

# **Draft recommendations from the Primary Health Reform Steering Group**

*Discussion Paper to inform the development of the Primary  
Health Reform Steering Group recommendations on the  
Australian Government's Primary Health Care 10 Year Plan*



## **Important note**

The views and recommendations in this report from the Primary Health Reform Steering Group (Steering Group) have been released for the purpose of seeking the views of stakeholders.

This report does not constitute the final position on these items, which is subject to;

- Stakeholder feedback; and

- Consideration by the Steering Group;

Please note, the recommendations in this report will inform the Australian Government's Primary Health Care 10 Year Plan (10 Year Plan) and do not constitute the Government's position on these items.

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## Executive summary

This report details the Primary Health Reform Steering Group (the Steering Group) draft recommendations on the Government's Primary Health Care 10 Year Plan (10 Year Plan), which aims to maintain and strengthen our world-class primary health care system in order to deliver the best possible health outcomes for all Australians.

The Government established the Steering Group in September 2019 to provide independent expert advice to guide the development of the 10 Year Plan for primary health care reform and implementation of the voluntary patient registration (VPR) measure for all Australians.

The Steering Group is co-chaired by Dr Steve Hambleton and Dr Walid Jammal, and includes expert representatives from consumer, allied health, Indigenous, medical, mental health, nursing, rural and remote health and practice management organisations, as well as from State and Territory Governments (See Appendices for more information on the Steering Group).

### Building upon reform

This report (and its recommendations) acknowledges and builds upon significant national policy work in primary health care reform over past decades. Whilst recognising the significant strengths of Australia's primary health care system, it highlights significant weaknesses in its current structure and funding. The current health system was designed to respond well to individual presentations but given the growing burden of chronic disease (1) and the need to focus on population health, system integration and prevention, it is no longer fit for purpose. Without attention, the primary health care system will have limited ability to respond to challenges in caring for Australian people over the next ten years and beyond. This particularly applies to care continuity for the growing number of Australians with chronic disease, mental health needs and frailty; workforce development; resourcing; regional service integration; and futuristic models of care. Without reform, the system will also continue to struggle to equitably serve Australians who have historically found it difficult to access effective health care, including many Aboriginal and Torres Strait Islander peoples.

In addition to care of the already unwell, Australia's health care system needs capacity building and re-orientation to promote wellbeing, prevent illness, undertake early detection and respond with early intervention to emerging illness at a time when there is maximum opportunity to alter the disease trajectory. This is particularly critical to achieving the Government's commitment to 'close the gap' in life expectancy between Indigenous and non-Indigenous Australians by 2031, recognising that preventable chronic disease continues to be a major contributor to the Indigenous health gap.

Primary health care reform has been a focus for many Commonwealth Commissions and advisory groups over the past decade.

- In 2009, the National Health and Hospitals Reform Commission identified and proposed several primary health care solutions to Australia's fragmented health care system. This included adoption of a Health Care Home model for general practice and Aboriginal Community Controlled Health Organisations (ACCHOs), and much closer integration between primary and acute care.
- In 2013, Australia's first National Primary Care Strategic Framework emphasised the role of Medicare Locals (since 2015, Medicare Locals were replaced with 31 Primary Health Networks [PHNs]) in working to better integrate the diverse players across the primary health care system, and create a geographically-based representation and commissioning body for relevant primary health care services.
- In 2016, the Primary Health Care Advisory Group made 15 recommendations to better equip primary health care to deliver optimal services for Australians with chronic disease. It more fully defined a medical home model of care, and its centrality to linkages between elements of Australia's complex

health care system; and raised the importance of patient activation and partnership in a continuous health care relationship. The health care home is further developed in this report with particular reference to its most fundamental element – VPR.

- Since 2016, the Council of Australian Governments (COAG) reform agreements have reinforced the health care home model of care, and in addition, committed jurisdictions to the consideration of joint commissioning and joint planning arrangements for general practice and primary care at PHN / Local Health Network (LHN) level. Similar recommendations were also made by the Productivity Commission's 2017 *Shifting the Dial* report.
- The recently released Medicare Benefits Schedule (MBS) Review has identified a sharper focus on continuity of care and chronic disease management for primary health care.
- The recent Productivity Commission Inquiry into mental health and suicide prevention, the Royal Commission into Victoria's Mental Health System and the Royal Commission into Aged Care Quality and Safety have also recognised how primary health care can enable improved health outcomes.

Australia's primary health care system delivers some of the best outcomes in the Organisation for Economic Co-Operation and Development (OECD). It is highly accessible, greatly valued by consumers and communities, and has widespread practice quality and safety benchmarks. However, compared with international peers, it is more poorly linked to the rest of the health care system and relies on patient out of pocket expenses. It is also almost entirely dependent on a fee-for-service, Medicare-linked business model. According to the Commonwealth Fund, Australia's health system is ranked second highest in the world. This is based on combined measures of access to care, quality, efficiency, equity and health care outcomes. When looking at these measures individually, Australia ranks number one in relation to efficiency and health care outcomes, however fourth in access and seventh in equity (2).

This disconnect creates significant challenges, with duplication, waste and inappropriate slippage of care into the most expensive (and often most unsafe) care setting. The challenges are particularly acute for disadvantaged Australians especially many Aboriginal and Torres Strait Islander people, residents of rural and remote communities, people from culturally and linguistically diverse (CALD) backgrounds, people with chronic disease, mental health conditions and frailty, and people facing socio-economic disadvantage.

An amplified primary health care focus and capacity building will enable the health care system to deliver the best and most person-centric model of care for the growing number of Australians facing these challenges. Local and international examples offer evidence of the roadmap and outcomes of well-integrated, appropriate, regional care models (3).

In the COVID-19 (and post COVID-19) environment, there will need to be an increasing focus on delivering best value to communities and patients with the resources available. This will require change in existing Commonwealth/State governance arrangements which are often fragmented and sometimes deliver inadvertent duplication, waste and lack of personalised care. This change should more systematically address the social determinants of health, which were so illuminated by the pandemic. This report recommends a more structured and nationally consistent framework to deliver optimal outcomes for all Australian communities, building on concepts of regional funds pooling and planning, as recommended by the commissions and advisory groups mentioned above.

Progressive models bring decision-making about resource allocation and service models as close as possible to where people live and are treated, and focus on areas for improvement, rather than a one-size-fits-all approach. Since their introduction as a core part of the architecture of Australia's health care system, ACCHOs have been providing community-led, comprehensive primary health care for Aboriginal and Torres Strait Islander people, considering the wider social, cultural, historical and economic determinants of health. Australia's wider health system can take many lessons from the holistic approach of our Indigenous

communities, particularly when developing models of care that are equitable and promote and safeguard integrated, person-centred care, with minimised risk of fragmentation.

There are also many other exemplars of innovation and progressive models in Australia, including better supporting people on their terms, drawing on multiple professionals' skills in care teams, building and sustaining collaboration, using data and information and embracing innovative funding through collaborative commissioning. A number of examples are presented in the Productivity Commission report 'Innovations in Care for Chronic Health Conditions 2021'.

Continuity of care - across time, settings, conditions and people - is increasingly important with the changing demographic of disease, and is an ongoing international theme in patient activation, lifestyle modification, prevention, care integration and chronic disease management. The themes of empowered patient centred care and continuity of care are further developed in this report, as is the importance of collection and quality use of data, and more targeted investment in translational research relevant to end-users of our health system.

A commitment to implementation across short, medium and long term horizons should be a point of difference between the 10 Year Plan and its forerunners. While there is a role for Government (both Commonwealth and State), real change will require peak bodies, practitioners and people living in Australia to play a role in implementation and change management.

## Summary of recommendations

### Person-centred health and care journey, focusing on one integrated system

- **Recommendation 1 (One system focus):** Reshape Australia's health care system to enable one integrated system, including reorientation of secondary and tertiary systems to support primary health care to keep people well and out of hospital
- **Recommendation 2 (Single primary health care destination):** Formalise and strengthen the relationship of individuals, families and carers with their chosen primary health care provider and practice
- **Recommendation 3 (Funding reform):** Deliver funding reform to support integration and a one system focus
- **Recommendation 4 (Aboriginal and Torres Strait Islander health):** Implementation of the National Agreement on Closing the Gap for Aboriginal and Torres Strait Islander peoples through structural reform of the primary health care systems
- **Recommendation 5 (Local approaches to deliver coordinated care):** Prioritise structural reform in rural and remote communities

### Adding building blocks for future primary health care – better outcomes and care experience for all

- **Recommendation 6 (Empowering individuals, families, carers and communities):** Support people and communities with the agency and knowledge to better self-care and manage their wellness and health within a system that allows people to make the choices that matter to them
- **Recommendation 7 (Comprehensive preventive care):** Bolster expanded delivery of comprehensive preventive care through appropriate resourcing and support
- **Recommendation 8 (Improved access for people with poor access or at risk of poorer health outcomes):** Support people to access equitable, sustainable and coordinated care that meets their needs

### Leadership and culture

- **Recommendation 9 (Leadership):** Foster cultural change by supporting ongoing leadership development in primary health care

### Primary care workforce development and innovation

- **Recommendation 10 (Building workforce capability and sustainability):** Address Australia's population health needs with a well-supported and expanding primary health care team that is coordinated locally and nationally for a sustainable future primary health care workforce
- **Recommendation 11 (Allied health workforce):** Support and expand the role of the allied health workforce in a well integrated and coordinated primary health care system underpinned by continuity of care
- **Recommendation 12 (Nursing and midwifery workforce):** Support the role of nursing and midwifery in an integrated Australian primary health care system
- **Recommendation 13 (Broader primary health care workforce):** Support and develop all appropriate workforces in primary health care to better support people, the existing health care workforce and achieve an integrated, coordinated primary health care system
- **Recommendation 14 (Medical primary care workforce):** Support, streamline and bolster the role of GPs (which includes Rural Generalists) in leading and coordinating care for people, while building and ensuring a sustainable and well supported medical primary care workforce

### Innovation and Technology

- **Recommendation 15 (Digital infrastructure):** Develop digital infrastructure and clinical systems to better support providers to deliver safe and effective care
- **Recommendation 16 (Care innovation):** Enable a culture of innovation to improve care at the individual / population level, build 'systems' thinking and ensure application of cutting-edge knowledge and evidence

### Research, data and continuous improvement of value to people, population, providers and the health system

- **Recommendation 17 (Data):** Support a culture of continuous quality improvement with primary health care data collection, use and linkage
- **Recommendation 18 (Research):** Empower and enable contextually relevant, translational and rapid research and evaluation in primary health care, addressing questions directly relevant to service delivery in localised context

### Emergency preparedness

- **Recommendation 19 (Primary health care in national and local emergency preparedness):** Deliver nationally coordinated emergency preparedness and response, defining Commonwealth, State and Territory roles and boosting capacity in the primary health care sector

### Implementation is integral to effective reform that delivers on the Quadruple Aim

- **Recommendation 20 (Implementation)**
  - Ensure there is an Implementation Action Plan developed over the short, medium and long-term horizons
  - Ensure consumers, communities, service providers and peak organisations are engaged throughout implementation, evaluation and refinement of primary health care reform

### Process for developing draft recommendations on primary health care reform

The Steering Group met 16 times between October 2019 and June 2021 to inform its advice and develop its draft recommendations.

The Steering Group was presented with information gained from extensive consultation with patients lived experience of the health system, communities, researchers, providers and PHNs. Consultations included 20 themed roundtables focusing on various population health groups, provider groups and issues in primary health care, and a sector-wide consultation group in November 2019. Over 400 organisations have been represented in the consultation process so far.

All participants brought expertise in their field of experience of the health system (See Appendices for further information on consultation process).

In developing their recommendations, the Steering Group considered new models of primary care emerging around the world and advances already under way in Australia.

In forming their recommendations and seeking input through consultation, the Steering Group developed and used a framework that included seven objectives and six enablers (see Appendices for further detail on objectives and enablers).



## Introduction

### What do consumers value about primary health care? What should they expect?

Australian consumers expect a future primary health care system to deliver coordinated, affordable, accessible and connected care. Consumers also want a primary health care service experience that responds comprehensively to their needs: a biopsychosocial model of health care.

The Steering Group's view is that in ten years consumers will be able to say;

• My health care team supports me to live the life I want to the best of my ability
• I access my chosen primary care service and they act in a coordinated manner with others involved in my care
• My primary health care service recognises that factors other than health care plays a role in my health and wellbeing
• I am shown how to use new kinds of services and supported to use them until I am confident
• My treatment journey records are in one place (e-records) for my care team to access with my consent so that I don't have to repeat my whole story every time
• I am able to use video-conferencing when face to face care is not essential and I am supported by remote monitoring that is relevant to my health care
• I don't have to avoid or put off care because of cost
• I plan my care with people who work together to understand me and my priorities, who respect my choices and bring together services to achieve outcomes important to me
• I am asked about my experience of the services I use and feel confident that this feedback is used to improve services for me and others
• I trust that I am in good hands and receiving the best care possible (quality, safety, best evidence)
• I am supported to understand my physical and mental health challenges and to set and achieve goals
• I am supported to manage my wellbeing and health care at home as much as possible
• When I use a new service or move between services and settings, there is a seamless handover and a plan in place for what happens next
• I am not disadvantaged and I don't miss out on services because of where I live, my diverse background or my lived experience

### Why do we need a strong primary health care system and what does the ideal primary health care system look like?

Primary health care is the main entry point for health care for most people, being the key diagnostic and referral pathway for care, after-care, long-term care and support in the community. The ideal primary health care system will equitably serve all people living in Australia, respecting who they are and what matters to them, while connecting them to the right care and the right supports.

It is intended that reform, including leadership and cultural shifts in the system, will continue to move the system from:

An illness system	to	A wellbeing system
Patient management with a focus on 'what is the matter with patients'	to	<b>Patient activation and person-centred care</b> with a focus on 'what matters to patients'
A focus on treatment	to	A focus on <b>health promotion</b> and <b>prevention</b> , while ensuring safe, quality care is provided when people need it
Multiple independent and sometimes competing providers	to	A <b>coordinated and integrated multidisciplinary health care team</b> focused on serving people (including across providers, provider-types, health care sectors and non-health sectors)
A volume-based system	to	A <b>value-based system</b>
A fragmented system	to	A <b>coordinated and interconnected system</b>

### What problem are we trying to solve?

Although Australia's primary health care system delivers some of the best care in the OECD, widespread consultation has revealed many problematic themes. These include outdated funding models, fragmentation in service delivery, inequitable access to care and significant out of pocket costs for consumers.

The current Australian health and disease demographic requires a whole-of-system reorientation to patient centred continuity of care with accessible, affordable and equitable primary health care at its heart.

The recommendations provide a clear value proposition and strategic pathway forward for reaffirming the primacy of primary health care in Australia and delivering ambitious and wide-ranging primary health care reform, with the necessary investments over time.

Concurrent reforms, for example aged care, preventive health care and mental health care, also require a high performing primary health care system that is integrated with other systems to be effective and will demand greater investment in primary health care to support them.

### What are we trying to achieve?

- A primary health care system that delivers care and is organised around consumers and the community.
- A move to an equitable system that proactively invests in the health and wellbeing of all Australians and seeks to overcome population health challenges, including addressing the longstanding gap in health outcomes between Aboriginal and Torres Strait Islander and non-Indigenous Australians.
- Emphasising the health systems focus on prevention and wellness.
- Highlighting the importance of generalism<sup>1</sup> in the foundations of our system to support a holistic approach.
- Future-proofing primary health care and enhancing its fitness for purpose.
- Addressing weaknesses and flaws – access, affordability, equity and continuity – to reorient the health system towards primary health care.
- Improving uptake of innovation opportunities (for example digital health and regional care models) to optimise care safety and quality wherever Australians live.
- Seamless transitions to and from quality secondary care and tertiary care systems.
- A less fragmented, less complex system.

### Advancing the Quadruple Aim

The *Quadruple Aim* is a well-regarded framework for optimising health system performance. It outlines four principles that governments, health care planners and providers need to concurrently focus on when examining the design and models of primary health care delivery (4). Its aims are:

1. Improve the **patient experience of care** (including quality of care and satisfaction);
2. Improve the **health of populations**;
3. Improve the **cost-efficiency of the health system**; and,
4. Improve the **work life of health care providers**.

The Steering Group have used the *Quadruple Aim* as a lens to test the intellectual and structural framework of their recommendations, to evaluate measures and directions captured and to prioritise actions for reform.

The recommendations were chosen because the Steering Group believe they (when taken in their entirety) deliver against the *Quadruple Aim*.

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<sup>1</sup> 'Rural Generalist Medicine' is defined in the Cairns Consensus Statement on Rural Generalist Medicine: Nov, 2013

### Effective implementation of primary health care reform

Effective implementation of primary health care reform is essential for evolving the primary health care system to that of the future, as outlined in these recommendations. Commitment, clear ongoing governance, leadership and processes will need to be in place to monitor and evaluate whether the plan is achieving the equitable outcomes required, in line with the Quadruple Aim.

Implementation of primary health care reform needs to be staged, with prioritised roll out of the most important measures.

There needs to be independent monitoring, evaluation, oversight and refining the implementation of reform, over the next ten years.

Reforming the system will be a change management challenge, with continuing leadership, independent advice and flexibility required for the 10 Year Plan to be implemented successfully.

Recommendation 20 outlines the Steering Group's recommended clear ongoing governance structure, as well as initial priorities to set the foundation for reform over the next ten years.

# Draft Recommendations from the Primary Health Reform Steering Group

## Person-centred health and care journey, focusing on one integrated system

### Recommendation 1 (One system focus)

**Reshape Australia's health care system to enable one integrated system, including reorientation of secondary and tertiary systems to support primary health care to keep people well and out of hospital.**

*This tailored Australian model will reinvigorate primary health care, placing it at the heart of the health care system and making it a lynchpin for continuity of care across all stages of life. A commitment to quality, access, efficiency and affordability should apply equitably across this system.*

*This recommendation aims to support a coherent and flexible system of delivering care and preventive services, utilising the various funding sources, services and programs so that it is easy for people to access the care they need. This will unify the health journey for people irrespective of their location and background, delivering care in a manner sensitive to the social, emotional, financial and cultural needs of people and communities.*

*This will reaffirm the importance of primary health care in Australia, with necessary investments and redirection of funding. It will future-proof a high performing and agile primary health care system that delivers coordinated services, integrated care and team-based approaches that are responsive to the needs of individuals, families, carers and communities. It will require culture change, strong governance and appropriate recalibration of financing and resources.*

#### 1. Actions to cover

- 1.1. **Long term reform agenda:** Enable integrated one health system thinking by leveraging the long term joint reform agenda that the Commonwealth and the States and Territories have agreed to through the National Health Reform Agreement (NHRA) Addendum 2020-2025.
- 1.2. **Dedicated funding investment and redirection:** Allocate a minimum percentage of health care spending to be assigned to primary health care with increased investment and redirection of funding towards primary health care. Additional investment in primary health care should also include quarantined funding to address Indigenous needs and disparity through community controlled primary health care arrangements.
- 1.3. **Local solutions and partnerships:** Enable flexibility for local solutions and partnerships, tailoring services, workforce and funding options to meet community needs, enabling primary health care to support people and keep them out of hospital, including:
  - 1.3.1. **Governance arrangements:** Develop appropriate governance arrangements that include investment and redirection of funding towards primary health care – nationally, regionally and locally - leveraging the principles outlined in the NHRA Addendum 2020-2025. This should include increased support for primary health care from secondary and tertiary services.
  - 1.3.2. **Commonwealth/State shared responsibilities:** Support and leverage regional governance framework to deliver pooled funded models of care, co-commissioning and other forms of payments, and to underpin shared responsibilities between the Commonwealth and State governments to deliver community centred care in parallel with volume based funding models<sup>2</sup>.

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<sup>2</sup> This is in line with conclusion 4.1 of the Productivity Commission Shifting the Dial report, Supporting Paper 5

- 1.3.3. **Integrated care system:** Support an integrated and coordinated care system, including in aged care, community care, disability and mental health services, as well as other social support services linked to the determinants of health.
- 1.3.4. **Build an evidence base to enable staged implementation:** Fund and evaluate a series of 10-15 vanguard regionalised initiatives featuring joint governance, planning, funds sharing and/or pooling and collaborative commissioning by PHNs, ACCHOs and LHNs to accelerate and demonstrate how implementation can occur.
- 1.3.5. **PHN capability and accountability:** Build the maturity and national consistency of PHNs in delivering regional approaches with ACCHOs, ensuring they are accountable under a performance and accountability framework, with a set of obligations, including regional health pathways.
- 1.4. **Empowered health care teams:** Build connected, multidisciplinary primary health care teams delivering flexible, innovative care and meeting community needs, including:
  - 1.4.1. **Staged implementation of successful models:** Build, learn from and expand successful and strength-based models of integrated, multidisciplinary team care that improves outcomes for people and incorporates workforces from the wider health and social care systems. This would include increased access to secondary, tertiary and social care providers to support primary health care, utilising both public and private businesses<sup>3</sup>.
  - 1.4.2. **Cultural change:** Embed workforce, funding and other primary health care reforms into evolving models of care and training (see recommendation 9).
  - 1.4.3. **Share learnings:** Increase performance transparency across the primary health care system, specifically identifying, rewarding and sharing successful examples of quality improvement, multidisciplinary teamwork and integrated care.

**Reform in line with this recommendation will be enabled by the following:**

- Under the auspices of the NHRA, ensure engagement with and the support of state and territory governments, cognisant of each party's critical role in achieving one integrated system covering funding sources, services and programs to enable local solutions and partnerships;
- Regional governance with clinical and community leadership;
- Forward thinking focus on prevention and services that improve outcomes for people;
- Flexibility to collaborate with and meet community needs to locally tailor services, workforce and funding options, within a national framework;
- Brokering Aboriginal-led solutions, including by supporting ACCHOs to play a stronger role in the regional integration of services using procurement and commissioning models that best suit communities and need (see recommendation 4);
- Funding reform (see recommendation 3);
- Common minimum dataset, data governance and use (see recommendation 17);
- Interconnected digital technologies (see recommendations 15 & 16); and,
- Effective use of research (see recommendation 18).

<sup>3</sup> See Productivity Commission Innovations in Care for Chronic Health Conditions for examples of successful innovations and features identified as distinguishing success innovations from other interventions

**How the recommendation achieves the Quadruple Aim:**

- Patient experience of care will be improved through more integrated and coordinated care that is responsive to their needs.
- Health of populations will be improved through continuously improving prevention, planning and provision of quality services matched to community needs.
- Cost-efficiency of the health system will be increased through improved collaboration across sectors that enables greater allocative efficiency in resources and health funding targeted towards keeping people well and out of hospital.
- Work life of health care providers will be improved through greater empowerment, improved collaboration with other providers and recognition of their important role in primary health care through increased funding.

## Recommendation 2 (Single primary health care destination)

### Formalise and strengthen the relationship of individuals, families and carers with their chosen primary health care provider and practice

*This recommendation aims to foster single primary health care destinations and equip them to provide multi-disciplinary, wrap-around care. This service base should be well connected with the people they serve, as well as other services, networks and supports, both in the community and secondary care systems.*

*It aims to establish the foundation for high performing, multidisciplinary, consumer-centred and integrated primary health care, building on lessons learned in the ACCHO sector and establishing a pathway for new investment in primary health care. It recognises that a person's journey in the health system starts with the service or provider they choose to present to, with referral to or contribution from other practitioners depending on the expertise required. This requires coordination and effective communication across the primary health care team and across sectors.*

*VPR is a building block for reform, helping formalise a single health care reference point. This will support the clinical governance, coordination, diagnostic and referral role of GPs for the majority of people, while improving coordination and integration of allied health and other services. It will enable the primary health care system to better adopt a medically led and coordinated multidisciplinary team approach to better support coordinated, wrap-around care for people. A person's GP will stay informed about their patient's care across primary, tertiary and social care settings, and will be better enabled to coordinate holistic care for their patients. Empowering consumers to choose and nominate their GP and register with their practice will ensure VPR is consumer led, providing an opportunity for people to choose to receive coordinated care through a formalised single health care destination that responds to and is aware of their changing care needs.*

*This change will embed and build upon current pilot initiatives relating to primary care reform as described by the Health Care Home principles of care<sup>4</sup> for general practices, ACCHOs, and rural multipurpose health services and facilitate broadening practice funding beyond the MBS (see Recommendation 3). This change will benefit people in greatest need of accessible, community-based and coordinated primary health care, particularly families with children within the first 2,000 days; people with complex chronic conditions, including mental illness; and older Australians. This change, however, will impact the culture and current business models in primary health care and will require strong leadership to be implemented effectively.*

The single primary health care destination could be:

- 'a future focussed' general practice backed by funding reform, with formalised links with a large range of multidisciplinary, wrap-around community and hospital services;
- an ACCHO; or,
- a community based health centre where people can receive comprehensive primary care and where a range of primary care and specialist services can also be available on-site, as well as in modes other than face to face.

## 2. Actions to cover

2.1. Implement and build on whole of population VPR, including:

- 2.1.1. **Registration with service:** Registration with a general practice, or ACCHO.
- 2.1.2. **Nomination of GP:** Nomination of a GP (including rural generalists) to support longitudinal continuity of care and to strengthen and build the relationship with the primary / integrated health care team.

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<sup>4</sup> see Report of the Primary Health Care Advisory Group p 19-21

- 2.1.3. **GP MBS services:** Preservation of chronic disease management and health assessment MBS items to the practice with which a person is registered.
- 2.1.4. **GP MBS telehealth:** Continuing GP MBS telehealth rebates for persons registered with a GP and practice (non-GP MBS telehealth rebates would not be impacted by VPR).
- 2.1.5. **Enhanced access:** Facilitate enhanced access, including after hours, to primary health care services through a patient's registered practice, supported by fee-for-service, block and blended funding.
- 2.1.6. **Patient supports:** Introduce care coordination and system navigation support, health coaching and social prescribing to link registered people to the services they need and improve care partnership and activation (see recommendations 8 and 13).
- 2.1.7. **Digital platform:** Develop digital platforms to support continuous quality improvement and multidisciplinary teamwork across the continuum of care, while reflecting and addressing barriers experienced in the Health Care Homes trial in relation to shared care systems and My Health Record (see recommendations 15 and 16).

**How the recommendation achieves the Quadruple Aim:**

- Patient experience of care will be improved through enhanced access to more coordinated and holistic wrap-around care that considers and responds to their changing care needs.
- Health of populations will be improved through capture of data on registered patient cohorts that enables equitable population health interventions.
- Cost-efficiency of the health system will be improved through regular primary health care providers who are able to provide a wide range of connected health services that keep people well and reduce pressure on other parts of the health system.
- Work life of health care providers will be improved through greater job satisfaction from an enhanced ability to coordinate holistic care for their patients, supported by funding that incentivises wellness and quality outcomes.



## Recommendation 3 (Funding reform)

### Deliver funding reform to support integration and a one system focus

*This recommendation aims to leverage off VPR to bring together the components of funding reform to support providers to tailor care to meet the needs of their patients, delivering value based care and facilitating redirection of funding from secondary/tertiary care to primary care and prevention. This will recognise and deliver alternative funding sources for primary health care service providers in addition to the fee-for-service MBS, supporting a one system focus with flexibility and greater longitudinal, multidisciplinary and value-based team care. It will deliver appropriate and sustainable funding reform that underpins and incentivises the best models of primary / integrated health care tailored to local circumstances, supporting access, affordability, equity and continuity of care for local people.*

### 3. Actions to cover

#### 3.1. Formalise regional planning and pooled funding arrangements to support value

**based care:** Formalise regional planning and funds pooling arrangements to create meaningful sharing of resources and reduced service duplication and fragmentation, in line with recommendation 1, including:

- 3.1.1. **Flexible funding models:** Ongoing development and implementation of flexible funding models, including collaborative commissioning, for community centred primary health care to provide local solutions in line with regional planning and coordination<sup>5</sup>.
- 3.1.2. **Across sector accountability to improve patient outcomes:** Embedding across sector arrangements to encourage collaboration, shared efficiency, responsibility and accountability, rebalancing and reorienting funds from acute care to primary care, with evaluation to assess outcomes. This should include developing mechanisms and governance arrangements to support appropriate accountability for patient outcomes when integrated care is delivered across health systems.
- 3.1.3. **Community needs:** Ensuring use of funding is in line with identified community needs at a regional level, based on a common set of shared goals and outcomes for the population and patients.
- 3.1.4. **Funding differences across sectors:** Recognising the differences and supporting efficient use of funding available across health (including redirecting some hospital based funding), mental health, aged care and the National Disability Insurance Scheme (NDIS) to deliver integrated outcomes for people. This needs to consider and assess the impact of any unintended consequences that primary health care funding reform may have on secondary/tertiary care.

#### 3.2. Funding reform for primary health care services: Create funding models to support best practice primary / integrated health care to help move the system from volume to value with necessary investments over time taking into account private business sustainability to achieve improved outcomes for people. This includes using flexible funding for individual service providers, including block and blended payment models, and bundled payment approaches aligning financial incentives with high quality care and quality improvement at an individual and population level.

- 3.2.1. **VPR:** Build on VPR to reform funding to support greater longitudinal, multidisciplinary and intersectoral team care. This should include over time pooling

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<sup>5</sup> This is in line with recommendation 2.1 (*implement nimble funding arrangements at the regional level*) of the Productivity Commission Shifting the Dial report 2017, as well as conclusions 6.1, 6.2 and 6.3 of Supporting Paper 5

- funding at a practice level, matching services to the needs of the patients at the practice.
- 3.2.2. **Innovative funding models:** Develop innovative equitably funded models for a range of primary health care services, including allied health, non-dispensing pharmacists, nursing, mental health services and rural and remote communities.
  - 3.2.3. **Investment:** Provide greater support for providers and practices, including innovative models for multidisciplinary and intersectoral team care.
  - 3.2.4. **Private Health Insurance (PHI):** Reform PHI funding to allow delivery of contemporary and evidence based primary care by allied health professionals and nurses.
  - 3.3. **Quality improvement:** Funding reforms need to support data collection, sharing and analysis, improving service delivery, reporting and accountability and improving and sustaining outcomes that matter to people across care settings.
  - 3.4. **Continuing evaluation:** Evaluate structures and services with the intention to embed those that achieve desired outcomes within the health system and remove structures and services that do not achieve outcomes that matter to people<sup>6</sup>. This should include addressing gaps in services identified by data and ensuring that funding does not negatively impact equitable access and service provision.
  - 3.5. **Patient-led:** Measure and report on outcomes based on achievement of goals set by patients.
  - 3.6. **Change management:** Support effective change management and cultural change towards alternative funding models in general practice and the broader primary and secondary health care team (see recommendation 9).

#### **How the recommendation achieves the Quadruple Aim:**

- Patient experience of care will be improved through tailored care that meets their needs, and the facilitation of greater longitudinal, multidisciplinary and value based care.
- Health of populations will be improved through pooled and targeted funding towards identified community needs and services that improve population outcomes.
- Cost-efficiency of the health system will be improved through more efficient use of funding, meaningful sharing of resources, reduced duplication of services and shared accountability across sectors to improve outcomes for patients, thereby reducing health care costs.
- Work life of health care providers will be improved through investment and flexible funding that enhances their ability to provide quality care to their patients and work within a collaborative team environment with other care providers across primary, secondary and social care sectors.

<sup>6</sup> This is consistent with recommendation 2.2 (*eliminate low-value health interventions*) of the Productivity Commission Shifting the Dial report 2017 and conclusion 7.1 of Supporting Paper 5.

## Recommendation 4 (Aboriginal and Torres Strait Islander health)

### Implementation of the National Agreement on Closing the Gap for Aboriginal and Torres Strait Islander peoples through structural reform of the primary health care systems

*Closing the gap in health and wellbeing outcomes between Aboriginal and Torres Strait Islander people and other Australians should be one of the critical objectives of the Primary Health Care 10 Year Plan. All actions taken to bring about primary health care reform need to work effectively towards this objective and recognise the ACCHO sector as a pivotal player in seeking to reform and improve our primary health care system.*

*This recommendation builds on all others throughout the Steering Group's draft recommendations and identifies specific actions to be taken to lift the longstanding burden of chronic disease experienced by Aboriginal and Torres Strait Islander people and ensure Aboriginal and Torres Strait Islander children and young people grow up healthy and strong, supported by a person and community centred, culturally safe primary health care system.*

#### 4. Actions to cover

- 4.1. **Procurement and commissioning:** Support Aboriginal and Torres Strait Islander community-controlled organisations to play a stronger role in the integration of services using regional procurement and commissioning models that best suit communities and need. Models should be tailored to regions and the different operations and networks of ACCHOs across the country. The aim should be to strengthen the ability and access of ACCHOs to operate as strong national, jurisdictional, regional and local health organisations and improve continuity of care and health outcomes for Aboriginal and Torres Strait Islander people. Staged implementation should occur with opportunities provided for ACCHOs to express interest in developing suitable models, drawing on lessons learnt from PHN and LHN commissioning and other regional health models operating nationally and internationally for disadvantaged populations.
- 4.2. **Integration of services within ACCHOs:** Continue to invest in the ACCHO model of comprehensive primary health care and minimise risk of fragmentation of medical care, including by supporting integration of non-prescribing pharmacists in ACCHOs.
- 4.3. **Shared decision-making and co-design:** Recognise the Sector as a key plank of Australia's primary health care system and require shared decision-making and co-designed structural reform nationally to improve Aboriginal and Torres Strait Islander health outcomes, with strong regional agreements between ACCHOs, mainstream service providers and hospitals.
- 4.4. **Resource ACCHOs:** Consistent with the new National Agreement on Closing the Gap, appropriately fund and resource Community Controlled Health Services as the preferred providers of primary health care services to Indigenous Australians so that they are accessible across Australia and Indigenous Australians can choose to access these services.
- 4.5. **ACCHO geographic coverage:** Support transitioning of government-run Aboriginal medical services to community-control where this will better meet the needs of communities and improve outcomes.
- 4.6. **Improve mainstream services:** Ensure Aboriginal and Torres Strait Islander people receive person-centred and culturally safe care through all mainstream primary health care services, including increased employment of Aboriginal and Torres Strait Islander health professionals and health workers in mainstream health care services.
- 4.7. **Data:** Strategic data investment with a high quality Indigenous status function in all datasets and use of patient reported measures. This should support continuous quality

improvement in an integrated health system that is Aboriginal and Torres Strait Islander-led.

- 4.8. **Digital infrastructure:** Efficient and effective delivery of care, including shared and integrated digital infrastructure and systems that enable a single health record and flexible delivery of services that support continuity of care, including support to maximise use of telehealth as an effective tool for ACCHOs and patients.
- 4.9. **Workforce:** Develop and support the Aboriginal and Torres Strait Islander workforce to work to top of scope in delivering primary health, mental health, aged care, disability and family support services to communities over the next ten years. This includes ensuring ACCHOs have access to highly trained GPs and other primary health care providers and that Aboriginal and Torres Strait Islander Health Practitioners and Workers are supported to increase the vital contribution they make to improving the health and wellbeing of communities, including through completion of Certificate Four qualifications in aged care and mental health.
- 4.10. **Access to Medicines:** Update the Pharmaceutical Benefits Advisory Committee (PBAC) guidelines to reflect the needs and priorities of Aboriginal and Torres Strait Islander peoples as outlined within the National Medicines Policy and to allow PBAC to make a direct referral for an item/s to be listed for Aboriginal and Torres Strait Islander peoples.
- 4.11. **Medical/Health Technology:** Amend the Terms of Reference and Guidelines for the Medical Services Advisory Committee (MSAC) to enable consideration of new medical technologies and medical services that will improve health outcomes for Aboriginal and Torres Strait Islander peoples.
- 4.12. **Concurrent reform:** Align directions from the new National Agreement on Closing the Gap, the National Aboriginal and Torres Strait Islander Health Plan and the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-31.

#### **How the recommendation achieves the Quadruple Aim:**

- Patient experience of care will be improved through community centred and culturally safe primary health care and flexible delivery of services that support improved health outcomes.
- Health of populations will be improved through measures that lift the longstanding burden of chronic disease experienced by Aboriginal and Torres Strait Islander people.
- Cost-efficiency of the health system will be improved through better capture of data that supports continuous quality improvement, as well as utilising digital infrastructure and systems to provide efficient and effective service delivery.
- Work life of health care providers will be improved through appropriate funding and resourcing that enables increased employment of Aboriginal and Torres Strait Islander health professionals and health workers and other primary health care workers, while supporting the Aboriginal and Torres Strait Islander workforce to work to top of scope.

## Recommendation 5 (Local approaches to deliver coordinated care)

### Prioritise structural reform in rural and remote communities

*This recommendation aims to support a community connected approach built around the strengths of rural and remote communities, where the community has equitable access to care and providers trust a system that supports and empowers delivery of high value care.*

#### 5. Actions to cover

- 5.1. **Support current innovative models:** Build on, support and expand innovative models of care that meet the particular needs of rural and remote communities, including community-controlled, workforce, funding and service models.
- 5.2. **Community needs:** Tailor services to meet the needs of individual communities, including social services, as well as providing employment conditions necessary to attract and retain the full spectrum of primary health care providers.
- 5.3. **Rural community controlled organisations:** Create Rural Area Community Controlled Health Organisations (RACCHOs), broadly modelled on the ACCHO model.
- 5.4. **Local partnerships and capacity:** Build community partnerships and local capacity to enable innovative, equitably funded models that meet specific population needs, such as place-based pooled funding (building on recommendations 1-3). This should consider required infrastructure and the wants and needs of health care workers and their families, as well as the diversity of models already in effective operation in private and state-funded practices, Royal Flying Doctor Service (RFDS) and ACCHOs.
- 5.5. **Local private practice and PHNs:** Support local private practice and PHNs to develop local infrastructure and networks (building local strength and confidence) especially to support ongoing community access to established services.
- 5.6. **Broad scope:** Enable broad scope rural doctors and rural generalists within a rural health system to improve capability, capacity and safety for the whole health care team in rural and remote communities.
  - 5.6.1. **Commonwealth/State divide:** Address the Commonwealth/State funding divide so services are designed to address need.
  - 5.6.2. **Blended payments:** Enable primary health care blended payments for all Australian settings.
  - 5.6.3. **Rural generalist training:** Introduce a rural generalist training approach to nursing and allied health.
  - 5.6.4. **National frameworks:** Develop national frameworks to support innovative rural solutions, including;
    - **Partnerships:** facilitation of partnerships between health services, professions, community service organisations delivering health and mental health programs and private business;
    - **Successful local models:** identifying strong localised models, with development and evaluation for upskilling; and,
    - **Technology:** enabling optimal use of digital health infrastructure and virtual care services.

**How the recommendation achieves the Quadruple Aim:**

- Patient experience of care will be improved through greater access to quality services in rural and remote areas.
- Health of populations will be improved through community based models of care that meet the needs of rural and remote communities.
- Cost-efficiency of the health system will be improved through health providers in rural and remote areas working to the top of their scope of practice to deliver high value care.
- Work life of health care providers will be improved with greater support, more development opportunities and better employment conditions for the range of primary health care providers working in rural and remote areas.

## Adding building blocks for future primary health care – better outcomes and care experience for all

### Recommendation 6 (Empowering individuals, families, carers and communities)

**Support people and communities with the agency and knowledge to better self-care and manage their wellness and health within a system that allows people to make the choices that matter to them**

*This recommendation aims to support all people living in Australia to be active drivers of their health and care priorities within an intuitive health care environment that enables people to access, understand, evaluate and apply health-related information and services. People should be equipped with the knowledge, ability and control to make choices with confidence that enable them to stay well, better navigate the system when unwell and to participate with confidence in shared decision making and goal setting. This recommendation (and recommendations 7 and 8) recognises that a person's health and wellbeing approach starts at home with preventive behaviours and, when required, informed self-management of short- and long-term health conditions. When a person requires additional care, it is important that they are able to access this simply and equitably through the health system.*

#### 6. Actions to cover

- 6.1. **Patient reported measures:** Systematically collect, analyse and use patient reported outcome and experience measures<sup>7</sup>, aligning the system and enabling providers to focus care on what matters to people.
- 6.2. **Simplify health care environment:** Improve the health literacy environment and continually build and tailor health and health system literacy<sup>8</sup>.
- 6.3. **Digital readiness:** Equip consumers and communities with the information and tools they need to benefit equally from digital and virtual health care.
- 6.4. **Individual health literacy and agency:** Enhance individual health literacy and consumer agency by supporting consumers with appropriately targeted health information and self-management support services and programs, recognising the particular needs of CALD, Aboriginal and Torres Strait Islander and rural and remote communities.
- 6.5. **Sources of information:** Promote and continuously improve reliable sources of information for people using easily accessible, up to date technology and digital platforms.

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<sup>7</sup> Use of Patient Reported Experience Measures (PREMs)/Patient Reported Outcome Measures (PROMs) is consistent with recommendation 2.3 of the Productivity Commission Shifting the Dial report 2017.

<sup>8</sup> This is consistent with recommendation 2.3 of the Productivity Commission Shifting the Dial report 2017.

**How the recommendation achieves the Quadruple Aim:**

- Patient experience of care will be improved through a simplified health care system, support to take a more active role in their health care, with greater choice and an emphasis on care that is focused on what matters to them.
- Health of populations will be improved through improved self-care and management of health and wellness, with supports that increase health literacy, with targeted information available.
- Cost-efficiency of the health system will be improved through reduced expenditure on unnecessary consults which may have been avoided if consumers had been able to find the appropriate care in the community setting in the first instance, as well as lower costs due to improved patient engagement with care plans and treatment regimes.
- Work life of health care providers will be improved through greater collaboration with consumers who are better able to self-direct to appropriate care, as well as better outcomes for patients, bringing greater satisfaction from work.



## Recommendation 7 (Comprehensive preventive care)

### Bolster expanded delivery of comprehensive preventive care through appropriate resourcing and support

*This recommendation aims to ensure prevention occurs across the lifecycle and has prominence in the system.*

#### 7. Actions to cover

- 7.1. **Utilise available guidelines:** Encourage and support general practices to implement preventive health care for their patients as detailed in the Royal Australian College of General Practitioners (RACGP) Red Book.
- 7.2. **Data and documentation:** Formalise, document and better capture the provision of the many preventive services currently delivered in primary health care in a manner that is valid, effective and does not inordinately impost on patients or practices.
- 7.3. **Tailor supports across lifecycle:** Tailor support across the lifecycle beginning with antenatal care and child development with family support to aged care.
- 7.4. **Allied health funding:** Fund preventive allied health services for people with GP-assessed risk factors such as pre-diabetes, and to support mental health.
- 7.5. **Funding of other services:** Develop, evaluate and support dissemination of preventive health services found to improve health outcomes at local, state and national level.
- 7.6. **Map local wellness services:** Capture the breadth of wellness activity available locally and ensure the patient's 'home' is able to match these effectively with patient need. This may be through a local services register that may be available through PHNs or Health Direct.
- 7.7. **Locally designed approaches:** Support locally designed approaches to prevention and addressing the social, emotional, financial and other determinants of health<sup>9</sup>.
- 7.8. **Enhance access:** Develop campaigns and programs to enhance access for population groups who tend not to engage with the primary health care system and may experience additional barriers to accessing care.
- 7.9. **Investment through VPR:** Use VPR data to enhance understanding of individual and community needs such that resources can be effectively allocated to high value primary and preventive health care.
- 7.10. **Embed prevention across the system and other sectors:** Align implementation of the 10 Year Plan with the National Preventive Health Strategy and the National Agreement for Mental Health and Suicide Prevention. Implement a *Health in All Policies* approach across sectors, considering lessons learned from prior attempts, as well as One Health initiatives (5). This needs to consider and recognise the fact that the current health system relies on the ongoing presence of illness, with broad cultural, funding and system change required to reorient towards prevention and wellness.

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<sup>9</sup> This is consistent with conclusion 4.1 of the Productivity Commission Shifting the Dial report 2017, Supporting Paper 5.

**How the recommendation achieves the Quadruple Aim:**

- Patient experience of care will be improved through tailored preventive health care that keeps people well and reduces the risk of burden of disease.
- Health of populations will be improved through reduced burden of disease across the population.
- Cost-efficiency of the health system will be improved through allocation of resources to high value primary and preventive health care, reducing the requirement for more expensive secondary and tertiary care, which in turn provides more opportunity to further redirect funding towards primary and preventive health care.
- Work life of health care providers will be improved through greater recognition and funding for the rendering of preventive health services.

## **Recommendation 8 (Improved access for people with poor access or at risk of poorer health outcomes)**

### **Support people to access equitable, sustainable and coordinated care that meets their needs**

*This recommendation aims to address the disconnects and disparities in the health care system and to improve equity and access to person centred, safe and quality health care, noting that health care encompasses mental health care, treatment and support.*

*This includes tailoring services to address health disparities for Aboriginal and Torres Strait Islander people, older people, people with mental illness, CALD communities, lesbian, gay, bisexual, transgender, intersex, queer and other sexuality, gender and bodily diverse people (LGBTI+) communities, people with disability, and families with children at risk of adverse childhood experience, with access to appropriate physical and mental health support. This also includes tailoring services for people living with disadvantage in order to deliver equitable and approachable services, for example for people living in lower socioeconomic geographic areas and adolescents who may not currently engage with health services.*

#### **8. Actions to cover**

- 8.1. **Tailor services through VPR:** Build on VPR to support tailored services for disadvantaged individuals, children at risk, families and communities that are appropriate, accessible, affordable, equitable and well-coordinated.
- 8.2. **Co-design solutions to address barriers to care:** Identify relevant barriers to care and co-design flexible and holistic models of care that bridge unmet need. This includes additional supports, programs and structures tailored for people with poor access or who suffer poorer outcomes, enabling their primary / integrated health care team to better support them. This should address system factors such as approachability, acceptability, availability, affordability and appropriateness, as well as individual abilities to perceive, seek, reach, pay for and engage in care (6).
- 8.3. **Interpreter services:** Provide universal access to interpreter services to support safe and effective health care delivery, including Aboriginal and Torres Strait Islander languages where possible.
- 8.4. **Streamline health system navigation:** Reduce fragmentation and complexity of the health and mental health system to enable individuals, children at risk and families to successfully navigate and access the services available.
- 8.5. **Additional coordination/navigation supports:** Introduce and evaluate trials of different approaches to care coordination and system navigation support, including patient health pathways and social prescribing to link people to the services and community connections that they need.
- 8.6. **Increase community awareness of available services:** Co-design local campaigns and programs to increase awareness and communicate services that are available to people.
- 8.7. **Concurrent reform:** Align with directions from the Royal Commission into Aged Care Quality and Safety, Vision 2030 for Mental Health and Suicide Prevention, Productivity Commission's Inquiry Report on Mental Health, the National Roadmap for Improving the Health of People with Intellectual Disability and the new National Agreement on Closing the Gap.

**How the recommendation achieves the Quadruple Aim:**

- Patient experience of care will be improved through greater and easier access to safe and effective health care that respects their background and lived experience.
- Health of populations will be improved through better access to care for people with poor access or at risk of poorer health outcomes, increasing equity and raising overall population health outcomes.
- Cost-efficiency of the health system will be improved through greater support to address the disproportionate burden of disease suffered by disadvantaged and underserved population cohorts.
- Work life of health care providers will be improved through greater access to support services, better understanding of patient cohorts, and an enhanced ability to support better outcomes for their patients, bringing greater enjoyment from work.

## Leadership and culture

### Recommendation 9 (Leadership)

#### Foster cultural change by supporting ongoing leadership development in primary health care

*This recommendation aims to foster leadership development and support all involved in primary health care to drive reform and build a culture of continuous quality improvement, supporting inter-professional collaboration, co-design and effective change management.*

*Strong leadership at all levels of the health system will be required to drive and enable significant behavioural and structural change to occur over the next ten years. It will require standing against underlying resistance structurally embedded in the health system through its fragmented, siloed and hierarchical nature, promoted largely through funding that incentivises throughput and episodic treatment of sickness. Change management will require leadership and change champions across the health sector, including all organisations and individuals who have and continue to contribute to the development of the 10 Year Plan, as well as all involved across the health and wider care systems.*

*This includes the various professional colleges, such as the Australian Association of Practice Management (AAPM), the Australian College of Rural and Remote Medicine (ACRRM), the Australian Medical Association (AMA), the RACGP, Australian Indigenous Doctors' Association (AIDA), Services for Rural and Remote Allied Health (SARRAH), Australian Nursing & Midwifery Federation (ANMF), Australian Primary Health Care Nurses Association (APNA), Pharmaceutical Society of Australia (PSA) and Rural Doctors Association of Australia (RDAA). This also includes existing structures, such as PHNs, LHNs and ACCHOs.*

*A clear ongoing governance structure to monitor and evaluate primary health care reform will also be required to support this leadership and enable change and effective implementation of reform over time. This will include bringing together all stakeholders involved and progressing broader systemic change that leverages the NHRA Addendum 2020-2025 (see recommendation 20 for more information).*

#### 9. Actions to cover

- 9.1. **Primary health care leadership:** Foster leadership in consumers, carers and their families, primary health care providers, practice managers, business owners, academics and the broader health and care system in delivering equity, continuous quality improvement and a whole-of-system focus.
- 9.2. **Change management:** Leverage this leadership to support cultural and change management across the range of reform activities towards a future-focused one health system, including;
  - 9.2.1. **Governance arrangements:** Governance arrangements that empower clinicians and consumers, carers and families to work together, contributing to care innovation and reform;
  - 9.2.2. **Role models:** Utilising positive role models and local champions<sup>10</sup>;
  - 9.2.3. **Clinician/consumer collaboration:** Adopting collaborative practices with consumers, carers and families and clinicians working together;
  - 9.2.4. **Early adopters:** Supporting and incentivising early adopters of change;
  - 9.2.5. **Development opportunities:** Providing opportunities for evaluation, research and ongoing development, including encouraging and enabling primary health care to lead research and innovation, targeting aspects in the Quadruple Aim;

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<sup>10</sup> See 'Champions Program' in recommendation 2.4 of the Productivity Commission Shifting the Dial report 2017

- 9.2.6. **Utilise existing structures:** Leveraging existing structures, such as PHNs, ACCHOs, the education and training sector and the various professional bodies to train and embed continuous quality improvement and reform thinking across professional development and primary / integrated health care. This includes expanding resourcing and internal expertise in PHNs to support quality improvement in allied health services;
- 9.2.7. **Shared learning and innovation:** Supporting, leveraging and disseminating innovative thinking and ways of working that improve clinical and service outcomes via awareness of best practice, use of data and research, and encouragement of service innovation;
- 9.2.8. **Business sustainability:** Reforming the system to better align business profitability and sustainability with high quality patient outcomes; and,
- 9.2.9. **Education and training:** Systematically include reform thinking (i.e. person-centred, value-based, team, one system and generalism) in the education and training of early career health professionals<sup>11</sup>, including undergraduate curricula and early career professional transition programs.

**How the recommendation achieves the Quadruple Aim:**

- Patient experience of care will be improved as they are given a greater voice in decision-making, planning and policy decisions that affect them.
- Health of populations will be improved through leadership that is attuned to population health needs.
- Cost-efficiency of the health system will be improved through opportunities for evaluation, research and ongoing development.
- Work life of health care providers will be improved through increased recognition, more leadership and development opportunities, incentives to facilitate change, and sense of achievement and professional satisfaction.

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<sup>11</sup> This is consistent with recommendation 2.3 of the Productivity Commission Shifting the Dial report 2017

## Primary care workforce development and innovation

These workforce recommendations aim to support a more mature multidisciplinary model of primary health care that is integrated, values generalism, as well as profession-specific expertise, and works together as a team for a common, shared purpose. They aim to enable workforce developments that bring about a consumer experience of one system. They aim to include traditional primary health care and emerging workforces, as well as secondary and tertiary care services.

These recommendations recognise that a person's journey in the health care system starts with the service or provider they choose to present to, with referral to or contribution from other practitioners depending on the expertise and services required. They also recognise that many providers already work within an established and trusted team of primary health care providers (whether co-located or virtually connected), effectively delivering comprehensive care to their patients.

These recommendations intend to meet people's needs through one integrated, accessible, equitable and sustainable primary health care team underpinned by improved communication across providers and bolstered by the single primary health care destination (recommendation 2). They are inclusive of all occupations in the primary health care team, fully utilising and supporting members of the team to work together to top of scope in a coordinated and safe way, with appropriate clinical governance.

In the majority of situations, and ideally, the GP is the central point of coordination, however there are cases where other providers will facilitate access to required services. Examples include some ACCHOs, rural and remote services, Nurse Practitioner (NP) services, mental health services and allied health professionals referring to specialists or other allied health services, while keeping the primary care practice that the person has registered with informed.

These recommendations both address the disparate issues faced by different professions in the primary health care team, while also building the capability and sustainability of the primary health care system as a whole to enable people to have equitable and sustainable access to the range of primary health care services as required, whether in person or remotely.

## Recommendation 10 (Building workforce capability and sustainability)

### Address Australia's population health needs with a well-supported and expanding primary health care team that is coordinated locally and nationally for a sustainable future primary health care workforce

*This recommendation aims to bolster workforce training and capability, as well as to better support appropriate workforce planning, distribution and retention that addresses the needs of local communities, including improving access in rural and remote Australia.*

*This will support an integrated multidisciplinary team, with providers working together in different ways, with appropriate clinical governance and patient safety, while ensuring care is not fragmented. This would include multidisciplinary teams that are virtually connected, and which are most often led and coordinated by the chosen general practice.*

*It recognises that rural and remote practitioners and the people they service must be included in policy development and design to appropriately reflect the local needs and drivers of workforce sustainability.*

#### 10. Actions to cover

##### 10.1. National workforce plans and strategies

- 10.1.1. **Comprehensive workforce plan:** Develop an integrated and comprehensive health workforce plan (encompassing plans described in Recommendations 11-14).
- 10.1.2. **Specific workforce strategies:** Leverage/implement and develop workforce plans and strategies targeted to specific parts of the primary care workforce, ensuring that the actions taken are embedded and support quality improvement, team-based primary health care and workforce sustainability.
- 10.1.3. **Link workforce strategies to local workforce needs:** Link primary care workforce initiatives with needs identified locally to improve planning, training and retention of aged care, NDIS and social care workforces.

##### 10.2. Workforce education, training and development opportunities

- 10.2.1. **Educational reform:** Promote interprofessional education and collaborative practice<sup>12</sup> across primary health care and secondary/tertiary care, including in training of early career health professionals.
- 10.2.2. **Education and training:** Align and continually update workforce and management education and training programs with population health needs, including cultural competency and the development of skills that support person-centred, holistic, safe and trauma informed care.
- 10.2.3. **Mental health training:** Increase uptake of mental health training for GPs, nurses, allied health and other primary health care providers.
- 10.2.4. **Development opportunities:** Provide/support/fund primary health care provider development opportunities, particularly in line with improving health equity and addressing disparities in care, for example provision of wound management services, delivering services to people living with disability, including psychosocial disability. Advancements in models of care and scope of practice will require appropriate updates to accreditation, compliance standards and legislation.
- 10.2.5. **Rural generalist models:** Develop and enhance rural generalist models in medicine, nursing and allied health.

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<sup>12</sup> See World Health Organisation (2010): Framework for action on interprofessional education and collaborative practice



### 10.3. **Attractive and sustainable career choice**

- 10.3.1. **Attract students and health professionals:** Attract more students and early career health professionals into the primary health care workforce as a sustainable career choice, with increased exposure to primary health care during training and mentorship.
- 10.3.2. **Transitioning pathways:** Develop pathways for senior health workforce transitioning from tertiary to primary care, recognising the contribution that their established skills can make to primary care, for example the advanced skills of Rural Generalist practitioners.

### 10.4. **Local needs**

- 10.4.1. **Local analysis, planning and coordination:** Support local and community-controlled workforce needs analysis, planning and coordination, including health pathways. Rural and remote workforce and funding planning needs to consider all sources of funding including MBS, NDIS, private health and block and blended payments to match local needs and to support integrated services that provide value in the community. It should also consider local aged care, social and community care services.
  - 10.4.2. **Support existing services:** Build on Rural Workforce Agencies to provide ongoing support to existing rural and remote primary health care services and health professionals, including required assistance to manage recruitment, for training and retention of staff.
- 10.5. **New models of service provision:** Introduce innovative, multidisciplinary and evidence-based workforce models where suitable, matched to services that meet community need<sup>13</sup>. This would include updating accreditation, compliance standards and legislation to reflect advancements in models of care and enable the primary health care workforce to work to top of scope.
- 10.6. **Equitable policy changes:** Ensure all proposed policy change is reviewed through an equitable, including rural and remote lens, to mitigate unintended consequences, including community-controlled, workforce, funding and service models.

#### **How the recommendation achieves the Quadruple Aim:**

- Patient experience of care will be improved as people receive high quality and integrated, multidisciplinary team care from highly trained providers who are supported to provide holistic care.
- Health of populations will be improved through workforce and management education and training programs that are aligned and continually updated to meet population health needs.
- Cost-efficiency of the health system will be improved through more appropriate workforce planning, distribution and retention that supports efficient use of resources.
- Work life of health care providers will be improved as primary health care is supported as a sustainable career choice and providers work within a collaborative team environment that values and recognises each profession, and provides opportunities for training and development.

<sup>13</sup> See '[A Framework for remote rural workforce stability](#)' by Strasser et al, 2018 for further information.

## Recommendation 11 (Allied health workforce)

### Support and expand the role of the allied health workforce in a well integrated and coordinated primary health care system underpinned by continuity of care

*This recommendation aims to better support the allied health workforce, including mental health providers, to work to top of scope within an integrated, multidisciplinary team care environment.*

*This includes investigating and staged implementation of innovative funding and care models, workforce planning and distribution, collecting data and enabling development of local solutions to support equitable access to allied health services.*

#### 11. Actions to cover

- 11.1. **Funding models:** Recognise, support and develop alternative funding models for allied health practitioners, including mental health providers, as independent providers of care, building on the extensive evidence-base for allied health-led interventions across key disease burdens.
  - 11.1.1. **Case conferencing:** Support and fund allied health professionals to participate in GP and non-GP medical specialist-led case conferences.
  - 11.1.2. **MBS Review Taskforce:** Implement in their entirety the recommendations from the MBS Review Taskforce related to allied health services, including mental health.
  - 11.1.3. **Funding reform:** Establish an allied health funding reform committee to oversee the funding reform process. Funding reform should enable development of local solutions to support access, including community health models, provision of preventive and early intervention services, rural health integrated programs and incentives to support access to workforces. This should draw on all current funding sources.
- 11.2. **Digital infrastructure:** Provide financial subsidisation to increase digital health infrastructure for allied health practices.
- 11.3. **Data:** Develop an allied health primary care minimum dataset, including staged implementation of data collection from allied health practice in conjunction with the Australian Institute of Health and Welfare (AIHW) primary care data asset project. This would include scaling up data collection from allied health practices through PHNs over time.
- 11.4. **Improved communication:** Develop secure messaging and software infrastructure to support allied health communication with general practice, My Health Record and the wider care system. This should improve interoperability of secure messaging ecosystem, with appropriate support and funding, including for allied health software vendors and allied health practices.
- 11.5. **Workforce plan:** Develop a coordinated National Allied Health Workforce Plan covering planning and distribution across health, mental health, disability and aged care, with identification of measures to address workforce shortages and maldistribution, including education initiatives and student placements.
- 11.6. **Strong clinical governance for allied health in primary care:** Introduce national strategies and financial supports and incentives to ensure strong clinical governance for Allied Health in primary care, including access to professional supervision and mentoring, professional development and career advancements.
- 11.7. **Research and translation:** Create an allied health research agenda to consolidate and build on allied health research base, with investment in allied health research and

knowledge translation. In line with broader directions in primary health care and this robust research, expand the role of allied health in the Australian public health care system.

**How the recommendation achieves the Quadruple Aim:**

- Patient experience of care will be improved through greater access to allied health services.
- Health of populations will be improved by long term engagement of allied health providers within local regions who are supported to develop tailored responses to population health issues locally and regionally.
- Cost-efficiency of the health system will be improved through increased access to community health models, provision of preventive and early intervention services, as well as rural health integrated programs that reduce the requirement for more expensive forms of health care.
- Work life of health care providers will be improved through flexible employment models and working arrangements, even distribution of professions for effective coverage and support for ongoing professional development, student placements and early career support.

## Recommendation 12 (Nursing and midwifery workforce)

### Support the role of nursing and midwifery in an integrated Australian primary health care system

*This recommendation aims to better support the nursing and midwifery workforce to work to top of scope within the multidisciplinary team care environment.*

*This includes investigating and staged implementation of innovative funding and care models, workforce planning and distribution, collecting data and enabling development of local solutions to support access.*

#### 12. Actions to cover

- 12.1.**Workforce strategy:** Develop a national primary care nursing strategy.
- 12.2.**Incentivise primary health care nursing:** Use block and blended payments to increase the utilisation of and to reduce the funding disparity between primary health care and aged care nursing and other parts of the health sector.
- 12.3.**Models of care – nursing and midwifery:** Develop, evaluate and implement effective multidisciplinary service models for patients requiring nursing and midwifery services, with rapid scale-up of effective models. These should be locally co-designed to ensure they align and expand upon existing locally-available services.
- 12.4.**Scope of practice – nursing and midwifery:** Support fully utilising the appropriately trained and credentialed nursing and midwifery workforce to work within primary health care teams to top of scope, within integrated health pathways. This includes clearly defining a scope of prescribing capacity for nurses and midwives.
- 12.5.**Models of care – midwifery:** Support the best model of care for integrated midwifery services, including; identifying lead sites nationally; holistic review of existing maternity and neonatal models; workforce planning; discussions with all key stakeholders; and, investigation of international care models.
- 12.6.**Scope of practice/collaborative arrangements –Nurse practitioners (NPs):** Review collaborative arrangements and establish scope of practice and credentialing frameworks for NPs.
- 12.7.**Models of care – NPs:** Define current NP models of care and build into national nursing strategy. This includes integration of NPs into aged care and mental health care services.
- 12.8.**Integration and funding reform:** PHNs and State based funders should work together to pool and realign funding and integrate community health workers, including maternal and child health, child and community nurses into primary health care based on registered population numbers and demographics. This will require leveraging the NHRA Addendum 2020-2025.

**How the recommendation achieves the Quadruple Aim:**

- Patient experience of care will be improved by having access to well-qualified and experienced nurses and midwives who are supported to be continually engaged in quality improvement and ongoing education.
- Health of populations will be improved as nurses and midwives within local regions are supported to develop tailored responses and models of care to population health issues in line with proven international care models.
- Cost-efficiency of the health system will be improved as funding is pooled and realigned from more expensive care to effective community-based health programs based on registered population numbers and demographics.
- Work life of health care providers will be improved by enabling the development and rapid scale-up of effective service models that support a collaborative team environment. Providers will also be supported to engage in ongoing professional development within integrated health pathways with appropriate training, supervision and credentialing.

## Recommendation 13 (Broader primary health care workforce)

**Support and develop all appropriate workforces in primary health care to better support people, the existing health care workforce and achieve an integrated, coordinated primary health care system**

*This recommendation aims to recognise the changing environment within which health care services are delivered and how people receive person-centred, culturally competent and evidence-based care. It aims to support the working life of health professionals and streamline system efficiency with accessible workforces for people, while embracing safe and quality services provided by new professions.*

### 13. Actions to cover

- 13.1. **Role and scope of all health professionals:** Recognise the role and scope of practice of all health professionals who contribute to primary health care, including practitioners who are Australian Health Practitioner Regulation Agency (AHPRA) registered and others who are self-regulated in line with the standards of the National Alliance of Self Regulating Health Professions (NASRHP). This should include confirmation of a nationally endorsed list of primary health professions.
- 13.2. **Non-traditional workforces:** Recognise, identify and support the broader non-traditional and emerging workforces involved in primary health care relevant to individual community need. Introduce training and support, with defined work titles, descriptions, roles and responsibilities to ensure safety of care for people and to protect unregulated health care workers from exploitation.
- 13.3. **Regulatory frameworks:** Ensure there are regulatory frameworks in place for all primary care workforces. This workforce may include:
  - **Health assistance:** Existing health assistant workforce – includes allied health assistants, assistants in nursing, personal care workers in aged care, mental health peer workers and disability support workers.
  - **Administrative:** Administrative, management roles and basic level clinical support roles, for example medical practice assistants (MPAs).
  - **Unregulated:** Other unregulated health care workers, particularly in the aged care sector.
  - **Traditional:** Traditional workforces, for example traditional Indigenous healers.
  - **Patient support workers:** Patient support roles, including translators, health coaches, social prescribing link workers, service coordinators/care finders, digital navigators and peer support workforce, particularly in mental health support and in the community.

**How the recommendation achieves the Quadruple Aim:**

- Patient experience of care will be improved by having access to the wide range of traditional, non-traditional and emerging workforces that provide safe and high quality services that support greater access to person-centred and holistic care.
- Health of populations will be improved by embracing the changing environment of health care services and how they are delivered to enable people to receive person-centred, culturally competent and evidence-based care for all population groups.
- Cost-efficiency of the health system will be improved as health professionals and the non-traditional workforce collaborate to streamline service provision and deliver efficient health care.
- Work life of health care providers will be improved as traditional providers are supported by a highly trained assistance workforce, and are able to facilitate better coordination of care and outcomes for patients by utilising the wide range of traditional and non-traditional professionals involved in care.

## Recommendation 14 (Medical primary care workforce)

**Support, streamline and bolster the role of GPs (which includes Rural Generalists) in leading and coordinating care for people, while building and ensuring a sustainable and well supported medical primary care workforce**

*This recommendation aims to encourage and facilitate greater supply and better distribution and retention of primary care medical practitioners, including in rural and remote areas.*

### 14. Actions to cover

- 14.1. **Supply:** Secure training pipeline for primary care, including GPs and rural generalists.
  - 14.1.1. **Incentivise primary health care medicine:** Promote primary health care as an attractive career pathway and foster greater mentorship in general practice and rural generalist medicine, particularly rural and remote practice. This should include in undergraduate courses and prevocational training.
  - 14.1.2. **Recognise rural generalist medicine:** Recognise rural generalist medicine as a specialty within the specialty of general practice.
  - 14.1.3. **Invest in primary health care medicine:** Invest in primary health care to reduce the financial pressure on the viability of private general practice and address the income divide between GPs and non-GP specialists.
  - 14.1.4. **Increased scope in rural and remote:** Recognise the increased scope of practice for the rural and remote primary care medical workforce through the MBS.
  - 14.1.5. **Research and teaching role models:** Support more primary care research and teaching role models for medical students, including role models working in rural and remote areas.
- 14.2. **Distribution:** Optimise distribution of general practice and rural generalist services.
  - 14.2.1. **Greater planning:** Develop more accurate supply and demand projections and increase supply of rural and remote training posts and student placements.
  - 14.2.2. **Training pipeline:** Establish an integrated medical training pipeline — based on student selection with a focus on rural origin; early and continuing exposure to rural practice; and vocational training based in rural area.
  - 14.2.3. **Supervision and supports:** Tailor supervision and supports for rural, remote and Indigenous training models.
  - 14.2.4. **Community supports:** Improve community readiness, including professional and family support for people in rural practice.
- 14.3. **Retention:** Retain and support primary care medical services, including private general practice, ACCHOs and other services providing primary care in rural and remote areas.
  - 14.3.1. **Rural Generalists:** Promote and support rural generalists as clinicians with the skills and competencies to commit to ongoing continuity of care models in rural and remote communities, providing leadership in multidisciplinary teams and understanding the specific health needs in that community.
  - 14.3.2. **Locum services:** Provide sustainable and quality locum services for rural and remote GPs and rural generalists by supporting adequate upskilling requirements and investigating appropriate social support and other incentives.
  - 14.3.3. **Fly-in fly-out workforce:** Support rural and remote primary health care services to develop and maintain appropriately trained fly-in fly-out (FIFO) workforce as temporary workforce filling where permanent residential appointment has proven difficult.



- 14.4. **Best practice support:** Enhance adjacent medical workforces and auxiliary aids in supporting the primary care medical workforce.
- 14.4.1. **Connectivity:** Improve connectivity with broader care team (digital and virtual technology, data).
- 14.4.2. **Decision support:** Improve clinical decision support.
- 14.4.3. **Teamwork:** Build the capacity of primary care medical working teams in order to achieve the Quadruple Aim.
- 14.4.4. **Inter-professional education:** Include inter-professional education at a range of levels such as undergraduate education and vocational training.
- 14.4.5. **Flexible employment:** Promote flexible employment models and working arrangements. Promote flexibility within and across practices (e.g. job sharing), locations (e.g. regional and remote) and sectors (private general practice, ACCHOs, public clinics, hospital, university [academic/teaching]).
- 14.5. **Development opportunities:** Promote evaluation, development and continuous quality improvement.
- 14.5.1. **Self-benchmarking and quality improvement:** Facilitate data driven self-benchmarking and quality improvement.
- 14.5.2. **Digital support:** Support the primary care medical workforce to deliver holistic care with digital means that support, accurate and up to date health pathways.
- 14.6. **Concurrent reform:** Align with direction of the National Medical Workforce Strategy, the National Mental Health Workforce Strategy and the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework (2016-2023).

#### **How the recommendation achieves the Quadruple Aim:**

- Patient experience of care will be improved by having access to highly trained and experienced GPs and rural generalists who are supported to be continually engaged in quality improvement and ongoing education.
- Health of populations will be improved by long term engagement of GPs and rural generalists within local regions who are supported to develop tailored responses to population health issues locally and regionally.
- Cost-efficiency of the health system will be improved by supply and retention of GPs and rural generalists, ensuring the viability of general practice and supporting localised health care that keeps people well and out of hospital.
- Work life of health care providers will be improved as the role of GPs and rural generalists are valued, recognised and supported as a sustainable career choice, with more support for development opportunities. Work life will be improved as providers work within a collaborative and supportive team environment with flexible employment and working arrangements, even distribution of professions and locum support for effective coverage.

## Innovation and Technology

### Recommendation 15 (Digital infrastructure)

#### Develop digital infrastructure and clinical systems to better support providers to deliver safe and effective care

*This recommendation aims to better support delivery of best-practice multidisciplinary team care through clinical decision support mechanisms and a digital infrastructure that better connects the primary health care workforce.*

*This includes, but is not limited to My Health Record, clinical information systems, clinical decision support, health pathways and shared care planning.*

#### 15. Actions to cover

- 15.1.**Interoperable infrastructure:** Develop interoperable secure digital infrastructure across the health sector to support team-based care, and connect services to improve transitions of care for people. This includes across primary and tertiary care, including general practice, specialist, allied health and pharmacy.
- 15.2.**Integrated clinical systems:** Develop integrated clinical systems to enable and support best practice clinical decision making, with real-time data collection and use.
- 15.3.**Workforce digital readiness:** Build capacity of primary health care to expand and use digital infrastructure and developing clinical systems, including multidisciplinary providers, administrators and managers.
- 15.4.**Consumer digital readiness:** Support digital readiness for people to embrace technology and digital modes of delivering care, as an adjunct to face to face services, including in relation to trust, social licence and capture of data. Provide additional resources and supports for people, where required, to support equitable access to data and digital modes of care for disadvantaged populations.
- 15.5.**Multidisciplinary communication:** Promote meaningful use of secure messaging between providers to improve care access and quality, including when telehealth consultations.

#### How the recommendation achieves the Quadruple Aim:

- Patient experience of care will be improved through access to modern technology and the capacity to receive interactive clinical services via effective integrated digital infrastructure.
- Health of populations will be improved by data and digital modes of care that inform and enable effective health pathways and shared care for all population groups.
- Cost-efficiency of the health system will be improved by effective data capture and interoperable secure digital infrastructure to support team-based care and improved transitions of care.
- Work life of health care providers will be improved by being able to provide best practice clinical care with improved communication with other providers and patients. Enhanced technology and secure digital infrastructure will support clinical decisions that enable providers to continually improve services whilst maintaining clinical autonomy.

## Recommendation 16 (Care innovation)

**Enable a culture of innovation to improve care at the individual / population level, build ‘systems’ thinking and ensure application of cutting-edge knowledge and evidence.**

*This recommendation aims to support primary health care providers to innovate with new ways of working and use of developing technologies, better supporting future-focused, holistic, person-centred care. Digital health, precision-medicine and care delivery innovation is progressing at an ever-increasing speed globally – Australia’s primary / community care sector should be ready to identify, adapt and translate relevant innovation as quickly and effectively as possible.*

*This includes building on current reform in telemedicine, secure messaging, My Health Record, care pathways, remote monitoring, point of care testing and genomics, and integrating innovation with other relevant sectors.*

### 16. Actions to cover

- 16.1. **Research translation and innovation body:** Create an Australian National Institute for Primary Health Care Research Translation and Innovation, responsible for tracking and sharing cutting edge, translatable innovation at national and international level, relevant to primary / community care. This should include mechanisms to involve stakeholders in identifying the problems to be addressed, and co-designing evidence-based innovation to address them (see recommendation 18).
- 16.2. **Support modern ways of working:** Encourage and enable new ways of working and advances in care through use of up to date technology, genomics and precision medicine, with a focus on improving equity in health outcomes and access to safe and quality services.
- 16.3. **Education and training:** Support peaks, education institutions and professional organisations to develop education, training and continuing professional development (CPD) resources to equip primary health care providers, including allied health primary care providers, to use up to date technology in line with preferences of people and communities.
- 16.4. **Process for continuous quality improvement:** Establish a continuous review process that can identify and fund innovation that has improved health outcomes and equity for people and communities in priority areas.
- 16.5. **Concurrent reform:** Align with directions from the new National Digital Health Strategy and recommendations 17 and 18 to ensure consistency.

#### **How the recommendation achieves the Quadruple Aim:**

- Patient experience of care will be improved by receiving innovative and holistic clinical care that is personalised and cutting edge, supporting them to achieve their health goals.
- Health of populations will be improved by shared innovation in care modalities that are able to be adapted and translated to support positive and equitable health outcomes in a wide variety of populations.
- Cost-efficiency of the health system will be improved by implementing processes which are able to identify and fund innovation that improves health outcomes and equity for people and communities in priority areas, reducing the requirement for secondary and tertiary care.
- Work life of health care providers will be improved through greater support and encouragement to utilise innovative ways of working and developing technologies which will allow them to provide future-focused, holistic and person-centred care.

## Research, data and continuous improvement of value to people, population, providers and the health system

### Recommendation 17 (Data)

#### Support a culture of continuous quality improvement with primary health care data collection, use and linkage

*This recommendation aims to support a culture of quality improvement through primary health care data collection, linkage and quality use that enables local and national level analysis of current health care services.*

*This will provide insights into how the system and providers can better support end-users and contribute towards improving provider and consumer experience.*

#### 17. Actions to cover

- 17.1. **Standardisation:** Build and report on standardised, minimum regional and national data assets with clean, quality and coded data.
- 17.2. **Integration and use:** Integrate, link and use data across the life course, including between providers and across health and care systems. This will require clinical and consumer governance and leadership over data that produces quality outcomes and enables continuous quality improvement.
- 17.3. **Equipped workforces:** Bolster capacity and provide additional supports for providers and practice managers to use their data to continuously improve their services for people.
- 17.4. **Patient reported measures:** Bolster use and utilisation of patient reported measures across the health care system to improve patient outcomes and experiences of care.
- 17.5. **Redirected funding based on data:** Redirect funding to address population health needs and support services that improve patient outcomes based on collected, nationally consistent and comparable data (incl., workforce, services, prevention etc.). This redirection should be enabled at a practice, local, regional and national level, in line with one-system focus (recommendation 1 and 3).
- 17.6. **Consumer information:** Educate consumers about their rights, as well as complaint and feedback processes.

#### How the recommendation achieves the Quadruple Aim:

- Patient experience of care will be improved as their feedback is recorded, reported and acted upon to continually improve their health outcomes and experiences of care.
- Health of populations will be improved by utilising data to continuously improve services and ensure that consumers are engaged in the governance and decision making that informs the priority of population health needs.
- Cost-efficiency of the health system will be improved through utilisation of data that is nationally consistent and comparable, supporting redirection of funding towards services that are proven to improve patient outcomes.
- Work life of health care providers and practice managers will be improved as they have access to, and are able to use their own quality data to continuously improve their services for people.

## Recommendation 18 (Research)

### Empower and enable contextually relevant, translational and rapid research and evaluation in primary health care, addressing questions directly relevant to service delivery in localised context

*This recommendation aims to support the highest quality health outcomes through targeted investment in translational research relevant to end-users of the health system.*

*This will provide insight and information on major issues impacting upon health and wellbeing of people and support sustained and effective system and funding reform. Through these actions the primary health care workforce will be empowered and enabled to develop research skills to answer clinical and community questions, as well as developing career pathways in primary health care.*

#### 18. Actions to cover

- 18.1. **Research translation and innovation body:** Target investment in translational research relevant to end-users of the health system by creating a single body (an Australian National Institute for Primary Health Care Research Translation and Innovation) to guide and support health services research to support evidence-based innovation. This should provide insight into how Australian health care can best benefit people and communities and include a specific amount of dedicated funding for research in relation to rural and remote areas.
- 18.2. **Framework for priorities and translation:** Enable flexibility and agility in research priorities over time and to inform any future policy changes or implementation. This should involve a framework with strategic principles for both developing research questions and translation of research into practice.
- 18.3. **Primary health care research capacity:** Build capacity and capability for research in primary health care and enable research and evidence to be translated into practice, with rapid scale up where appropriate, including:
  - 18.3.1. **Governance framework:** Reinstate a national governance framework to guide the most practically relevant research and its translation into primary health care practice, based on the framework that already exists from the Primary Health Care Research Education and Development Strategy that operated from 2000 to 2014. This will require dedicated, substantial funding and should link with broader reform intentions in the NHRA Addendum 2020-2025.
  - 18.3.2. **Practice-based research networks:** Support practice-based research networks to reduce fragmentation and improve collaboration across sectors, including introduction of clinician academic positions for allied health professions and nursing in line with medical professions.
  - 18.3.3. **Collaboration:** Use the National Institute to improve coordination, collaboration and translation of research through knowledge-based exchange and networking, to help bridge the gap between research creation and research use, supporting rapid scale up and expansion of effective services. This includes fostering collaboration between people and communities, primary health care workers, academics, clinicians, health executives and policymakers.
  - 18.3.4. **PHN and ACCHO facilitation:** Consider how research can be supported and facilitated through PHNs and regional ACCHOs, with clear governance and direction provided in relation to research. This will involve academic partnerships, and should include research co-creation, and development of strategies to enable relevant new concepts and models of care to be tested, as well as enhancing what

is already established. These partnerships should include clear expectations about the type and quality of research required.

- 18.3.5. **Workforce capability and opportunities:** Bolster research capabilities of primary health care workforce across all professional groups and develop research leaders through fellowships, research grants, PhDs, mentorships and greater recognition of research experience as professional development.
- 18.3.6. **Role models:** Directly link research to teaching and interested practices where relevant, building on primary health care research and teaching role models.
- 18.3.7. **Data return:** Research teams should report back to communities where research has been conducted to enable community members to benefit from the research findings.

**How the recommendation achieves the Quadruple Aim:**

- Patient experience of care will be improved as research in primary health care is translated into practice quickly and they receive proven treatments that achieve more positive health outcomes.
- Health of populations will be improved by coordinated management and targeted investment for research that is relevant for high priority population groups. This increased research capacity will support rapid upscaling and expansion of effective services.
- Cost-efficiency of the health system will be improved by enabling new concepts and models of care to be tested that are relevant to patients or population groups. Innovation is encouraged through targeted investment as well as enhancement of proven established models.
- Work life of health care providers will be improved through the development of research skills to enable them to more effectively answer clinical and community questions and achieve better health outcomes for their patients. There will also be increased career pathways in primary health care linked to research opportunities, with research experience recognised as professional development.

## Emergency preparedness

### Recommendation 19 (Primary health care in national and local emergency preparedness)

**Deliver nationally coordinated emergency preparedness and response, defining Commonwealth, State and Territory roles and boosting capacity in the primary health care sector**

*This recommendation aims to better support and coordinate emergency preparedness and response to respond to local needs and utilise all available resources, including workforces and local services.*

#### 19. Actions to cover

- 19.1. **Commonwealth/State responsibilities:** Define Commonwealth and State roles, including consideration of lessons learnt from COVID-19 pandemic, nationally and regionally. This includes defining the role of PHNs and regional ACCHOs and enabling flexible practicality in a crisis to enable primary health care providers to continue delivering services. ACCHOs need to be front and centre in these discussions given the successful pivotal role they have played to date protecting Aboriginal and Torres Strait Islander people from the potentially catastrophic impact of the COVID-19 pandemic on communities and in relation to other natural disasters, including bushfires.
- 19.2. **Commitment to Closing the Gap:** Deliver on the commitment in the National Agreement on Closing the Gap to engage with Aboriginal and Torres Strait Islander representatives, before, during, and after emergencies such as natural disasters and pandemics to make sure that government decisions take account of the impact of these decisions on Aboriginal and Torres Strait Islander people and that Aboriginal and Torres Strait Islander people are not disproportionately affected and can recover as quickly as other Australians from social and economic impacts.
- 19.3. **Frameworks for local integrated solutions:** Develop frameworks, partnerships and plans that integrate health care providers from across sectors to produce local solutions, particularly defining the role of primary health care providers, including GPs, nursing, allied health, mental health first responders and pharmacy.
- 19.4. **Awareness and availability of current plans:** Increase awareness and availability of current plans, including national, local and practice-based.
- 19.5. **Allied health roles in emergency response:** Develop in conjunction with the allied health sector a national disaster and emergency response plan that outlines key allied health and care roles needed by the community, including in-home supports for older people and people with disability, ensuring continuous availability and appropriate planning is undertaken by governments.
- 19.6. **Primary health care during emergency response:** Bolster use of local primary health care resources during emergencies and maintain or improve consistent access to allied health services required by older people, people with chronic and complex conditions and people with disability.
  - 19.6.1. **Primary health care in disaster management:** Develop arrangements that facilitate greater inclusion of primary health care providers in disaster management, including representation on relevant disaster committees and plans and providing training, education, and other supports.
  - 19.6.2. **Response networks:** Implement and expand rural emergency response networks (RERN), building on RERNs currently in Australia and lessons learned from international experience.



- 19.7. **Mature PHNs and partnerships:** Boost capacity and capability of the primary health care sector for emergency preparedness and response, including maturing of PHNs and jurisdictions to develop nationally consistent partnerships and appropriate resource provision and communication through emergency preparedness and response.
- 19.8. **Mental health services during disaster recovery:** Bolster connection with mental health service providers following disasters.
- 19.8.1. **Local planning and delivery:** Refine arrangements to support localised planning and delivery of appropriate mental health services during the recovery phase of a disaster.
- 19.9. **Data:** Enhance health and mental health datasets to measure and share health impacts related to disasters, including mental health impacts both immediately and through the recovery phase.

**How the recommendation achieves the Quadruple Aim:**

- Patient experience of care will be improved through continued access to health and mental health services during and post emergencies and disasters.
- Health of populations will be improved by the integration and collaboration of health care providers to support regional and local access, as well as an increased awareness of services available to specific populations.
- Cost-efficiency of the health system will be improved as PHNs and jurisdictions develop nationally consistent partnerships to ensure resource provision and funding measures are effectively and efficiently implemented locally, regionally and nationally. Sharing of data and analysis will support improved forward planning for recovery of health and community services.
- Work life of health care providers will be improved as emergency planning and resources are facilitated through local and regional partnerships that understand the community's needs. Providers will be supported and enabled to continue delivering services and ensuring community access to required clinical services during and after emergencies.



## Implementation is integral to effective reform that delivers on the Quadruple Aim

### Recommendation 20 (Implementation)

- Ensure there is an **Implementation Action Plan** developed over the short, medium and long-term horizons.
- Ensure consumers, communities, service providers and peak organisations are engaged throughout implementation, evaluation and refinement of primary health care reform.

*This recommendation covers the required governance structure for evaluating and refining the implementation of primary health care reform with continuing sector involvement, including consumers, communities, services providers and peak organisations. It includes, scope/nature/design of the implementation plan, suggested immediate priorities, and how monitoring, evaluation and refinement should take place in a staged and step-wise approach.*

*It needs to have regard to the links between primary health care reform and other plans, strategies, reviews, Government decision-making and cross-jurisdictional actions that depend on or have a downstream impact on the continuing effectiveness and value of primary health care in Australia. This includes for individuals, families, carers and communities, and their service providers, considering the contribution primary health care can make to the continued efficiency of the health system and social care.*

#### 20. Actions to cover

- 20.1. **Independent oversight group:** Establish an independent oversight group to provide advice on stepped implementation, prioritisation, evaluation and refinement of the 10 Year Plan. Representatives on this group should include consumers, relevant health sector bodies, government representatives from the Commonwealth, States and Territories and independent expert advisors.
- 20.2. **Implementation, evaluation and refinement:** Introduce transparent processes for implementation, evaluation and refinement. Evaluation should be independent and accountable, with staged and prioritised implementation and refinement over time. It should align with other cross-jurisdictional commitments and reform priorities, including the NHRA Addendum 2020-2025 and the new National Agreement on Closing the Gap.
- 20.2.1. **Implementation Plan:** Co-design a stepped Implementation Action Plan with specific, measurable, achievable, realistic goals with specified timeframes.
- 20.2.2. **Monitoring and Evaluation Framework:** Co-design a Monitoring and Evaluation/Research Framework for the 10 Year Plan, with accountabilities assigned. Progress should be continually monitored by the oversight group, structured around short-, medium- and long-term timeframes and measured against progress towards its objectives in line with the Quadruple Aim, particularly equity of access in rural, remote and Aboriginal and Torres Strait Islander communities. Evaluation should use a variety of performance measures, including patient reported measures, broader health outcomes and costs data, along with qualitative data from consumer and provider feedback. This framework should enable the ability to evaluate systems change and cease services where appropriate.
- 20.2.3. **Collaboration:** Collaborate closely with and ensure ongoing involvement of the broad range of leadership, institutions and organisations across the health sector, including:
- Users of health services;

- Relevant professional bodies;
- Researchers;
- Community-based bodies, such as ACCHOs;
- Private health care providers;
- Associated agencies, like the AIHW, the Australian Digital Health Agency and the Australian Commission on Safety and Quality in Health Care (ACSQHC);
- All bodies with a role in education and training of the primary health care workforce;
- The national network of PHNs; and,
- States and Territories, through the NHRA and other cross-jurisdictional commitments.

20.3. Implement the building blocks for reform over the next ten years, including:

- 20.3.1. **Investment:** Increase investment in primary health care;
- 20.3.2. **VPR:** To have offered all Australians VPR with a general practice, ACCHO, or rural multipurpose health centre, allowing access to a single health and care destination coordinating prevention and care delivery;
- 20.3.3. **Formalised regional planning and governance:** Require all PHNs and LHNs to have formalised regional planning and funds pooling governance agreements in place to create a united focus on integrated care delivery and unlock meaningful sharing of resources, and reduced service duplication and fragmentation;
- 20.3.4. **Data collection and use:** Develop and measure, in association with peak bodies, service data collection and meaningful use across settings and the care continuum;
- 20.3.5. **Health literacy:** Scope and develop a primary health care consumer health literacy and self-management support program; and,
- 20.3.6. **Research:** Develop the specifications for an Australian Institute for Primary Health Care Research Translation and Innovation.

# Appendices

## Abbreviations

<b>AAPM</b>	Australian Association of Practice Management
<b>ACCHO</b>	Aboriginal Community Controlled Health Organisation
<b>ACRRM</b>	Australian College of Rural and Remote Medicine
<b>ACSQHC</b>	Australian Commission on Safety and Quality in Health Care
<b>AHPA</b>	Allied Health Professions Australia
<b>AHPRA</b>	Australian Health Practitioner Regulation Agency
<b>AIHW</b>	Australian Institute of Health and Welfare
<b>AMA</b>	Australian Medical Association
<b>CALD</b>	Culturally and Linguistically Diverse
<b>COAG</b>	Council of Australian Governments
<b>CPD</b>	Clinical Professional Development
<b>FIFO</b>	Fly-in fly-out
<b>GP</b>	General Practitioner
<b>LGBTI+</b>	Lesbian, gay, bisexual, transgender, intersex, queer and other sexuality, gender and bodily diverse people
<b>LHN</b>	Local Health Network
<b>MBS</b>	Medicare Benefits Schedule
<b>MPA</b>	Medical practice assistants
<b>MSAC</b>	Medical Services Advisory Committee
<b>NASRHP</b>	National Alliance of Self Regulating Health Professions
<b>NDIS</b>	National Disability Insurance Scheme
<b>NHRA</b>	National Health Reform Agreement
<b>NP</b>	Nurse Practitioner
<b>OECD</b>	Organisation for Economic Co-operation and Development
<b>PBAC</b>	Pharmaceutical Benefits Advisory Committee
<b>PHI</b>	Private Health Insurance
<b>PHN</b>	Primary Health Network
<b>PREMs</b>	Patient Reported Experience Measures
<b>PROMs</b>	Patient Reported Outcome Measures
<b>RACGP</b>	Royal Australian College of General Practitioners
<b>RACCHO</b>	Rural Area Community Controlled Health Organisation
<b>RERN</b>	Rural Emergency Response Networks
<b>RFDS</b>	Royal Flying Doctor Service
<b>VPR</b>	Voluntary Patient Registration

## Definitions

Where appropriate, glossary definitions from external sources have been adapted to fit the context of the Primary Health Reform Steering Group draft recommendations.

Definitions	Description
<b>Aboriginal Community Controlled Health Organisations (ACCHOs)</b>	A primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive and culturally appropriate health care to the community which controls it, through a locally elected Board of Management.
<b>Allied Health Services</b>	Allied health encompasses a broad range of health professions, who are not doctors or nurses, working in a range of settings, including primary care, to improve community health and wellbeing.
<b>Blended Funding</b>	Blended funding encompasses a combination of different funding sources and mechanisms.
<b>Block Funding</b>	Block funding is population-based funding of service providers based on the population served and the health needs of the community. The payments are paid in a lump sum on a periodic basis.
<b>Bundled Payments</b>	Bundled payments describe a method of payment where services, or different elements of care, are grouped together into one payment.
<b>Chronic Conditions</b>	<p>Various terminology is used to describe chronic health conditions, including 'chronic diseases', 'non-communicable diseases', and 'long-term health conditions'. The term 'chronic conditions' encompasses a broad range of chronic and complex health conditions across the spectrum of illness, including mental illness, trauma, disability and genetic disorders.</p> <p>Chronic conditions:</p> <ul style="list-style-type: none"> <li>• have complex and multiple causes;</li> <li>• may affect individuals either alone or as comorbidities;</li> <li>• usually have a gradual onset, although they can have sudden onset and acute stages;</li> <li>• occur across the life cycle, although they become more prevalent with older age;</li> <li>• can compromise quality of life and create limitations and disability;</li> <li>• are long-term and persistent, and often lead to a gradual deterioration of health and loss of independence; and</li> <li>• while not usually immediately life threatening, are the most common and leading cause of premature mortality.</li> </ul>
<b>Closing the Gap</b>	<p>The objective of the Closing the Gap Agreement is to overcome the entrenched inequality faced by too many Aboriginal and Torres Strait Islander people so that their life outcomes are equal to all Australians. Improvements to the lives of Aboriginal and Torres Strait Islander people occurred under the Council of Australian Governments' (COAG) National Indigenous Reform Agreement (NIRA), known as Closing the Gap, starting in 2008. In July 2020 a new Agreement made by a Coalition of Aboriginal and Torres Strait Islander Peak Organisations, and all Australian Governments took effect. Primary health will contribute to achieving 3 socio-economic outcomes:</p> <ul style="list-style-type: none"> <li>• Outcome 1: Aboriginal and Torres Strait Islander people enjoy long and healthy lives.</li> </ul>

Definitions	Description
	<ul style="list-style-type: none"> <li>• Outcome 2: Aboriginal and Torres Strait Islander children are born healthy and strong.</li> <li>• Outcome 14: Aboriginal and Torres Strait Islander people enjoy high levels of social and emotional wellbeing.</li> </ul>
<b>Culturally and Linguistically Diverse People (CALD)</b>	Culturally and linguistically diverse people describes and reflects people from a diverse range of cultural and linguistic backgrounds. The Australian Bureau of Statistics indicate the CALD population by country of birth, languages spoken at home, English proficiency, cultural heritage and religious affiliation.
<b>Determinants of health (also social determinants of health)</b>	Determinants of physical and mental health are factors that influence how likely people are to stay healthy or to become ill or injured. The Australian Health Performance Framework identifies: health behaviours; personal biomedical factors; environmental factors; and socio-economic factors.
<b>Fee For Service</b>	Fee for Service is an Australian primary health care funding method that pays for individual services through patient benefits and out-of-pocket payments (e.g. MBS), typically transactionally based on single episodes of service.
<b>Genomics</b>	Genomics is the study of genes and their functions, and related techniques. Genomics addresses all genes and their interrelationships to identify their combined influence on the growth and development of the organism.
<b>Health Care Home (HCH)</b>	The HCH program was developed for patients with chronic and complex conditions to create a home base where a shared care plan is developed and implemented by a team of health care providers. A Health Care Home is an existing general practice or ACCHO that provides comprehensive primary health care, in the one place.
<b>Health coaching</b>	Health coaching is the practice of health education and health promotion within a coaching context to enhance the well-being of individuals and to facilitate the achievement of their health-related goals
<b>healthdirect</b>	healthdirect Australia is a national, government-owned, not-for-profit organisation supporting Australians in managing their own health and wellbeing through a range of virtual health services. Their role is to work in partnership with federal, state and territory governments to help address key priorities and challenges across health, ageing and social service sectors.
<b>Health literacy</b>	Health Literacy refers to the ability of people to access, understand and apply information about health and the health care system so as to make decisions that relate to their health.
<b>Health Pathways</b>	Health Pathways is a web-based portal available for point of care use by clinicians to help make assessments and manage care across primary and specialist care, all in the local context. Health jurisdictions and bodies like PHNs tailor the content of Health Pathways to reflect local arrangements and opinion, and deploy their own instance of Health Pathways to their clinical community. It is designed for general practice teams, including allied health and other health professionals.
<b>Lived experienced</b>	Lived experience is the knowledge and understanding people get when they have lived through something. It can mean being family or a friend supporting someone. People with lived experience are considered experts on their lives and experiences. These insights of

Definitions	Description
	people brought together with the expertise, knowledge and skills of health practitioners focuses on needs of the people rather than on organisational or provider priorities.
<b>Medicare Benefits Schedule (MBS)</b>	Medicare is a national, government-funded scheme that subsidises the cost of personal medical services for all Australians and aims to help them afford medical care. The MBS is the listing of Medicare services subsidised by the Australian Government.
<b>My Health Record</b>	My Health Record is an online platform for storing the health information of individuals, including their Medicare claims history, hospital discharge information, diagnostic imaging reports and details of allergies and medications.
<b>Patient activation</b>	Patient activation is the process through which health providers engage or motivate a patient to play an active role in their own health and care. This is instead of the more traditional and passive role of being 'told what to do' by a health professional.
<b>Person centred</b>	Person-centred describes treatment, care and support that places the person at the centre and in control of the design and delivery of their own care and considers the needs of the person's carers and family. Also referred to as person-led care.
<b>Pharmaceutical Benefits Scheme (PBS)</b>	The PBS is a national, government-funded scheme that subsidises the cost of a wide variety of pharmaceutical drugs, covering all Australians, to help them afford standard medications. The PBS lists all the medicinal products available under the PBS and explains the uses for which subsidies can apply.
<b>Pharmacogenomics</b>	Pharmacogenomics is the study of genetic variations that play a role in our ability to metabolise and respond to drugs, both in terms of efficacy and toxicity. Testing assesses the type of response a patient may have to a particular drug. Testing before prescribing medication can provide information about the likely effectiveness or risk of side effects for the patient.
<b>Pooled funding</b>	Pooled funding combines one or more separate health funding streams going to various providers and brings them together into a single, flexible resource pool. Funds are generally distributed by a regional authority that has responsibility for purchasing and/or providing specified health services for the population in that area.
<b>Population health</b>	Population health is typically the organised response by society to protect and promote health and to prevent illness, injury and disability. Population health activities generally focus on: <ul style="list-style-type: none"> <li>• prevention, promotion and protection rather than on treatment</li> <li>• populations rather than individuals</li> <li>• the factors and behaviours that cause illness. It can also refer to the health of particular subpopulations, and comparisons of the health of different populations</li> </ul>
<b>Practice Incentives Program (PIP)</b>	The PIP supports general practices to make ongoing improvements to enhance capacity, improve access and provide quality health outcomes for patients.
<b>Precision medicine</b>	Precision medicine is a tailored approach to disease prevention and treatment that takes into account differences in people's genes, environments, and lifestyles. It is underpinned by genetic and genomic testing (sequencing), the results of which enable better prediction, prevention, diagnosis and treatment of disease.

Definitions	Description
<b>Preventive health</b>	<p>Approaches and activities aimed at reducing the likelihood that a disease or disorder will affect an individual, interrupting or slowing the progress of the disorder or reducing disability.</p> <p>Within this broad definition there are some more specific characterisations:</p> <ul style="list-style-type: none"> <li>• primary prevention, which reduces the likelihood of developing a disease or disorder</li> <li>• secondary prevention, which interrupts, prevents or minimises the progress of a disease or disorder at an early stage</li> <li>• tertiary prevention, which halts the progression of damage already done.</li> </ul>
<b>Primary Health Networks (PHNs)</b>	<p>Primary health care organisations established as part of the National Health Reform Agreement to coordinate primary health care delivery and address local health needs and service gaps. Their purpose is to drive improvements in primary health care and ensure that services are better tailored to meet the needs of local communities.</p>
<b>Risk factors</b>	<p>A risk factor is determinant that represents a greater risk of a health disorder or other unwanted condition or event. Some risk factors are regarded as causes of disease; others are not necessarily so.</p>
<b>Social prescribing</b>	<p>Social prescribing is 'a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services'.</p>

## Primary Health Reform Steering Group

The Steering Group was established as a time-limited body to provide independent expert advice to the Department of Health (the Department) on the development of the 10 Year Plan and the implementation of the VPR measure for Australians.

The Steering Group is advisory in nature and is not a decision-making or funding body. The final decisions on these reforms rests with the Commonwealth Minister for Health.

The Steering Group met 16 times between October 2019 and June 2021 to discuss a range of themes and enablers and develop its advice to the Government. Members of the Steering Group also participated in the themed roundtable consultations relevant to their expertise.

### Steering Group membership

Name	Member
Dr Steve Hambleton	GP; Co-Chair of the Steering Group
Dr Walid Jammal	GP; Co-Chair of the Steering Group
Dr Tony Bartone (to July 2020) Dr Chris Moy (from October 2020)	Australian Medical Association
Dr Harry Nespolon (to July 2020) A/Prof Ayman Shenouda (July - October 2020) Dr Karen Price (from October 2020)	The Royal Australian College of General Practitioners
Dr Ewen McPhee (to October 2020) Dr Sarah Chalmers (from November 2020)	The Australian College of Rural and Remote Medicine
Dr Dawn Casey PSM	The National Aboriginal and Community Controlled Health Organisation
Ms Leanne Wells	The Consumers Health Forum of Australia
Ms Cathy Baynie	Australian Association of Practice Management
Ms Karen Booth	Australian Primary Health Care Nurses Association
Ms Gail Mulcair	Allied Health Professions Australia
Mr Phil Calvert	Australian Physiotherapy Association
Prof Claire Jackson	Professor in General Practice and Primary Care Research, The University of Queensland
Mr Adrian Carson	Chief Executive Officer, Institute for Urban Indigenous Health
Dr Gabrielle O’Kane	National Rural Health Alliance
Dr Leanne Beagley	Mental Health Australia
Dr Nigel Lyons	NSW Ministry of Health
Dr Allison Turnock	Tasmanian Department of Health



## Purpose of the Steering Group *(Terms of reference)*

The Steering Group is contributing to the development of the 10 Year Plan, including advising on scope and possible inclusions, by:

- Providing advice on major issues impacting on delivery of timely, quality, and efficient and personalised primary health care in Australia;
- Identifying opportunities for system and funding reform (including interface issues with other sectors, particularly aged care, disability, social care mental health and preventive);
- Identifying proposals for short, medium and long term reform options for consideration by Government;
- Identifying workforce and implementation issues and developing mitigation strategies; and
- Providing advice on consultation opportunities and approaches.








The Steering Group is also advising on the implementation of the voluntary patient registration measure, including on:

- Expected levels of service delivery to registered patients;
- Development and implementation of a compliance framework;
- Stakeholder engagement strategies, change management and associated communication activities;
- IT infrastructure changes required at the practice level to support the implementation of the measure; and
- Evaluation of the measure.

The advice is whole of systems focussed albeit dependent on opportunities that are within the remit of the Commonwealth.

## Framework for developing recommendations: objectives and enablers

The Steering Group used a framework for developing its recommendations, including a set of seven objectives for reform:

Objective	Aim
<b>Improving Access</b> 	<b>Equitable access to the best available primary health care services</b>
<b>Closing the gap</b> 	<b>Improve health outcomes for Aboriginal and Torres Strait Islander people</b>
<b>Keep people well in the community</b> 	<b>Manage people's health and wellbeing in the community</b>
<b>Continuity of care</b> 	<b>Support continuity of care across the health care system</b>
<b>Integration</b> 	<b>Support health system integration and sustainability</b>
<b>Future-focused</b> 	<b>Embrace new technologies and methods</b>
<b>Safety and Quality</b> 	<b>Support continuously improving safe and quality primary health care services</b>

These objectives are supported by six enablers to build the capacity of the health system and target actions for reform:

### Patients

Enhance patient activation, improve health literacy and shared decision-making.

### Funding Reform

Appropriate and sustainable funding reform that underpins the best models of care tailored to local circumstances.

### Workforce

A health workforce that works together, operating at top of scope and supported by education, training, and skills development.

### Innovation and Technology

Support innovation and new technologies to better manage care.

### Leadership and Culture

Foster leadership, inter-professional collaboration and co-design, and effective change management to ensure cultural shifts in the system.

### Research and Data

Support a systematic program of research, data development and evaluation to support continuous improvement and build systems that support consented, secure, and timely sharing of data across the health system to support service planning and resource allocation.

## Consultation process

The draft recommendations of the Steering Group have been informed by extensive consultations with patients lived experience of the health system, communities, researchers, providers, peak organisations and PHNs. More than 20 consultations have been held, with representatives from over 400 organisations.

### Consultation Group

The Steering Group drew on the views of a large Primary Health Reform Consultation Group to help test the coverage of the recommendations. The first meeting of the Consultation Group on 25 November 2019 comprised over 100 organisations and focused on the priorities for the future of primary health care reform in Australia.

### Targeted consultation

The Department, in consultation with the Steering Group, hosted targeted consultations on known issues and themes identified for consideration as part of the future focus of primary health care between October 2019 and December 2020. The consultation schedule was affected by COVID-19 during 2020, resulting in a four-six month delay. These roundtables included people with lived experience, academics, representatives from peak organisations (health and related sectors) and PHNs.

The topics and themes for the consultations included:

- A series of targeted roundtables with consumers.
- Rural and remote health, including a focus on support for the rural and remote primary health care workforce.
- Older Australians with a focus on improved health care services for older Australians whether living in residential aged care or in the community.
- People living with Dementia.
- Aboriginal and Torres Strait Islander health care including learnings from the Aboriginal Community Controlled Health Service model.
- After-hours care.
- General Practitioners (and a forum with General Practice Training Advisory Committee [GPTAC] - GPs in training and GP registrars).
- Primary Health Networks.
- Improving health care for people with disability.
- Improving the health care for people with intellectual disability.
- The role of nursing and midwifery in the primary health care system.
- The role of allied health providers in the primary health care system.
- First 2,000 days of life.
- Mental health care in primary health care settings.
- Preventive health in primary health care settings.
- The role of private health insurance in primary health care.
- The health needs of the LGBTI+ community.
- The health needs of people from CALD backgrounds.
- Practice Managers, practice leadership and culture.
- A future-focussed roundtable, with an emphasis on new technologies such as genomics, point of care testing, telehealth, screening, and other innovative technologies.

## Summary of themes from consultations

The key themes emerging from consultations were:

**Access:** Not all Australians have equitable access to primary health care, and not all Australians have equitable health outcomes. There should be a focus on actions or approaches to improve access to timely, affordable, and convenient primary health care, particularly for rural and remote communities, Indigenous Australians, older Australians (including in residential care) and other disadvantaged or marginalised groups. Access to GP services in the after-hours period is variable, particularly in rural areas, and concerns were raised regarding the ongoing viability of the medical deputising model. There is broad support for enhancing access through telehealth and embracing other technologies such as remote monitoring.

**Integration and person-centred care:** Concern was raised about the fragmented nature of the health system which can adversely impact the quality of, and experience of care for the patient. Consumers commented that the system is difficult for patients (and providers) to navigate and improving health literacy is important. Strong support exists for actions which improve integration, particularly the interfaces between primary health care and the hospital sector, palliative care, aged care, disability, mental health, and other social support services. Technology and data were identified as a key enabler for integration, particularly My Health Record and secure messaging and interoperability of software to allow for seamless transfer of clinical information across providers. Reform of funding models was also identified as an opportunity to drive integration.

**Funding models:** Funding for primary health care is complex with variable funding mechanisms. There was broad agreement that pure fee-for-service models do not encourage fully integrated care, provide limited incentives for flexible team-based care and reward throughput instead of value of care. There is support for more flexible funding approaches, including blended funding to support workforce collaboration amongst GPs, nurses, allied health professionals and others within the primary health care team and coordinated funding approaches across the primary, secondary and tertiary care sectors to support system integration.

**Workforce:** There is a need to address workforce maldistribution and shortages of GPs, allied health, and nursing providers in rural and remote areas. Locally driven workforce models and community solutions are favoured. There is broad agreement on the importance of maximising team-based care and for providers working at top of scope. ACCHOs were identified as a successful model incorporating multidisciplinary health teams, which supports well-integrated and coordinated care for patients.

**Prevention:** There is a continuing need for emphasis on cross sectoral work to address upstream health factors and social determinants of health, supporting prevention, early intervention, and the effective management of chronic conditions. There are multiple enablers that can support this, including funding reform to support effective care in the first 2,000 days, continuity of care, maximising the use of the allied health and nursing workforce and improving health literacy and health system literacy among patients, carers and the broader population.

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