Care Models alongside Usual Care Teams:** fund acute care clinics and crisis care outreach teams within the usual operations of not for profit clinics.
- **Focus on Health Equity Outcomes:** Tie incentive payments to improvements in patient screening, health literacy and ultimately health outcomes and equity measures (e.g. reduced hospitalizations, improved chronic disease management, increased preventive care in target groups).
- **Data Tracking and Evaluation:** Integrate data sharing between primary care and hospitals to monitor the impact on service use and health outcomes. Conduct ongoing evaluation to inform broader roll-out to willing general practices.
- **Create capacity:** fund the capital costs of expanded service provision in current locations and new sites where there are aggregations of disadvantaged groups currently receiving inadequate care and enable the sharing of resources between organisations with similar missions and values to spread capacity more broadly.
- **Align with Medicare's Vision:** Use the model to demonstrate how strengthening primary care for the most vulnerable can fulfill the Medicare system's intent – improving health for all Australians and reducing overall system costs.

Underpinning these key recommendations are a list of principles which should underpin any move to create new policy and program responses.

This proposal targets those communities and patients who currently experience the worst health outcomes and the greatest barriers to care. By investing in comprehensive, high quality primary care for these groups, the government can reduce pressure on hospitals, improve health equity, and yield long-term economic benefits (through a healthier, more productive population). In turn practices will be able to offer more care and ensure staff are less exposed to risk, burnout and sub-optimal work conditions. The approach is in line with recommendations from the Primary Health Care 10-Year Plan and the Strengthening Medicare Taskforce, which call for new funding models to enhance team-based care. Government and industry reports have repeatedly highlighted that *business-as-usual will not adequately support disadvantaged populations.* The time is right for an innovative funding solution. The Health Equity Coalition member organizations are ready to implement this model and share outcomes nationally. With appropriate funding and policy support, this initiative can become a blueprint for a stronger, fairer primary health care system, ultimately ensuring "Stronger Medicare" is not just a slogan but a reality for all.

Origin Statement

This paper is the work of the Health Equity Coalition, a Brisbane based informal association of not-for-profit organisations. The paper has been critiqued by a number of peak bodies and found to align with their calls for health reform over many years. Hence, we submit this work for consideration as a more detailed application of how investing in health reform could support better healthcare for those who need it most. In embracing this direction, the policy intent of the Medicare System will be achieved, stronger people, stronger providers, stronger practices and a stronger Australia through a stronger Medicare system.

Guiding Principles/ Proposed Models

The following principles set out the foundational requirements for improving access, equity, and quality in general practice—particularly in communities experiencing significant disadvantage. They highlight the financial, structural, and operational conditions needed to support team-based, patient-centred care and to address growing health inequalities. These principles are drawn from frontline experience and informed by evidence on what works in delivering sustainable, high-quality care to complex patient populations.

To provide clarity and alignment with strategic reform goals, these principles are grouped under five key themes:

The Economics for Change

- **Principle 1: Equalise funding** to make caring for disadvantaged populations financially sustainable and attractive to providers.
- **Principle 2: Address rising health inequality,** which is increasing pressure on tertiary services due to inadequate primary care access.
- **Principle 3: Reform MBS incentives** to support comprehensive care for patients with complex needs, particularly the disadvantaged.

The Case for Teamwork

- **Principle 4: Recognise the value of patient-centred care**, which takes time but improves outcomes—benefiting funders more than providers.
- **Principle 5: Prioritise continuity of care**, which delivers measurable patient benefits, creates more satisfying work and system-wide savings.
- **Principle 6: Avoid overloading stretched primary care**, which risks degrading care quality for the most vulnerable.
- **Principle 7: Fund nursing roles adequately**, especially in not-for-profit practices, to support their continued leadership in care delivery.
- **Principle 8: Accelerate team-based care** by enabling all team members to work to the top of their scope and address rising workforce shortages and care deficits.
- **Principle 9: Resource larger, multidisciplinary teams** for highly marginalised populations, including allied health and peer workers.

Funding What Matters

- **Principle 10: Implement patient enrolment models** to support data-driven care planning and evaluation.
- **Principle 11: Introduce incentivised salaried roles** in high-need clinics to provide financial certainty and improve workforce recruitment.

- **Principle 12: Fund acute care clinics and crisis care responses** within general practices to improve access and continuity of care to vulnerable populations.

Addressing Need and Scale

- **Principle 13: Design clinical spaces to support team-based, flexible models of care** and offer to patients care settings which are dignified and culturally appropriate**.**
- **Principle 14: Support access to capital for charitable practices** to enable sustainable growth and adoption of expanded teams in routine care.
- **Principle 15: Partner with innovative practices** to develop scalable, replicable models of care.
- **Principle 16: Recognise infrastructure costs** as a rising component of the cost of delivering high-quality care.
- **Principle 17: Use real-world costing data** to develop a fair, equitable, blended funding model.

Governance and Capacity Growth

- **Principle 18: Incentivise student placements** in high-need areas to grow the future workforce.
- **Principle 19: Invest in clinical governance** to ensure safe, effective, outcome-driven team care.
- **Principle 20: Fund corporate governance capacity** for complex, evolving general practice and primary models which will increasingly involve integration with other services.
- **Principle 21: Create flexible funding pools** to support general practice teams working with the most disadvantaged address the social determinants and access challenges their patients face.

Background and Case for Change

Health is an investment in economics and a driver of productivity and economic growth. Price Waterhouse Coopers reported that investing in general practice reduces the costs of secondary care and releases productivity through a healthier workforce[i]. The World Health Organisation produced a conceptual framework in 2018 describing the economic value of primary care[ii](figure 1). It found that investing in primary care has a multiplicity of benefits in terms of economic gain over investing in secondary care.

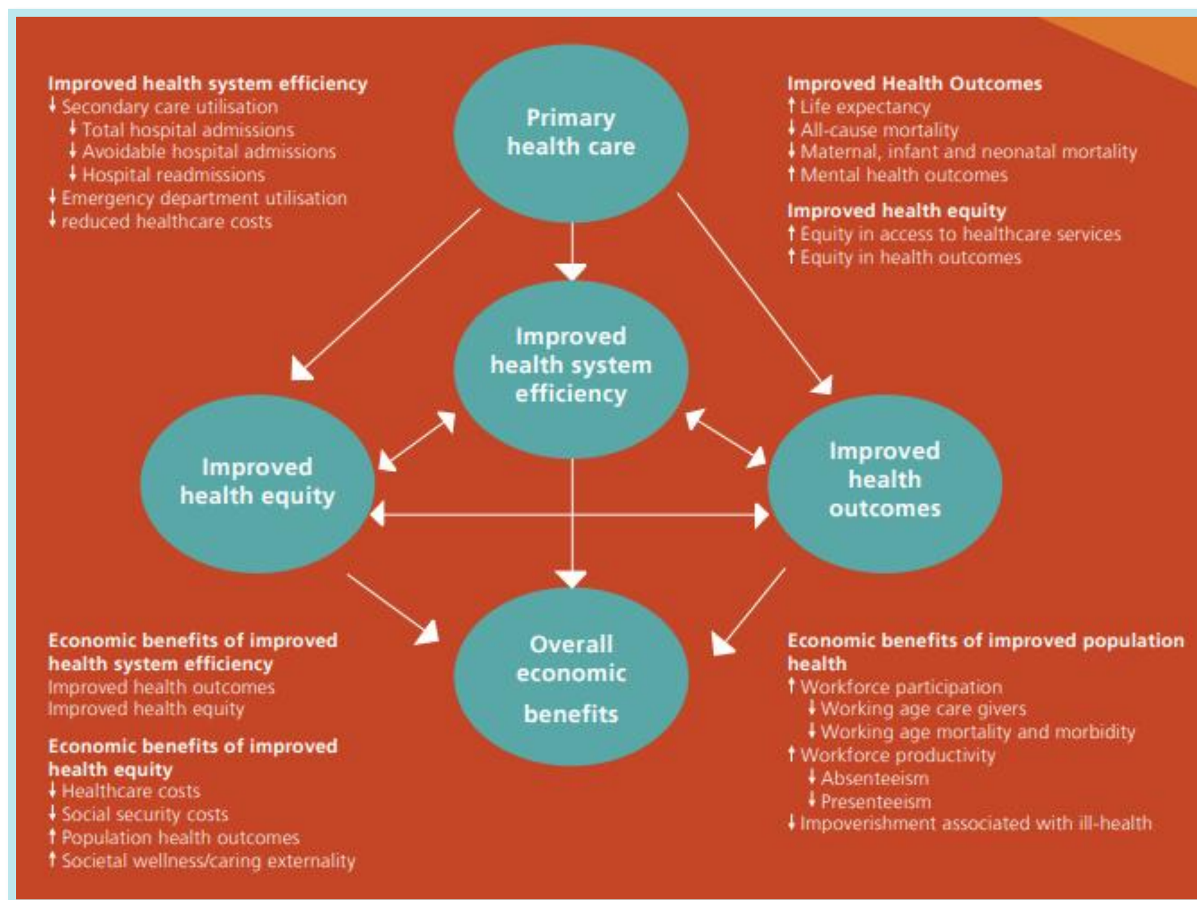


Figure 1: WHO conceptual framework

McKinsey's Global Institute has written about how prioritising health improves prosperity using the American healthcare system as a case in point[iii]. America is often held up with derision as a fragmented and high cost, two-tiered healthcare system. Commentators are starting to note that rising cost of living pressures, falling rates of private health insurance and increasing gaps charged by health service providers,[iv] which in 2016-17 saw half of all patients incur out of pocket costs for non-hospital Medicare services, are making Australia similar to America. The trend away from bulk billing increased with the recent Productivity Commission Report into government services noting that less than half of all Australians were bulk billed when attending a general practice[v] despite the government introducing a tripling of bulk

billing incentives in November 2023. The rates of bulk billing are highly variable by region meaning that many patients are in localities where care which is free at point of care is effectively beyond their reach[vi]. Recent announcements by government of very significant investment in general practice care are aimed at reversing the trend by extending bulk billing incentive payment access to the entire population. The goal is for nine out of ten episodes of care to be bulk billed in general practice by 2030[vii]. However, that aim is already being challenged by industry commentators as an unlikely outcome[viii].

The current average out of pocket gap is $46 resulting in revenue per standard consultation to a practice of nearly $89. Only a proportion of that fee is retained by the general practitioner providing the patient care. The new funding model promises $69.56 in revenue per patient. This is a shortfall of $20 a patient. For practices in more affluent communities where private billing is standard, there will be little economic incentive to embrace becoming a fully bulk billing clinic. Even in mixed billing practices, the conversion rate to being fully bulk billed is expected to be low come November 2025. The extra income from each private billed patient offsets much of the 12.5% additional practice incentive payments practices will be eligible for if they bulk bill all patients.

In poor communities, which already have bulk billing doctors, the investment by government will be welcome relief. In such communities, the majority of patients are bulk billed[ix]. However, the rates of bulk billing have dropped from previous levels despite the November 2023 tripled bulk billing incentive. That change merely stabilised rather than delivered quantum improvement in access to bulk billing.

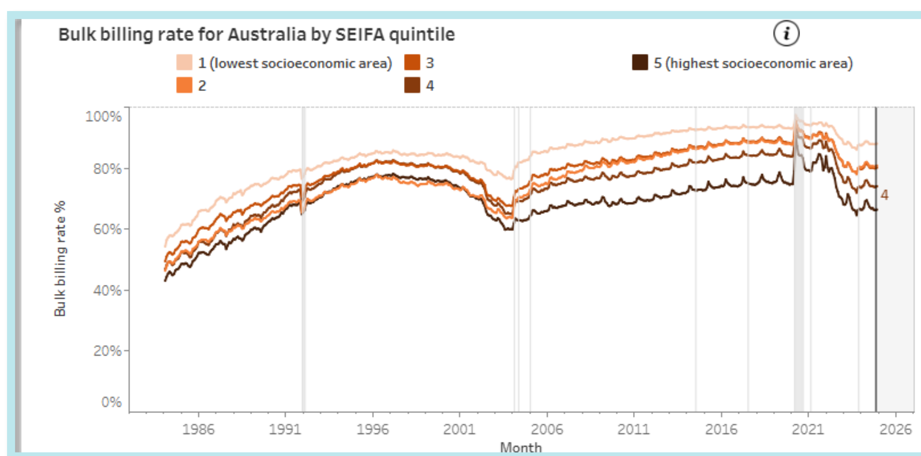


Figure 2: Bulk Billing rates in low socioeconomic areas

This suggests that bulk billed care is less attractive to providers and practices because of the differential in income. Where practices have no access to bulk billing incentives i.e. for patients without concession cards or age-based incentives, rates of bulk billing are significantly lower[x]. This is giving rise to real gaps in care and shifting of costs to high care and high-cost environments when primary care could be better utilised. This is most evident in the care journeys of the most disadvantaged. Reform efforts should start there.

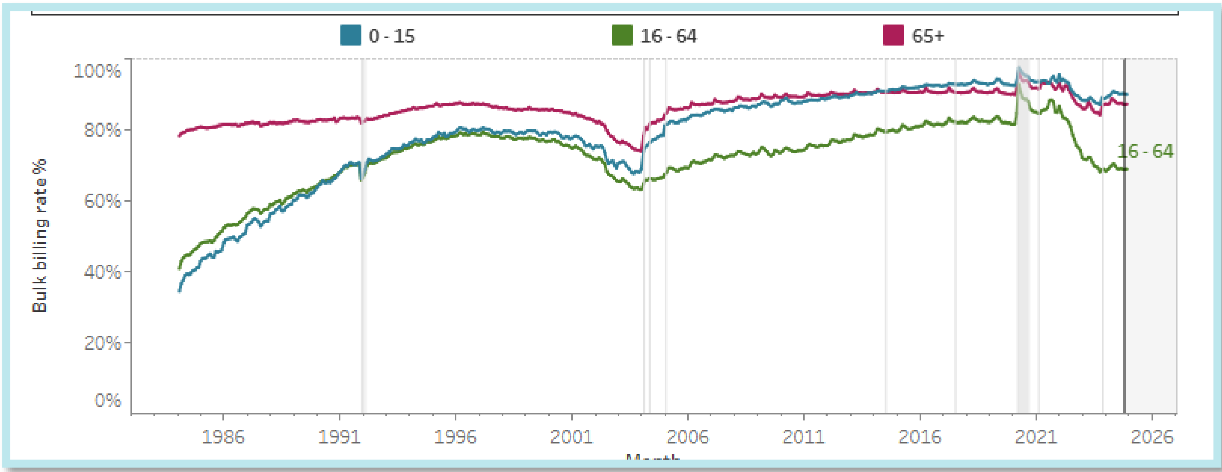


Figure 3: Comparison of Bulk billing rates in Australia by age group

Part 1: The Economics for Change

Principle 1: Equalise funding to make caring for disadvantaged populations financially sustainable and attractive to providers

Will investments in bulk billing support programs result in access to more and better care?

The focus on health outcomes and other measures of high performing systems has been in literature since 2007 with the introduction of the Triple Aim of Healthcare. Over time, the sector has enhanced the model based on observations of where things fall down. In 2014 that led to workforce considerations becoming a focus. Burnout in an era of workforce shortage was becoming a rising feature of data and concern for health administrators. More recently, health equity was included[xi] in what is now known as the Quintuple Aim.

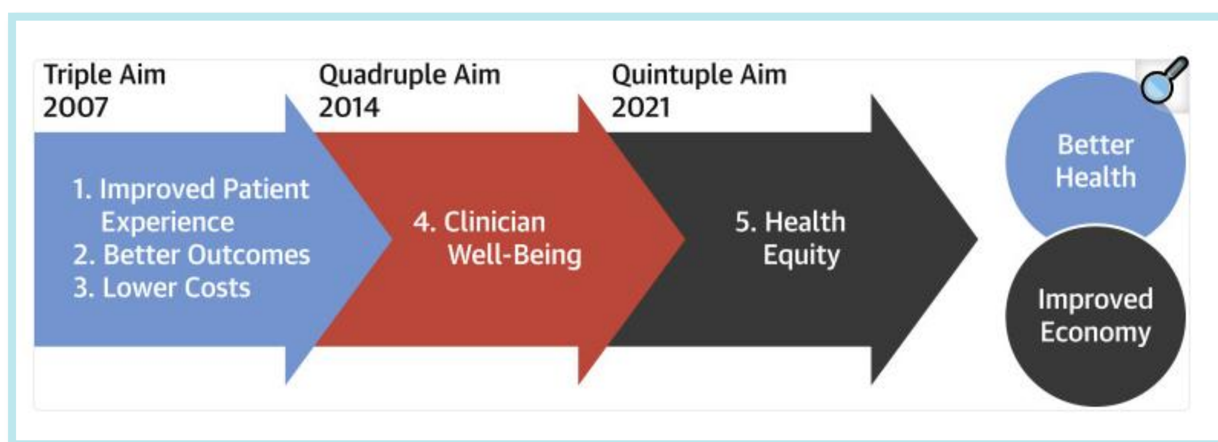


Figure 4: Quintuple Aim

It reflects growing awareness that despite much language in use about patient centred care, the outcomes achieved in the most disadvantaged and marginalised populations continue to lag those of more affluent communities. Such poor health outcomes come at a cost to the individual in terms of early mortality. Queensland data shows that living in a disadvantaged catchment results in three years less life than other regions[xii]. People living with mental health diagnoses as well as those from the non-English speaking diaspora of Africa, the Middle East and parts of Asia are likely to see even more life years lost[xiii]. Even whilst alive, these populations are likely to have a reduced wellbeing span, even if they have similar lifespan due to the chronic health issues they face. Such loss can be as much as 12 years of additional health burden[xiv].

This robs the economy of many years of active participation from these peoples. It also erodes the productive income earning years of patients making them more likely to need subsidised healthcare for longer. It also robs our communities of the contribution of wise

elders. The extended period of morbidity of such individuals also creates a burden for carers. They are also faced with reduced workforce participation and increased care costs.

Such populations also cost more to serve. RACGP analysis showed that low SES groups are 1.3 times more likely to have preventable hospitalisations and 1.4 times more likely to use emergency departments[xv]. They present late for care which means they are more likely to use secondary care for treatments.

Australia has a growing problem around inequitable health outcomes according to data from Victoria University[xvi]. Under commission from the Department of Health and Ageing they presented data in late 2024 which showed that:

- On average almost one in two Australians has a chronic condition. However, the rates are grossly inequitably distributed; 1 in 3 living in the most disadvantaged areas have two or more chronic conditions compared to 1 in 8 living in the least disadvantaged areas
- The 10 million Australians living in the 40% of communities with the highest levels of disadvantage are at increased risk of poor health and early death.
- The rates of early death are accelerating in the poorest communities in comparison to affluent areas where longevity is growing.
- For some diseases like cancer and COPD, rates in advantaged areas are falling whilst in poor areas they are rapidly trending upwards.

If data as compelling as Australia's Health Tracker shows such stark outcomes for those in the bottom 40% of incomes, the reality for those in the bottom 10% of incomes is even more troubling. Such communities have been studied by Jesuit Social Services since 1999 resulting in the series of "*Dropping off the Edge*" (DOTE) Reports. The latest, from 2021[xvii], shows that persistent disadvantage continues to be multi-layered. It is best measured through a combination of income, incarceration rates, unemployment, domestic and family violence rates and public housing use. A total of 37 measures from air quality to teen pregnancies and foster care have been distilled to identify those communities most at risk of persistent disadvantage. The reports have found that against many indicators, the most extremely disadvantaged locations often have rates of risk factors 300% greater than state averages.

The DOTE work notes that health is a significant indicator of disadvantage. Poor health encompasses physical and psychiatric disability as well as overall access to care. It correlates with low income due to inability to work, the cost of medicines and health care services and greater social exclusion including that triggered by being isolated at home. Significantly, the DOTE work shows how poor health leads to a higher risk of lifetime disadvantage. For those receiving disability payments, payments for being a carer or parenting payments to single teens, rates of ongoing reliance on welfare in the next generation were a multiple of the state average. This is why health and economic outcomes need to be considered together as inter-dependent rather than mutually exclusive policy objectives.

In the most disadvantaged communities, rates of disability, psychiatric admissions, suicide, and need for assistance with activities of daily living were far higher than other communities. However, access to general practitioners and primary care services in these same

communities is not equitable. Given studies have demonstrated need in such communities is higher, the current spatial distribution models used by government have limited correlation to need in metropolitan areas of endemic disadvantage. This is made more severe as these same peoples often lack transport to travel to areas where care is more available. They also have less capacity to pay for such care which is less likely to be bulk billed. Even if they can access care, the extra time and proportional cost of access means these people are hardest hit.

The exact location of disadvantage is made more complex because some groups of extremely marginalised patients attend general practice services outside of communities where they live. Clinics catering to LGBTIQ+ people, people experiencing homelessness, people with addiction, and those catering to people of refugee background peoples are examples. Many of these clinics are housed in inner-city locations where rates of private billing and general health outcomes are high. The result for such clinics is aggregation of demand from those hardest to serve in a system which ignores this increased complexity. This occurs in communities blind to the plight of such patients as data to demonstrate need is not routinely analysed and published.

Dr Julian Tudor Hart called the outcome of such processes the Inverse Care Law. He first published his findings in 1971 in the Lancet[xviii] noting that the Inverse Care Law operates more completely where medical care is most influenced by market forces. Australia’s privatised model of general practice services is one of the most market driven health sectors in the OECD. It is from such communities that the concept of “six-minute medicine” first emerged in Australia. Such models of care do not cater to the biopsychosocial needs of the very patients they are most likely to offer care to. Hence, access to poor quality care can further erode health outcomes. Australia’s highly fragmented system means that no single funder collects data on the total costs of care for such patients. No funder has the motivation to drive down costs of care as the points of access by such patients are shared between primary and secondary care. For that reason, those who are most marginalised represent a great opportunity for bi-lateral cooperation and formulation of new funding and care models shared between the States and Commonwealth.

Principle 2: Address rising health inequality, which is increasing pressure on tertiary services due to inadequate primary care access.

Bulk billing doctors and clinics have costs of occupancy of facilities, insurance, reception staffing, nursing supports and income to the medical team themselves to consider. The Medicare Schedule was initiated in 1984 and has been following a patchy course of indexation ever since[xix].

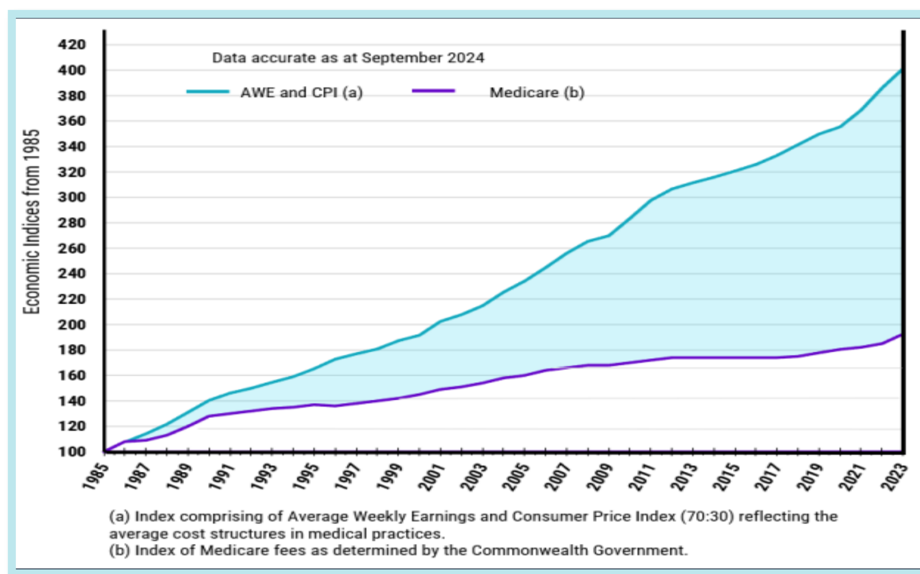


Figure 5: Indexation of Medicare fees

The MBS rebate was later set at 100% of the Scheduled Fee for general practitioner services and smaller percentages for non-GP specialist and other groups of providers to address growing calls that the MBS did not reflect the costs of service provision in general practice. The lack of indexation is evident in the graph presented by the RACGP in their 2024 Health of the Nation Report[xx]. The cumulative impact of the gap in indexation has been calculated by the AMA as being worth $8.6B since 1994[xxi].

Case Study:

Outgrowing the Model: Rising Costs in a Changing Brisbane

With Brisbane's population tripling since 1970[1], costs of housing have multiplied. Accounting for inflation over the period you could buy over three houses in 1984 using the value of the average Brisbane property today. Another way of looking at the cost creep is that in 1984 a house cost about three years of total income to pay off. In Brisbane it now takes seven. That means rents alone are a far more significant cost for practice operators than they were when the MBS was created. The costs of paying off fitouts, which routinely tally over a million dollars for a standard practice, also weigh down profitability.

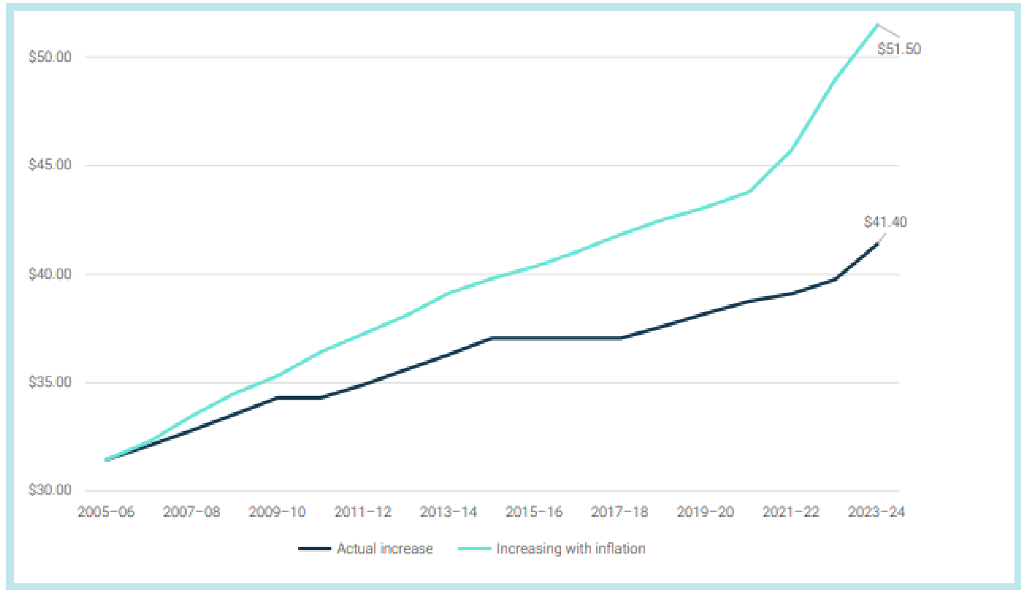


Figure 6: MBS patient rebate for 20-minute consultation-actual increase versus indexation

However, no formal efforts have been made to genuinely overhaul the schedule or the basis of pricing in the decades since.

The Scheduled Fee is noted on the MBS website as being "reasonable on average for that service having regard to usual and reasonable variations in the time involved in performing the service on different occasions"[xxii]. The setting of the fee is controlled by government and over the last decade has not reflected inflation. This led to many groups claiming the sector had been shortchanged billions of dollars[xxiii]. The government appears to have accepted that reality noting in its most recent announcement that the over $8B it proposes to inject to restore bulk billing will overcome the gap created by under-investment in the sector.

Investments in primary care have been assessed as solving challenges occurring in other parts of the health system. For providers of care in the most disadvantaged communities, hospitals reaching out asking high quality providers to step into the breach around high-risk populations is a standard occurrence. The system benefits were described by the RACGP in stark terms in 2020[xxiv]:

Figure 7: Metrics to assess the health benefit of a high-performance general practice and its link to general practice

Metrics to assess the benefits	Proxy to link general practice to health benefit	Assumed high-performance general practice benefit
Preventable hospitalisation for ACSC	Continuity of care	6.2% reduction in hospital admission
ED presentation	All features of general practice[12]	10% reduction in ED presentation
Hospital readmission	Outpatient visit within 7 days	12% reduction in hospital readmission
Workforce productivity	Assumption based on preventable hospitalisation	6-8% reduction in absenteeism
QALY	Access to general practice	9-20% reduction in mortality

The vision put forward by the RACGP in response was to embed high-performing general practice which delivers patient-centred, continuous, comprehensive, coordinated, high-quality, accessible care at the centre of policy and funding. In disadvantaged areas this has never been more important. Summary assessments of care delivered in bulk billing clinics in such communities constantly notes:

- Short consultations in clinics which advertise each episode is structured to address just one problem – hard to do if the patient has multi-morbidities, polypharmacy, requires an interpreter or has psycho-social issues.
- The use of independent contractor and locum workforces who are often part-time and short-term and working in walk-in clinics. This reduces the ability for patients to be known and understood by a clinical team. Such teams are often supported by such a skeleton of nursing and reception staff that doctors are expected to do their own recalls amongst a busy schedule of clinical activity leading to delays in care.
- The waiting times in such clinics are high leading to the stressed clinical team focussing on urgent matters rather than screening, preventative health and health education.
- Limited team members and operation in increasingly corporate models with strict performance targets means limited attention is available to coordinate care in what is a complex and largely public hospital provider network. With no incentive to shepherd patients through complex systems; they get dropped from waiting lists if they do not attend appointments and jump more hurdles for admission than if referred privately leading to later presentations.
- Access is used as the over-riding indicator of health service provision. The focus on volume ensures critics of bulk billed clinics can point to regular instances of low value care which create revenue but not impact. Completion of a hasty care plan but no subsequent reviews of that care plan indicate that billing rather than care planning and patient management are over-riding factors with such services.

Principle 3: Reform MBS incentives to support comprehensive care for patients with complex needs, particularly the disadvantaged.

Understanding the drivers of poor health is increasingly focussed on the social determinants and lifestyle factors. The commercial determinants of health mean that in poor communities' access to appropriate housing is a growing challenge resulting in greater food insecurity, overcrowded living environments and people experiencing relationship stress and family violence. This increases the impact of the social determinants which are listed by WHO as encompassing:

- **Income and social protection** – falling rates of value in welfare payments means that increasing numbers of welfare recipients are falling further below the poverty line
- **Education** – in the poorest catchments educational attainment and even literacy levels can be far lower, inhibiting patient health literacy and ability to self-manage in a system which expects patients and carers to wear the largest component of healthcare provision
- **Unemployment and job insecurity** – high rates of casualised and gig economy work mean that people in communities of socioeconomic disadvantage struggle to attend medical appointments due to loss of income leading to overreliance on after hours and emergency services
- **Working life conditions** – people are more likely to work in manual and dangerous occupations associated with negative health impacts
- **Food insecurity** – low incomes and working extended hours in low paid jobs mean that quality food preparation can be challenging
- **Housing and environment** – such communities report the highest rates of over-crowded housing, less sporting facilities and more danger on the streets
- **Early childhood development** – children in such communities are less likely to attend daycare, present to school with previously undetected vulnerabilities and less home support for learning, due to parents often working multiple jobs and having less educational attainment themselves
- **Social inclusion and non-discrimination** – first nations peoples, those from a migrant background, people living with a disability and those identifying as LGBTIQ+ are over-represented in such communities and all experience high rates of discrimination and isolation
- **Structural conflict** – the widening divide between rich and poor in Australia fosters psychological ferment which is often accompanied by higher rates of domestic and community violence, gang association and poor access to other community resources
- **Access to affordable health services of decent quality** – the highest rates of closures of general practices have been in the poorest communities and those remaining have increasingly embraced walk-in models scheduling eight patients per hour.

Consumers are speaking up. Consumers Health Forum conducted a survey in 2022 with over 5100 respondents. The numbers of patients noting lack of affordability impeding their care was startling: [xxv]

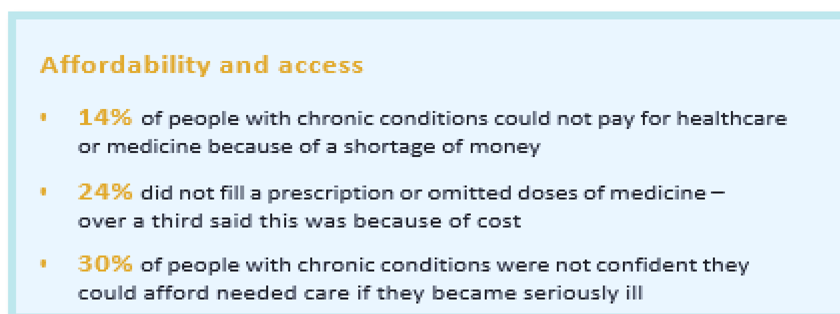
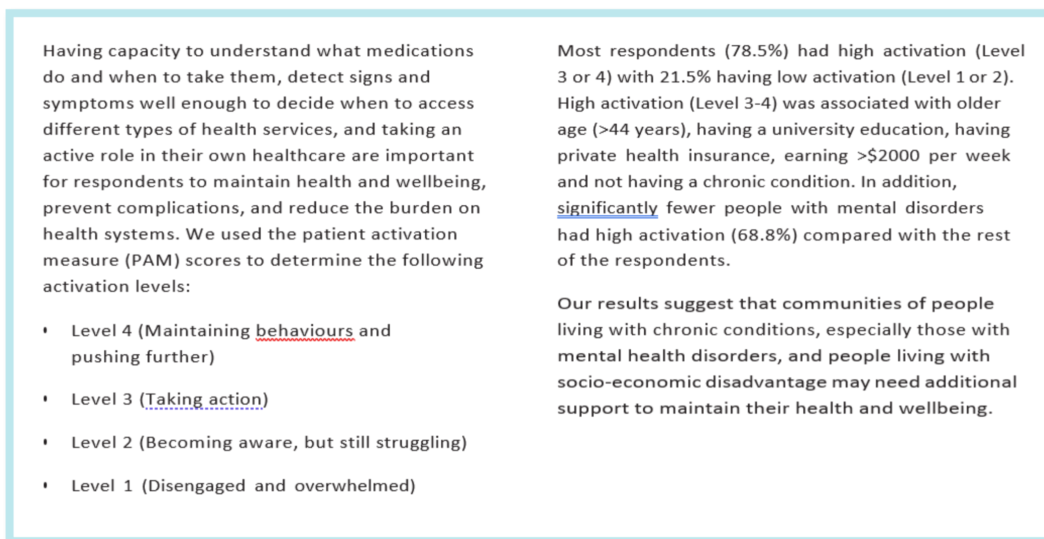


Figure 8: Survey results from consumer Health Forum (2022)

What was even more noticeable in the report was the patient responses were directly correlated with their activation level. This is the first time a large Australian dataset has shown how patient health literacy and motivation to engage in self-care might be distributed amongst the wider community. 21% of patients fell into the least enabled group of patients. Given this report was compiled from data from patients engaged with a peak body and literate enough to participate, this is likely to under-report the numbers of patients with limited self-care capacity. The report noted that people living in the most disadvantaged areas will need more supports to maintain their health as more patients in such communities have low activation levels. Their conclusion is justified with patient activation being shown to be linked to rates of both general practice and hospital use in numerous studies around the world[xxvi][xxvii].

NSW Health adopted use of PAM scores in Western Sydney with the intent of sharing this data with practices participating in the LUMOS study. Understanding where a patient fits on the PAM continuum enables a care team to decide which language, support strategies and follow-up activity will ensure a patient understands their care options and can navigate health systems. Working with patients in such ways has been shown to lift PAM scores. Even one move on the PAM continuum saves healthcare costs and improves patient outcomes. However, it takes a trained and vigilant care team to offer the right supports. This often involves more use of nursing time and time explaining health matters to patients. Currently, the incentives in general practice focus on volume and do not reward such behaviour.


Having capacity to understand what medications do and when to take them, detect signs and symptoms well enough to decide when to access different types of health services, and taking an active role in their own healthcare are important for respondents to maintain health and wellbeing, prevent complications, and reduce the burden on health systems. We used the patient activation measure (PAM) scores to determine the following activation levels:

- Level 4 (Maintaining behaviours and pushing further)
- Level 3 (Taking action)
- Level 2 (Becoming aware, but still struggling)
- Level 1 (Disengaged and overwhelmed)

Most respondents (78.5%) had high activation (Level 3 or 4) with 21.5% having low activation (Level 1 or 2). High activation (Level 3-4) was associated with older age (>44 years), having a university education, having private health insurance, earning >$2000 per week and not having a chronic condition. In addition, significantly fewer people with mental disorders had high activation (68.8%) compared with the rest of the respondents.

Our results suggest that communities of people living with chronic conditions, especially those with mental health disorders, and people living with socio-economic disadvantage may need additional support to maintain their health and wellbeing.

Figure 9: Capacity for self-care among Australians living with and without chronic conditions (Consumers Health Forum Study Results)

Supportive care which provides patient education, preventative health screening, care coordination and addresses the social determinants of health has been a feature of the aboriginal medical centre model for many decades. The rest of general practice has not been able to access the funding or even the industrial mechanisms to deliver peer workers and community input into the management of local general practices. In disadvantaged areas and in clinics supporting those who are homeless, involved with problematic substance abuse use and dependence and youth at risk, indigenous patients are over-represented. However, such services are not able to access funding for additional supports for Aboriginal and Torres Strait Islander patients despite many being run as charitable enterprises and having community representation on their Boards.

Consumers Health Forum and the RACGP called for the adoption of social prescribing across the country as one mechanism to improve care for the most complex and disadvantaged. Their conviction was based on input from over 100 subject matter experts at a roundtable in November 2019[xxviii]. They continue to advocate for social prescribing initiatives[xxix]. Many clinics providing care for the most marginalised incorporate social workers and nurse care coordinators in their teams. Such staff are currently funded via a patchwork of grants and special funding from state sources rather than being a core member of the primary health care team. In many instances, these same staff spend considerable time trying to locate general practice services near where their clients live as surrounding general practices are unable or unwilling to offer appropriate care.

Some organisations serving the most disadvantaged offer a blend of housing, employment, disability, drug and alcohol and community support services. Medical care has been a minor component of their offering. Historically, it was easier for clients to access bulk billed care but changes to funding over the last decade have seen many not for profits open small medical services to address a growing gap in care. Due to funding models, these are often

run parallel to rather than fully integrated with the other services run by the same organisation.

Others have ramped up social prescribing and wider care support services to include outreach models and primary care delivery which is largely coordinated by nurses and allied health providers. They address the housing instability, domestic and family violence and women and children at risk supports needed to maintain a focus on wellness amongst vulnerable populations. Integrating medical and non-medical supports through one provider means clients are known, enabled and the root causes of their health issues addressed perhaps even before dire symptoms lead to presentations. Such an approach has solid international comparators in the US federally qualified health centre models, Indian Health Service and even Māori care clinics in New Zealand.

The blend of health and community care for vulnerable populations is really the logical evolution of primary care but is beyond what has traditionally been considered a general practice in Australia. The only sector to be enabled to consider such a wider primary care agenda has been the ACCHO sector. The Institute for Urban Indigenous Health in Southeast Queensland has created the scale across what were originally small and struggling Aboriginal Medical Services to encompass a more comprehensive primary care model.

The lack of funding for medical services which can address the needs of clients and more actively engage with the wider primary care teams being run out of such organisations mean such organisations are reluctant to scale up general practice operations. This is largely due to the time involved in taking histories, identifying the psycho-social drivers of presentation to care and engaging in patient education around their health and behavioural support needs in a manner appropriate to the patient's culture, health literacy and motivations. The costs of running the practices are often subsidised by other social and community care activities. This is inequitable when these same organisations are doing heavy lifting across their portfolio of services. It is also unappreciated as the widespread myth is that bulk billing is both available and sustainable. It is increasingly neither.

Part 2: The Case for Teamwork

Principle 4: Recognise the value of patient-centred care, which takes time but improves outcomes—benefiting funders more than providers.

Multi-disciplinary team-based care delivered in primary care offers patients the opportunity to matter and discuss what matters to them in a trusted therapeutic environment. Each consultation should offer the opportunity to engage at the level the patient dictates around issues which are important to both the patient and the provider. This takes time. Done well quality primary care prevents disease arising, identifies conditions early and engages patients in proactive condition management which averts the need for use of secondary and tertiary care.

Too often, clinics providing care to patients with complex presentations are forced to be flexible in how they deliver care, the team members involved in care and the very place of care. Sadly, the funding system around them takes no account of this adaptability and patient focus. The consequence is that clinics face difficult choices; adopt a model of care unsuited to patient needs or absorb the additional costs by cross-subsidising with income from other sources. Not for profit providers have been electing to use the second option for decades. However, the ability to do so is becoming increasingly constrained by rising costs and reduced margins on other programs and a rapidly vanishing volunteer workforce and philanthropic funding stream.

In the United States, evolution of the Affordable Care Act and even insurer models mean that increasing attention has been paid to sharing the savings from improved care outcomes and reduced hospital use with the primary care groups contributing the most to those savings. Australia has not embraced value-based care modelling. Our fragmentation of funding between federally funded primary care and state based secondary care also means that the very arms of government make negotiation of shared reward contracts difficult to imagine. The case for investing in primary care is higher in clinics serving the most disadvantaged because they are the same groups making most use of secondary and tertiary care services, especially state funded services. It is these same services receiving repeated contact from state hospitals wanting to hand over patients with no ongoing primary care provider in attempts to reduce their own costs. This simply accumulates costs in the sector least funded to care for patients based on their need.

Principle 5: Prioritise continuity of care, which delivers measurable patient benefits, creates more satisfying work and system-wide savings.

Providing high connectivity and comprehensive primary care has been shown to deliver a benefit cost ratio of $1.60 for every dollar spent on primary care in participating sites in NSW[xxx]. This is from sites serving largely mainstream clients whose use of tertiary healthcare facilities would be lower than for those working exclusively with disadvantaged patients. The conclusion drawn from the LUMOS data analysis was that it is more cost efficient to allocate resources to support having continuity of care within high quality practices as hospital demand is reduced. This is particularly the case for the young and older patients. It is these patient demographics most likely to be within the most disadvantaged patients served by not-for-profit providers. Obtaining data on the returns to the sector when serving more complex patients has not been attempted and would be vital for supporting a more equitable funding model for primary care providers to those most disadvantaged. With efforts underway to create a LUMOS like data linkage infrastructure nationally, access to this data will soon be available and could underpin the funding shifts which would enable more effective general practice provision in high need communities.

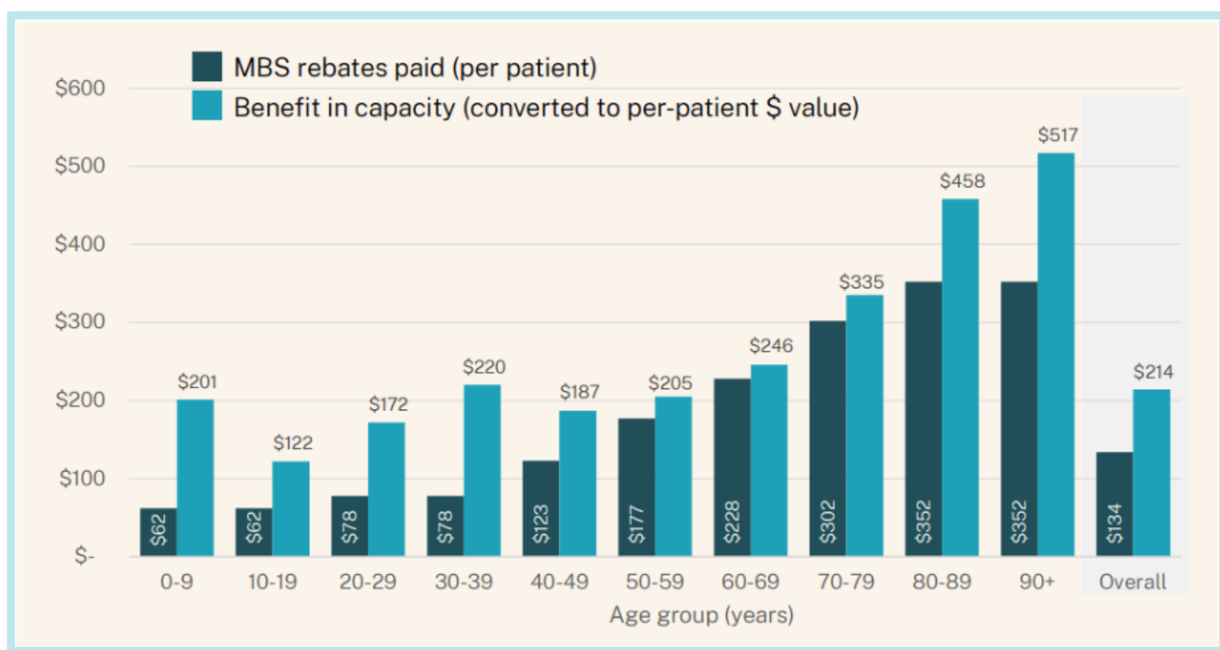


Figure 10: LUMOS study data findings

Principle 6: Avoid overloading stretched primary care, which risks degrading care quality for the most vulnerable.

Such small, specialised not for profit clinics also suffer from shortages of staff, especially doctors, as the remuneration is less and the challenge of work so great. This situation has been exacerbated with the creation of Urgent Care Clinics which like the AMS model pay doctors an hourly rate which far exceeds the current income available to doctors working in low SES and charitable service providers.

Doctors working with nurses in the absence of solid mental health, pharmacy and allied health teams can lead to burnout. The frustration of only ever being able to deal with some parts of the healthcare need due to lack of access to a team of care pushes providers to the limits of their scope of practice and still leaves patient needs unmet. GPs working more like general physicians or facing severe and complex disability and mental health issues without the right diagnosis and access to secondary care presents doctors with difficult choices and much stress. This can lead to GPs exiting those workplaces and returning to more mainstream general practices where referral to private physicians is rapid and advice received clear and actionable. Mostly, it results in reliance on a part-time workforce of doctors offering a session or three as their “charitable contribution”. The result is challenges with both access and continuity of care.

Some organisations have embraced nurse led models to address the lack of medical service provision. Many of these nursing models are staffed by Registered Nurses doing outreach work and intensive case support. This can work well until the patient needs medications or more interventional management. There, nurses spend much time trying to locate doctors in ‘usual’ practices willing to address the diagnostic, medication and referral needs of patients. This could be more efficiently addressed if the provider had an internal medical model the outreach and primary care nurses could rely upon. Such team members could also work well in combination with Nurse Practitioners, some of whom are already employed in addiction and homeless clinics. However, their rarity means that building a nurse and GP model will be more viable as registered nurses constitute around 80% of the primary health care nursing workforce. Without such internal teams, vulnerable people tell their story time and again, in various settings, a re-traumatising and stigmatising reality.

Principle 7: Fund nursing roles adequately, especially in not-for-profit practices, to support their continued leadership in care delivery.

Nurses are often the primary constant in not-for-profit primary care teams. They are stretched providing triage, health navigation, health coaching and chronic disease supports. Many of the nurses have an extended scope of practice due to being mobile and working without medical colleagues for much of the week.

Funding for wound care which is nurse led would also address the disproportionate demand for wound management related to living rough, IV drug use, the burden of diabetes and skin tears in the elderly. 87% of nurses in primary care report performing wound care regularly[xxxi]. Studies by QUT[xxxii] found a practice like Inala Primary Care had nurses spending more than double the amount of time on wounds as other general practices involved in studies of primary care wound management. In addition, such practices face the perverse incentive associated with Medicare; the absence of funding for wound dressings coupled with the inability of patients to pay for high quality wound dressings. This means that patients return every two to three days for basic wound dressings for months at a time. This occasion of service is bulk billed to Medicare and absorbs both nursing and doctor time. If access to wound care products was subsidised, such patients could visit at longer intervals; reducing the number of visits they face, time in clinic and exposure to other infections whilst saving the MBS. Modelling by the AMA, which calls for a funded wound consumables scheme, shows a return of $8.68 for every dollar spent on such a model[xxxiii]. We propose that implementation of the MBS Review Wound Management Taskforce Working Group occurs first in not-for-profit general practices where the demand is highest and impact likely to be greatest.

Under the current funding arrangements for team-based care, accredited practices are eligible for a Workforce Incentive Payment (WIP). This payment, whilst recently increased, has a maximum cap per practice of $130K per year. The full sum is only paid to the largest of practices meaning most receive well less than $100K per year; insufficient to pay even one nurse. Nurses are the most frequently subsidised team members through this incentive.

General practice nurses are becoming harder to attract and retain. In the life of the current government, wages for registered aged care nurses have increased by an average of $22K per year. Pre-election announcements could see them increase by another 12%[xxxiv]. That means nurses in hospital and aged care settings will be paid vastly more than nurses working in general practice. The result will be inflation of nursing wages in primary care which has consistently lagged other sectors. However, a natural ceiling exists which is that general practice income is not reflective of nurses deployed or their costs. It is therefore likely that general practice nurses will remain underpaid; a major challenge in growing and retaining this critical workforce.

The APNA 2024 Workforce Survey[xxxv] shows distinct differences in career plans for those nurses who are regularly and often using their scope of practice and those who are not. Just 15% of those using their scope of practice plan to leave primary healthcare nursing in the next 12 months. Sadly, 26% of those occasionally or rarely working to their scope are likely to leave. Therefore, general practice can retain nursing workforce by more adeptly funding and deploying members of the care team to care for patients.

Case Study:

Serving the Sickest: How the Current Model Penalises High-Need Practices

For practices with many frequent attenders, the calculation of WIP is disadvantageous. For a practice like Inala Primary Care, we have 4 times the national average of patients attending 20 or more times a year. This group of nearly 300 patients takes up nearly ¼ of all our medical staffing time. That means that our total active patient population is smaller than our total appointment activity reflects. Other practices seeing more of the worried well just once or twice a year get to count more active patients and therefore claim more incentive payments.

The unintended consequence is that our nursing workforce is less subsidised despite seeing double the number of chronic wound patients. This is driven by higher rates of diabetes amongst patients who total 18% of the total patient population or more than four times the national average. Given such patients are also more likely to present with acute illnesses that need hospitalization, nursing teams spend much more of their time triaging patients and monitoring them whilst waiting for ambulance retrievals than would be the norm. Such practices are forced to subsidise this nursing activity from general billing revenues which are already 39% lower than for our Brisbane South, predominantly bulk billing cohort. Such choices impact practice viability.

For nurses used to working in clinics with a complex care profile, their skills are in high demand as they are more used to nurse led activity, understand mental health and complex chronic disease management. This means they are perfect for recruitment to becoming the Nurse Managers in aged care facilities or clinical nurse consultants in hospital outpatient settings where their income can be 60% higher than in general practice. Those same facilities have human resources teams aggressively trying to recruit to address government ratios. General practice usually has a single practice management role trying to cover very many functions and too often without recognised management skills. So, whilst the increase to the WIP was well received by primary care, the fact remains that the WIP is a subsidy not a bundled payment model. WIP contributes well less than 20% of the costs of nursing staff in many general practices according to various benchmarks and government analysis.

Implementation of a new vision for team-based care in general practice accompanied by a blended funding model which funds nursing and other non-medical clinical time would trigger uptake of more team-based care according to peak bodies[xxxvi]. RACGP data shows that

General Practitioners are highly supportive of embedding other clinical team members[xxxvii]. 32% called for improved support for multi-disciplinary teams. Notably, the same report shows that GPs working in indigenous health settings reported much higher job satisfaction than their counterparts. One of the key differences is that such GPs are part of extended care teams.

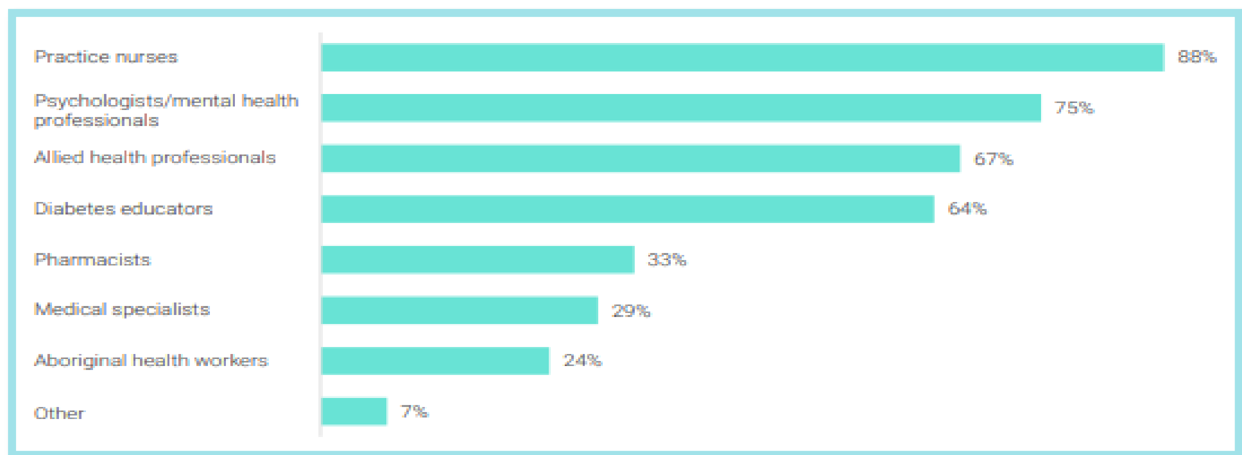


Figure 11: GP Perspectives on health professionals that most benefit patient health in general practice terms (RACGP DATA)

The whole notion of incentive payments as supplements to core income has not enabled general practice to embrace the team-based care patients, especially those who are disadvantaged, deserve. Nor has it allowed the sector to embrace the vision for care which it has been promoting for years. The model for high-performing patient care espoused by the RACGP calls for[xxxviii]:

- Patient centred, coordinated and high-quality care which is fostered by engaged leadership
- This in turn ensures that patients have access to timely, holistic and comprehensive quality care where care coordination and accessibility are addressed
- All patients build a relationship with a GP within a practice so that continuous care enables the patient to be known, understood and their needs addressed
- In such a trusting environment, mutuality of care is fostered so that patients, their families and carers are empowered to be part of the care team and build self-management capacity
- The practice uses data and patient information from across the health system to ensure timely, coordinated care which increases access to services required at a population level
- Having built foundations based on patients and the use of their data a multidisciplinary team can more easily coordinate the comprehensive and ongoing nature of care required
- Such care will extend to preventative health and earlier intervention activities and the promotion of wellness inducing activity

- All of which is done to contribute to and utilise evidence-based practice, and
- Support the education and training of health professionals of all disciplines which is ongoing and improved by routine data enabled quality improvement activity which builds patient safety
- The result of which is more effective and efficient use of health resources.

These same emphases have come through the co-design process enacted by the Health Equity Coalition which has defined its core operating principles as:

Patients

- Patients are considered genuine partners in the implementation and delivery of the model of care
- Continually work towards equity of health care access and outcomes
- Support patients by meeting their holistic health and social care needs
- Patients, their support teams and community are at the centre of the model of care

Workforce

- Develop a sustainable approach to workforce management with defined career pathways for workers
- Establish employment conditions which foster true collaboration and integration.

Location

- Promote accessibility for both patients and employees
- Recognise the unique location and population-specific needs of HeC members while leveraging shared services for efficiency
- Create an environment that welcomes, builds trust with and responds to population and community needs.

Program Governance

- Create inclusive and respectful multiple disciplinary team meetings which leverage the skills and experience of all clinicians.
- Engage meaningfully with a diverse range of consumers through inclusive and varied approaches
- Utilise the lived experience of patients, clinicians and professionals to design, guide and improve the model of care

Data & digital infrastructure

- Utilise data to inform the design and ongoing adaption of the model of care
- Share information responsibly, ensuring confidentiality while promoting collaboration among health professionals.

Clinical Governance

- Establish shared responsibility and shared decision-making processes to achieve true clinical integration
- Establish overarching clinical governance that embeds social support, positive learning and development opportunities

Figure 12: Core Operating Principles generated by the Health Equity Coalition

A series of workshops developed the model below as the preferred patient journey:

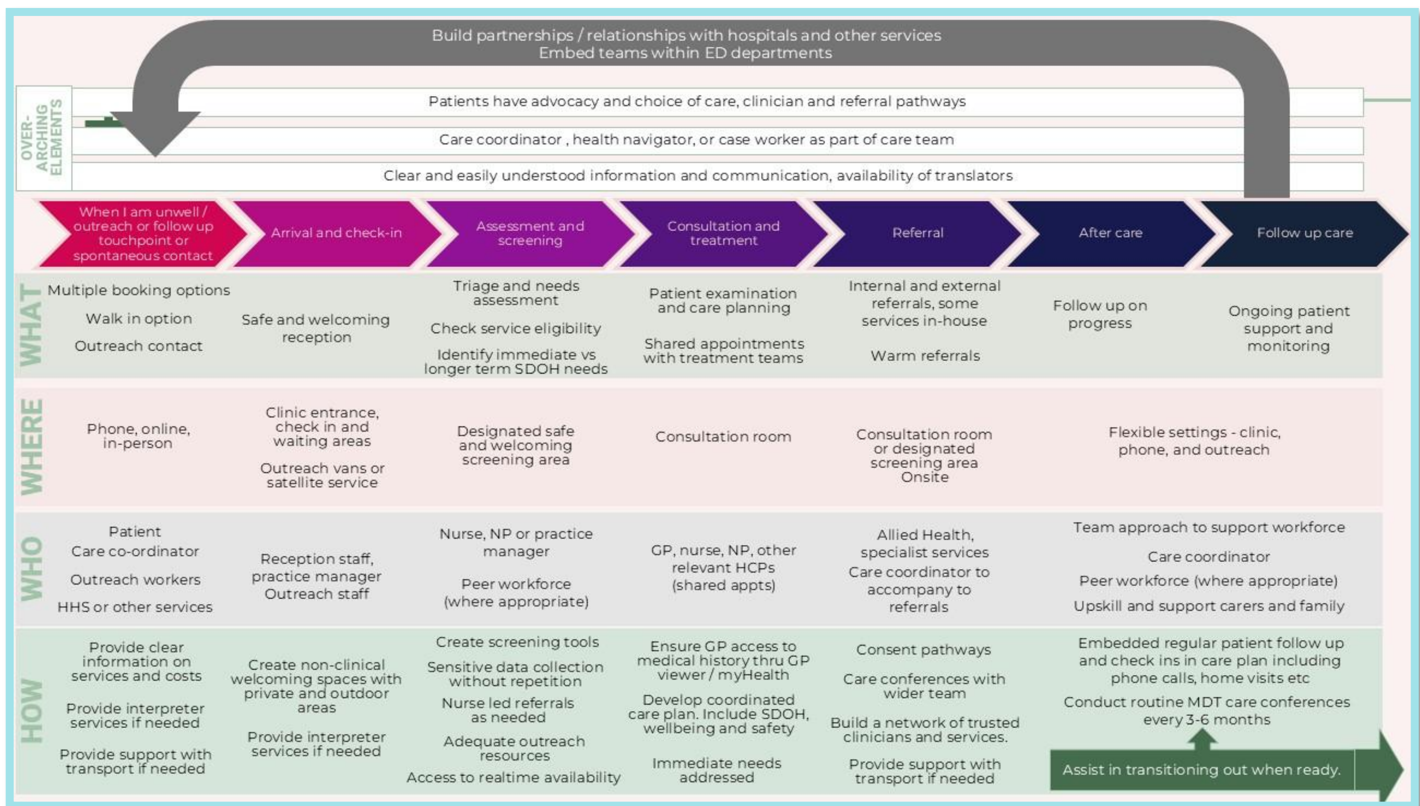


Figure 13: Preferred patient journey model within Health Equity Coalition Sites

To enable this vision to come to life a blended funding model of both MBS income and non fee for service payments would be welcome. Such an approach has been recommended in the Primary Health Care 10 Year Plan [xxxix], supported by the Strengthening Medicare Taskforce[xl] and outlined for implementation in the Review of General Practice Incentives Report[xli]. The General Practice Incentives Review went further recommending a ratio of 1:1 between General Practitioners and other clinical staff by 2032. Most notably, the report recommended this ratio should be higher in more disadvantaged catchments and clinics serving the most disadvantaged. On average, 60% of practice income should come from non fee for service payments.

The work of the Health Equity Coalition considered models of care currently in place in disadvantaged catchments in the United States, Canada and the United Kingdom. It identified all were significantly more team based than the care options funded through Australia's Medicare system. The various models were all more amenable to the work being undertaken in not-for-profit clinics serving marginalised patients. They also enabled the practice to expand reach more cost-effectively through deploying non-medical team members to their top of scope of practice; a significant advantage when care is being rationed due to inability to recruit GPs and the unsustainable costs of running general practice services.

NACCHO completed a workforce audit in 2024 which found a ratio in their clinics of over three non-GP clinicians for each GP. Health Equity Coalition members serve patients with severe

and complex mental health diagnoses, a background of trauma, a history of problematic substance use and dependence, low educational attainment, complex chronic disease and polypharmacy. Such patients are more likely to have an ethnic background, need interpreters and low trust in institutions. Hence, the challenges of care in clinics serving the bottom 10% of income earners are likely to shadow those of any aboriginal medical service.

With 32% of GPs set to exit the workforce entirely over the next five years and 61% of those responding to the RACGP Health of the Nation Report noting plans to scale back their work the reduction in GP hours will be dramatic. It need not be a crisis if team-based care can be appropriately implemented and financially supported. In other countries, the ratio of GPs to population is far lower but the use of non-medical team members to address patient need is far higher. For example, in the EU 3.7 doctors per 1000 people are registered. In Australia it is nearly 4 patients per 1000 people[xlii]. Sadly, in the UK and elsewhere the most disadvantaged areas have the worst ratio of GPs to patients with a GP expected to manage 2450 patients, 300 more than affluent areas[xliii]. In Australia, few GPs manage more than 1000 patients due to our highly GP centric funding model. Such figures give rise to hope that as GPs exit the workforce, introduction of team-based care embedded in practices will enable those GPs remaining to manage a greater number of patients.

Making that hope a reality will require significant investment in clinical governance, systems and practice leadership to ensure that teams have time to coordinate their activities. Unless this occurs, the result could simply be task substitution masquerading as team-based care. In populations of patients who struggle to advocate for themselves and have more complex issues to manage, the consequences could be dire and fragmentation of care a real risk.

This is critical more broadly as patient complexity is on the rise due to ageing and chronic conditions resulting in more consultations. When Medicare was initiated the average yearly GP attendance was 3.8. It is now 6.8 and rising[xliv]. Such frequency of visit has been a reality in poor areas for many years; they are the canary in the coal mine for the health system. They also generate more referrals to hospital than other catchments. Together this means that disadvantaged catchments are an ideal setting to aggressively implement team-based care. Funding for such teams would come through a blend of payments.

Principle 8: Accelerate team-based care by enabling all team members to work to the top of their scope and address rising workforce shortages and care deficits.

The NUKA system of care from the South-Central Foundation in Alaska has evolved to address the needs of indigenous and remote communities across the southern peninsula of the country. This model has been adopted by the Institute for Urban Indigenous Health and their experience of implementation drawn upon in development of this paper. The core members of the team include:

- A GP
- A Nurse involved in care coordination, health coaching and chronic disease support
- A medical practice assistant
- A Link Worker
- A receptionist who performs the role of patient advocate and navigator

This size of team has been found to support roughly 230 patients with complex needs. Within many practices there would be multiple teams of this nature. The NUKA model is now active across a variety of regions where first nations people are the predominant population in Alaska. In these broader settings a similar team structure, with less link worker inputs, can serve as many as 7-800 patients with less complex needs. Discussions with the South Central Foundation team and those from the Cambridge Health Alliance in Boston would indicate that this model of teamwork should be a core consideration for adoption in general practices in Australia interested in offering more comprehensive, team based and quality care.

In settings with aggregations of complex patients would be care support teams working across multiple core teams. Members would include:

- Pharmacy
- Podiatry
- Psychology/Mental Health Nursing with counselling skills
- Midwife/Child and Maternal Health Nursing
- Dietetics
- Alcohol and other drugs counsellors
- Physiotherapy
- Diabetes Educators
- Peer Workers
- Visiting Psychiatrists and even General Medicine Physicians

In summary, within a standard sized practice serving a complex patient cohort the total staff complement, and functions could look like:

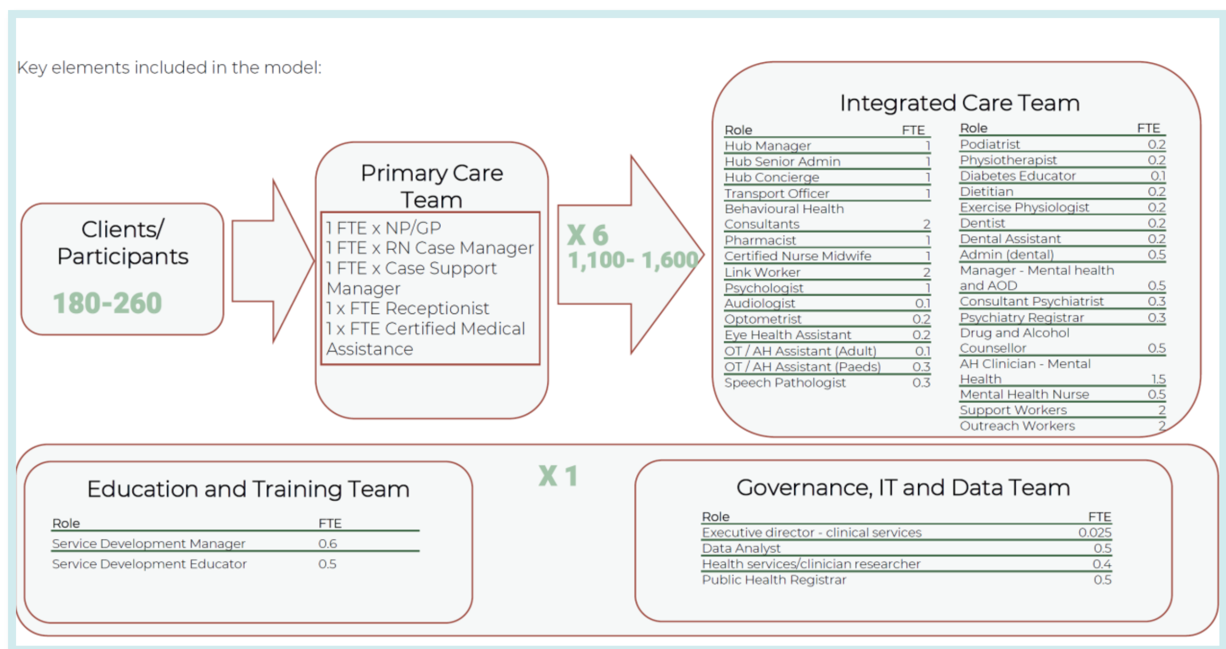


Figure 14:NUKA system of care model applied to marginalised and complex patient group settings

Around such a team would need to be those overseeing clinical governance, data analysis, engaging in population health research and responses, service integration initiatives and evaluation of new initiatives. Such teams would be very engaged with other health and social care service providers leading to shared resourcing of services and co-creation of new models of care. Transitioning to such a model and enabling the team to stay nimble as knowledge evolved and services matured would involve considerable investment in upskilling of both clinicians and health system players with management functions.

Not every patient needs access to an expanded care team of this nature. For services supporting those who are homeless or have active addictions it is likely that every patient needs support within a model like this. For practices working in disadvantaged locations, a large proportion of their patient group will require such expanded supports as they will have many diagnoses requiring attention. For younger and healthier members of the population in such catchments, they will benefit from access to a team who knows them and is funded to engage in more proactive care inclusive of screening and development of health literacy. These additional steps alone will be sufficient to change patient trajectory and reduce the number who over their life course need access to the fully scaled up team.

Determining which patient needs access to the full expanded team will require completion of a complexity assessment. The Health Equity Coalition has developed a complexity tool which builds on work encapsulated in the HARP Tool (modified for use in the intake process of the Health Care Home Program) and the Boston Matrix (incorporated into the Primary Sense data extraction system). Both of those tools spend limited time exploring the psycho-social realities of patients. It is these factors which determine the generalised patient complexity and need for comprehensive team support as agreed by Health Equity Coalition clinical teams. Clinicians noted that patients can have multiple diagnoses but if under active management from a collaborative array of private specialist physicians and allied health the patient journey

can be managed through use of case conferences and solid care planning visits. If that same list of diagnoses is attached to a patient reliant on the public hospital system, with no private health insurance or capacity to pay for allied health and even a couple of psycho-social issues, the complexity of management rapidly escalates. It is here that the differentiation of work delivered through not-for-profit practices takes on a new dimension which needs to be aided by a dramatically expanded team.

Selecting patients who can access which team of care will require proving up the screening tool. In turn, those patients should be voluntarily enrolled at the practice to cement the mutual obligation between patient and provider to continue their care journey together. This will deepen the knowledge each has of the other and the commitment to working together. Data sharing with funders of the nature of enrolled patients, their use of the team, their health outcomes over time and other relevant factors will enable evaluation and refinement of the model of care. It will also enable government to target practices with like cohorts and justify the additional primary care spending against savings accrued in other settings.

Currently, data sharing with government relies on which MBS billing codes are applied. Very little can be ascertained about the patient. All that Medicare can describe is that some doctors bill many more long consultations. The drivers of that care or the outcomes from it are invisible to the system. The reality is that every doctor has some patients with complex presentations. However, if that clinic is in an area where patients can afford gap payments, longer consultations are better remunerated through larger gaps. If the care team can refer them off to others for ongoing care and those extended care team members communicate effectively, even complex cases can be dealt with in shorter time. This directly impacts income to providers and to practices.

Case Study:

Safe Space, Unmet Needs: Managing Acute Mental Health Without Adequate Infrastructure

Background: A client regularly presents at our service, accessing the Needle and Syringe Program (NSP) for equipment for his methamphetamine use. The Harm Reduction workers have observed symptoms including disorganized speech, hallucinations, and paranoia, indicative of an acute psychotic episode. The client will provide his first name, but no other details, therefore we cannot link him in with acute mental health services. He obviously finds our service a safe space, as they like to hang around the building in both the drop-in and reception. However, these areas are shared small and confined spaces. His behavior can be perceived as intimidating, due to his disorganized speech, hallucinations that cause him to pace around the area, shadow boxing and shouting at anyone that enters these areas. The lack of a calming space to remove the patient from these areas make it difficult for staff to conduct de-escalation procedures. As a result, other clients in these areas became unsettled and concerned for their own safety. Staff struggled to effectively de-escalate the situation due to the inadequate setting.

Case Study: (continued)

Safe Space, Unmet Needs: Managing Acute Mental Health Without Adequate Infrastructure

Intervention: The organisation's facilities are not well-suited for handling acute mental health episodes, which contribute to a challenging experience for both the client and the staff. To manage the situation, staff have taken the client outside the building to the car park garden area. This space is a public area with limited privacy, exposing the client to passersby, whom in their deteriorated mental health state, starts to be abusive and threatening to these passersby's. It is important to note that only older and more experienced staff will deal with this client. Newer and less experienced staff, refuse to do so as they feel threatened by him (which is perfectly acceptable). On a number of occasions, the ambulance service has been called, as the assessment of both clinical and non-clinical staff is that this client needs a mental health assessment and inpatient stay for a period of time to stabilise them and allow them to receive the treatment they require. However, on each occasion, as soon as the ambulance presents, they will run from the premises. Lack of last name, address and date of birth also prohibit us from making an appropriate referral to acute mental health.

Outcome: The reality is that the organisation is currently in a situation where an extremely unwell client presenting with symptoms that are indicative of an acute psychotic episode, is regularly accessing the service as they feel that it is a safe space. Requests for support from the ambulance service are irrelevant as the client runs away as soon as they approach. Whilst risk mitigation strategies have been put in place to manage this client, less experienced staff are afraid of this client. In addition, the client's deteriorated mental health condition is prohibiting them from cooperating with a safety plan for accessing our services.

Conclusion: This case highlights the importance of well-designed facilities and a comprehensive, holistic approach to client care, which will allow a safe and private space to manage this client. That space should prohibit other clients and the public becoming unsettled or concerned for their own safety, and allow staff to effectively de-escalate the situation.

In addition, the following requirements/processes would also benefit the client to ensure they received appropriate care, and relieve staff safety concerns:

- Mental Health accredited nurse, who could focus on such clients and complete comprehensive mental health assessments:
- Access to a bulk billing Psychiatrist, for diagnosis, treatment plan and who will collaborate with the team (clinical and non-clinical) to provide holistic care, via funding or brokerage:
- Increase in funding to attract experienced qualified counselling staff, with experience in both alcohol and other drugs and mental health:
- Multi-disciplinary case conference, for complex clients attended by a psychiatrist, clinical and non-clinical staff including peer workers: and
- Additional space to allow visiting services to have a safe and private space to support clients, such Acute Mental Health teams, etc to enable warm handovers to other services.

Principle 9: Resource larger, multidisciplinary teams for highly marginalised populations, including allied health and peer workers.

When working with complex patients efficiency can be gained via team activity. Our model proposes over 2 non-medical clinicians for each Doctor or Nurse Practitioner within a teamlet structure in addition to a Medical Practice Assistant. Access to an MPA who works up patients, ensures interpreter are on hand, chases outstanding results and helps the patient prioritise their reason for visit frees up minutes of doctor time. That same MPA could then work with onsite nurses to engage in further patient education and care coordination which might be more impactful and extensive than that the doctor attempts to deliver in time constrained consultations. Where a patient is in distress or needing supports to navigate other parts of the health and social care system, the onsite Link Worker could engage in social prescribing to ensure the patient gains access to all they need. Finally, internal referrals could be provided to the allied health team to ensure interventions are provided to common issues. Onsite mental health supports could ensure those with mental health issues are better managed. This is a very different workflow than possible in primary care now. It will ensure that doctors and nurses are better supported to support those patients who most need care. It will mean more patients can be seen by the same Doctors and Nurse Practitioners. Through the support of the MPA and ongoing huddles less fragmentation of care is likely to arise.

This more intensive model of care will only be required by the most complex of patients who are a sub-set of the general population. They tend to cluster in disadvantaged regions and make greater use of specialty clinics serving LGBTIQ+ and homeless communities and addictions specialist and migrant clinics. They also arise as patients age, develop multiple conditions and experience cognitive decline. Therefore, in regions with much older patient populations the model could also prove to be useful and acceptable to providers and practices. In rural and remote areas where medical capacity is extremely stretched, a broader team could be used to multiply the impact of Doctors and Nurse Practitioners.

In more generalised practices, patients can usually fund and navigate their way to allied health and other services so less of those team members will be required. Their higher health literacy and engagement with their health means that less care coordination will be required. Hence, the small teamlet model with less inclusion of a link worker would be appropriate in most practices in Australia which are open to team based care. In such instances, it is possible that such a teamlet could support around 7-800 patients offering more comprehensive and continuous care which is very patient centred. Of course, this paper focusses on the needs of providers to patients with complex needs. However, it does point to a logic for wider embrace of such a model in catchments and practices which elect to embrace team based care. Therefore, this paper would endorse the expansion of team based care to the wider general practice community on the 1:1 ratio endorsed in the General Practice Incentives Review.

Principle 10: Implement patient enrolment models to support data-driven care planning and evaluation.

The absence of a comprehensive team can create delays in access to care and reliance on acute care settings for late presentations. Within even hospital-based settings the capacity of patients to access the right care team can depend upon demand in emergency departments at time of presentation, frequency of attendance at the emergency department and the staffing of that hospital. It would be a more cost-effective model to offer a team of care in a community setting which the patient found accessible and acceptable.

The use of a team is something some not for profit providers have been accelerating for many years. Their capacity to do so is highly dependent upon the grants they can access, the longevity of those grants, the job security and scope offered to team members, the funds available to create the clinical governance required to manage team-based working safely for patients and providers and the suitability of facilities the team members are working out of.

Case Study:

Positive Patient Experience at Better Access Medical Clinic Sunshine Coast

Background: A patient with a history of substance use dependence and an undiagnosed severe and persistent mental health disorder presented at the Better Access Medical Clinic. The clinic's well-designed facilities and comprehensive care approach contributed to an excellent patient care experience.

Incident: The patient arrived at the clinic and was greeted in a well-designed reception space by a Peer Worker. The Peer Worker's primary role was to assist in linking clients to relevant services. The Peer Worker took the patient to a private talking room that was calming and created a warm and neutral space. Through initial conversation, the Peer Worker built trust and rapport with the patient and conducted a brief assessment. While the Peer Worker engaged in this level of care the reception team were able to continue managing phone calls and patient arrivals and exits.

Assessment: During the assessment, it was noted that the patient had been struggling with substance dependence issues for a long period, with significant use of illicit drugs (e.g., methamphetamines) and diverted pharmaceutical drugs (benzodiazepines and ADHD medications). The patient had been injecting methamphetamines weekly, initially using them with intimate partners to enhance their sexual relationships but had developed a dependence over time. The patient also had a history of poor diet/nutrition and sleep disorder due to long-term dependence. The patient reported significant mental health disturbances, including delusions, paranoia, manic behaviour, and persistent depression and anxiety. The patient was not currently working due to health issues but remained the primary carer for a 7-year-old child.

Case Study: (continued)

Intervention: Based on the initial assessment, the Peer Worker made several appointments for the patient, including:

- An appointment with the Better Access Medical Clinic GP
- Visits to the acupuncturist and naturopath
- An initial screen for the specialist AOD therapeutic program intake
- An immediate referral to the Needle and Syringe Program to chat with a Harm Reduction Worker

The patient was immediately walked over to the Harm Reduction Worker, who discussed the patient's injecting drug use and provided clean injecting equipment. The patient was offered access to Point of Care Testing (POCT) for Hepatitis C, HIV, and several sexually transmitted infections (STIs), including syphilis and HIV. The test results were available within moments, and the Harm Reduction Worker provided a post-test discussion, revealing a positive HCV antibody result and negative STI results. Further POCT PCR confirmatory testing for HCV was conducted by the same Harm Reduction Worker, which also came back positive, indicating active HCV infection. A referral to a Nurse Practitioner with a scope of practice in Hepatology and Sexual Health was made on the same day.

Outcome: The Nurse Practitioner discussed treatment options and health maintenance with the patient, and a follow-up appointment for direct-acting antiviral treatment was scheduled for the same week. The patient visited the GP the following day for a long appointment to discuss mental health concerns, diet/nutrition, sleep disturbance, and sexual health. The GP and practice nurse started the patient on a Mental Health Care Plan and scheduled a further appointment for a Chronic Disease Management Plan.

Later that week, the patient saw a visiting registered dietitian to discuss dietary concerns and accessed the acupuncturist and naturopath for treatment of sleep disturbance, stress, anxiety, and a pre-existing injury causing pain. With the patient's consent, the GP worked closely with the AOD Therapeutic teams to prioritize access to counselling and therapeutic group programs. The patient began regular counselling with a registered *counsellor and attended the TreeHouse Parenting Group Program, a ten-week therapeutic group for parents with associated substance use and mental health concerns.* Brokerage funding was available via the Therapeutic Program, and the Peer Worker collaborated with the Therapeutic Team to access these funds, allowing the GP to arrange and pay for a specialist psychiatrist assessment.

In the meantime, the patient had already started direct-acting antivirals for HCV treatment with the Nurse Practitioner, who liaised with the GP on the patient's progress. The Peer Worker continued their involvement in the patient's care, developing a case management plan to support various components of the treatment and integrating support for employment externally. This assistance helped the patient return to part-time permanent work. The patient also began accessing the Therapeutic Treehouse Parenting Program to strengthen their confidence, skills, and coping strategies as a parent, enabling social connection with other single parents with similar life experiences.

Conclusion: This case highlights the importance of well-designed facilities and a comprehensive, holistic approach to patient care. The Better Access Medical Clinic's environment and multidisciplinary team enabled effective and compassionate care, resulting in a positive patient experience and significant improvements in the patient's health and well-being.

What that team will be doing for patients with complex presentations has already been demonstrated as being different. Sadly, the MBS is blind to complexity. The MBS rewards volumes of patients seen. That is easier to do in catchments with large numbers of largely well and educated patients who require infrequent and short visits.

RACGP data notes the number of longer consultations is rising more generally and GPs are spending more time with patients[xlv]. This is leading to growing calls to update the MBS to reflect the real costs of performing longer, slower care and overall modernise how Medicare works. Hence, this issue is not one just affecting not for profit providers. However, they are the canary in the coalmine around how challenging the funding environment has become so attending to their needs provides a test case for what could be scaled up more generally.

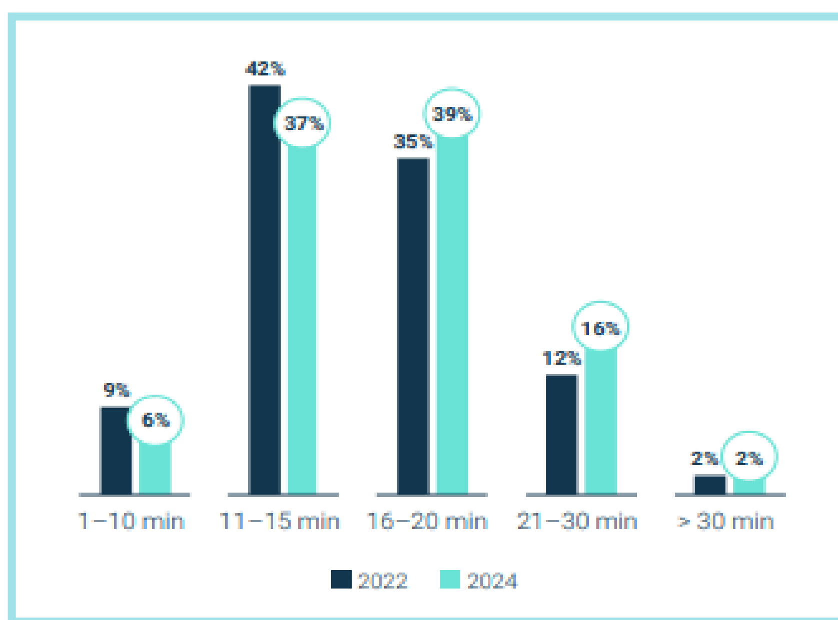


Figure 15: Cubiko data: GPs are spending more time with patients compared to two years ago

Using Cubiko Touchstone data for Brisbane, the home of the Health Equity Coalition, the difference this makes is clear. It most impacts those serving disadvantaged communities with quality care. Clinics offering comprehensive care for the disadvantaged see an average of 2.8 patients per hour rather than the 4.13 patients per hour recorded in general and five per hour in predominantly bulk billing clinics in Brisbane's south. That means individual patients are taking longer than 20 minutes rather than the 18 minutes reported as the average by the RACGP in high quality care settings. That in turn is a multiple of the length of time taken in standard bulk billing clinics where six minute care has become endemic. This tends to concentrate patients with more complex needs into charitable clinics offering longer consultations and more comprehensive care. Such a reality further penalises the teams of care both financially and via cognitive burden. Patients with greater needs tend to book in more frequently making appointments available for those who may only need to attend a handful of times a year less accessible. The result is such patients engage with other providers

who may charge, eroding the base of easier, better paid medicine. The rate per minute of appointments over 20 minutes is significantly lower than shorter care episodes.

Duration	MBS item + bulk billing incentive	Rate per minute / per hour	Compensation compared with a six minute consult
6 minutes	$41.40 + $20.65 = $62.05	$10.34 per minute. $620.50 per hour.	Pays **100%** the rate of a 6 minute consult
12 minutes	$41.40 + $20.65 = $62.05	$5.17 per minute. $310.25 per hour.	Pays **50%** the rate of a 6 minute consult
18 minutes	$41.40 + $20.65 = $62.05	$3.45 per minute. $206.83 per hour.	Pays **33%** the rate of a 6 minute consult
24 minutes	$80.10 + $20.65 = $100.75	$4.20 per minute. $251.88 per hour.	Pays **41%** the rate of a 6 minute consult
30 minutes	$80.10 + $20.65 = $100.75	$3.36 per minute. $201.50 per hour.	Pays **32%** the rate of a 6 minute consult
36 minutes	$80.10 + $20.65 = $100.75	$2.80 per minute. $167.92 per hour.	Pays **27%** the rate of a 6 minute consult
42 minutes	$118.00 + $20.65 = $138.65	$3.30 per minute. $198.07 per hour.	Pays **32%** the rate of a 6 minute consult
60 minutes	$191.20 + $20.65 = $211.85	$3.53 per minute. $211.85 per hour.	Pays **34%** the rate of a 6 minute consult

Figure 16: MBS data: Rate per minute statistics

Where patients are older, and predominantly on pensions or families are disadvantaged, reliant on welfare and have many social determinants to address, the number of visits per year per patient is a multiple of the Australian average. This is not surprising given national data already shows disproportionate use of the health system by those who are younger and older. Add in poverty, racism, trauma and other social determinants and it is easy to see why rates of visitation would be very different to Australian averages.

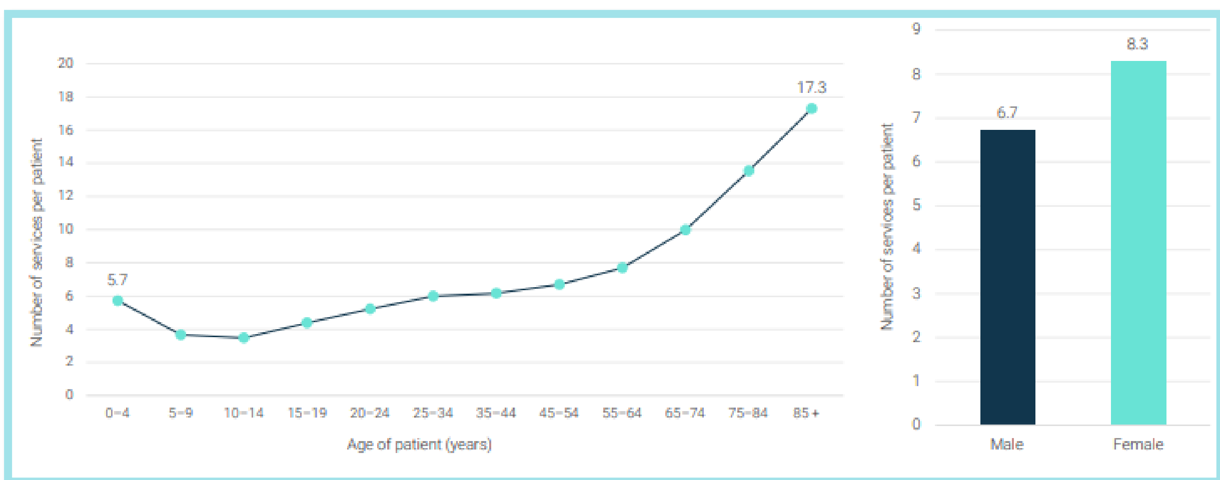


Figure 17: RACGP Data: Females and older people remain the highest users of GP services

This slower medicine results in significant reductions in income simply because the Medicare Schedule pays less per minute the longer you spend with a patient yet the costs of care per minute are likely to increase. This is logical as patients requiring fuller examinations are likely to need nursing input, ambulance retrieval, referrals, repeat visits, carer education and liaison with other service providers used by the patient. This results in use of space, consumables, reception and clinical team time. In many instances, it also means care coordination, a

component of care barely recognised in the MBS model and scarcely addressed in current practice incentives, is a fundamental component of services.

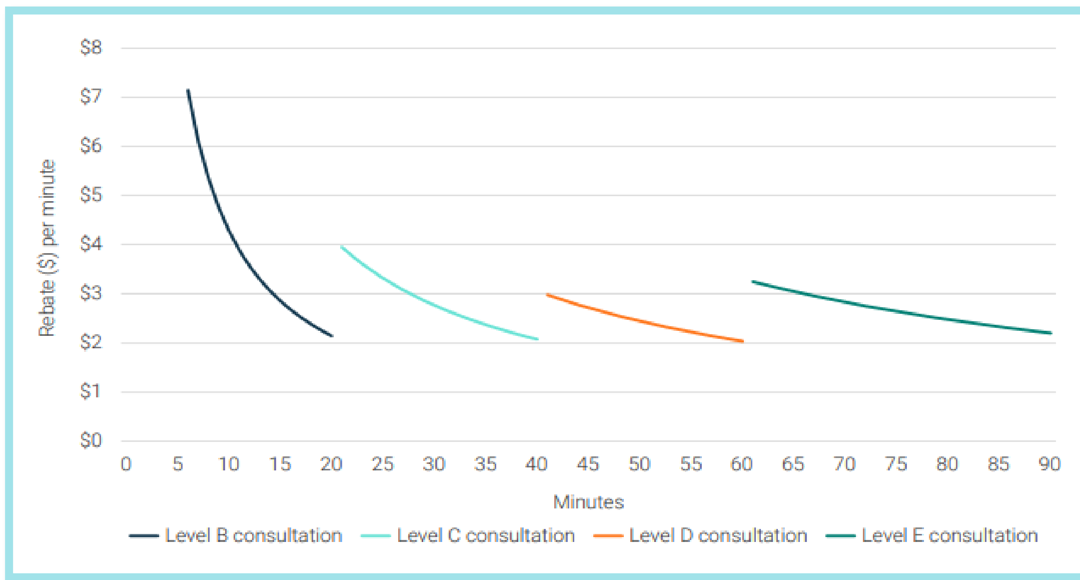


Figure 18: MBS Patient rebate per minute for standard GP consultation items depicted by RACGP

That is a crisis for practices given the decline in real investment in general practice so evident in health data[xlvi]

Figure 19: Health data around investment in general practice

The average mixed billing GP clinic in Brisbane's south bulk bills 64% of patients and achieves income of $405 per hour. Bulk billing clinics practicing slow medicine achieve just $291 per hour; a difference of 39%. This makes sense given consultations over 20 minutes are reimbursed at over 40% less per minute than consultations lasting eight minutes. The majority of work in clinics serving more complex patients will be well over 20 minutes in duration.

Case Study:

Beyond the Consultation: Meeting Cultural and Language Needs in Primary Care

Inala Primary Care provides around 11% of attending patients with access to an interpreter. The time taken for these consultations constitutes 26% of total medical diarised time in the practice. In addition, accompanying family members and bi-lingual staff provide additional episodes of care which meet the language and cultural needs of one of Queensland's most diverse populations. The vast majority of these consultations are for patients who have eligibility for a concession card meaning care is bulk billed. To support these patients the practice also embeds on a part-time basis a refugee health nurse provided by Mater Health Services and a social worker specific to the needs of NESB groups. These support team members access rooms at no charge to the practice. The reception team orders interpreters and makes future bookings for NESB patients unable to communicate in English at other health services to ensure patients attend care recommended by their medical team. Where possible they encourage such care providers to book interpreters in the language used by the patient and communicate other care concerns flagged by doctors. Studies of the costs of this activity show a cost contribution to the practice of over $440K per year. This is made up of direct costs of the additional staff time involved and the opportunity cost of lost rent.

This revenue difference exists despite such clinics providing 1/3rd more chronic disease care as indicated by billing of CDM Items as a percentage of total billings. Chronic disease items, whilst well paid, are generally bulk billed, involve nursing costs and do not make up for the difference in patient throughput or the lack of out of pocket expenses paid by at least 36% of patients (effectively doubling income for over 1/3rd of all work).

The recently announced tripled bulk billing incentive for all Australians, which will come into effect from November 2025, will benefit those clinics currently delivering mostly bulk billed care. It is likely that clinics currently mixed billing less than 30% of patients will resume being almost entirely bulk billing. However, even as that funding model is implemented it stands to exacerbate the income difference between those providing comprehensive care and those offering quick, walk-in medicine. The growing gap relates to the number of patients seen per hour. If you see more patients who have historically been working and are therefore in better

health you will stick to booking six or more patients per hour. You will benefit enormously from all of those patients now being eligible for bulk billing incentives.

Case Study:

Welcome but Insufficient: Why Bulk Billing Incentives Don't Bridge the Gap

68% of Inala Primary Care's patients have pension or concession cards. However, those with concession cards and welfare dependence make up the vast majority of attendees each week. Consequently, around 90% of care is bulk billed. Modelling of the impact of the introduction of universal incentives for bulk billing shows that the practice will gain around $228K in additional payments as a result of bulk billing everyone. With the 12.5% incentive payment for bulk billing around $247K in additional receipts are anticipated once the loss of privately billed income is accounted for. That is a welcome rise in revenues. However, it only pays for the higher ratio of nurses to doctors employed at the practice than in surrounding practices. It does not provide the capacity to pay doctors more, it simply makes losses to the organisation less. It does not recognise the additional reception team members required as just 9-12% of patients will book online in any given week due to limited health literacy and internet access (standard practices see over 40% of care booked online saving reception costs). Had the practice been able to triple the number of patients paying an out of pocket fee which was calculated at the standard AMA rate (IPC out of pocket costs average around $36 not the $45-50 common in other practices), the gain to the practice would have been a multiple of the impact of the bulk billing changes.

The missing link in funding is enrolment. Matching bulk billing access to enrolment and through enrolment access to larger teams of care provided with a loading for equity will provide an incentive for practices and providers to respond more effectively to the new funding stream. For providers, where the majority of their patients were already eligible for bulk billing, as they had poor health and limited capacity to work, the expansion of bulk billing will impact at the margins which is why additional funding needs to be offered to support sustainable service delivery.

In slow and complex care clinics, GPs frequently demand a higher percentage of billings to ensure they receive an adequate income. This occurs whether the clinic focusses on mental health, substance misuse, homelessness, refugee health or care in social housing communities. Practice fees of as little as 20% of billings are common (compared to an industry average of 30-35%). The alternative is that GPs are paid salaries which enable them to benefit from salary sacrifice. The costs of salaries for such GPs and Nurse Practitioners far outstrips the usual threshold of 70% of billings being split with the doctor or NP. The result for practices is being able to spend less on overheads inclusive of practice nursing and reception supports. This perpetuates the cycle of stress for doctors meaning they are more inclined to work part-time undermining the continuity of care for patients and access to appointments in the clinic.

To ensure a suitable complement of nurses who are not burnt out with work pressure, practices in the most disadvantaged areas have the choice to offer almost no nursing support

for a high throughput, medical centric model of care (common in walk in corporate clinics) or subsidise the costs of nursing and other team members from other sources of income. If they are fortunate, they may be able to complement incomes with grants from state agencies to employ additional nursing and allied health. However, such grants are hard to gain, short in length and foster a separation of team members working to different performance indicators which is not good for the patients or the providers.

This exposes the Medicare promise as a myth. The lack of universal insurance for the poorest and most complex means their care lives up to the Inverse Care Law; those who need care the most get the least access to care…unless someone other than the health system funder pays. This is what charitable groups have been doing for years. Now however, the gap between income and outgoings has grown so markedly Boards are asking questions about sustainability; jeopardising access to care. It was this danger which led to the formation of the Health Equity Coalition.

Principle 11: Introduce incentivised salaried roles in high-need clinics to provide financial certainty and improve workforce recruitment.

Practices serving the most disadvantaged are typically charitable structures already. That means many are offering salaried positions for Medical Officers. However, the rates of pay are usually below that offered in Aboriginal Medical Services which in turn are below those offered in private practices were billing $5-600 per hour is common. This means attracting and retaining medical staff is more difficult.

Not for profit providers to marginalised communities are also more likely to employ female staff and overseas trained doctors. Both groups suffer from aspects of disadvantage. The documentation around the gender pay gap in general practice is clear; women performing more "tears and smears" work i.e. mental health and women's health activity, earn significantly less than their colleagues who have more time to do procedural work or see more patients per hour. Women are over-represented as the medical, nursing and allied health staff in the Health Equity Coalition services.

Case Study:

When the Door Closes: What Happens When Patients Can't Reach Their Trusted GP?

Terry was an intensely private man, whose experiences in childhood made it hard to trust others. In August he was released from prison after 9 months. The conviction had been a wake-up call, and he had managed to stay off hard drugs while he was incarcerated, despite them being everywhere. Upon release he went to stay with his parents some 50km from the old neighbourhood; there was nowhere else for him to stay. He went to a few different GPs locally but didn't find one that he trusted. He needed to sort out several issues: he wanted to quit smoking and his diabetes was out of control. As Christmas approached, he had become increasingly unsettled with anxiety and panic attacks. He was worried about relapsing into substance abuse. The only health professional who knew about his childhood was his old GP. He decided to call his old GP to book in for a telehealth appointment, but was told there would be no Medicare rebate because he hadn't been there in person for over a year. The well-meaning receptionist told him there would be no Medicare rebate, "unless it is for sexual or reproductive health, or mental health?" Terry was embarrassed to be asked about this and hung up. He rang again some weeks later in great distress and the telehealth consultation lasted over an hour, all unbilled time.

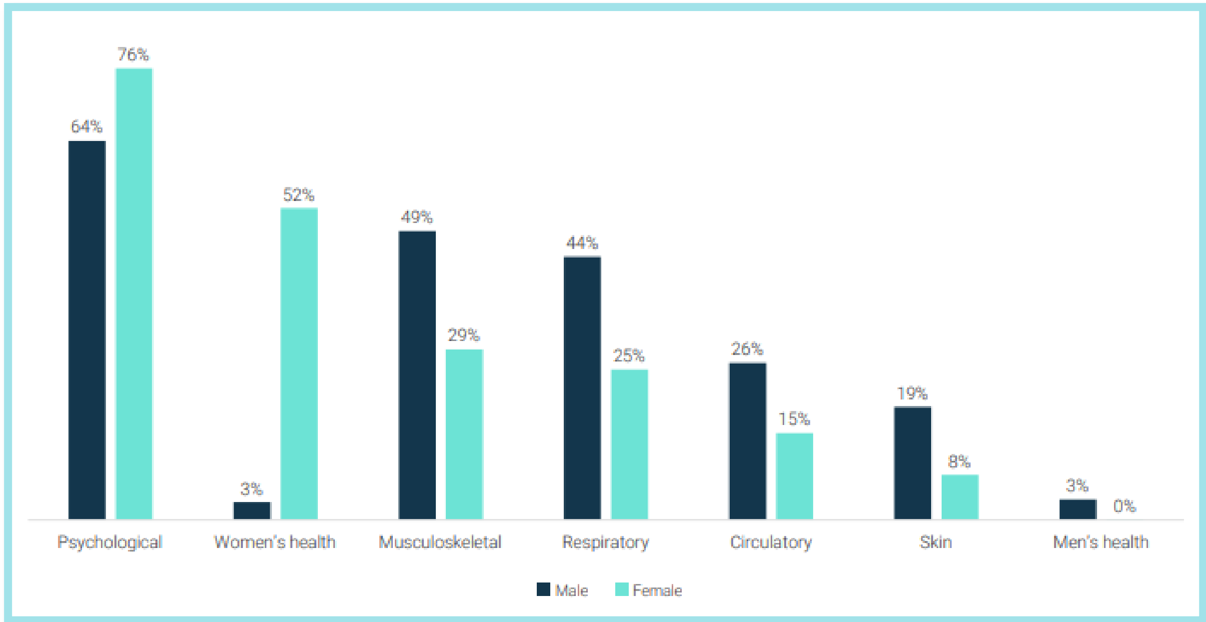


Figure 20: Female GPs see more psychological presentations according to RACGP data

In addition, such communities suffer from more itinerant attendance. Patients are less likely to have cars than the average Australian. When it is extremely hot, very cold or raining, patients do not attend their appointments. The No Show Rate in such clinics on such days undermines income for Doctors, Nurse Practitioners and the practice further making the budgeting process more complicated and risky. It is for this reason that corporate clinics in such communities routinely offer a walk in model. That way, if attendance is lower in a given day due to weather, doctors can be occupied seeing whoever filters in and leave early as

Case Study:

From Toe Pain to Hospital Bed: The Hidden Risks of Fragmented Care

On Monday, Michael's toe was very sore. He could barely walk on it. He tried to book with his regular GP but the next available appointment wasn't until Thursday, and he was in agony. He booked a telehealth for Thursday but also went straight to the clinic down the road where you don't need an appointment. The doctor suspected gout; arranged some blood tests and an x-ray. The doctor prescribed him prednisolone, a steroid drug, because Michael mentioned he had been told to avoid NSAIDs. (Michael was diabetic and had had a heart attack before.) Thursday he had the telehealth he had already booked; the toe was improved but he was feeling increasingly "off" over the last few days, and was hoping the blood tests and x-ray would shed some light on why. The results weren't on My Health Record and the GP would have to chase these results later. The GP suspected prednisolone had caused Michael's sugars to become dangerously high, but Michael didn't have a glucometer at home and had no way of getting to the clinic other than driving, which didn't seem a good idea if he was unwell from high sugars. The GP arranged an ambulance for Michael so he could be assessed at the hospital.

demand is low. The result is less continuity of care, long wait times to see a doctor and patients mixing their care. Combinations of walk in clinics and access to booked appointments for their planned episodes of care in a quality service are common. The result is fragmentation of care as patients often deny accessing walk in clinics. They want to be seen as loyal to their "main" doctor. The consequences can be devasting with multiple prescriptions for the same agent being prescribed but dispensed under different brands leading patients to take multiple doses of the same drug or other medication misadventures.

The consequence of such a setting is that not for profit practices would be very open to introduction of an incentivised, salaried model of general practitioner remuneration. Wages for doctors could be set at reasonable levels, equivalent to those achieved in the aboriginal medical service environment or for dual qualified doctors working in state health systems. In addition, quarterly top ups calculated to reward those who have been able to build full diaries and engage patients in chronic disease services with higher revenue per appointment could be offered. Within the Doctor rate, time would be funded for the following critical tasks so necessary to ensure high quality care for vulnerable and complex patients:

- Daily huddles with their Medical Practice Assistant to plan the interactions with the patients scheduled for the day and use the MPA to brief broader team members on support required for patients that day
- monthly review of their patient panel with the Medical Practice Assistant, Pharmacist and Nurses to plan engagements with patients who have not visited and may need to, follow-up patients whose health is unstable and delegate care activity to the rest of the team so that the doctor does not need to see every patient
- time to engage with public hospital specialists involved with patient care who need to be chased for advice and who frequently refuse to be scheduled for case conferences
- conduct of patient chart audits to ensure that quality care is in place following agreed guidelines and delivering on quality improvement targets set by the team at the clinic

The calculation of the amount of salaried time available to a clinic would be linked to patient enrolment. In clinics serving the homeless and very itinerant, like injecting drug users who may not always be able to enrol, the number of patient appointments delivered by the clinic in the previous quarter would be used to indicate demand. In this way, clinics could continue to grow as their team scales up and patients respond to the service offering. If a blanket block funded amount for salaries were provided, the clinics would end up like public hospitals; rationing care based on salaried time not patient need. Given primary care is so much more affordable and easy to scale up than hospital care, it makes no sense to limit providers to an annual funding amount. It is better to scale based on enrolled patients and ratio of team members needed to those patients.

Not for profit providers are open to salaried models as many already offer this arrangement. Not for profit providers need not fear payroll tax implications as they are exempt from state taxes like payroll tax. Hence, they can employ hundreds and even thousands of staff with no threat of bleeding income into tax. This mechanism further restricts the take-up of this more comprehensive model of care to those organisations whose history, values and service provision most closely aligns with the needs of the most complex patients. It is unlikely that

even high-quality practices serving sub-sets of complex patients will convert to being a charitable organisation. Therefore, government can be more targeted with its expenditure.

Case Study:

When Life Gets in the Way: Barriers to Attendance in High-Needs Populations

Inala Primary Care uses HotDoc as the booking engine for appointments in line with many clinics across the country. The system sends SMS reminders to patients booked the next day. In addition, practice reception team members ring every patient booked for a long appointment, booked for a chronic disease management plan or health assessment or who has not consented to being contacted by SMS (over 1/3rd of all patients). Finally, the practice has a "No Show Fee" levied on patients who do not attend. Collecting this fee is successful in about half of cases as patients simply refuse to re-book for appointments or take the debt with them as they move into another rental or housing option. Despite providing cards to patients listing their next appointment and engaging in such costly reminder activity, the clinic runs a No Show rate of over 7%. On Brisbane's southside, the standard no show rate is less than 1%. Sadly, knowing when a patient will not attend is not possible as appointments can be skipped across the day. With so many patients having large families, mental health issues and being reliant on public transport, overbooking and making patients wait in clinic is not current practice. That simply leads to more abuse of reception staff, patients storming out before appointments causing another no show or being so agitated by their appointment that they are less able to engage.

Principle 12: Fund acute care clinics and crisis care models within general practices to improve access and continuity of care to vulnerable populations.

Such clinics could also mount an acute care clinic to ensure patients who are sick on the day can be seen and sorted. Patients in disadvantaged catchments have less capacity to recognise how sick they may or may not be. They may also have cognitive dissonance about addressing their health. If your life is dictated by a frequent medical schedule of appointments, you are loathe to add another appointment if you can possibly avoid it. Hence, the patients present late when their symptoms are simply too awful to ignore. Often this requires the team to "rescue" the patient, a lengthy exercise. Often, they then spend time counselling them about why they really need to go to hospital as primary care resources at not adequate for the hours of monitoring, further investigations or introduction of new medications which the patient might need.

Other patients simply have so many other matters distracting their attention to their own wellbeing that early symptoms are not detected or ignored as other more pressing family or life factors are the focus. Hence, they present only when their health is a challenge and need a team of care to stabilise their deterioration. Using that same team to contact them after an acute episode to address other factors which were obvious but not able to be prioritised on the day would enable patients to address underlying health issues, get preventative health supports and screening so that they do not become another statistic of disadvantage.

Some patients who are especially anxious tend to visit more frequently for re-assurance which can lead to over-testing and over-reliance on their GP. Other patients who have many conditions are so tired of the regularity of contact with the medical system that they present late when unwell and accept appointments for the next day if their GP is already busy. This means they can be acutely ill by the time they are reviewed.

Case Study

Many Clinics, One Missed Diagnosis: The Cost of Care Without Continuity

Maria, 45, is busy with 3 kids and a fulltime job. After she attended a local walk-in bulk billing clinic for a UTI, one of her kids pointed out she'd only been at the doctor for a UTI 6 weeks ago. She checked the booking confirmations and saw that she had actually had four UTIs in the past 12 months -- she hadn't realised it had been that many, and she had been attending different doctors and different clinics, wherever she could get in. The next UTI came a month later, and she mentioned to the GP that this was her 5th in a year. The GP ordered an ultrasound which showed an advanced bladder cancer.

We propose an acute care clinic as the solution to free up GP time from less critical consultations and increase access in communities and for patients where GP capacity is already overwhelmed. This would reduce the likely use of emergency departments which

tend to ignore some of the driving reasons for visit by such patients, exacerbating the overall pattern of medical dependence. Such a clinic would be led by the practice Pharmacist and Practice Nurse or a Nurse Practitioner if they are available. Patients attending the acute clinic, which would typically run each morning, would be streamed:

- Patients with urinary tract infections and respiratory presentations most likely to need anti-biotics – patients worked up and the GP or NP invited to provide a script
- Children who have been unwell overnight presenting with rashes and post-viral symptoms – history taking by the team and review by the supervising doctor
- Patients with emergent wound issues and chronic wounds – wounds dressed and where necessary anti-biotics and ointments prescribed by the overseeing GP or NP
- Patients with mental health diagnoses needing to be assessed for safety – patients engaged and scheduled for review by the practice Psychologist or Mental Health Nurse or where their usual GP has diary capacity reviewed by their GP

Ideally, such clinics would over time allow the pharmacist or nurse to prescribe medications to the patients under protocols similar to those for pharmacy prescribing trials or Nurse Practitioner scopes. The scripts would be captured in the patient chart, where necessary consultation would occur with the patient's usual GP and the episode recorded in the one patient record enabling all members of the team to continue care. Such a move would further free up GP time whilst allowing the model of care to mature under supervision of the GP. Preliminary modelling of the impact of such a team shows that an average practice could increase patient flow by around 20-30% each day creating much additional access in communities which need it most. All would be delivered at a very cost effective price and alleviate the need for additional urgent care clinics which may not provide the inclusive care required by disadvantaged patients.

There are particular populations most likely to benefit from acute care clinics embedded within their usual general practice. Youth who are transient or homeless frequently present without a Medicare Card as they have fled domestic violence or other home-based conflict. They are often too young to have considered applying for a Medicare Card before. It can take months to support them to do so. Services like Brisbane Youth Service and Micah Projects make up the difference by offering free care.

Migrants awaiting the issue of a Medicare Card, family visitors from the wider Pacific or those awaiting asylum are also facing a healthcare system which has no front door. Treating their conditions in community settings, like those run by Health Equity Coalition members, is more personalised, appropriate and less costly than those patients being forced to access state funded Emergency Departments. The rise of Urgent Care Clinics has not diverted this group away from hospitals as UCC's also require Medicare Care Cards for all attendees. The result of our proposal would be similar to that which occurs in federally qualified healthcare centres in the United States; those without visas in that system can attend a FQHC free of charge and obtain access to care despite being deemed "illegal aliens" by other bureaucracies.

Continued support of the homeless and transient by nurse led crisis care teams would also be supported through the model.

Principle 13: Design clinical spaces to support team-based, flexible models of care and offer to patients care settings which are dignified and culturally appropriate**.**

The combination of an expanded team with an enhanced scope of practice means that practice infrastructure needs to change. In disadvantaged areas, patients present to medical centres as a trusted, professional organisation which is free to access. They arrive with need for paperwork to be signed for government programs, in distress from the burden of life, confused by the communication received from hospitals and seeking care navigation supports. Such needs are often disclosed in person in waiting areas. This is because use of telephones can be limited due to budgets, language and cultural background. Reception areas are not suited to such interactions. Soft entry spaces where patients could be triaged and channelled to more appropriate services within the team rather than routinely booked to see a doctor would be culturally safer and more respectful.

For patients using public transport or walking in, lounge areas which could be used to accommodate their early arrivals to appointments. That would mean less exposure to patients who are infectious and less interactions between patients who might have cultural differences or behavioural issues.

The increased rate of mental health presentations and need for care coordination and social prescribing means that clinics need supportive emotional spaces rather than relying entirely on wet clinic rooms. Access to these areas would also facilitate the sharing of resources across the health and community care sector so that community lawyers, financial counsellors, educational advisors, domestic and family violence services, child and family programs and settlement services could all co-locate; reducing the navigation challenges for patients and improving the potential for comprehensive and collaborative care.

Teams themselves need huddle spaces where warm handovers can occur, planning of patient engagement can be charted and reviews of patients conducted. These spaces could also be used for case conferencing with hospitals and other members of the care team and planning of projects so central to the evolution of models of care.

Finally, larger group spaces are also required. Here cooking classes, group physiotherapy and rehabilitation services, group mental health, shared medical appointments and other community engagement activities like patient advisory committees could all be convened. Given the size of the teams, the spaces would also be used for regular clinical governance meetings and team meetings. This would be far more appropriate than clustering in small tea rooms shared with non-clinical staff who may not need to hear the case reviews for patients they serve.

Case Study

Adversity in the Patient Experience at Better Access Medical Clinic

Background: A patient with a history of mental health issues, including acute psychosis, presented at the Better Access Medical Clinic. The clinic's facilities were older and not well-suited for handling acute mental health episodes, which contributed to a challenging experience for both the patient and the staff.

Incident: The patient arrived at the clinic's waiting room in an acute state of psychosis, prior to they had been observed running in and out of the moving traffic in front of the building. The clinic lacked a calming space to remove the patient from the general waiting area, which made it difficult for the staff to conduct de-escalation procedures. As a result, other patients in the waiting room became unsettled and concerned for their own safety. The staff struggled to effectively de-escalate the situation due to the inadequate setting.

Intervention: To manage the situation, the staff decided to take the patient outside the building to the car park garden area. This space, however, was a public area with limited privacy, exposing the patient to passersby. Despite these challenges, the staff were eventually able to de-escalate the patient. The patient agreed to present to mental health services at the Royal Brisbane and Women's Hospital (RBWH).

Outcome: The patient was transferred to RBWH, where they were admitted for a short period and later discharged. However, the patient returned to the Needle and Syringe Program (NSP), an ancillary service run by QuIHN from the same building, later that evening around 6:30 pm. The patient was still in psychological distress, though in a milder state than during the initial presentation at the GP clinic. The RN was still on the duty, reassessed the patient, and with the help of a counsellor drove the patient home, as the environment was deemed to be overstimulating for the patient, and was causing her further anxiety. The NSP staff managed to make a follow-up appointment with the GP for the following day.

Conclusion: This case highlights the importance of having appropriate facilities and spaces within medical clinics to handle acute mental health episodes. The lack of a calming space and the need to use a public area for de-escalation compromised the patient's privacy and the safety of other patients. It underscores the need for improvements in clinic infrastructure to better support patients with mental health issues and ensure effective and safe de-escalation procedures.

Part 4: Addressing Need and Scale

Principle 14: Support access to capital for charitable practices to enable sustainable growth and adoption of expanded teams in routine care.

Building such facilities requires capital. In an era of increasing land prices, skyrocketing building costs and more conservative lending practices, many not for profit providers lack access to capital. Their Boards are volunteer and therefore unwilling to provide Director's Guarantees. The result is that traditional banking loans are inaccessible to fund growth and expansion.

In America, the Federally Qualified Health Centre Program provides access to loans for building programs and technical assistance to support expansion for smaller health centres. The government also provides loan guarantees to enable access to more traditional finance, covering 80% of capital infrastructure projects[xlvii]. Hence, if an organisation needs to access $1M to fitout a space they could borrow $800K from a bank with government providing a loan guarantee for the amount. The organisation would provide the remaining $200K from donations or reserves. The organisation then pays routine monthly principal and interest payments to the bank using operating cashflows from expanded service provision to pay down the loan. Over time, the loan is paid out and the organisation owns the fitout or even the entire building they have purchased.

Australian hospital funding and aged care programs recognise that capital costs and service delivery costs are two components of operation. Separate funding allocations and allowances are made for each. Within primary care there is no acknowledgement of the infrastructure needed to deliver care.

Within the independent schools sector government makes available fees to pay for educating students against a schedule of costs rated by area and parent income. Schools with less affluent parents gain more in fees per student. In addition, government makes funds available to a block grant authority in each state from which independent schools can bid for funds to build new facilities. Such grants are then paired with capital the schools raise themselves through debt or fundraising to build the new infrastructure required to deliver modern curriculum elements or expand.

With not for profit practices providing a key role in the delivery of healthcare and often other aspects of social care, it would make sense to create a block grant system in each state from which not for profit providers could bid for funds. The scale of the fund could be related to the known population size of very low income earners and those suffering addiction, mental health and homeless challenges. In addition, incentives could be applied to create community hubs where health, social and community care services could all be clustered enabling patients who use all of those services to more easily navigate the web of government and non-government supports. For example, a larger grant or percentage of cost could be available if the facility was the anchor for such a community hub.

Principle 15: Partner with innovative practices to develop scalable, replicable models of care.

For medical service providers, clustering would also make it easier to form partnerships to address the root causes of many presentations. This is the sort of place based response called for in "Getting Australia's Health on Track 2024". In taking this approach, the opportunity to expand service provision in areas of need multiplies as shared facilities can be created. This could reduce the overall cost of service provision. What is needed is access to reliable funding mechanisms so that organisations are not land locked in inner city locations which no longer serve their purpose or populations well.

Once a building is owned, it is far easier to gain future lending as property is a recognised form of security for bank lenders. The only caveat would be for buildings in rural and remote areas where future sales of the building and building values can be highly variable. Hence, finance sector interest is low in such locations. Banks often require a higher level of investment by the property owner in such instances and will only lend 50-60% of the building cost. This is because banks understand the risks involved in more regional locations and rural areas. They offset that risk by demanding more shared investment and may also apply higher interest charges. Therefore, any grant funding pool would need to account for regional variation with capacity to fund a higher proportion of building costs. With lower land values in many such regions, the additional funding might be offset by a lower overall cost of build per project.

Corporate practice groups do not suffer the same challenges accessing capital. They routinely raise large sums of cash from investors. This is used to purchase both practices and the buildings they operate from. In exchange, practices need to provide strong cashflow to support payment of dividends. In addition, they need to demonstrate growth in turnover to grow the value of the entity and provide uplift in equity to investors. This is most probable in metropolitan and larger regional locations with sufficiently well populations who need access to only sporadic doctor centric occasions of service. They can produce the volume of patients needing access to shorter consultations which sustain the income required to fund both expansion and investor returns. This business model has been a key driver of the six minute medicine which is now an endemic feature of the general practice landscape.

For privately owned clinics, the owners typically provide Director's Guarantees for business debt linked to personal assets. This is typically a personal home. For some, it might be money from their personal superannuation fund which is used to purchase a building which is then rented to the business which operates the practice. This can be low risk if the owner intends to work in the practice for many years and build a viable business they can sell. However, their capacity to access capital will be constrained by the total equity they have in their own home or the balance of their superannuation fund. For young doctors this can be a real impediment to becoming a practice owner as their home equity might be low even whilst their income to sustain a loan can be sufficient. This is one reason why fewer young doctors are becoming practice principles, solidifying the drive to corporatisation of healthcare.

Banks are increasingly recognising this challenge and offering more cashflow linked loans for healthcare businesses. They typically scale up from being largely interest only repayments in the first few years to principal and interest by the third or fourth year. The loan life is typically the length of the practice's lease of the building or even longer periods where the building is owned by those working in the practice. The banks benefit from acquiring the personal banking of such doctors and practice owners whilst mitigating risk with reference to personal assets as guarantees.

For government this represents a major challenge. New practices have been largely created by the corporate and private sector over the last decade. Not for profit providers have been squeezed by operating margins on one side and rising property prices on the other. This makes expansion to new sites or expansion of existing sites achievable only for those with long trading histories, deep cash reserves and legacy property assets to cross-collateralise. Only a very small number of charitable general practices fit this category, effectively stymieing growth and innovation in this part of primary care.

Some charitable groups have handed over their property assets to developers on the condition they retain access to a strata title area within a new build or a long-term lease at low cost. Even doing these creative property deals usually involves considerable upfront legal costs and architect and consultant fees which can quickly tally to hundreds of thousands of dollars. Such ventures can quickly run down cash reserves which is why within coalition partners a number of such proposals have fallen over.

Advice from social infrastructure experts during the co-design phase of this project highlighted the following costs for development:

1. new build with need to purchase land - $20K per square metre of facility
2. existing inner-city land available for redevelopment - $18K per square metre of facility

These costs include allowance for the very substantial costs for architect fees, engineering inputs, town planning consultants, property advice and council fees. They are also very dynamic given building costs have driven inflation in recent years. The continuing shortage of trades means that even as access to building materials becomes easier, the costs of construction will still outpace inflation.

The incursion of costs around new builds is also not necessarily related to typical grant milestones. The costs of architect fees to produce a high-level design, quantity surveyors to cost that design, legal costs for engaging developers and property consultants to advise on land and program management can all tally hundreds of thousands of dollars before any soil is turned. At least some of this work would need to be undertaken before an organisation could submit a funding application. This means success rates with any grant scheme or subsidy program would need to be high to offset the very real risk of expenditure which would be incurred. Alternatively, a grants program to fund project scoping would be necessary so that these costs could be incurred and more reliable funding bids submitted without jeopardising the cash reserves of primary care proponents. It would also ensure smaller players were not excluded from the grant pool.

Typically, grants for buildings are paid around milestones like purchase of land and various stages of construction. Those delivering the projects are paying building contractors every month rather than by stage of construction as the facilities are commercial and governed by related contracts. Other consultants also demand monthly payment of invoices. Therefore, upfront loading of grants or subsidies would be required to ensure organisations commissioning major build projects had the cashflow to continue. This would be especially critical if the organisation was constructing a health and community hub. They may have access to funding for their component of the build but be creating a larger facility which other government agencies or private providers could rent. Such income would not be available until the building is constructed and leased leading to potential shortfalls in capital during the early construction period.

This might lead to some recipients outsourcing risk to the property development sector. Property developers typically model new projects for at least a 30% uplift in value. This is used to offset the risk of delays in building approvals, availability of building contractors and delays in completion of the build; all of which mean interest is being paid with no revenue. Avoiding the need to pay the property sector for such risk would be critical to ensuring a more affordable building program.

Investors make choices between opportunities. Choice is centred on the assessment of risk and rate of return. The higher the risk, the higher the rate of return needs to be. Corporate practices with a known brand, systematised business model and capacity to generate cashflows of an understood quantum in areas with a plentiful supply of patients can attract capital which demands the smallest return. Therefore, their costs in rent or occupancy charges are often lower than for other entities which might have less bargaining power with landlords or operate smaller or more boutique sites. These smaller sites by virtue of their operating models will still need nursing areas, sterilisation facilities, a certain number of consultation wet spaces, reception and staff areas. However, they will have fewer revenue generating rooms to pay for the general space every practice needs. Consequently, the percentage cost of the capital investment will be higher. Irrespective of what sort of practice occupancy outgoings are involved, the cost of maintenance will be roughly the same. The exception is regional areas where access to trades can be tight. Consequently, they charge a higher rate to paint walls, do plumbing or electrical works.

Investment Risk	Location	Organisational Structure	Capital Investment Required ($/sq.m Index 100 pts base line)	Investor Return Hurdle (% of Capital Investment)	Sustainable Occupancy Cost (% EBITDA)	Sustainable Occupancy Cost (% of Capital Investment)	Annual Maintenance Cost ($/sq.m. on 10 year programme)
Low	Suburban Centre	Corporate / large private	100	5.5 - 6%	7- 8%	2.5-4.5%	$100
Medium	Metro	NFP / Mission Based / Medium sized private	105	7.5 - 9%	8- 10%	3 – 6%	$100
High	Regional	Small individual Practice	115	10 – 15 %	5-10%	5 – 7%	$120

Principle 16: Recognise infrastructure costs as a rising component of the cost of delivering high-quality care.

Simply having access to suitable space does not mean that space will stay fit for purpose. General practice's falling real revenues means that practices across the country have neglected maintenance and refurbishment programs and equipment replacement. This is most evident in terms of ICT systems which are a patchwork of legacy hardware which impedes the take-up of digital health solutions. Ensuring that practices have modern, connected and secure ICT is critical to advancing the cause of data sharing with funders, PHNs, other providers and patients.

In addition, equipment needs to be maintained, and facilities renewed. This will be very apparent as practices move to incorporate more members within care teams. If only moderate efforts are made to embrace team-based care practices may be able to refurbish to create an extra consultation room for nurse chronic disease work. Reception areas might be revamped to accommodate an office for a Practice Manager. More wholesale refurbishment and extension of facilities will require certainty about income related to new models of care. This is where commitment to the move to blended payments being the majority of income is central.

Practices will take more risks if the sources of funding are committed over the longer term. Pilots of less than five years will not give the time horizon to pay back large capital investments. Therefore, practices will be less inclined to embrace change and contribute to the data which could identify both strengths and weaknesses of any new model of care. Achieving the vision for general practice noted in the 10 Year Primary Health Care Plan and General Practice Incentives Review by 2032, it is important that activity start now. That is a very rapid change program which will benefit from early leaders who can share their lessons with others.

The not-for-profit sector is values driven and keen to ensure all Australians receive access to great care. They have a history of partnering with others and sharing their data with grant funders and program evaluation teams. They have strong clinical governance as they report to Boards which have more transparent reporting and audit requirements. Hence, the not-for-profit sector is an ally in efforts to commence new funding arrangements as they will have more openness and maturity around data sharing to enable evaluation. Their patient group is also the population most likely to benefit from team-based care, offering early wins during program implementation.

Principle 17: Use real-world costing data to develop a fair, equitable, blended funding model.

In order to know how much funding is required to run a practice effectively, access to costs of operation is needed. Australia has never had access to information on costs of care in general practice due to its privatised nature. Theoretically, MBS fees have been set based on what health economics has dictated as a reasonable price based on returns from the intervention. More often they have been made based on available funding in budget announcements. Distribution of fees to doctors has been veiled by individual contracting agreements resulting in limited market data on doctor income. Hence, ground up costing has never been attempted in general practice.

The General Practice Incentives Review recommended creation of an independent pricing authority for primary care. This recommendation has been well received across the sector. Working with that recommendation will involve undertaking an audit of the sector. There is no industry standard for how general practices create their charts of accounts or treat different sources of income and cost. With few industry benchmarks around, the percentage to be allocated to overheads, wages and other common expense categories is hard to generalise. This means it is hard for the sector and its stakeholders to know how they are really performing. With increasing costs of capital required to create the facilities practices operate from, getting a return on that investment is critical. In addition, practice owners manage other risks and create value which should receive compensation. Ensuring any such review of practice costs reflects both the income, costs and opportunity costs of capital is critical because there are many other easier ways to earn money than running a business.

With tight income and pressure on profitability, general practices have neglected maintenance of facilities and professional development of their teams. These expense categories are easier to ignore. They are not directly related to current operating activity and tangible income streams. Consequently, no benchmarks exist in relation to standard allocations for building maintenance or return on investment in property.

With many private practice groups using superannuation funds to purchase the property they operate from, obtaining a return from that use of funds is imperative. Doctors or practice owners will be reliant upon that property to produce a liquidity event which bolster's their funds cash when they need to draw down income to retire. Alternatively, they need to be confident the property will produce reliable and ongoing rent which can be used as income in retirement. Many general practice facilities are small and unattractive for other uses. The advent of team-based care means that more space and therefore more investment will be required. For older doctors and practice owners such investment could be unattractive, holding back the move by the sector to exactly the sorts of models required to improve access, health equity and health outcomes. For that reason, an opt in approach is recommended.

The not-for-profit sector has no such time horizons as the organisations continue to have a life well beyond that of any individual employee or stakeholder. Their investments are not

personal. They have the capacity to manage across a portfolio of assets and ensure those assets are serving the organisation's mission. That mission is more likely to align with the needs of health system funders as the focus is on patients not providers needing a professional outlet or income. Therefore, ensuring more not for profit practices are supported to move into team-based care is a way for government to advance its policy objectives more quickly.

This could include providing grants to such practices to scale up. This has been an approach used for practices in regional and rural locations in the past. Aboriginal medical services have also been able to access capital grants programs. This would be one way for government to support not for profit practices "catch up" on the erosion of incomes and extra burden of service delivery they have worn for the last decade, and which has impacted their revenues more severely than for other parts of the sector.

The agricultural sector has a long history of receiving low interest loans, capital grants and debt forgiveness in order to adopt new technology or serve out a drought. Agricultural activity is a key part of the economy and critical to employment in many regional and rural areas. Healthcare now constitutes the largest employer in the economy. Without good health and access to healthcare, people and economies atrophy. Therefore, there is a growing argument that the calls for socialisation of medicine via institution of bulk billing fee caps in primary care should be accompanied by programs to address capacity through funding capital and operational programs.

The need to access cleaner data across the entire spectrum of cost in running a general practice is very clear. From surveys of practices, data could also be gathered about what is not currently funded e.g. clinical governance time, a full-time Practice Manager role, regular building maintenance, engagement with other stakeholders from PHNs to other providers in the continuum of care to improve the patient care journey and so much more. If general practice is to be transformed to meet the vision set by the sector which aligns with what high performing primary care systems deliver, these are important considerations. The Health Equity Coalition group could provide a test case for understanding costs of operation and costs of expansion. They could also provide costs of transformation as a practice moves to embrace enrolling patients, using data to manage population care needs and enhancing the team-based nature of care. Importantly, such data will include the costs of collaborating with health and social care players to introduce more integrated, value generating and place based responses as not for profit providers are generally more engaged with the wider health and social care system than traditional practices. This could be an important input into Australia's early journey to embrace value based healthcare principles.

Section 5: Governance and Capacity Growth

Principle 18: Incentivise student placements in high-need areas to grow the future workforce.

General practices in high need catchments can provide high quality teaching programs for all manner of clinicians. The patient group typically has pathology, meaning that even short stints on the clinical floor lead to high rates of exposure to patients with multi-morbidity and social complexity. Debriefing on such patient encounters with experienced clinicians is a valuable learning experience. Sadly, many not for profit providers have such skeleton staffing that the additional burden and cost of supporting registrars, nurse trainees and new graduate allied health providers is not sustainable. This needs to change as other practices already use their teaching programs as a primary point of recruitment and retention of workforce. However, it needs to be done safely so that junior clinicians are not asked to manage complex care with limited supervision. This reality simply perpetuates the Inverse Care Law with the most unskilled clinicians and poorest paid doing the most complex work; an unfair burden. It also leads to high rates of burnout resulting in loss of valuable workforce in areas of highest need.

Introduction of teams of care as envisaged in this paper will enable participating practices to:

1. Offer more placements across the clinical spectrum improving the options for Universities to place the growing number of students of all disciplines
2. Ensure such trainees have exposure to cross-disciplinary insights as the team of care will include voices from across the clinical divide
3. Cement equity at the heart of teaching programs by showing students how the social determinants impact lives and reinforcing the value of comprehensive, quality care
4. Embrace integrated models of care as they will experience services which combine health, social care and other support services in one location. This will also improve their knowledge of partnership management and governance of teams of care.
5. Expose trainees to clinical governance as such practices mine their data to identify unmet needs, innovate around models of care and evaluate the impact and run ongoing quality improvement initiatives to ensure services are best practice
6. Introduce community placements for public health registrars and nurse practitioners whose current vocational pathway is largely centred around hospital settings and large community health programs ensuring our future workforce is more informed by the needs of disadvantaged areas and capable of contributing in those communities
7. Add into Clinical Leadership roles time for overseeing a dynamic teaching program which will attract more clinicians to more senior roles
8. Foster a research culture as ongoing innovation around models of care will lead to program evaluation and publication of results which deepen the contribution of primary care to research whilst creating more clinician researcher registrar placement options

Given the complex nature of the patient load, junior and trainee clinicians will need additional time to take patient histories and case conference with supervising teaching staff. If the teaching load is undergraduate and not recompensed this time is effectively drawn from income producing opportunities, further disadvantaging the practice and provider. It is proposed that additional funding for hosting students of all types is provided to such practices in order to incentivise those same students to return to work in areas and with populations who are currently underserved.

Finally, these clinic environments should be eligible for hosting overseas trained doctors within their moratoria period. This would create more access to workload for clinics in desperate need of more staffing. Additional funds to supervise those doctors to ensure in their early years their scope of practice expands to suit the Australian healthcare system and the more complex needs of these patient groups would be vital.

There are overseas trained clinicians of all types waiting for placements to demonstrate currency of practice whilst waiting for exams and registration. This process can take years. Currently, they are working in hospitality and many other non-clinical roles and de-skilling. They could be deployed under supervision in these larger teams of care and enabled to retain clinical competence.

The last group who could be supported to obtain career pathways are volunteers. Those with lived experience have made a measurable and meaningful impact in the mental health and disability sectors for many years. Those with histories of problematic substance use, homelessness and even migration and trauma could make significant differences to the insights a team has and the relevance of care. They need to be inducted and supported in their roles. In the process, they may find capacity to become trained in health related careers which would ensure more of the health workforce reflects the needs of the most vulnerable.

Principle 19: Invest in clinical governance to ensure safe, effective, outcome-driven team care.

Patients attending not for profit practices are likely to be the least health literate in the population. Their ability to advocate for themselves and manage through episodes of fragmented care is impeded. Therefore, the likelihood of adverse events and accessing less patient centred care are higher. Good clinical governance is required to:

- Ensure patient advisory committees have a role in determining the nature of service provision and engage in co-design of new models of care which are culturally safe and respectful for minority populations. Participants in such committees should have their time recognised and clinical governance skills developed.
- Monitor data and create interventions particularly around screening, preventative health and chronic conditions which ensures health outcomes are improving amongst vulnerable patients through offering more proactive and patient centred care
- Support the teams of care and integrated care models existent in such practices where more points of contact need coordination and various partners need to be accommodated to reduce the risk of fragmentation of care
- Contribute to the research and policy arenas good data which highlights priority investments
- Ensure rapid replication of models of care which work to similar practices and locations around the country further boosting the creation of improved equity of health outcomes
- Improve participation in clinical trials so that care and innovation reflects the needs of such populations
- Oversee population health and public health initiatives which are more required in such practices and communities
- Manage the turnover of staff which is likely to remain higher than in other practice environments due to more stressful workloads and lower remuneration even with access to improved funding models

Performing this work involves considerable time away from patients. Hence, creation of Clinical Director roles with paid hours to oversee clinical governance is vital to ensuring organisations deliver safe, effective and innovative care whilst supporting teaching programs. Nurse Manager roles will also be required to oversee the larger nursing teams in place in such practices. The combination of allied health and specialty medical services will also require oversight so our proposal includes budget components for new roles which undertaken this critical data analysis, team support and planning roles.

Principle 20: Fund corporate governance capacity for complex, evolving general practice and primary models which will increasingly involve integration with other services.

Supporting the clinical governance functions of any practice should be well resourced and highly skilled practice management. The extended nature of the teams of care proposed for these practices and increased adoption of salaried employment models means that the human resource function alone is more extensive than in small, independent contractor and largely medical general practices. In addition, they will occupy larger spaces, use more consumables given the nature of presentations, need access to more data and involve more partnerships in care.

The use of home visitation and engagement in outreach services to care for the most needy of patients means many will need access to fleet vehicles to conduct or extend existing care. In other instances, room hire arrangements or expansion of current social care outposts to include medical care will be in order to address patients where they are at. Currently, many providers only offer centralised services as they have not had the risk appetite or access to staffing to place services in communities of need. This creates an additional burden on patients to travel considerable distances to access suitable care from more city based locations. Hence, the scale of what practice managers are overseeing will rapidly increase under these proposals.

The management of non fee for service payments both in terms of allocation and reporting on use of funds will involve more time and attention to detail than simply calculating revenue splits. Attending meetings with other related service providers to ensure patients can access community legal services, have comprehensive home and mental health services and their family and financial supports are adequate involves liaison and negotiation skills. Managing this infrastructure behind the care needs dedicated skills and significant funded time. Hence, a Practice Manager who knows how to work practice software and put through a billing is grossly inadequate. The practice management function needs strong financial, legal, HR, IT, business development and governance knowledge. They need to be able to create systems and manage complex system interactions. They also need to be able to contribute to and shepherd strong and positive cultures. Such people will generally be post-graduate trained.

Practice Managers of this calibre routinely earn $250K a year running larger private specialty practices. General practice managers typically earn less than half of that, a remuneration package unattractive to university qualified staff. Therefore, specific payments need to be available in order to attract the right combination of clinical and governance staff.

Finally, all charitable organisations are required to report to independent Boards. Their operations need to be audited annually, and the results presented to members and the Australian Charities and Not For Profits Commission. Such organisational governance is becoming increasingly stringent. Members attending Annual General Meetings are asking for more detailed reporting and corporate accountability from Boards. The costs of an annual

financial audit will be somewhere between $25K for small organisations and $60K for larger operations. Finding venues to host Annual General Meetings can be another cost. Board and Committee Chairs will dedicate significant time to the required functions and be personally exposed to the legal ramifications of non-compliance. Increasingly, charities are paying Directors for their time in recognition of the scrutiny over their role. Charities which cannot offer compensation are being left behind in terms of recruiting Directors with the skills they need to continue to transform operations.

With health being a sector known for litigation and ongoing policy change, attracting high calibre Directors remains a challenge for many organisations. At the very least, such Directors should be able to access paid professional development and have costs of attending strategic planning sessions and longer meetings which take them away from work covered. This may extend to accommodation for off-site forums to ensure the rigorous review of policies and plans are conducted at least annually.

The results of such focussed energy will be impressive. At the inaugural Stronger Medicare Awards, the vast majority of Award recipients were engaged in charitable activity with many working through not-for-profit organisations. Holding an annual awards ceremony for such recipients is insufficient recognition to create a sustainable sector. Funding which enables good governance is key to stimulating growth and enhanced performance.

Principle 21: Create flexible funding pools to support general practice teams working with the most disadvantaged

Patients who are marginalised or living on the lowest socioeconomic catchments are the least likely to be able to afford allied health and specialist medical care. However, their diagnoses and lifestyle risks mean they are most likely to benefit from earlier and more comprehensive interventions. Those interventions could span purchase of equipment to make living with their conditions less risky at home through to access to clinician time to improve their self-management capacity.

Inala Primary Care participated in a larger study which tracked 225 participants who were on the NDSS database. Doing a retrospective chart audit, the research group found that access to dietetics was crucial for individuals at risk of developing type 2 diabetes because it provided personalised nutrition care that was found to significantly delay or prevent the onset of the disease. It also found that patients who had pre-diabetes and received dietetic support reported higher satisfaction and better management of their condition. Those not receiving nutrition care when most at risk of disease were found to have missed opportunities for early intervention and lifestyle change that could prevent the onset of diabetes[xlviii].

The current team care arrangement system is only for patients who already have a chronic condition. If they are at risk of a chronic condition, they cannot access the Medicare funded allied health visits triggered by a TCA until after diagnosis. This seems the reverse of what a preventative health methodology would imply. In other systems around the world, those at high risk of health complications are increasingly being afforded access to supports from child and maternal health nurses to dietetics, mental health supports and health coaching. This is because adverse childhood event scores and patient activation measures as well as other measures of psycho-social risk are used to underpin the framing of healthcare solutions. Avoiding the additional cancer and chronic disease burden in populations at far higher risk of disease is valued by health insurers as a way of preventing cost escalations amongst their insured populations.

This proposal makes the case for enrolling patients, collecting data which would enable risk stratification and from there enabling access to more appropriate team-based care. Included in the team approach should be access to allied health beyond the current five visits funded in a team care arrangement. The reality is that for someone with multi-morbidity, five visits is grossly insufficient. For patients with diabetes, four visits will typically be consumed by podiatry leaving just one visit with another health professional. If the patient develops a vascular ulcer on their foot, they could consume four visits to podiatry within the space of just some weeks. Hopefully, such care would reduce the risk of surgery or amputation to their

feet, proving the value of these team members. However, it leaves the remainder of the year uncovered with allied health contact which could avert further risk.

Case Study:

No Diagnosis, No Support: Justin's Story of Exclusion and Crisis

Justin, 25, has attended the emergency department every week or two for the last couple of years. He has complex childhood trauma, having survived an abusive biological household and another abusive foster home, followed by years of residential care. He has had pervasive suicidal thoughts since his teenage years, and struggled for years with heavy drug use. He hasn't used drugs for years, but his moods are more erratic as a result, not less. He is on Jobseeker payment and has struggled to stay in a job for long because of mood swings and impulsive behaviour. He also gives the impression of a mild intellectual disability, but he has never been assessed, having dropped out early after never having attended any one school for long. He attends the emergency department frequently for emotional crises and suicidal ideation. He is not eligible for any public funded psychiatry. He cannot afford private psychiatry or psychology. He certainly cannot afford neuropsychiatry. As he has not had a proper diagnosis or exhausted his treatment options, he is rejected for NDIS support.

The Health Equity Coalition proposes that where an enrolled patient population is substantially constituted by patients whose screening points to high levels of complexity and risk, additional pools of funding to fund both in-house allied health team members and access to sub-specialty allied health should be provided. Such pools of funding could enable the practice to purchase visits to a hand specialist physiotherapist after an injury or a vestibular physiotherapist after repeated falls. Such care might be more targeted than that available through more generalist allied health.

In addition, the practice should have a pool of funds available to purchase clinic consultations for specialist physicians where public waiting lists are 60 days beyond recommended access times. This is important as patients waiting for a diagnosis cannot access medications which might alleviate their symptoms and enable them to resume more normal functioning. Such patients tend to engage in repeated visits to their GP in pain, distress and with other symptoms being triggered by depression and inactivity. This creates more costs to the system from testing, medications and general practice visitation. Earlier access to a diagnosis, even in the absence of ongoing care through an outpatient setting, enables the patient and care team to dimension the presenting problem and develop a clearer management strategy. This clarity reduces the stress for everyone. It can also enable access to other funding sources like the NDIS.

Finally, the fund could be used to purchase medications where it is clear the patient has no funds to remain compliant with their medication schedule and tends to skip medications. This is a rising problem in disadvantaged communities with patient reports of non-adherence due to costs being as high as 9.4% of women and 5.5% of men[xlix]. The data is drawn from the Australian Bureau of Statistics Patient Experience Survey, a data collection which has smaller sampling from the most disadvantaged patient groups. Hence, it is likely that in populations served by Health Equity Coalition members, the rates of medication non-adherence are far higher.

Case Study:

When Systems Assume Support: The Fallout of Unfunded Transitions

When Margaret's breast cancer was diagnosed, it had already spread to her brain. She woke up with a limp on her 60th birthday. Her ability to do things for herself deteriorated quickly. She would never return to her cleaning job, but her husband Richard still took her to their weekly swing dancing class, even when he had to wheel her.

Her greatest fear was to die alone on an unfamiliar hospital ward like her mother had. Her husband Richard promised he would not let this happen. He quit his truck driving to become a full-time carer. It was easy enough to downsize; they rented a one bedroom townhouse for $450 a week. With Margaret's new disability pension and Richard's carer payment, plus rent assistance, they had about $1350 combined income a week. It was doable.

It was hard work for both of them. Margaret needed a lot of help, and Richard, who had always worked long and irregular hours driving long haul, now found himself doing all the cooking, cleaning, helping Margaret with dressing, bathing, toileting, and coordinating an endless succession of appointments, medications, and treatments.

Margaret died a dignified death at home, two months after her 61st birthday. She had survived longer than anyone expected. Centrelink ended her disability pension but paid out the next 3 months' worth as a lump sum; most of this went towards the cost of her funeral. Richard now found himself very alone in a very empty house cluttered with medicines and assistive devices. After 3 weeks of grieving and cleaning, he decided it was time to go back to work. The trucking company was happy to have him back, but he was due for a medical review. He was 61 years old and hadn't seen a doctor for himself for two years.

A few weeks later, the doctor diagnosed him with diabetes; his sugars were so high he had to start a new medication straight away. And he admitted that he had been feeling tight in the chest when walking up a hill, which he had been chalking up to unfitness but the doctor thought it needed more assessment for angina. The doctor prescribed some extra medications for his blood pressure and cholesterol, and some aspirin.

Case Study: (continued)

When Systems Assume Support: The Fallout of Unfunded Transitions

Going from zero to four medications was manageable, but the bad news was that he could not be signed off for his licence until he was signed off by a diabetes doctor and a cardiologist. The doctor wrote him referral letters to each. It was a non-starter; when he called their rooms, they were each going to cost about $300 -- which he'd get about $140 back from. His income had dropped to $680 per week since Margaret's death, which left him with $230 after rent. Even if he ate less for a week to cover the gap payment, he simply wouldn't have enough money in his bank account to cover the pre-gap amount. He went back to the GP and got a public referral; the GP explained it would take months to be seen, and he could not return to truck driving before that.

His sister was worrying about him; she told him to see a psychologist. He got a referral from the GP; the gap for one visit would $120. He put psychology in the "too hard basket" for now, though his moods were getting darker.

He had a bigger problem. He had about 8 weeks left until his carer payment ended entirely. If he didn't have a job by then, he would need to go on Jobseeker. With full rent assistance, this would give him just under $50 a week after his rent. The maths didn't add up. He let the realtor know he needed to break the lease; the re-letting fee would be the equivalent of 2 weeks' rent ($900) and he would need to keep paying until the new tenants started their lease. He had no idea how he was going to afford this or the cost of moving. Richard had always taken pride in meeting his obligations and was likely to end up in QCAT over this.

Richard had been married at age 22 and had only worked as a truck driver. Now at age 61 and 6 weeks bereaved, he started applying for sharehouses, and for menial jobs he'd never done before.

Complex Care Unpacked: Scenarios from two worlds in the singular world of the MBS

Presentation	Duration	Bulk billing (under new changes)
Hudson, age 16, presents with acne, requesting treatment options. Script for topical retinoid. Referred to private dermatologist if no response in 3 months.	10 minutes	$69.56
Karen, age 42, presents with new onset seasonal hay fever, reporting sneezing and itchy eyes. Started on antihistamines and a nasal corticosteroid spray. No referral needed unless symptoms persist.	9 minutes	$69.56
Eliza, age 25, requests a repeat prescription for her oral contraceptive pill. No concerns. Script reissued. Brief counselling on cervical screening and LARC options.	12 minutes	$69.56
Mike, age 37, a recreational runner, reports heel pain worse in the morning—likely plantar fasciitis. Advised on stretching and supportive footwear. Referred to a private physiotherapist.	8 minutes	$69.56
Jasmine, age 28, reports fatigue and has a history of iron deficiency. Bloods ordered. If ferritin low again, referral to private infusion clinic arranged.	8 minutes	$69.56
Thomas, age 34, presents following a relationship breakup, describing low mood but coping at work, no red flags. Referred to private counsellor.	12 minutes	$69.56
David, age 45, attends to discuss permanent contraception. He and his partner have two children and have decided not to have more. Referred to a private urologist for vasectomy.	10 minutes	$69.56
Bella, age 5, presents with her mother after another ear infection. This is her fourth in 6 months. Treated with antibiotics today; referred to a private ENT for further assessment.	8 minutes	$69.56
Anita, age 51, describes hot flushes, poor sleep, and irregular cycles. Likely perimenopausal. Bloods done, discussion of risks and benefits of MHT. Trial of transdermal estrogen prescribed. Referral to private gynaecologist if not improving.	12 minutes	$69.56
George, age 76, presents for his annual driver's licence medical. No significant past medical history, well-controlled BP, remains independent. Form completed and signed.	8 minutes	$69.56
Claire, age 39, requests a review, noting a new mole on her back. Dermoscopy suggests atypia. Booked for a privately billed excision at the clinic. If further issues arise, will refer to a private skin specialist.	12 minutes	$69.56
Nathan, age 21, presents with an eczema flare, especially on the hands. Likely stress-related. Mild topical steroid prescribed and advised regular use of emollients. Referral to private dermatologist if ongoing.	9 minutes	$69.56
Total billings over 2 hours	118 minutes	$834.72
Billings per hour		$417.36
Hourly income to cover practice costs (on 70:30 split)		$125.21
Doctor revenue per hour (on 70:30 split)		$292.15

A typical two hours in a clinic with standard patients: income assessment

Presentation	Duration	Bulk billing (under new changes)
Maria, age 56. A Spanish-speaking woman on the Disability Support Pension presents in tears, overwhelmed by worsening pain and insomnia from fibromyalgia. She ran out of meds and hasn't slept properly in days. She also has long-standing depression and is caring for a grandchild. Interpreter used. Immediate support and medication review provided. Needs coordinated pain management, pharmacist review, MHCP re-referral, and possible carer support.	26 minutes	**$104.25**
Gary, age 70. His daughter brings him in after he was found wandering confused at night. He is on the aged pension with vascular dementia and multiple comorbidities, including ischaemic heart disease and diabetes. On 12 medications. The family can manage him at home but needs urgent cognitive assessment, medication rationalisation, ACAT referral, and discussion of future care planning. At the end of the consultation his daughter starts crying and needs further support.	28 minutes	**$104.25**
Steven, age 52. On DSP for schizophrenia, lives in a supported accommodation facility. Presents with cough and poor diabetes control. Smokes, has metabolic syndrome, is on clozapine, and has difficulty attending specialist appointments. Overdue for clozapine and diabetes monitoring, needs coordination with practice nurses and community mental health service.	18 minutes	**$69.56**
Amina, age 44. A refugee woman with PTSD, poorly controlled hypertension, and chronic back pain. She has limited English and relies on her teenage son to interpret. Disclosed recent domestic violence and fears becoming homeless. She struggles to access allied health and is on multiple medications. Needs interpreter, MHCP, safety planning, referral to DV support, and chronic disease management.	29 minutes	**$104.25**
Robert, age 62. On JobSeeker, recently discharged from hospital after pneumonia. Presents short of breath and noncompliant with COPD meds. Lives alone, with comorbid poorly controlled diabetes and alcohol use. Needs acute care, re-engagement with community nursing, diabetes care planning, and AOD referral.	17 minutes	**$69.56**
Total billings over 2 hours	118 minutes	**$451.87**
Billings per hour		**$225.94**
Hourly income to cover practice costs (on 70:30 split)		**$69.78**
Doctor revenue per hour (on 70:30 split)		**$158.16**

Two Hours in the world of more complex medicine: Revenue assessment

In the second scenario, many of the patients could benefit from access to allied health and additional physician care. To enable coordination of care and improved wellbeing they need other supports which could be provided by Medical Practice Assistants, Nurses and Link Workers. Medicare currently funds medical time, not surprising in a system set up before some allied health professions had even been created. The patient group with complex presentations needs funding for a team of care and time for those in that team to coordinate their work to ensure quality and patient safety.

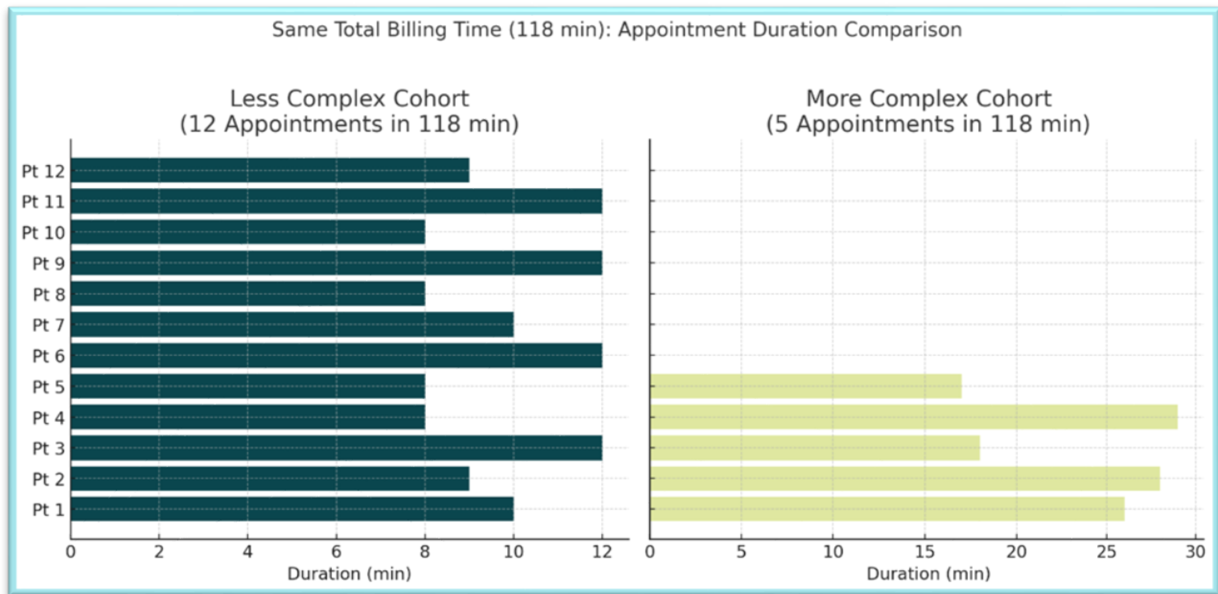


Figure 23: Same Total Billing time (118 minutes): Appointment Duration Comparison

Two plausible hours with a complex cohort and a simpler cohort. Both doctors are working hard but one is earning half as much and the clinic has barely any money to fund operations let alone the extended team. The questions would be: why would a doctor choose to work in the second clinic? And how is the second clinic meant to cover costs?

This paper has outlined the case and provided de-identified case scenarios to highlight the sorts of needs which could be filled. The difference between a paper and practice is simply funding to make it happen.

Conclusion

This paper has outlined the economic, social and clinical case for improved investment in the hardest to serve areas of primary care. The approach means that addressing health equity will become a mainstream occupation of our primary health care system. The paper continues the thinking outlined in many recent Government commissioned reports which have heralded a new era of team-based care by providing detail around the costs and constraints for implementation. It reinforces the need for a move to blended payments which dramatically reduce the reliance on fee for service to enable reform of primary care services. In the process, teams will be deployed at a full scope of practice which enables improved quality and continuity of care. By focussing on the most needy of patients, where complexity and affordability have been barriers to care provision and access, the paper outlines the case for additional needs based investments which will keep patients away from hospitals and more expensive interventions.

There is little danger in creating an implementation plan for comprehensive team-based care in not-for-profit practices. They are small in number, doing work others deem worthwhile, are most at risk of closure without funding change and have a history of innovation. The Primary Healthcare Alliance Statement in response to the Scope of Practice Review Recommendations noted that there was almost universal and highly positive support for blended payments. It also noted the next strongest support came for prioritising rural, remote and under-serviced areas[l]. Services supporting injecting drug users, those who are homeless and unstably housed, those in social housing areas and of diverse cultural backgrounds are providing care to under-serviced populations.

The poor health outcomes of such groups are stark. The most recent Chief Health Officer's Report [li] for Queensland, only released in March, notes that disadvantaged areas have potentially preventable hospitalisation rates 84.8% higher than advantaged areas. The median age of death is also 79, three years shy of Queensland counterparts. For many of the patients served by not-for-profit practices, patients who reach the age of 70 are unusual and generally in far poorer health than average Australians. The cost of caring for them under existing models of care is not effective, efficient, dignified or sustainable for providers.

A focus on earlier and more comprehensive supports in primary care is long overdue. The General Practice Incentives Review called for a ratio of 1:1 GPs to non-GP clinicians, more in disadvantaged areas. Having explored the ACCHO Census data which shows 3 non-medical clinicians for each doctor we propose a ratio of two non-medical clinicians and a medical practice assistant for each doctor as the core funded team in primary care providers serving the most complex patients. That team would be supported by wider service provision which brings care out of hospital settings and into the reach of those who need it most. The model is inspired by NUKA principles as successfully piloted locally at the Institute for Urban Indigenous Health and endorsed in the General Practice Incentives Review.

We therefore propose that patients would have a core team surrounded by a support team of less frequently accessed clinical supports to address more specific conditions and needs.

The wider team would address the huge lack of access by poor communities and marginalised people to mental health services and allied health. It would also have access to pools of funding to support purchase of critical devices whether they are more appropriate dressings or devices to enable better and safer living at home. Funds to gain access to targeted advice from specialist physicians more familiar with common infectious diseases, mental health conditions and metabolic disorders more prevalent in the populations served would take pressure off public outpatients and enable creation of more seamless integration of care between primary and secondary providers.

In addition, we propose the creation of acute care clinics both embedded within the practices and with outreach models attached as appropriate to ensure those patients living at the margins have access to care closer to where they are living, where they are known and can be followed up. This will reduce demand at tertiary facilities and ensure the holistic needs of patients can be addressed over time.

The facilities housing these enhanced teams and models of care would be attractive, enabling, and well maintained. The teams working within them would be well supported by improved practice management functions, equipment and professional development. They would be actively engaged in clinical governance, place based collaboration and teaching to ensure care delivery to patients now and into the future was well planned, integrated and safe.

The time for implementation of this model is now. Through a coalition of providers, we propose to continue to co-design implementation stages, share training, systems and even people. This will make implementation more cost effective. It will ensure viable roles and support for those roles across the network making it easier to attract and retain good people despite the workforce crisis which plagues the health sector and not for profit providers in particular. It will also enable a more detailed evaluation of the implementation and impact. The lessons learnt will help keep the providers in this coalition growing and focussed on the care of disadvantaged communities. It will also enable government to consider how to implement a cut down version of these teams in usual general practices which elect to participate. In communities full of retirees, such extended teams, which reflect the needs of patients, will be well received by many practices and providers.

The proliferation of disadvantage into new catchments is an emergent challenge to our health and social care systems. Therefore, our proposal enables providers to grow as need demands rather than being restricted to current points of presence and components of care. The basis of funding is patient need, enrolment and data exchange. The output is funding which enables continuity and comprehensiveness of care in primary care settings. The outcome will be improved health outcomes and cost containment amongst those with complex needs.

Our vision will enable the formation of community hubs which co-locate services from across primary, community and social care and other service providers. Place based responses which deal with the triggers for endemic and worsening disadvantage have been shown to be effective. They need structure, certainty and investment for the long-term. This will include a major building program to ensure the teams have suitable facilities from which to work. In

the process, patients in need will not be turned away from care or given less than optimal care as occurs today.

The providers in the coalition have more than 150 years of service provision through their charitable entities. They remain committed to the long term, hard work and community need. They require further commitment from government to address growing demand and the root causes of too many healthcare presentations. The model proposed enables planning of population level interventions and ongoing proactive, quality care.

Our willingness to lead the way by extending on our already comprehensive care models will create a path for others to follow. That will enable the journey of wider reform to proceed at pace and with greater confidence through what will hopefully become an opt in model. Sharing of our lessons learnt, systems, governance, partnership working and outcomes will ensure that our proposed funding model can benefit the other not for profit provider groups across the country.

Primary care faces many challenges. We have outlined them and created principled responses in this paper, most of which apply to the diversity of practices in our sector. Some require a move beyond reliance on an entirely private sector response to the need in our communities. In many instances, it means the vast majority of funding could occur through patient enrolment triggered non-fee for service payments. This should not be surprising as the need in primary care is not homogenous. Reliance on a funding and provider model which is uniform in response has never made sense. Organisations like those in the coalition have made up the balance for decades. We now need the balance to turn in favour of our patients and teams so that the scale of rising need can be effectively addressed. This would be the core pillar of an equitable and strengthened Medicare system.

Table of Figures

Figure 1: WHO conceptual framework 7
Figure 2: Bulk Billing rates in low socioeconomic areas 8
Figure 3: Comparison of Bulk billing rates in Australia by age group 9
Figure 4: Quintuple Aim 10
Figure 5: Indexation of Medicare fees 13
Figure 6: MBS patient rebate for 20-minute consultation-actual increase versus indexation 14
Figure 7: Metrics to assess the health benefit of a high-performance general practice and its link to general practice 14
Figure 8: Survey results from consumer Health Forum (2022)....17
Figure 9: Capacity for self-care among Australians living with and without chronic conditions....18
(LUMOS STUDY Results)....18
Figure 10: LUMOS study data findings....21
Figure 11: GP Perspectives on health professionals that most benefit patient health in general practice terms (RACGP DATA) 25
Figure 12: Core Operating Principles by the Health Equity Coalition 26
Figure 13: Preferred patient journey model....27
Figure 14:NUKA system of care model 30
Figure 15: Cubiko data: GPs are spending more time with patients compared to two years ago 36
Figure 16: Cubiko data: Rate per minute statistics....37
Figure 17: Cubiko Data: Females and older people remain the highest users of GP services....37
Figure 18: MBS Patient rebate per minute for standard GP consultation items....38
Figure 19: Health data around investment in general practice....38
Figure 20: Female GPs see more psychological presentations....43
Figure 21: Examples of less complex cohort....66
Figure 22: Examples of more complex cohort 67
Figure 23: Same Total Billing time (118 minutes): Appointment Duration Comparison 68

References and Footnotes

Statements in this document are supported by the following works:

[i] https://www.ama.com.au/sites/default/files/2022-11/AMA%27s-plan-to-Modernise-Medicare-Why-Medicare-indexation-matters.pdf
[ii] https://www.who.int/docs/default-source/primary-health-care-conference/phc---economic-case.pdf
[iii] Linzer K., Remes J., Singhal S. McKinsey Global Institute; October 5, 2020. How prioritizing health is a prescription for US prosperity.https://www.mckinsey.com/~/media/McKinsey/Industries/Healthcare%20Systems%20and%20Services/Our%20Insights/How%20prioritizing%20health%20is%20a%20prescription%20for%20US%20prosperity/How-prioritizing-health-is-a-prescription-for-US-prosperity.pdf
[iv] https://www.aihw.gov.au/reports/health-welfare-expenditure/patient-out-pocket-spending-medicare-2016-17/contents/summary
[v] https://www.pc.gov.au/ongoing/report-on-government-services/2025/health/rogs-2025-parte-overview-and-sections.pdf
[vi] https://www.health.gov.au/sites/default/files/2024-08/medicare-statistics-per-patient-bulk-billing-dashboard-2023-24.pdf
[vii] https://alp.org.au/news/strengthening-medicare-more-bulk-billing-more-doctors-more-nurses/
[viii] https://theconversation.com/labor-and-the-coalition-have-pledged-to-raise-gp-bulk-billing-heres-what-the-medicare-boost-means-for-patients-250604
[ix] https://www.aihw.gov.au/reports/medicare/medicare-bulk-billing-gp-attendances-monthly-data/contents/dashboard
[x] https://www.aihw.gov.au/reports/medicare/medicare-bulk-billing-gp-attendances-monthly-data/contents/dashboard
[xi] Coleman K., Wagner E., Schaefer J., Reid R., LeRoy L. Agency for Healthcare Research and Quality; 2016. Redefining Primary Care for the 21st Century. White Paper. (Prepared by Abt Associates, in partnership with the MacColl Center for Health Care Innovation and Bailit Health Purchasing, Cambridge, MA under Contract No.290-2010-00004-I/ 290-32009-T.) AHRQ Publication No. 16(17)-0022-EF.
[xii] https://www.choreport.health.qld.gov.au/
[xiii] https://www.aihw.gov.au/reports/cald-australians/social-determinants-health-cald/contents/about
[xiv] Quality-Adjusted Life Expectancy by Socioeconomic Disadvantage and Remoteness Area; Population norms for Australia
[xv] https://www.racgp.org.au/FSDEDEV/media/documents/RACGP/Advocacy/Economic-evaluation-of-the-RACGP-vision.pdf
[xvi] https://content.vu.edu.au/sites/default/files/documents/2024-10/australias-health-tracker-chronic-conditions-by-socioeconomic-status-report.pdf
[xvii]https://static1.squarespace.com/static/6170c344c08c146555a5bcbe/t/61958bf805c25c1e068da90f/1637190707712/DOTE_Report+_Final.pdf
[xviii] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(71)92410-X/fulltext
[xix] AMA Fees List
[xx] https://www.racgp.org.au/FSDEDEV/media/documents/Health-of-the-Nation-2024.pdf
[xxi] https://www.ama.com.au/sites/default/files/2022-11/AMA%27s-plan-to-Modernise-Medicare-Why-Medicare-indexation-matters.pdf
[xxii] https://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=GN.10.26
[xxiii] https://www.ama.com.au/sites/default/files/2022-11/AMA%27s-plan-to-Modernise-Medicare-Why-Medicare-indexation-matters.pdf
[xxiv] https://www.racgp.org.au/FSDEDEV/media/documents/RACGP/Advocacy/Economic-evaluation-of-the-RACGP-vision.pdf
[xxv] https://www.chf.org.au/our-work/reports/the-consumer-sentiment-survey-the-voice-of-australian-health-consumers-2022
[xxvi] https://www.health.org.uk/reports-and-analysis/briefings/reducing-emergency-admissions

[xxvii] https://www.diabetesresearchclinicalpractice.com/article/S0168-8227(11)00287-7/abstract
[xxviii] https://www.racgp.org.au/FSDEDEV/media/documents/RACGP/Advocacy/Social-prescribing-report-and-recommendation.pdf
[xxix] RACGP - GPs emphasise the power of social prescribing
[xxx] https://www.health.nsw.gov.au/lumos/Pages/lumos-high-connectivity-cba.aspx
[xxxi] https://www.apna.asn.au/hub/APNA-workforce-survey/media-coverage
[xxxii] Determining the actual cost of wound care in Australia | Wound Practice & Research: Journal of the Australian Wound Management Association
[xxxiii] https://www.ama.com.au/solutions-to-the-chronic-wound-problem-in-australia
[xxxiv] https://alp.org.au/news/extra-26-billion-to-deliver-another-pay-rise-for-aged-care-nurses/
[xxxv] https://www.apna.asn.au/hub/APNA-workforce-survey/media-coverage
[xxxvi] https://www.ama.com.au/articles/delivering-better-care-patients-ama-10-year-framework-primary-care-reform
[xxxvii] https://www.racgp.org.au/FSDEDEV/media/documents/Health-of-the-Nation-2024.pdf
[xxxviii] https://www.racgp.org.au/advocacy/advocacy-resources/the-vision-for-general-practice/the-vision/the-model-for-high-quality-patient-care
[xxxix] https://www.health.gov.au/resources/publications/australias-primary-health-care-10-year-plan-2022-2032?language=en
[xl] https://www.health.gov.au/resources/publications/strengthening-medicare-taskforce-report?language=en
[xli] https://www.health.gov.au/our-work/review-of-general-practice-incentives#final-report
[xlii] https://tradingeconomics.com/australia/physicians-per-1-000-people-wb-data.html#:~:text=Physicians%20(per%201%2C000%20people)%20in,compiled%20from%20officially%20recognized%20sources.
[xliii] https://www.rcgp.org.uk/News/research-statement-conference-2024
[xliv] https://www.aihw.gov.au/reports/primary-health-care/general-practice-allied-health-primary-care
[xlv] https://www.racgp.org.au/FSDEDEV/media/documents/Health-of-the-Nation-2024.pdf
[xlvi] https://www.racgp.org.au/FSDEDEV/media/documents/Health-of-the-Nation-2024.pdf
[xlvii] https://www.ruralhealthinfo.org/topics/federally-qualified-health-centers/funding
[xlviii] How do healthcare providers support people with prediabetes to eat well? | Australian Journal of General Practice
[xlix] https://www.mja.com.au/journal/2024/221/8/cost-barriers-medication-access-australia-analysis-patient-experience-survey#:~:text=The%20data%20show%20that%209.4,in%20the%20previous%2012%20months.
[l]https://www.apna.asn.au/files/Advocacy/PHN%20Congresss/PHC%20Alliance%20Statement%20Scope%20of%20Practice%20Review%20Recommendations.pdf
[li] https://www.choreport.health.qld.gov.au/