

Report from the Primary  
Health Reform Steering Group

# **Recommendations on the Australian Government's Primary Health Care 10 Year Plan**

September 2021

# Contents

<b>Executive summary .....</b>	<b>3</b>
Building upon reform.....	4
Process for developing draft recommendations on primary health care reform .....	6
Concurrent reform .....	6
<b>Introduction.....</b>	<b>7</b>
Primary Health care .....	7
What is primary health care? .....	7
Providers of primary health care .....	7
What do consumers value about primary health care? What should they expect? .....	8
Why do we need a strong primary health care system and what does the ideal primary health care system look like? .....	9
What problem are we trying to solve?.....	9
Consultation on draft recommendations .....	10
What are we trying to achieve for a high performing primary health care system? .....	10
Advancing the Quadruple Aim .....	11
Effective implementation of primary health care reform .....	11
<b>Recommendations for primary health care reform .....</b>	<b>12</b>
Person-centred health and care journey, focusing on one integrated system .....	12
Recommendation 1 (One system focus): .....	12
Recommendation 2 (Single primary health care destination): .....	13
Recommendation 3 (Funding reform): .....	15
Recommendation 4 (Aboriginal and Torres Strait Islander health): .....	16
Recommendation 5 (Local approaches to deliver coordinated care): .....	17
Adding building blocks for future primary health care – better outcomes and care experience for all .....	18
Recommendation 6 (Empowering individuals, families, carers and communities): .....	18
Recommendation 7 (Comprehensive preventive care): .....	18
Recommendation 8 (Equitable access for people with poor access or at risk of poorer health outcomes): ..	19
Leadership and culture .....	19
Recommendation 9 (Leadership): .....	19
Primary health care workforce development and innovation .....	20
Recommendation 10 (Building workforce capability and sustainability): .....	20
Recommendation 11 (Allied health workforce): .....	21
Recommendation 12 (Nursing and midwifery workforce): .....	21
Recommendation 13 (Broader primary health care workforce): .....	22
Recommendation 14 (Medical primary health care workforce): .....	22

Innovation and technology.....	23
Recommendation 15 (Digital infrastructure): .....	23
Recommendation 16 (Care innovation): .....	23
Research, data and continuous improvement of value to people, population, providers and the health system .....	24
Recommendation 17 (Data): .....	24
Recommendation 18 (Research): .....	24
Emergency preparedness .....	25
Recommendation 19 (Primary health care in national and local emergency preparedness): .....	25
Implementation is integral to effective reform that delivers on the Quadruple Aim.....	25
Recommendation 20 (Implementation):.....	25

## How to implement the Steering Group's recommendations ..... 26

Overview of the pillars.....	27
Pillar 1 – One system focus .....	27
Pillar 2 – Equitable experience of evidence-based primary health care (person, family, carer, community) .....	32
Pillar 3 – Continuous quality improvement, safety and future focus across the system, for consumers and providers .....	36
Pillar 4 – Bolstering rural health.....	40
Pillar 5 – Aboriginal and Torres Strait Islander health.....	42
Pillar 6 – Health workforce.....	44

## Appendices..... 78

Appendix 1: Primary Health Reform Steering Group.....	78
Appendix 2: Consultation process.....	80
Appendix 3: Framework for developing recommendations: objectives and enablers .....	83
Appendix 4: Outline of related Australian Government strategies, plans and reports .....	85
Appendix 5: The principal providers in primary health care settings in Australia.....	87
Appendix 6: Case studies and examples .....	89
Appendix 7: Spectrum of payment models.....	99
Appendix 8: Abbreviations .....	100
Appendix 9: Definitions .....	102

## Executive summary

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

The Steering Group includes expert representatives from consumer, allied health, Aboriginal and Torres Strait Islander, medical, mental health, nursing, rural and remote health and practice management organisations, as well as from state and territory governments (See Appendix 1 for more information on the Steering Group).

The recommendations in this report have resulted from a comprehensive consultation process. The Steering Group has consulted widely with diverse populations, including those that experience health inequities, such as Aboriginal and Torres Strait Islander peoples, people with disability, older Australians, culturally and linguistically diverse people, and the lesbian, gay, bisexual, transgender, intersex, queer and other sexuality, gender and bodily diverse people (LGBTIQ+) community. The contribution of these groups has assisted the Steering Group to understand their experience. Health care organisations, peak bodies, researchers and state and territory governments were also consulted in the formation of the recommendations.

Primary health care is essential to improving health outcomes for everyone living in Australia. It is best placed to work with people in their communities to address the main causes of, and risk factors for poor health. It also has a role in combatting the emerging challenges and maximising opportunities for health care in the future. Further, the 2020 Organisation for Economic Co-operation and Development (OECD) report – *Realising the Potential of Primary Health Care*, found by reconfiguring the delivery of primary health care with multi-professional teams, equipped with digital technology, and seamlessly integrated with specialised care services, doctors, nurses, pharmacists and community health workers would be enabled to provide more effective care. Empowering patients and measuring how primary care services deliver results that truly make a difference to their lives are also key for the provision of high performing care<sup>1</sup>.

The Medical Benefits Schedule Review<sup>2</sup> recognised the importance of Primary Care. Australia's recent experience during COVID-19 has confirmed the critical importance of primary health care. The COVID-19 health response has also led to significant transformation in the delivery of health care in a short space of time. Some long-term reforms planned for the 10 Year Plan, such as the roll out of telehealth, have been implemented. These positive changes have reset the landscape for primary health care reform and reinforced the need, and opportunities, for further improvement and additional funding to complement the Medicare Benefits Schedule (MBS).

Into the future, as we learn to live with COVID-19, it is imperative that Australia repositions primary health care so it can build on the innovative practices employed during the COVID-19 pandemic and ensure their wider adoption as health systems move into the pandemic recovery phase. This will also be critical for making health systems more resilient to health crisis in the future.

This report includes 20 recommendations. The first recommendation 'One System' focuses on bringing Australia's health care system together to deliver care through one integrated system. Combined with the second recommendation 'a single primary health care destination', they support the development of Voluntary Patient Registration as a foundational step to primary health care reforms.

A whole-of-population model of VPR will preserve high quality telehealth in primary health care beyond COVID-19. VPR will provide the structure for system-wide reform that will support a shift from episodic care towards longitudinal, preventative, multi-disciplinary team based models of care.

VPR will provide a platform for coordinated, integrated and digitally enabled health care and for funding reform to minimise waste and improve the cost-effectiveness of the health system.

For Australian's using the health care system these reforms are intended to create person centred, primary care led health system that is easy to navigate, and underpinned by shared data, which is used to drive quality improvement, that both improves people and practitioners experience while reducing waste and informing resource allocation.

<sup>1</sup> OECD. *Realising the Potential of Primary Health Care*. Paris : OECD Health Policy Studies, OECD Publishing, Paris, <https://doi.org/10.1787/a92adee4-en>, 2020.

<sup>2</sup> Taskforce, Medicare Benefits Schedule Review. *MBS Review Taskforce – Final Report 2020*. 2020.

## Building upon reform

This report (and its recommendations) acknowledges and builds upon significant national policy work in primary health care reform over past decades. While 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<sup>3</sup> and the need to focus on population health, system integration and prevention, it is no longer fit for purpose. Without attention, particularly enhanced funding and more contemporary models of care, 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 reorientation 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 (ACCHs), 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 diversity of providers 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 health care at PHN/Local Health Network (LHN) level. Similar recommendations were also made by the Productivity Commission's 2017 *Shifting the Dial report*.
- The Medicare Benefits Schedule (MBS) Review<sup>4</sup> has identified a sharper focus on continuity of care and chronic disease management for primary health care.
- The Productivity Commission Inquiry into mental health and suicide prevention<sup>5</sup>, the Royal Commission into Victoria's Mental Health System and the Royal Commission into Aged Care Quality and Safety and the National Digital Health Strategy have also recognised how primary health care can enable improved health outcomes.

<sup>3</sup> Australian Institute of Health and Welfare. Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015. 2019.

<sup>4</sup> Taskforce, Medicare Benefits Schedule Review. *MBS Review Taskforce – Final Report 2020*. 2020.

<sup>5</sup> Productivity Commission. *Mental Health, Report no. 95*. Canberra

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 wellintegrated, appropriate, regional care models.<sup>6</sup>

As Australian's are experiencing longer lives and living with chronic diseases for longer, 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 health 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.

Contemporary models of care 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. ACCHs are a leading example of the benefits of working with local communities to co-design a fit-for-purpose health service.

Since their introduction as a core part of the architecture of Australia's health care system, ACCHs have been providing local community-led, comprehensive primary health care for Aboriginal and Torres Strait Islander people, while 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 Aboriginal and Torres Strait Islander communities, particularly when developing models of care that are equitable and promote and safeguard integrated, person-centred care, with minimised risk of fragmentation.

PHNs are an equally critical part of the health system landscape with capacity to evolve and mature – specifically to support collaborative commissioning and provide the flexibility to pursue progressive, localised responses to health care needs through service development, designed with local clinical and community input.

There are also many other exemplars of innovation and progressive models of care in Australia that include characteristics such as 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. Several examples are presented in the Productivity Commission report 'Innovations in Care for Chronic Health Conditions 2021'.<sup>7</sup>

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 endusers 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. Real change will require all levels of government, peak bodies, practitioners and people living in Australia to play a role in reshaping Australia's primary health system throughout its implementation.

<sup>6</sup> World Health Assembly, 69. (2016). Framework on integrated, people-centred health services: report by the Secretariat. World Health Organization. <https://apps.who.int/iris/handle/10665/252698> (accessed 17 September 2021)

<sup>7</sup> Productivity Commission 2021, *Innovations in Care for Chronic Health Conditions*, Productivity Reform Case Study, Canberra.

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

The Steering Group met twenty times between October 2019 and September 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 Appendix 2 for further information on consultation process).

In developing their recommendations, the Steering Group considered new models of primary health 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 Appendix 3 for further detail on objectives and enablers).

## Concurrent reform

The Steering group acknowledges there are reforms currently under way that are priorities within other planning and strategic documents. These reforms will make significant inroads to improve primary health care or provide the building blocks for the recommendations in this report.

The Steering Group recommends that primary health care reform should leverage and integrate with these current and ongoing reform priorities.

Appendix 4 provides a list of those strategies and agreements that the Steering Group has taken into account when shaping their recommendations in this report.

## Introduction

### Primary Health care

#### What is primary health care?

The 1978 World Health Organization (WHO) Declaration of Alma-Ata (the 1978 WHO Declaration) defined primary health care widely. The WHO Declaration considers primary health care to cover multiple aspects, including:

- Addressing the main health problems in the community (from preventive to rehabilitative services)
- Covering a range of essential health services (from health promotion to treatment of conditions)
- Involving and coordinating health and non-health sectors (including agriculture, housing, industry and others)
- Relying on both medical and non-medical health workers.<sup>8</sup>

In 2018 the 1978 WHO declaration was reaffirmed as part of the Declaration of Astana.

The Organisation for Economic Co-operation and Development (OECD) has characterised the value of primary health care as follows: As the first point of contact, primary health care that provides comprehensive, continuous, and co-ordinated care is key to boosting preventive care, treating those who need care, and helping people become more active in managing their own health.

It adds that effective primary health care can improve outcomes at a lower cost than for hospital and secondary care and helps to avoid unnecessary hospitalisations. Countries with strong primary health care systems have better health outcomes. Good primary care makes health system more efficient, for example by reducing rates of avoidable hospitalisations and unnecessary emergency department visits.

The OECD see the strengthening of primary health care as offering opportunities to make health systems more efficient, effective and equitable.<sup>9</sup>

#### Providers of primary health care

Primary health care providers respond to the needs of individuals, families, carers and communities. Embedded in local communities, providers cover the needs of people with diverse requirements and lived experiences. This entails meeting the needs of people who access episodic care, people with chronic conditions or with complex care needs and people at risk of poorer access or outcomes.

The mode and place of services can vary: health care, and connection to social care, can be provided in person or via telehealth or telemedicine and other types of virtual or remote service provision.

A variety of public and private providers cover access to community-based health care for people who are not admitted to hospital. It is delivered by Specialist General Practitioners together with a range of health professionals<sup>10</sup> with diverse skills and expertise, with scopes of practice that are discharged in a competent and ethical manner in line with service needs and organisational capability.

The principal providers in primary health care settings in Australia include Specialist General Practitioners and are detailed in at Appendix 5.

<sup>8</sup> World Health Organization, Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6-12, September 1978. See: [https://www.who.int/docs/default-source/documents/almaata-declaration-en.pdf?sfvrsn=7b3c2167\\_2](https://www.who.int/docs/default-source/documents/almaata-declaration-en.pdf?sfvrsn=7b3c2167_2) (accessed 17 September 2021)

<sup>9</sup> OECD (2020), Realising the Potential of Primary Health Care, OECD Health Policy Studies, OECD Publishing, Paris, <https://doi.org/10.1787/a92adee4-en> (accessed 17 September 2021)

<sup>10</sup> 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).



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

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

The Steering Group's view is that in ten years consumers will be able to say all of the following.

<ul style="list-style-type: none"> <li>• My health care team listens to and understands what matters to me, develops a care plan in collaboration with me and my family and carers, and supports me to live the life I want to the best of my ability</li> </ul>
<ul style="list-style-type: none"> <li>• I access my chosen primary health care service and its multidisciplinary team acts in a coordinated manner to provide care, treatment and service coordination with others involved in my care</li> </ul>
<ul style="list-style-type: none"> <li>• My primary health care service recognises that factors other than health care plays a role in my health and wellbeing and takes that into account in my care plan</li> </ul>
<ul style="list-style-type: none"> <li>• I am shown how to use new kinds of services and I am supported to use them until I am confident</li> </ul>
<ul style="list-style-type: none"> <li>• My treatment journey records (e-records) are available for my care team to access with my consent so that I don't have to repeat my whole story every time</li> </ul>
<ul style="list-style-type: none"> <li>• I am able to use video-teleconferencing when face to face care is not essential and I am supported by remote monitoring that is relevant to my health care</li> </ul>
<ul style="list-style-type: none"> <li>• I don't have to avoid or put off care because of cost</li> </ul>
<ul style="list-style-type: none"> <li>• 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</li> </ul>
<ul style="list-style-type: none"> <li>• 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</li> </ul>
<ul style="list-style-type: none"> <li>• I trust that I am in good hands and receiving the best care possible (quality, safety, best evidence)</li> </ul>
<ul style="list-style-type: none"> <li>• I am supported to understand my physical and mental health challenges and to set and achieve goals</li> </ul>
<ul style="list-style-type: none"> <li>• I am supported to manage my wellbeing and health care at home as much as possible</li> </ul>
<ul style="list-style-type: none"> <li>• 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</li> </ul>
<ul style="list-style-type: none"> <li>• I am not disadvantaged, and I don't miss out on services because of where I live, my diverse background or my lived experience</li> </ul>

## 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	<b>A wellbeing system</b>
Patient management with a focus on 'what is the matter with patients'	to	<b>Patient activation</b> and <b>person-centred care</b> with a focus on <b>'what matters to patients'</b>
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	<b>A 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	<b>A value-based system</b>
A fragmented system	to	<b>A coordinated and interconnected system</b>

## What problem are we trying to solve?

According to the Commonwealth Fund 2021, Mirror Mirror Report<sup>11</sup>, Australia's health system is ranked third 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 equity and health care outcomes; however, second in efficiency, sixth in care process and eighth in access to care.

Australia's primary health care system delivers some of the best outcomes in the OECD. It is highly accessible, greatly valued by consumers and communities, and has widespread practice quality and safety benchmarks.

However, compared with international peers, primary health care is more poorly linked to the rest of the health care system and relies disproportionately on patient out of pocket expenses. It is also almost entirely dependent on a fee-for-service, Medicare-linked business model that results in a focus on volume of care and throughput and not value for the patient. There is fragmentation in service delivery and lack of connection with subspecialist care, hospital care and community care leading to duplication and waste.

There is also underfunding of the primary health care system resulting in inequitable access to care with significant out of pocket costs for consumers and in many cases a one-size-fits-all approach that disadvantages significant populations within our communities. This disconnect creates significant challenges, with duplication,

<sup>11</sup> Schneider, Eric, et al. *Mirror, Mirror 2021: Reflecting Poorly: Health Care in the US Compared to Other High-Income Countries*. s.l. : The Commonwealth Fund, August 2021.

waste and inappropriate variation in care that leads to the most expensive (and often most unsafe) care setting being used. The challenges are particularly acute for disadvantaged Australians especially many Aboriginal and Torres Strait Islander people, residents of rural and remote communities, people from CALD backgrounds, people with chronic disease, mental health conditions and frailty, and people facing socio-economic disadvantage.

## Consultation on draft recommendations

The final recommendations and actions in this report are informed by feedback from extensive consultation the department held in 2019 and 2020. In addition, the Steering Group released draft recommendations for consultation with the sector over a 6-week period from 15 June – 27 July 2021. There was broad support for the draft recommendations, in particular the feedback highlighted the following:

- Suggestions on the scope and implementation of VPR, including clarity on the benefits for patients and providers
- Support in addressing equitable access and funding complexity for disadvantaged groups and better understanding on how disability, aged care, justice systems can work together
- Support for investing in primary health care and support for re-balancing of fee-for-service and other forms of funding, moving to blended funding, coordinated care and continuity of care, supported by safe data sharing and digital technology and solutions
- Support for multidisciplinary team-based care in primary health care settings, supported by funding models, and recognising the distinct role of nurses and allied health practitioners
- Closing the Gap – support for furthering the coverage, adding to scope and funding security for community-controlled organisations in line with national Closing the Gap commitments
- Readiness to move to regionally based coordinated action or local solutions.

A comprehensive summary of stakeholder feedback is at Appendix 2.

## What are we trying to achieve for a high performing primary health care system?

- A primary health care system that delivers high quality, integrated and coordinated 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 peoples and non-Indigenous Australians
- A health system that has greater focus on prevention and wellness
- Highlighting the importance of generalism<sup>12</sup> in the foundations of our system to support a holistic approach
- 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

<sup>12</sup> 'Rural Generalist Medicine' is defined in the Cairns Consensus statement on Rural Generalist Medicine: Nov, 2013

- Seamless transitions to and from quality secondary care and tertiary care systems
- A less fragmented, better integrated and less complex system
- Implementation of the National Safety and Quality Primary and Community Healthcare Standards developed by the Australian Commission on Safety and Quality in Health Care with the aim to protect the public from harm and improve the quality of health care delivered (Launched on 12 October 2021).<sup>13</sup>

## Advancing the Quadruple Aim

The *Quadruple Aim* is a wellregarded 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.<sup>14</sup> It aims to:

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**
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 must be viewed together and are interdependent in order to achieve the Quadruple Aim.

## 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 immediately required 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 ongoing governance structure, as well as initial priorities to set the foundation for reform over the next ten years. This recommendation must leverage the National Health Reform Agreement (NHRA) to embed this long-term reform agenda between both Commonwealth and state and territory governments.

<sup>13</sup> [https://www.safetyandquality.gov.au/sites/default/files/2021-07/final\\_draft\\_national\\_safety\\_and\\_quality\\_primary\\_and\\_community\\_healthcare\\_standards\\_june\\_2021.pdf](https://www.safetyandquality.gov.au/sites/default/files/2021-07/final_draft_national_safety_and_quality_primary_and_community_healthcare_standards_june_2021.pdf) (accessed 24 September 2021)

<sup>14</sup> Bodenheimer, Thomas and Sinsky, Christine. From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. *The Annals of Family Medicine*. 2014. Vol. 12, 6. 573-576. DOI: <https://doi.org/10.1370/afm.1713>. (accessed 17 September 2021)

# Recommendations for primary health care reform

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

### Recommendation 1 (One system focus):

#### Reshape Australia's health care system to deliver care through 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.
- This recommendation will assure the consumer experience is of a single system, not a disjointed poorly coordinated set of services.
- 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. A commitment to quality, access, efficiency and affordability should apply equitably across this system. 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 support 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.
- Central to the reshaping of the health care system is the development of joint commissioning of health services at the local level through collaboration between clinicians, consumers, the PHNs, the Local Hospital Districts (LHDs), state health ministries, and the Commonwealth. Commissioning is a strategic, evidence-based approach to planning and purchasing services and is intended to be outcomes-focused to support health services centred on the needs of patients. The commissioning process provides a holistic approach to service procurement, with the outcomes from each commissioning cycle factored into the next.<sup>15</sup>
- Ensuring any reorientation of services or funding is based on evidence and emphasis on care upstream at the start and not at the end. This will incorporate prevention and will deliver increased efficiencies and cost savings to the funders.
- Dedicated funding and investment are required through the allocation of a minimum percentage of health care spending to primary health care. Any additional investment in primary health care should also include quarantined funding to address the needs of Aboriginal and Torres Strait Islander peoples and disparity through community controlled primary health care arrangements.
- It is important to acknowledge the funding differences across sectors and support efficient use of funding available across health, 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.

<sup>15</sup> Department of Health | Fact Sheet: PHNs: Commissioning Health Services (accessed 20 August 2021)

### 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 ACCHs 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)
- Effective use of research (see recommendation 18).

### 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 and create an ongoing partnership and 'home base' for safe and comprehensive individual and family health care over time

- The single primary health care destination could be:
  - » a comprehensive general practice ('MyGP') backed by funding reform, with formalised links to a large range of multidisciplinary, wrap-around community and hospital services
  - » an Aboriginal Community Controlled Health Service
  - » a community-based health centre where people can receive comprehensive primary health care and where a range of primary health care and specialist services can also be available on-site, as well as in modes other than face to face.
- This single health destination 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 connects a multi-disciplinary team of health professionals dedicate to supporting a person with their health needs and assisting with navigation of the health system (see Appendix 5).
- It aims to establish the foundation for high performing, multidisciplinary, consumer-centred and integrated primary health care, building on lessons learned in the ACCH sector. 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 the foundation building block for this reform, formalising a single health care reference point. This will support the clinical governance, coordination, diagnostic and referral role of General Practitioners (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 (MyGP) 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 them.
- Empowering consumers to choose and register with a practice of their own choice and identify a GP within the 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.
- VPR will embed and build upon current pilot initiatives relating to primary health care reform as described by the Health Care Home principles of care<sup>16</sup> for general practices, ACCHs, 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.
- VPR will establish a platform for new investment in primary and integrated health care to improve the outputs, person-focus and cost effectiveness of the health system.
- VPR will impact the culture and current business models in primary health care and will require resourcing and strong leadership to be implemented effectively.

### Characteristics of the single primary health care destination

Single health care destinations will be settings where people can receive enhanced access to holistic, coordinated care, preventative services, and wrap around support for multiple health needs. They will feature the following core characteristics. These are pre-requisites for the delivery of optimal health access and outcomes for future Australian communities. Some are complementary to or refinements of current approaches to the provision of primary health care in Australia, others represent transformational reform.

1. **Voluntary patient registration** with a provider and practice to establish a formal agreement between patients and a clinical 'home-base' for optimal coordination, management and support for their ongoing health care. This enables patients and providers to work together and with the wider health system to improve partnership, identify accountability for ongoing preventive and ongoing care; reduce duplication of services and unnecessary tests; and support better health care across the system.
2. **Patients, families and their carers as active partners in their care**, with the aim of putting patients in control of their own care with the knowledge, skills and confidence to manage their health, supported by access to health information, their health care team, service navigation support, and families and carers where appropriate.
3. **Patients have enhanced access** to services through their chosen practice including telehealth support where clinically appropriate and effective. In time, this will include access to additional telehealth support and other forms of after-hours care including advice or care to avoid unnecessary emergency department and hospital admissions out of hours. Over time, other service enhancements would be added and integrated such as social prescribing and other modes of virtual care.

<sup>16</sup> see Report of the Primary Health Care Advisory Group p 19-21

4. **Patients nominate a preferred clinician** within the practice who is aware of their problems, priorities and wishes, and is responsible for their care coordination. They have the clinical expertise and accountability to lead the ongoing care of the patient, oversee the delivery of continuous and comprehensive care, and to provide the all-important link between the patient, their family and carers and the health system more broadly.
5. **Flexible service delivery and care teams are enabled through shared, integrated care planning** that spans primary health and acute care, as required. The MyGP practice coordinates care across all elements of the health care community, enabled where appropriate by care planning, secure messaging, electronic clinical exchange, and supported by appropriate funding models.
6. **The MyGP practice is committed to care that is of high quality and is safe.** Care planning and clinical decisions are guided by evidence-based patient health care pathways and care and treatment goals agreed with consumers. They are supported by best-practice decision-support tools.
7. **The practice makes a commitment to high quality data collection and analysis** to constantly review and improve performance. This includes the systematic use of patient reported measures such as Patient Reported Experience Measures (PREMS) and Patient Reported Outcome Measures (PROMS) to improve and innovate services over time.

### Recommendation 3 (Funding reform):

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

- Funding reform is an essential part and is intertwined with all other recommendations. It is well known that investing in high quality primary care will deliver downstream savings to the health system.
- The Australian model of health care funding is divided with funding of General Practice (and other primary and secondary care providers) and funding of hospital care sourced from both Federal and Jurisdictional governments respectively. This dichotomy hampers strong multidisciplinary care that follows the patient throughout their transitions of care from community to hospital and back again.
- VPR, coupled with broader funding reform, will facilitate strategic redirection of funding from secondary/tertiary care to primary health care and prevention to deliver downstream savings in the secondary/tertiary sectors. It will support alternative funding sources for primary health care service providers in addition to the fee-for-service MBS, to improve equitable access and support a one system focus with flexibility and greater longitudinal, multidisciplinary and value-based team care. It will also support further appropriate and sustainable blended funding models; to underpin and incentivise the best models of primary / integrated health care tailored to local circumstances, to supporting access, affordability, equity and continuity of care for local people.
- Funding reform frameworks should be embedded in to the NHRA to underpin the strategic direction of reform and to support the governance structure for locally informed investments in primary care. Outcomes will be measured and should include better health outcomes, reduced length of stay in hospital, reduced emergency department presentations, reduced unplanned re-admissions and improved sustainability of the whole health system.
- A range of funding models exist that should be chosen to incentivise the benefits being sought by local health care needs. They can include those listed below all of which can be blended and tailored to provide the right balance of incentives to achieve patient centred, high quality health care:
  - » Fee for service
  - » Service incentives based on services provided to an individual registered patient
  - » Block funding based on services to provided to a cohort of patients

- » Workforce block funding
- » Bundled payments for an individual treatment cycle, or for multimorbidity, or for a cohort of patients
- » Capitated payments for a population of registered patients
- » Shared savings schemes based on outcomes
- » Quality incentive payments.<sup>17</sup>

A diagram that illustrates these funding models is provided at Appendix 7.

Each of these payment types has its benefits and risks. No one funding type poses a universal solution to achieving true high quality health care. The blend of types required will ultimately depend on the local needs and collaborative agreements reached regionally, as well as the willingness, ability and sustainability of local and regional providers to participate and work together to achieve the Quadruple Aim.

- By moving the emphasis on our health system to prevention (and support for self care/health literacy) and early intervention we will keep our population healthy and will collect Australian data to support this.
- 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. This should include addressing gaps in services identified by data and ensuring that funding does not negatively impact equitable access and service provision.
- Patient-led: Measure and report on outcomes based on achievement of goals set by patients.
- 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).

#### 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 peoples and other Australians is 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 ACCH sector as a pivotal player in seeking to reform and improve our primary health care system.
- This recommendation also factors in the specific social determinants identified in the National Agreement on Closing the Gap, July 2020, that effect the health outcomes of Aboriginal and Torres Strait Islander peoples.
- This recommendation builds on all others throughout the Steering Group's draft recommendations and identifies specific actions to be taken to reduce 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.

<sup>17</sup> Dawda, Paresh. Australian Healthcare and Hospitals Association, 'Bundled Payments: Their role in Australian Primary Health Care. s.l. : Australian Healthcare and Hospitals Association, September 2015.

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

##### Structural reform and innovation must be locally informed

- This recommendation aims to support a community connected and coordinated approach built around the strengths of local communities to deliver equitable access to care and to empower and support providers to deliver high value care.
- Facilitate partnerships between health services, professions, community service organisations delivering health and mental health programs and private business.
- Enabling optimal use of digital health infrastructure and virtual care services.
- Structural reform and innovative solutions must be prioritised in rural and remote communities:
  - » Services should be tailored to meet the needs of individual communities, including social services, as well as providing employment conditions necessary to attract and retain the appropriate range of primary health care providers. These include a broad scope rural doctors and rural generalists within a rural health system to improve capability, capacity and safety for the whole health care team
  - » Where they exist support local private practices and PHNs to develop local infrastructure and networks (building local strength and confidence) specifically to support ongoing community access to established services
  - » Address the Commonwealth/state funding divide so services are designed to address need
  - » Community partnerships and local capacity should be leveraged and supported by 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 ACCHs
  - » Support of and cooperation with local private practice, where they exist, and PHNs is needed to develop local infrastructure and networks to building local strengths that underpin ongoing community access to established services.
- To translate these objectives into action in an integrated way where there is insufficient investment or poor integration or both, a new model of care should be considered to specifically meet the unique needs of each rural community. Rural Area Community Controlled Health Organisations (RACCHOs), broadly modelled on the ACCHs model and locally tailored, can provide the foundation on which to deliver responsive, sustainable, accessible, local community care.<sup>18</sup>

<sup>18</sup> <https://www.ruralhealth.org.au/sites/default/files/Infographic-proposal-for-better-health-care-a4v2.pdf> (accessed 27 September 2021)

---

## 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 improve health literacy 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 a responsive health care environment that enables people and their carers in the context of their community, 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 and health promoting behaviours and, when required, informed selfmanagement 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.
- It is important individual health literacy and consumer agency is enhanced 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.
- Promoting and continuously improving reliable sources of information is required so people can easily access up to date technology and digital platforms.

### Recommendation 7 (Comprehensive preventive care):

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

- This recommendation aims to ensure prevention and health promotion occurs across the lifecycle and in the community. It relies on the input of all primary health care service providers and includes medical, nursing, allied health providers and the healthcare support workforce including Aboriginal Health Workers. Prevention should include secondary and tertiary prevention to improve the quality of life and disease management of people with existing disease to reduced symptom exacerbations and disease progression.
- Preventative health measures should align with the National Preventative Health Strategy.
- This recommendation aims to also support MyGP providers to opportunistically and proactively interact with their enrolled populations to maintain their physical and mental health and wellbeing by implementing evidence based preventive activities in primary care such as those detailed in *The Red Book*.<sup>19</sup>

---

<sup>19</sup> <https://www.racgp.org.au/download/Documents/Guidelines/Redbook9/17048-Red-Book-9th-Edition.pdf> (accessed 17 September 2021)

### Recommendation 8 (Equitable 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 sufficient funding to allow tailoring of the services to address health disparities for Aboriginal and Torres Strait Islander people, older people, people with mental illness, CALD communities, LGBTIQ+ communities, people with disability, and families with children at risk of adverse childhood experiences. 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.
- The value of social prescribing and link and support workers with lived experienced cannot be underestimated to provide tailored support to specific populations.
- It will also involve advocating for improving access to the NDIS and aged care and improving the interface of these systems to ensure those with a disability or who are aged can better navigate these systems and make choices on how they engage with these systems rather than the complex system that sees many people excluded from entering relevant programs.
- Early identification and supports to access to relevant targeted interventions, should be in place with a particular focus on children with developmental disabilities and those at risk of poor development and adverse childhood experiences due to neglect, abuse or trauma, or in out-of-home care environments, for example, a range of relevant allied health services and mental health supports are accessible to support the first 2,000 days of a child's life and extend across childhood and adolescence.
- Funding should also be provided for universal access to interpreter services to support safe and effective health care delivery, including Aboriginal and Torres Strait Islander languages where possible.

---

## 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 with consumers 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 systems that incentivise 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 organisations, such as the Australian Association of Practice Management (AAPM), the Australian College of Rural and Remote Medicine (ACRRM), the Australian Medical Association (AMA), the Royal Australian College of General Practitioners (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 Allied Health Professions' Australia, the Australian Allied Health Leadership Forum and Rural Doctors Association of Australia (RDAA), Australian Psychological Society, Royal Australian and New Zealand College of Psychiatrists (RANZCP), Australian College of Mental Health Nurses (ACMHN) and Allied Health peak bodies. This also includes existing structures, such as PHNs, LHNs and ACCHs.
- Consumer insights and lived experience are important to improving and innovating services. Strategies to equip consumers and carers with the leadership and representational skills to work collaboratively with clinicians and health service and program managers are included in this recommendation.
- 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).

## Primary health care workforce development and innovation

These workforce recommendations aim to support a more mature multidisciplinary model of primary health care. This model must be integrated, values generalism, as well as profession-specific expertise, and gives up professional prerogative in order to work 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 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 their full scope in a coordinated and safe way, with appropriate clinical governance.

In the majority of situations, keeping a person's chosen primary health care practice informed, ultimately ensures all members of the multidisciplinary team are informed and facilitates them working together to provide the right services at the right time.

Better informed and coordinated primary health care teams free up capacity and support sustainability of the primary health care system as a whole to enable people to have equitable 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 planned 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.

- Interprofessional education and training are crucial to future interprofessional collaborative practice and must be part of educational frameworks.
- Integrated care requires integration of people and a culture of mutual respect and working towards a common shared purpose. This will support an integrated multidisciplinary team, with providers working together in different complementary ways and to full scope. Appropriate clinical governance will ensure care is not fragmented to deliver patient safety. This would include that multidisciplinary teams, which share information, are virtually connected in conjunction with 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 including funding from a variety of sources.
- This includes activities that will 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.
- It is also important to provide, support and 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.

### 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 principles and funding models to support equitable access to allied health services**

- This recommendation aims to better support the allied health workforce, including mental health providers, to work to their full scope within an integrated, multidisciplinary team care environment.
- This includes the development of local solutions and may require staged implementation of innovative funding and care models to deliver equitable access to allied health services based on local needs and data collection.

### 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 their full 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.
- This needs to be supported by improvements in the career and education pathway for nurses. That is flexible, built around professional needs, adapted to specific workplace needs and specific pathways such as rural generalism.



### Recommendation 13

#### (Broader primary health care workforce):

##### **Support and develop all appropriate workforces in primary health care to better support people, 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.*
- *This includes supporting activities that will improve the quality of practice management and uplifts the capabilities of the administrative workforce to support the delivery of person-centred care.*

### Recommendation 14

#### (Medical primary health 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 health care workforce**

- *This recommendation aims to encourage and facilitate greater supply and better distribution and retention of primary health care medical practitioners, including in rural and remote areas.*
- *This includes recognising the increased scope of practice for the rural and remote primary care medical workforce through the MBS.*
- *Outer metropolitan General Practice also needs to be a focus for workforce distribution but needs to be approached separately from rural and remote issues.*
- *Medical workforce distribution needs to be a focus for the whole health sector, and the Australian health system needs to have more of its medical graduates choose Primary Care/General Practice/Rural Generalist Medicine as a career. This is likely out of scope for this project but is nonetheless an important issue to highlight.*
- *There are multiple other changes occurring to look to address this including the transition to College-led training, the introduction of the National Rural Generalist Pathway and the proposal for recognition of Rural Generalist Medicine as a specialty within the field of General Practice.*
- *In particular, college-led training will allow the profession to recruit with a whole of career focus, rather than just the training aspect. This will also allow for continuity of support throughout the training pipeline, for appropriate supervision and support in the diverse rural and remote clinical contexts that GPs and RGs work in.*

## 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 information sharing, 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, remote monitoring and engagement tools and shared care planning.*
- *It is critical that the user interface be co-designed with clinicians and patients so that both the use and sharing of data is integrated seamlessly into the clinical workflow to increasing the delivery of precision health care to our population.*
- *This includes the sharing of structured interoperable data with other members of the health care team including non-GP specialists, pharmacists, dentists and allied health care providers both real time, near real time and asynchronously.*
- *That same data can then be reviewed to support quality improvement and regional service planning and resource allocation within locally informed governance structures.*
- *This will support the primary care medical workforce to deliver holistic care with digital means that support, accurate and up to date health pathways.*

### 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, asynchronous care, My Health Record, care pathways, remote monitoring, point of care testing, genomics, and integrating innovation with other relevant sectors.*
- *It is important there is support for, funding of and encouragement of new ways of working. This includes advances in care through use of contemporary technology, genomics and precision medicine, with a focus on improving equity in health outcomes and access to safe and quality services.*

---

## 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, regional, 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.
- This recommendation builds on recommendation 15.
- It is important that reforms to funding in the primary health care support data collection, sharing and analysis, improving service delivery, reporting and accountability and improving and sustaining outcomes that matter to people across care settings.

### 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.
- This will support building 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.

---

## 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.
- This also includes coordinated prevention and recovery activities to ensure there are sufficient resources available to support prevention activities post an emergency.

---

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

### Recommendation 20 (Implementation):

#### Ensure there is an implementation action plan to support improvements over the short, medium and long-term horizons

#### Ensure consumers, communities, service providers and peak organisations are engaged throughout implementation to enable concurrent evaluation and refinement of primary health care reform

- Create a 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, suggested immediate priorities, and how monitoring, evaluation and refinement should take place in a staged and stepwise approach.
- This includes continuous and ongoing engagement through strong stewardship to ensure a line of sight from recommendations through to implementation.
- It needs to have regard to the links between the 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.
- Leverage the NHRA Recommendation to embed the long-term reform agenda between the Commonwealth and the jurisdictions.

# How to implement the Steering Group's recommendations

This section provides tangible actions for how the Steering Group recommendations could be implemented over the ten years. They have been grouped under six pillars that capture the 20 recommendations of the Steering Group over the short, medium and long term.

For each pillar cases studies, examples and narratives are provided to further illustrate these principles in action and provide a living example of how these principles can work in practice. These examples illustrate the importance of codesign with local funders and providers to meet the needs of the community. They are not meant to represent exhaustive solutions for each pillar.

Foundational short-term actions are those that the Steering Group recommend can occur in the next 12 months in the current environment in Australia. These are intended to be tight, deliverable and ready to go. Medium term actions require iterative implementation based on solid foundations and collection of data and research, intended to be implementable within three years. Actions over the long term will depend on iterative understanding and growth, including outcomes data, research and priorities.

Overarching principles include equitable access to care, prevention and addressing wider/social determinants of health and funding reform.

## Summary of the pillars

- Pillar 1 – One system focus
- Pillar 2 – Equitable experience of evidence-based primary health care
- Pillar 3 – Continuous quality improvement, safety and future focus across the system, for consumers and providers
  - » Need ongoing governance and implementation framework
  - » Need leadership from professional organisations and change management
  - » Leverage data – benchmarking, linking and building a culture of data driven improvement
  - » Embrace digital and virtual care
  - » Encourage research and innovation
- Pillar 4 – Bolstering rural health
- Pillar 5 – Aboriginal and Torres Strait Islander health
- Pillar 6 – Health workforce

## Overview of the pillars

### Pillar 1 – One system focus

**This pillar primarily covers recommendations 1, 3, 4, 5, 7, 8, 15 and 19.**

It includes the required steps to reshape Australia's health care system to enable one integrated system focused on reorienting the secondary and tertiary systems to support primary health care to keep people well and out of hospital, enabling flexibility for local solutions and partnerships, tailoring services, workforce and funding options to meeting community needs. This will involve 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 includes developing mechanisms and governance arrangements to support appropriate accountability for patient outcomes when integrated care is delivered across health systems. In addition to this VPR will ensure that the preferred practice and coordinating general practitioner can both receive and distribute information relevant to the patient's journey. This will support a more 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.

It will also be important that governance arrangements are designed to empower clinicians and consumers, carers and families to work together, contributing to care innovation and reform.

This pillar involves building on the long-term reform agenda through the NHRA Addendum 2020–2025 to drive local solutions and partnerships, with appropriate governance arrangements between PHNs, LHNs and other organisations to create a united focus on care delivery to unlock meaningful sharing of resources, reduce service duplication and fragmentation, and simplify the health care environment for people. It includes Commonwealth and state shared responsibilities to support an integrated and coordinated care system involving funding reform, and the building of an evidence base to enable staged implementation and shared learning across Australia and the wider care system.

It should support equitable access to high quality health care services, as well as comprehensive preventive care, emergency preparedness and other social services, including justice, social care, housing, aged care, disability services, psychological support services and childcare.

It is underpinned particularly by pillar 3, which includes the expansion and integration of digital infrastructure and virtual care, collection and sharing of quality data and research for improvement, and most importantly leadership and resourcing for change management and shared learnings across the system. It is also underpinned by an equipped and empowered healthcare workforce in pillar 6.

This pillar should support a more equitable experience of primary health care for communities, including in rural and remote areas and Aboriginal and Torres Strait Islander health.

Solutions to address the barriers to care should be co-designed in order to be flexible and to provide 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.<sup>20</sup>

<sup>20</sup> Levesque, Jean-Frederic, Harris, Mark F and Russell, Grant. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health*. 2013. Vol. 12, 18.

## Case Study: NSW Health – Collaborative Commissioning

NSW Health has developed and used Collaborative Commissioning to accelerate value-based health care<sup>21</sup>.

There are six principles that guide Collaborative Commissioning:

1. Joint responsibility between providers and organisations
2. Strong consumer engagement, embedding accountability to the community served
3. Local design of care pathways for improved outcomes for patients
4. Funding reform, including flexible purchasing and provider arrangements, realignment of resources and outcome-based payments
5. Use of data analytics, business analytics, implementation support, and digital technologies supported by Lumos
6. Encouraging continuous learning to support improvement and innovation.

A number of collaborative commissioning models are at the joint development or implementation phases.

### Spotlight on Northern Sydney partnership<sup>22</sup>

Although the Northern Sydney Collaborative Commissioning initiative is still officially in the development phase, they have already commenced delivering improved services for frail and older people in their area.

The partnership between Sydney North Health Network (SNHN) and Northern Sydney Local Health District (NSLHD) is focused on improving rapid care for frail and older people in Northern Sydney. It aims to respond to the needs of frail and older people with more proactive, timely and connected support that is tailored to each person's needs and gives choice with where care is provided.

While there are a range of features planned to deliver this vision, the partnership have already commenced two services to enhance GP-led management in the community:

Geriatrician Outreach to Primary Care – over a 10-week period, NSLHD Geriatricians have had 129 interactions with GPs across northern Sydney (52% in-person visits; 44% by phone) to increase specialist input into GP-led patient planning and care in the community for frail and older people.

Concierge Service (branded as 'Health Navigators') is available to provide support for health care professionals in northern Sydney to navigate, troubleshoot and coordinate community-based primary health, aged and social care and some hospital-based services for elderly, frail and vulnerable people within their care.

### The Western Sydney Care Collective<sup>23</sup>

Is a collaboratively designed model of care developed jointly by the Western Sydney LHD and Western Sydney PHN. They have come together to develop and implement three models of care: cardiology in the community, value based urgent care, and rapid access to care in the community.

More information on this program can be found in Appendix 6 Case Study: Western Sydney NSW – The Western Sydney Care Collective.

<sup>21</sup> <https://www.health.nsw.gov.au/Value/Pages/collaborative-commissioning.aspx> (accessed 16 September 2021)

<sup>22</sup> <https://www.health.nsw.gov.au/Value/Pages/collab-commissioning-ns-spotlight.aspx> (accessed 27 August 2021)

<sup>23</sup> <https://www.wslhd.health.nsw.gov.au/western-sydney-care-collective> (accessed 16 September 2021)

## Case Study: NSW Health – Lumos program<sup>24</sup>

### What is Lumos?

Lumos is the largest collaboration between NSW Health and PHNs in NSW. It links consumer data across primary, ambulance, acute care, cancer registry, death registry and notifiable conditions registry data to enhance understanding of the consumer journey through the healthcare system to inform policy and planning.

### How was Lumos developed and implemented?

NSW Health developed the idea for Lumos when it discovered that some people with chronic conditions were first being identified by the state healthcare system when their health had worsened and they were hospitalised, with little information about their primary care. The purpose of Lumos was to enable better service planning at the system level, with the potential to identify significant gaps in care, particularly through inclusion of primary care information. It started as a four-year pilot in 2016 to assess the feasibility of linking data from general practices to other data across the NSW healthcare sector. During this phase, 40 general practices were involved across four PHNs, covering 400,000 patients. Currently, Lumos is in its scale-up phase, with over 300 practices (representing all 10 PHNs) involved in the program, capturing about two million consumer journeys through the NSW health system.

### What has Lumos achieved?

The richness of the Lumos dataset has provided valuable information, which allows stakeholders to:

- better understand the positive effects of primary care in reducing readmissions
- refine their statistical models. For example, more information on individual characteristics can help identify those people most at risk of developing certain chronic conditions
- improve outcomes for people with undiagnosed chronic conditions. For example, Lumos has shown that the risk of hospitalisation for diabetes and chronic kidney disease is halved with early recognition in primary care
- identify opportunities to implement data-driven improvements in the planning of system-wide models of care
- use innovative and enhanced data analytics in order to extract lessons from health interventions.

Insights published from Lumos has shown that practices that see their patients more often are associated with fewer emergency department presentations and hospital admissions than practices who see their patients less often, indicating that general practice activity can have a positive effect on hospital visits.<sup>25</sup>

*(continued next page)*

<sup>24</sup> Productivity Commission, March 2021, 'Innovations in Care for Chronic Health Conditions' <https://www.pc.gov.au/research/completed/chronic-care-innovations/chronic-care-innovations.pdf> (accessed 17 September 2021)

<sup>25</sup> <https://www.health.nsw.gov.au/lumos/Pages/gp-activity-insight.aspx> (accessed 17 September 2021)



### What makes Lumos successful?

The success of Lumos relies on:

- developing trusted relationships across the healthcare system by commencing the pilot in areas where PHNs and Local Health Districts (LHDs) already had mature relationships and meeting regularly with stakeholders and incorporating their feedback on the design
- highlighting the value of data by giving reports to GP practices and PHNs summarising aggregate statistics and by providing visual dashboards outlining the health trends of a practice population. These are sent at least every six months
- ensuring rigorous privacy standards are upheld throughout the linking process.

### Where to next for Lumos?

- Lumos is continuing to build stakeholder support especially with LHDs, technology vendors and individuals. This involves conducting targeted interviews and focus groups with stakeholders to determine high-value uses of the data. To further these efforts, Lumos has obtained ethics approval with the Aboriginal Health and Medical Research Council Ethics Committee to conduct specific analyses on the health outcomes of Aboriginal and Torres Strait Islander people.
- Lumos aims to expand state-wide so it can generate insights on up to four million consumer journeys across the NSW health system.

For more information on the Lumos project go to: <https://www.health.nsw.gov.au/lumos/Pages/default.aspx> (accessed 17 September 2021)

### Case Study: WA Primary Health Alliance – Comprehensive Primary Care – Social Work Program

As part of commissioning services to embed the Quadruple Aims of Patient Centred Medical Home, WA Primary Health Alliance has commissioned a program for Social Workers to be introduced into Comprehensive Primary Care (CPC) General Practices.

Designed and developed by WA Primary Health Alliance with GPs, CPC builds capacity and capability within primary care to offer more individualised care to the patient. Designed and developed by WA Primary Health Alliance with GPs, through this program we work intensively with general practices across the state to identify and understand their specific needs and offer tailored support to assist them to deliver a patient-centred model of care that is sustainable and improves patient outcomes. Committed to achieving the highest standards in quality and safety, CPC is a GP-led, place-based, systematic, tailor-made approach, offering much more comprehensive support than a one-size-fits-all model. Aligning to the principles of the Patient Centred Medical Home (PCMH) model, it ensures care is co-ordinated, accessible and locally based, where possible.

More information on this program can be found in Appendix 6 Case Study – WA Primary Health Alliance – Comprehensive Primary Care – Social Work Program.

Source: Case study provided by WA Primary Health Alliance

See also Appendix 6 for Case Study: South Eastern NSW Primary Health Network (PHN) – COORDINARE. The Consumers Health Forum of Australia has pioneered Collaborative Pairs Australia, a joint leadership development program for consumers and clinicians based on the UK Kings Fund program.

### How the pillar addresses 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, which 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.

## **Pillar 2 – Equitable experience of evidence-based primary health care (person, family, carer, community)**

**This pillar primarily covers recommendations 2, 3, 6 and 8 and 15.**

It covers the foundational steps to support people's access to coordinated, equitable and evidence-based primary health care by formalising and strengthening their relationship with their chosen primary health care provider and practice, while enhancing access to the wide range of primary health care services.

The focus of this pillar is to facilitate access to multidisciplinary, coordinated, integrated and high quality primary health care services, supported by funding reform. These changes will benefit people in greatest need of accessible, community based care, particularly people with complex chronic conditions, Aboriginal and Torres Strait Islander people, rural and remote communities, people living in low SIEFA areas that may or may not be in rural and remote locations, older people, people with mental illness, CALD and LGBTIQ+ communities, support assisting those living with a communicable disease, people with disability and families with children at risk of adverse childhood experience.

VPR will provide a mechanism to enable greater coordination and more effective communication across the primary health care team and across sectors, as well as to facilitate new investment in primary health care that is responsive to people's needs and based on the latest evidence and collection of data.

Funding reform will support access to high quality general practice, allied health, non-dispensing pharmacists, nursing, mental health services, social care, after hours and paramedic services. Funding reform underpins moving the system from a throughput to benefit the provider to better outcomes for the patient.

This pillar is underpinned and supported by the one system focus and pillar 3, including leveraging high quality data to support improvement, embracing digital and virtual care to support care provision and multidisciplinary communication, and most importantly leadership across the system and resourcing for change management. It is also underpinned by an equipped and empowered healthcare workforce in pillar 6.

## **Benefits of VPR**

### **For people and person-centred care**

- A regular practice and preferred provider (usually a GP) that is better funded to care for them. A provider who knows them and their personal experiences and family circumstances, works with other members of their care team, supports self-management and connects with other services, networks and supports
- Helps people stay healthy and well through continuity of care, tailored care and trusted relationships
- Access more likely to high quality, coordinated and team-based care.

### **For service providers**

- Improves and formalises the connection people already have with their preferred practice, providing high quality, safe and pro-active care, in partnership with people and communities
- Allows practices to be funded for and build on the services they already provide, formalise, and strengthen relationships and access continued rebates for GP telehealth and reserves other MBS items of high value to the practice
- Adds funding flexibility and using blended funding arrangement to support continuity of care and meeting the needs of the communities served
- Changes to the Practice Incentives Program – Indigenous Health Incentive (PIP IHI) announced in the 2021–22 Budget, including the move to a one-off registration process. This will enable integration of PIP IHI and VPR in the future
- Improves the work experience by focusing on people's needs and supporting collaboration with other clinicians, areas of expertise and service providers.

### **For population health**

- Experiences of populations are captured throughout their care journeys, providing opportunities to use data to inform early interventions and better tailoring of care
- Supports coordination of care and effective communication across the primary health care team and across sectors, particularly for those populations in need of integrated care
- Reduced inequity through access to better funded and tailored care for known, registered populations, including Aboriginal and Torres Strait Islander people and people with diverse characteristics or lived experiences.

### **For Australia's health system**

- Focuses on high value care, improved efficiency and minimising waste
- Improves the framework for better, trusted sharing of data to support quality improvement
- Reduces the burden on other parts of the health system, adding to system sustainability.

### Case Study: PHN North Western Melbourne – Collaborative Commissioning in Melbourne’s West

Improving and Promoting Community Health (IPC Health) provides social prescribing program that is a person-centred aiming to improve overall wellbeing in non-medical ways in conjunction with a client’s GP or healthcare worker. They connect clients with local community or exercise groups and links into services like parenting support or legal and financial advice.

#### Maryn, 54-year-old male

**Initial presentation:** Living at home with his elderly father in Brimbank who provides financial and daily living supports and recently unemployed from his long-term job due to COVID-19.

Referred to Social Prescribing by Diabetes Educator as she felt there may be a link between his lack of engagement in his health care and that he did not have a regular routine and had a poor social life. She felt that he needed a reason to get up in the morning and felt by joining in a community group that he would become more motivated.

#### Services offered:

Sons of the West-Community education and support program  
Diabetes Educator  
Exercise Physiologist  
Dietician

#### Outcomes:

Improved Confidence  
Improved connection to community  
Increased drive and motivation for physical health  
Improved mental health due to social engagement

#### Introduction and history

- Past history Type 2 Diabetes Mellitus, hypertension, hypercholesterolaemia, obesity, amputated first and fifth toes R foot, and depression
- Poorly controlled diabetes managed with insulin
- Actively engaged in High Risk Foot Clinic at IPC Health for regular foot assessments and management
- He had not participated in any form of exercise, despite much encouragement
- Referred to Social Prescribing by Diabetes Educator as she felt there may be a link between his lack of engagement in his health care and that he did not have a regular routine and had a poor social life. She felt that he needed a reason to get up in the morning and felt by joining in a community group that he would become more motivated.

#### Outcomes:

This client is now making active steps to engage in his health and wellbeing. He is proactively seeking support to better manage his diabetes and participate in a suitable exercise program that will improve his fitness and overall health.

Through the participation in the Sons of the West program, he has developed motivation to take the necessary steps required to improve his health. He has seen the benefits that regular exercise and eating a healthy diet can provide, so is keen to continue.

He is now making better choices, which is having a positive impact on his physical and mental wellbeing.

*Source: Case study provided by Mental Health Australia*

### How the pillar addresses 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 connected primary health care providers who are able to provide a wide range of coordinated 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 provide holistic and value-based care for their patients.

See also Appendix 6 for an example – Characteristics Single Primary Health Care Destination.

### Pillar 3 – Continuous quality improvement, safety and future focus across the system, for consumers and providers

This pillar primarily covers recommendations 9, 15, 16, 17, 18 and 20.

It underpins continuous quality improvement, safety and future focus across the system and supports actions across all other pillars.

Cultural shift is required across the health system. This will require collaboration between members of these systems and understanding of how they can better support an individual and their health care needs.

The NHRA 2020–2025 recognises that: 'responsibility for health is shared between the Commonwealth and the states, and that all governments have a responsibility to ensure that systems work together effectively and efficiently to produce the best outcomes for people, including interfaces between health, aged care and disability services, regardless of their geographic location'.<sup>26</sup>

Those cultural shifts are also required in primary care practices to move from a focus on the immediate needs of the patients in front of them to the needs of their enrolled population over time. This is a significant change that should be delivered in small steps. It will require sustained and coordinated leadership from clinical champions, peak organisations, PHN's and LHD's.

Cultural shifts need to be supported by evidence through data collection and research that can be translated into policy. Actions are required to 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.

Activities that will support the cultural shift required include:

- an **ongoing governance and implementation** framework to support effective implementation, evaluation and refinement of primary health care reform over the ten year period
- fostering of **leadership** and resourcing for **change management** across the system
- supporting the whole primary care workforce to achieve a minimum level of digital maturity
- leveraging **data** by benchmarking, linking and building a culture of data driven improvement
- embracing **digital and virtual care** that supports one health system and equitable experience of primary health care
- encouraging **research and innovation** with maximised uptake nationally.

<sup>26</sup> Addendum to National Health Reform Agreement 2020-2025, May 2020 [https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2021-07/NHRA\\_2020-25\\_Addendum\\_consolidated.pdf](https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2021-07/NHRA_2020-25_Addendum_consolidated.pdf) (accessed 17 September 2021)

#### Example: Using the Model for Improvement in Healthcare

The science of process improvement is gaining traction across many health systems around the world. Clinician-led and locally developed models for using clinical data to drive improvement in care provision is foundational to continuously improving health care and helping patients achieve what matters to them. Many such models have been developed, including Six Sigma, Lean, and the Model for Improvement.

The Model for Improvement<sup>27</sup> is a powerful yet simple tool that provides primary care practices a framework for developing and testing change and improving processes of care.<sup>28</sup> The approach is embedded in a philosophy and culture of continuous quality improvement, and that there is an opportunity for improvement at every process on every occasion.<sup>29</sup> The model asks practices to consider three questions and is combined with rapid iterative cycles of change known as PDSAs (Plan Do Study Act).

- What are we trying to accomplish? (and why change?)
- How will we know that a change is an improvement? (the data)
- What changes can we make that will result in improvement?

The model relies on practices adopting an organizational approach and frequently using data they collect themselves to improve and enhance care. The measurement philosophy and paradigm is based on improvement and is distinctly different from the research and audit (accountability) paradigm.<sup>30</sup>

The measurement philosophy requires the frequent and regular collection of data (usually indicators of care and process or proxy-outcome measures) to understand the variation in the indicators over time through visual analysis tools such as run charts and statistical process control charts. This allows practices to benchmark their own performance against their own historical and continuously collected data. When combined at cluster level, cross fertilization of successful improvements can occur.

Practices can learn from each other leading to improvements at system level. Rather than benchmark to set targets, key performance indicators or 'average' performance, they can learn from highly successful peers. Improvements are rewarded, not hitting set targets. Publicly sharing improvements fosters a culture of innovation, clinical leadership, and data driven improvements.

<sup>27</sup> <http://www.ih.org/resources/Pages/HowtoImprove/default.aspx> (accessed 16 September 2021)

<sup>28</sup> <https://qualitysafety.bmj.com/content/qhc/28/7/582.full.pdf> (accessed 27 September 2021)

<sup>29</sup> <https://www.ncbi.nlm.nih.gov/books/NBK2682/> (accessed 16 September 2021)

<sup>30</sup> [https://www.researchgate.net/publication/309881794\\_Measurement\\_for\\_improvement](https://www.researchgate.net/publication/309881794_Measurement_for_improvement) (accessed 28 September 2021)



### Case Study: Western Queensland – eConsultant Partnership Program

An example where clinical systems are supporting multidisciplinary care is the eConsultant Partnership Program. A proof-of-concept study that commenced in 2018, it is a multi-partner program that delivers an asynchronous secure electronic consultation (eConsultant) model of care that links GPs with timely clinical advice from an online physician. The study commenced in one urban general practice and progressed to a pilot study in four rural remote practices in Western Queensland (one private, one aboriginal community-controlled, and two Royal Flying Doctor Service general practices).

Those sites involved saw a reduction in the need for a traditional Outpatient Department (OPD) appointment, strong connection between the general practice community and a remote physician, and improved access to care for complex comorbidities for remote patients, including those using indigenous primary care.

More information on this program can be found in Appendix 6 Case Study: Western Queensland – eConsultant Partnership Program.

### Example: Patient engagement and monitoring apps

Electronic shared care and monitoring platforms are being currently developed and used around the country. These apps provide a secure interface or bridge between the patient and the desktop (or mobile) software of their providers, as well as a tool used to integrate care between all of the patient's care team.

Patients can download the apps and link with their practice and care provider directly. The apps can also display the patient's shared care plan, their clinical metrics from their GP's desktop software, as well as their own health care goals. They can also sync data from other devices such as blood glucose monitors and step counters.

Using a dashboard and central administration access, providers can remotely monitor and communicate with numerous patients in their cohorts, as well as securely link multidisciplinary teams to individual patients.

The goal of these apps is to engage and activate patients in their own care, by allowing patients to:

- track their progress against their goals and targets
- input their own metrics such as their blood pressure and blood sugar readings
- view their shared care plan
- communicate securely with their providers.

Source: Example provided by Dr Walid Jammal

### How the pillar addresses the Quadruple Aim:

- Patient experience and safety of care will be improved through continuously improving the quality of services that simplify and streamline the experience of care, while supporting people to access and utilise their own health data, as well as use evolving digital technologies
- Health of populations will be improved through a more connected and responsive health care system that is informed by data and able to target resources to address population needs in a timely manner
- Cost-efficiency of the health system will be improved through better utilisation of resources in line with high quality and systematic use of data that informs funding changes and further reform
- By harnessing the intrinsic motivation of care providers to improve the care of their patient, work life of health care providers will be improved when they can use the tools at their disposal and drive innovation, transformation and data driven improvement. This will require significant support for leadership and change management.

## Pillar 4 – Bolstering rural health

This pillar primarily covers recommendation 5 and is across all others.

It includes specific actions that build on the strengths of rural and remote communities to support equitable and sustainable access to primary health care, prioritising structural reform for local approaches to deliver coordinated care. This includes in relation to workforce, models of care, funding arrangements, emergency preparedness and research.

This also includes investment 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.

This pillar should be supported by all other pillars.

### Case Study: Alpine Health VIC – Rural health model of care

Alpine Health demonstrates an innovative model of care meeting the needs of the local rural community. It is a Multi-Purpose Service (MPS) with three sites in the Alpine Shire towns of Bright, Mount Beauty and Myrtleford in Victoria. As well as MPS services, Alpine Health provides integrated and sustainable local community health services including community nursing, maternity and newborn, mental health, nutrition and dietetic services, breast care, cardiac and pulmonary rehabilitation, diabetes management and awareness programs. Alpine Health supports a philosophy that an educated, engaged community is a healthy community. They work in partnership with their health consumers and community to ensure they are meaningfully involved in health policy planning and service delivery.

The model supports interprofessional approaches to community health, with multi-disciplinary teams working in partnership to provide holistic continuity of care, including working closely with local general practices to ensure integration of services. Alpine Health partners with local Aboriginal health organisations and specialist services to support local Aboriginal and Torres Strait Islander communities. Education and training of a locally grown health workforce is a priority, highlighted through the proactive approach taken by Alpine Health to the development of training courses and education services, scholarships, as well as work placements for students.

Funding is provided through a diversity of funding streams, with the aim of balancing accountability and regulatory obligations with the flexibility to respond to local priorities and emerging needs.

Source: Case study provided by National Rural Health Alliance

### Case Study – Rural Doctor’s Network – Collaborative Care Workforce Models for remote and Rural Communities<sup>31</sup>

#### What is the Collaborative Care Program?

The Collaborative Care Program is a community-centred approach to addressing the primary health care challenges in remote and rural NSW. These challenges include the recruitment and retention of health practitioners, financial sustainability of health services, and continuity of care. The program received government funding in March 2021 and is expected to run until June 2022.

#### Where are these projects?

The program in 2021–22 will develop and test unique primary health care workforce models in five locations, or ‘sub-regions’, across remote and rural NSW:

1. The 4T’s (Tottenham, Tullamore, Trangie and Trundle)
2. The Canola Fields (Canowindra and its surrounding towns)
3. Lachlan Health Region (based around Parkes, Forbes and Condobolin)
4. Snowy Valleys Health Region (Tumut, Batlow, Adelong, Tumbarumba)
5. Wentworth Shire.

These projects integrate with existing Australian Government and NSW Ministry of Health initiatives.

#### What happens beyond June 2022?

The Collaborative Care Program will test how these innovative approaches might address challenges more broadly in remote and rural Australia. The Rural Doctor’s Network will be looking to strengthen its partnership with the Australian Government to expand the scope of activities to include other remote and rural communities.

More information on this program can be found in Appendix 6 Case Study: Rural Doctor’s Network – Collaborative Care Workforce Models for remote and Rural Communities.

#### How the pillar addresses 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.

<sup>31</sup> Collaborative Care Workforce Models for Rural and Remote Communities ([nswrdn.com.au](http://nswrdn.com.au)) (accessed 8 September 2021)

## Pillar 5 – Aboriginal and Torres Strait Islander health

**This pillar primarily covers recommendation 4 and is across all others.**

It focuses on implementation of the National Agreement on Closing the Gap for Aboriginal and Torres Strait Islander peoples through structural reform of the primary health care system. Actions within this pillar and across all others aim 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.

This pillar should be supported by all other pillars.

### Example: Aboriginal and Torres Strait Islander Community Controlled Health Services

Aboriginal and Torres Strait Islander community controlled comprehensive primary health care services are unique. Each is controlled by the Community receiving the service. Cultural Authority is guaranteed as each service is governed by a community-elected board. The local community identifies needs and demands that is service 'delivers care our way'.

The Model is an act of self-determination. Self-determination cannot be achieved through any other model. It is true to the universal principles of primary health care articulated in the 1978 Declaration of Alma-Ata which stated that 'people have the right and duty to participate individually and collectively in the planning and implementation of their 'health care'.

The model of primary health care integrates health promotion, community development and social action with clinical services and individual health care.

The continuity of care offered in community-controlled services will decrease rates of potentially preventable hospitalization (PPH)<sup>32</sup>, a standardised system-level measure of the operational capacity of primary care functioning<sup>33</sup>. One major<sup>34</sup> study concluded that fifty percent more health gain could be achieved if health programs were delivered to Aboriginal populations via Aboriginal community control, compared to the return on investment if the same programs were delivered via mainstream primary care services.

A recently planned transition of a remote primary health care service from government management to community control increased utilisation of primary health care by 408%<sup>35</sup>. This transition accelerated immunisation rates. It reduced the proportion of low-birth weight babies to less than 10% of the entire birth cohort. It increased employment of qualified Aboriginal and Torres Strait Islander people.

Source: Example provided by National Aboriginal Community Controlled Health Organisation

See Appendix 6 for two case studies;

- Case Study: Far North WA – Kimberley Aboriginal Medical Services
- Case Study: South East Queensland – Institute for Urban Indigenous Health.

### How the pillar addresses 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 using 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.

<sup>32</sup> Lavoie J, Philips-Beck W, Kinew K et al. The relationship between rates of hospitalization for ambulatory care sensitive conditions and local access to primary healthcare in Manitoba First Nations communities. *Can J Public Health* 112, 219–230 (2021). <https://doi.org/10.17269/s41997-020-00421-3>

<sup>33</sup> Ma G, Ward JE. Location and primary health care reform. *Med J Aust* 2020; 213 (3):

<sup>34</sup> Vos T et al. Assessing Cost-Effectiveness in Prevention (ACE-Prevention): Final Report. 2010, ACE-Prevention Tam: University of Queensland, Brisbane and Deakin University: Melbourne

<sup>35</sup> Myott, P., Martini, A. & Dwyer, J. 2015 Miwatj and East Arnhem: Case study, The Lowitja Institute, Melbourne.

## Pillar 6 – Health workforce

This pillar primarily covers recommendations 10 to 14.

It has specific actions to 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.

It includes a comprehensive and integrated health workforce plan to address workforce shortages, meet health system and population health needs with an adequately skilled workforce, enabling providers to work to full scope of practice. The health workforce plan includes specific strategies and actions to address the disparate issues faced by different professions in the primary health care team, including allied health, nursing, midwifery, medical, mental health, quality practice management, Aboriginal and Torres Strait Islander health workers and non-traditional workforces.

It also includes actions to encourage mutual support and enablement for multidisciplinary team care, while building capacity and sustainability of the workforce as a whole. It will be important to ensure there is a link between the primary care workforce initiatives and what has been identified locally to improve planning, training and retention of aged care, NDIS and social care workforces.

This pillar should support and be supported by all other pillars.

### Case Study: Department of Health – Health Care Homes Program

The Health Care Homes (HCH) Program, which was trialled between 2017 and 2021, centred around an evidence-based, coordinated, multi-disciplinary model of team-based care, which aimed to improve efficiency and promote innovation in primary care services. The model moved away from a fee-for-service, GP workflow based model of care to a bundled payment approach, which gave participating practices more flexibility to design care around the needs of the enrolled patient, and to improve patient satisfaction and health outcomes.

One of the primary benefits of the HCH model reported by practices at the 2019 HCH Forum was that the bundled payment model allowed team members the flexibility to take on roles, which used their qualifications and allowed them to work to their full scope of practice. Moving away from pure fee for service and the MBS requirement that (most) services to the patient be provided by the GP enabled them to refocus on the importance of team-based care and to redistribute roles, responsibilities and tasks. This 'sharing of the workload' across team members, while remaining under the clinical governance of the patient's chosen GP, led to innovation in service delivery, enhanced service capacity, and improved efficiency and effectiveness.<sup>36</sup>

Bundled payments also allowed practices and GPs to realign their workflows in a collaborative manner. As well as servicing the patient's attending in person, funding alternative to the MBS allowed the practice team and GP to outreach to patient cohorts in order to proactively provide care that was required using various modalities including telehealth, email, and patient engagement apps.

In addition, the introduction of share care planning under the HCH model ensured that care was delivered by a multidisciplinary team, including specialists, allied health professionals and pharmacists, in a more integrated and coordinated way. Some HCH patients reported better communication between their care team and positive experiences with accessing allied health services, such as physiotherapy and dietetics.<sup>37</sup>

The final evaluation report for the HCH Program is planned to be published in early 2022.

### Case Study: Newcastle NSW – Cardiff ATUNE Health Centre

Opened in 2020, the Cardiff ATUNE centre is a 'one stop health facility', with an integrated medical centre incorporating specialist and general medical practice, allied health services and complimentary medical care.

In the ATUNE model of care, each person working on-site is directly employed by ATUNE Health Centres and works collaboratively to provide multi-disciplinary treatment across areas such as osteopathy, psychology, physiotherapy, speech pathology, dietetics and podiatry. Allied health is recognised as essential to the best delivery of care for the community and clients.

ATUNE has a unique approach to funding care. ATUNE charge all clients a levy and pool some of the professional fees, which helps pay for some of the additional costs of providing the integrated service.

ATUNE offers a comprehensive client assessment program called an Integrated Team Assessment (ITA), a comprehensive health assessment and management process that involves five different health professionals who work collaboratively to identify a client's health issues and to develop an integrated treatment management plan.

A common vision, function and purpose helps break down professional walls and barriers that are historically created, developing a truly integrated model. The business systems unite their professionals for the benefit of their clients.

Source: Case Study provided by Allied Health Professions Australia

<sup>36</sup> Australian General Practice Accreditation Limited 2019. *Health Care Homes Forum Outcomes Report*

<sup>37</sup> Health Policy Analysis 2020. *Evaluation of the Health Care Homes program – Interim evaluation report 2020, Volume 2: Main report.*



### **Case study: Western Sydney Primary Health Network (WSPHN) – Integrating non-dispensing pharmacists and diabetes specialist care into general practice<sup>38</sup>**

Western Sydney Primary Health Network (WSPHN), in partnership with the Western Sydney Local Health District (WSLHD), jointly fund and deliver alongside general practices across the region an integrated diabetes pathway.

WSPHN funds non-dispensing pharmacists to work in a number of general practices across western Sydney. They also fund outreach diabetes teams consisting of a staff specialist endocrinologist, and diabetes educators. Together they run joint clinics with GPs and their nursing staff that focus on patients finding it hard to manage and live with their diabetes.

Joint case conferences with the patient and their carer, the GP, the practice nurse, the diabetes educator, the non-dispensing pharmacist, and the endocrinologist are held either in person at the GP practice or virtually. Drawing on the services of other allied health providers as needed, this has had the effect of providing a wrap around service that empowers the patient and their carer as well as upskilling the primary care workforce in the management of complex diabetes, all based at the general practice 'home base' of the patient's choosing. Data and care plans are shared across the providers.

Outpatient waiting times, the need for hospital based services, and improved patient outcomes are achieved. Early evidence from NSW Health's Lumos dataset, reported in Western Sydney Diabetes Annual Review<sup>39</sup>, shows this model of care is having a significant mean reduction in patients enrolled in HbA1C of -0.71% (95% CI). A 1% reduction in HbA1C reduces the risk of death by 21%, myocardial infarction by 14%, microvascular complications by 37%, and amputation by 43%. This is a powerful signal that confirms the effectiveness of the program.

*Source: Case Study by Western Sydney PHN and Dr Walid Jammal*

### **How the pillar addresses 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, training programs and health pathways 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>38</sup> [https://wentwest.com.au/wp-content/uploads/chronic\\_disease\\_prevention\\_and\\_management/Report\\_General-Practice-Pharmacist-Program\\_201809.pdf](https://wentwest.com.au/wp-content/uploads/chronic_disease_prevention_and_management/Report_General-Practice-Pharmacist-Program_201809.pdf) (accessed 17 September 2021)

<sup>39</sup> <https://wentwest.com.au/about-us/partnerships/western-sydney-diabetes/> (accessed 17 September 2021)

## Pillar 1: One system focus

### Pillar 1 – One system focus (recommendations 1, 3, 4, 5, 7, 8, 15, 19)

Includes Leverage NHRA (PHNs/LHNs); Integration; Local and community led solutions; One system funding reform; Digital and virtual care; Comprehensive preventive care

(This pillar should support pillar 2, rural and remote and Aboriginal and Torres Strait Islander health) (This pillar needs to be supported by CQI and workforce)

Foundational short term (within 12 months)	Medium term (within three years)	Over the long term
<p><b>Formalised governance agreement:</b></p> <ul style="list-style-type: none"> <li>• <b>Require governance agreement:</b> Require all PHNs, LHNs and other organisations (e.g. RFDS) to have formalised regional planning and funds pooling governance (co-commissioning) agreement in place to create a united focus on integrated care delivery and unlock meaningful sharing of resources, and reduced service duplication and fragmentation.</li> <li>• <b>Concurrent reform:</b> This leverages the NHRA Addendum and should be at the heart of the National Agreement for Mental Health and Suicide Prevention (NAMH&amp;SP).</li> <li>• <b>Consider successful examples:</b> Successful examples in Australia of where this is currently occurring should be considered, to support applying nationally in a consistent manner.</li> <li>• <b>Interface with establish governance structures:</b> Discussions with ACCHs, state and territory affiliates and NACCHO will be held to determine how they might participate in formalised governance agreements for regional planning, joint priority setting, sharing of resources and reduced service fragmentation within regions.</li> <li>• Map existing allied health service relationships with PHNs, ACCHs and LHNs, ensuring existing and required relationships are mapped and gaps identified.</li> <li>• Systematically review consumer, carer and community engagement practices of PHNs and LHNs. Showcase exemplars and develop best practice principles and an improvement plan.</li> <li>• <b>Community needs:</b> 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.</li> </ul> <p><b>Regional solutions:</b></p> <ul style="list-style-type: none"> <li>• <b>Funding of other services:</b> Develop, evaluate and support dissemination of preventive health services found to improve health outcomes at local, state and national level.</li> <li>• <b>Map local wellness services:</b> 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.</li> <li>• <b>Locally designed approaches:</b> Support locally designed approaches to prevention and addressing the social, emotional, financial and other determinants of health.</li> <li>• <b>Enhance access:</b> 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.</li> </ul>	<p><b>Formalised governance agreements:</b></p> <ul style="list-style-type: none"> <li>• <b>Combined local needs assessments:</b> Leverage regional governance agreements and information from VPR, as well as data linkage, to bring together local needs assessments by PHNs Health Workforce Agencies (HWAs) and LHNs, focusing on equity of access and wider determinants of health and mental health (see pillar 3 for data linkage). Assessments should consider what the major problems are, which population groups are most disadvantaged<sup>40</sup>, the best solutions and the most appropriate professionals. Agreements should include better capturing and sharing of data across PHNs, ACCHs and LHNs to support efficient planning, delivery and review of services.</li> <li>• <b>Innovation and funding following need:</b> Agreements should be innovative and fit particular need, with funding available when a need is identified, for example through bundled payments linked to VPR.</li> <li>• <b>Integration and funding reform:</b> PHNs and state based funders should work together to pool and realign funding and integrate community health workers, including maternal child health, child and community nurses into primary health care based on registered population numbers and demographics.</li> <li>• Build in consumer co-design principles and best practices as integral to regional planning, decision making and solutions and invest in education and training to skill-up clinicians, PHN and LHD staff to work effectively with consumers and their insights</li> <li>• <b>Regional solutions:</b> Fund and evaluate a series of 10–15 vanguard initiatives featuring joint governance, planning, funds sharing and/or pooling and collaborative commissioning by PHNs, ACCHs, state and territory affiliates and NACCHO and LHNs to accelerate and demonstrate how implementation can occur). Ensure that funding is appropriately weighted to enable equity across rural and remote communities within these regions. Models must be tailored to regions and the different operations and networks of ACCHs across the country to improve continuity of care and health outcomes for Aboriginal and Torres Strait Islander people.</li> <li>• Include at allied health professions across regionalised initiatives according to community need.</li> </ul>	<p><b>Formalised governance agreements:</b></p> <ul style="list-style-type: none"> <li>• <b>Shared responsibilities:</b> Regional governance agreements to deliver pooled funding models of care, co-commissioning and other forms of payments (such as shared savings), underpinned by shared responsibilities and co-design with consumers and communities</li> <li>• <b>Collaborative commissioning,</b> including funding and resources (e.g. workforce, such as social workers and other allied health shared between practices)</li> <li>• <b>Integrated care system:</b> Build on regional governance agreements and lessons learned to expand one system focus to include social services, including justice, social care, housing, aged care, disability, psychosocial support services and childcare.</li> </ul> <p><b>Direct resources:</b> Build on linked data to direct resources to primary health care services, particularly for preventive health initiatives, including reducing medication adverse events and hospital admissions.</p> <p><b>Regional solutions:</b> Integrated approaches to effectively address major health problems, with resources weighted equitably to improve access for regional and remote communities and populations most in need, including Aboriginal and Torres Strait Islander people.</p> <p><b>Staged implementation of successful models:</b> 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, using both public and private businesses.</p>
<p><b>Patient flow and transitions of care:</b></p> <ul style="list-style-type: none"> <li>• <b>Tailor supports across lifecycle:</b> Tailor support across the lifecycle beginning with antenatal care and child development with family support to aged care.</li> <li>• <b>Primary health pathways:</b> Resource and measure work on safety and quality consistency through health pathways development by PHNs and LHNs, ensuring all stakeholders in the primary health care system are involved in the pathways development.</li> <li>• <b>Social prescribing:</b> Develop a national social prescribing framework linked with primary health care, enabled through PHNs (see CHF, RACGP and Mental Health Australia proposal). This should support self-care and wellbeing for persons in the community.</li> <li>• <b>Health and health system literacy:</b> Scope and develop a primary health care consumer health literacy and self-management support program. This should include health system literacy training for people and primary health care practice and management staff.</li> <li>• <b>Increase community awareness of available services:</b> Co-design local campaigns and programs to increase awareness and communicate services that are available to people.</li> <li>• <b>Enhance care post-hospital discharge:</b> Supporting GPs to provide high-quality, integrated healthcare after a significant health event will reduce hospital re-admissions. Reducing hospital re-admissions has the potential to produce significant savings for the health system, while ensuring patients stay healthier in the community. This could be supported with a SIP or other types of blended payments</li> </ul>		

<sup>40</sup> This should include, but not be limited to, addressing health disparities for Aboriginal and Torres Strait Islander people, rural and remote communities, low SEIFA areas that may or may not be in rural and remote locations, older people, people with mental illness, CALD and LGBTIQ+ communities, people with disability and families with children at risk of adverse childhood experience.

**Pillar 1 – One system focus (recommendations 1, 3, 4, 5, 7, 8, 15, 19)**

Includes Leverage NHRA (PHNs/LHNs); Integration; Local and community led solutions; One system funding reform; Digital and virtual care; Comprehensive preventive care

(This pillar should support pillar 2, rural and remote and Aboriginal and Torres Strait Islander health) (This pillar needs to be supported by CQI and workforce)

Foundational short term (within 12 months)	Medium term (within three years)	Over the long term
<p><b>PHNs</b>  <b>Capability and accountability:</b> Broaden the focus and develop a clear performance and accountability framework for PHNs to integrate care that supports the needs of the population they service, including clearly articulating their role. Commonwealth funding arrangements should be based on principles that need to be met, while allowing local determination of methodology, process and areas of need relevant to that community. This includes working in collaboration with all stakeholders in the primary health care system, including GPs, allied health, nurses, practice managers, ACCHs, pharmacy and social work. Working in collaboration with ACCHs should include in relation to community controlled commissioning/ procurement, not solely as providers of care.</p>	<p><b>PHNs:</b></p> <ul style="list-style-type: none"> <li>• <b>PHN capability:</b> Use the performance and accountability framework to build the maturity and national consistency of PHNs, ensuring more mature PHNs are not unnecessarily limited.</li> <li>• <b>PHN governance:</b> Greater transparency of arrangements.</li> </ul>	
<p><b>ACCHs:</b></p> <ul style="list-style-type: none"> <li>• <b>Closing the Gap:</b> Recognise ACCHs as a key plank of Australia’s primary health care system and require shared decision-making and co-designed structural reform nationally and regionally to improve Aboriginal and Torres Strait Islander health outcomes, supporting community engagement and empowerment, with stronger integration of services across PHNs, LHNs, ACCHs, mainstream providers and hospitals. Implementation Plans under the new National Agreement on Closing the Gap will set in train appropriate funding and resourcing of ACCHs 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. These plans will also invest in the ACCH model of comprehensive primary health care and minimise risk of fragmentation of medical care, including by supporting integration of non-prescribing pharmacists in ACCHs.</li> </ul>	<p><b>ACCHs:</b></p> <ul style="list-style-type: none"> <li>• <b>Transition to community-controlled:</b> Support transitioning of government-run Aboriginal medical services to community-control where this will better meet the needs of communities and improve outcomes.</li> </ul>	
<p><b>Interface with aged care, disability and mental health:</b>            Develop a gap analysis of allied health service provision in primary health, aged care and disability sectors.</p>	<p><b>Interface with aged care, disability, child and maternal health and mental health:</b> Trial of funded primary health care providers (whatever profession best suited) located within aged care services to scaffold clinical skills of existing staff and to help transfer/discharge/keep care in place. This MUST include community care services for people living independently at home.</p> <p>Actions should link in with the Government’s response to the Royal Commission and recent Budget measures, including supporting improved integration of aged and primary health care for Indigenous Elders; aim to support expansion of ACCHs to include aged care.</p>	
<p><b>Comprehensive preventive care:</b></p> <ul style="list-style-type: none"> <li>• <b>Concurrent reform:</b> Link with National Preventive Health Strategy and support increase in funding.</li> <li>• <b>Allied health services:</b> Fund preventive allied health services for people with GP-assessed risk factors such as pre-diabetes, and to support mental health.</li> <li>• Develop funding models and selected targeted interventions initiated. (For example, refer to the Economic Value of Physiotherapy review – APA   Economic value of physiotherapy (Australian.physio), as well as other AHP’s evidence research).</li> </ul>	<p><b>Comprehensive preventive care:</b></p> <ul style="list-style-type: none"> <li>• Evaluate selected allied health targeted interventions.</li> </ul>	<p><b>Comprehensive preventive care:</b></p> <ul style="list-style-type: none"> <li>• Universal access to early intervention, involving required allied health services, at minimal cost to patients.</li> </ul>
<p><b>Emergency preparedness:</b></p> <ul style="list-style-type: none"> <li>• <b>Freely available resources:</b> Provide freely available resources on emergency preparedness to primary health professionals and practices, including what you need to know; what you need to have prepared; who you need to engage with; and, how this work will be done in the funding envelope available.</li> <li>• <b>Commitment to Closing the Gap:</b> 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.</li> <li>• <b>Commonwealth and state roles:</b> 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 ACCHs and regional ACCHs and enabling flexible practicality in a crisis to enable primary health care providers to continue delivering services. ACCHs, state and territory affiliates and NACCHO 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.</li> <li>• Include rural and remote clinicians in their community’s emergency response – includes local hospital, health professionals and ACCHs – state emergency planning to compile list of non-state resources to include in emergency response.</li> <li>• <b>Awareness and availability of current plans:</b> Increase awareness and availability of current plans, including national, local and practice-based.</li> <li>• <b>Mental health services during disaster recovery:</b> Bolster connection with mental health service providers following disasters.</li> <li>• <b>Frameworks for local integrated solutions:</b> 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.</li> <li>• <b>Response networks:</b> Implement and expand rural emergency response networks (RERN), building on RERNS currently in Australia and lessons learned from international experience.</li> <li>• <b>Local planning and delivery:</b> Refine arrangements to support localised planning and delivery of appropriate mental health services during the recovery phase of a disaster.</li> </ul>	<p><b>Emergency preparedness:</b></p> <ul style="list-style-type: none"> <li>• <b>Allied health roles in emergency response:</b> 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.</li> <li>• <b>Primary health care in disaster management:</b> 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.</li> <li>• <b>Mature PHNs and partnerships:</b> 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.</li> </ul>	<p><b>Emergency preparedness:</b></p> <ul style="list-style-type: none"> <li>• <b>Primary health care during emergency response:</b> 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.</li> <li>• <b>Data:</b> 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.</li> </ul>

## Pillar 2: Equitable experience of evidence-based primary health care (person, family, carer and community)

### Pillar 2 – Equitable experience of evidence-based primary health care (person, family, carer, community) (recommendations 2, 3, 5, 6, 8, 15)

Single, continuous, coordinated, Medical Destination; Person centred and empowered; Supported by the rest of the health system; Primary health care funding reform; Collaborative team care with empowered providers and consumers; Enhanced and equitable consumer access to required services, e.g. allied health, social care, mental health; Patient centred health care neighbourhood; Digital and virtual care; After hours

(This pillar should support rural and remote and Aboriginal and Torres Strait Islander health) (This pillar needs to be supported by one system, CQI and workforce)

#### Foundational short term (within 12 months)

**VPR:** with effective messaging and education to show intended benefits for people, providers, population and health system, being a fundamental building block, pathway and mechanism for further investment in evidence-based primary health care services that improve outcomes for people:

- Offer all Australians VPR in with a general practice (medical home-'MyGp'), ACCHs, or Rural Area Community Controlled Health Organisation (RACCHO), allowing access to a single health and care destination coordinating prevention and care delivery. This includes a systematic approach to preventive health activities and include appropriate flexibility/exemptions to support equitable access to services where VPR may be difficult, may not be possible or preferred.<sup>41</sup> Identify appropriate process for VPR – i.e. opt-in (based on practice visited 3 times in last 24 months) supported by patient information on VPR, the benefits of having a medical home, and enhanced capacity registration provides to directing funding to support service provision. It will involve registration with a service and nomination of a GP (including rural generalists).
- **VPR telehealth:** Introduce permanent GP telehealth items linked to VPR and NPs and practice nurses working in general practice, ACCHs and RACCHO. Allow telephone consults between registered nurse (on behalf of patient) in RACF and GP to be deemed the same as between patient and GP. Consider appropriate exemptions to accessing telehealth services, for example ongoing COVID-19 complications, vulnerable groups (for example people experiencing homelessness) and allowing telephone consultations in remote communities who do not have Internet access to allow video consultations.
- **Telehealth patient end supports:** Consider extending appropriate patient end telehealth supports, especially in rural and remote areas.
- **High value MBS items:** Link high value MBS items to VPR, such as care planning items, review items (chronic and mental health), health assessments and medication reviews.
- **Enhanced access to after hours:** Facilitate enhanced access to after hours primary health care services through a person's registered practice, supported by a blend of fee-for-service and block funding. Consider barriers and facilitate greater access to after hours services through ACCHs for Aboriginal and Torres Strait Islander people.
- **Patient supports:** Introduce and evaluate trials of different approaches to care coordination and system navigation support, including health coaching, patient health pathways and introduce a systematic approach to social prescribing<sup>42</sup> to link registered people to the services and community connections they need, improving care partnership and activation.
- **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.
- **Wound care:** Design a mechanism for supporting access/payment for patient wound consumables.
- **Rural Area Community Controlled Health Organisations (RACCHOs):** Include the establishment of RACCHOs as a feature to support the rollout of VPR (see pillar 4).

#### Medium term (within three years)

**VPR:**

- **Telehealth:** Support integration of telehealth into clinical practice systems to streamline access and payment (built on digital infrastructure).
- **Remote monitoring:** Resource use of remote monitoring for at-risk patients (built on data, research and digital infrastructure).
- **Tailor services:** Link VPR with social services depending on the needs of the community.
- **High value MBS item changes:** Bring in MBS Review recommendations item changes tied to VPR, for example tying chronic disease management and care planning items together. Equalise the rebate between GP chronic disease management plan preparation and review to support longitudinal care.
- **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.

#### Over the long term

<sup>41</sup> To support equitable access to care, VPR requires appropriate flexibility/exemptions to support addressing health disparities for Aboriginal and Torres Strait Islander people, rural and remote communities, low SEIFA areas that may or may not be in rural and remote locations, older people, people with mental illness, CALD and LGBTIQ+ communities, people living with disability and families with children at risk of adverse childhood experience.

<sup>42</sup> See joint proposal from CHF, RACGP and Mental Health Australia



**Pillar 2 – Equitable experience of evidence-based primary health care (person, family, carer, community) (recommendations 2, 3, 5, 6, 8, 15)**

Single, continuous, coordinated, Medical Destination; Person centred and empowered; Supported by the rest of the health system; Primary health care funding reform; Collaborative team care with empowered providers and consumers; Enhanced and equitable consumer access to required services, e.g. allied health, social care, mental health; Patient centred health care neighbourhood; Digital and virtual care; After hours

(This pillar should support rural and remote and Aboriginal and Torres Strait Islander health) (This pillar needs to be supported by one system, CQI and workforce)

**Foundational short term (within 12 months)**

**Funding reform:**

- **Workforce Incentive Program (WIP):** Expand and remove caps on the WIP Practice Stream to increase a general practice's ability to employ nurses, allied health, non-dispensing pharmacists and Aboriginal health practitioners/workers. Develop an accountability framework for WIP to encourage provision of high quality clinical care. This may lead to a graded model of WIP where practices provide evidence of using the team members for provision of high quality care, with principles and flexibility to meet community needs based on the data available, including community qualitative input. This should consider appropriateness in a range of settings and additional required supports, for example rural and remote areas.
- **Innovative funding reform:** Map current funding mechanisms to objectives to inform enhanced blended funding, incentivising patient outcomes and impact. Enhance accountability for existing funding payments such as WIP and PIPQI payments so that they enhance use of HCPs to full scope of practice.
- Ensure modelling innovative equitably funded models for allied health has begun.
- **Allied health:** Establish an allied health funding reform committee to oversee the funding reform process.
- Ensure committee established, bridging funding allocated, local solutions identified via mapping and gap analysis, funding models developed.
- **Establish a Mental Health Service Incentive Payment (SIP):** to deliver continuous and regular care for those with complex needs, and enhance access to medical services for people presenting with mental health issues. This would be payable when a patient receives a GP mental health plan, at least one review per year of the mental health plan (MBS Items 2713 or 2715), and a physical health assessment (given the high incidence of physical health concerns associated with mental health). To encourage continuity of care, these SIP payments would be limited to enrolled patients.
- **Establish a Service Incentive Payment (SIP) for over 75s:** This would incentivise the provision of the continuous and complex care required by this group. It will also enhance the delivery of preventative health activities by GPs to keep older people healthier. Payments would be tiered for the delivery of comprehensive care for people over the aged of 75 and Aboriginal and Torres Strait Islander people 55 and over. Propose higher payments would be provided for more complex care, including home visits. To encourage continuity of care, these SIP payments would be limited to enrolled patients.

**Allied health specific services:**

- **Telehealth:** Extend and make permanent Allied Health telehealth items.
- **Case conferencing:** Support and fund allied health professionals to participate in GP and non-GP medical specialist-led case conferences, as well as where appropriate, allied health initiated and led multi-disciplinary case conferences.
- **MBS Review Taskforce:** Implement in their entirety the recommendations from the MBS Review Taskforce related to allied health services, including mental health.

**Residential aged care facilities and disability care homes:**

- Involve primary health professions in Clinical Governance and Safety.

**Community based home aged and disability health care, including in rural and remote areas:**

- VPR driven supplementary **funding to support** coordination and **service provision**

**GP supported palliative care:**

- VPR driven supplementary funding to support coordination and service provision to support care in place and hospital avoidance where clinically appropriate.

**Medium term (within three years)**

**Funding reform:**

- **WIP:** Change WIP funding to be based on registered patients, rather than enrolled population.
- **A blend of block and bundled funding to general practice based on VPR:** Use VPR as a basis for voluntary and flexible funding in general practice that supports quality care based on complexity and need of registered patient cohort.
- **Chronic disease management and team care arrangements** Consider access to additional nursing and allied health services for registered patients, in addition to those available under CDM. This should be based on patient need (assessed by data frameworks around VPR), rather than a set number of services and should be funded to support this, for example through block or blended payments.
- **Incentivise primary health care nursing:** Use block payments to increase the utilisation of, and to reduce the disparity between primary health care and aged care nursing and the other parts of the health sector.
- **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, paramedic services and rural and remote communities, building on the work of the National Rural Health Commissioner and suggested models.
- **Allied health funding:** Develop alternate and equitable funding mechanisms for allied health care provided as part of a patient's care plan.
- **Private health insurance:** Include reforms to Private Health Insurance (PHI) to allow delivery of contemporary and evidence based primary health care by allied health professionals, as well as to recognise general practice and nursing services.
- **Pooled funding:** Appropriate local and regional pooled funding building on 'one health system' and registered patient cohort, noting numbers and demographics of registered population may not be representative of total population.
  - » Rollout of innovative equitably funded models for allied health.
  - » Develop overarching and funded local solutions, including where allied health professionals refer to specialists or other allied health services.
- **Establish a Disability Health Incentive Payment (SIP)** Implementing a SIP for people with disability would support the delivery of comprehensive and continuous GP-led care for this group. SIP would be based on completion of three disability-health related GP visits and a health assessment. This measure would expand health assessments to include all people with disability. To encourage continuity of care, these SIP payments would be limited to enrolled patients. This investment could be measured through current SIP payment mechanisms.
- **Introduce health assessments for those aged 65 to 74:** This measure would amend GP Management Plan eligibility criteria or expand health assessments to include all over 65s. Eligibility could be linked to patients who are voluntarily enrolled with their practice. This investment could be measured through linking VPE data to MBS item number reports.

**Over the long term**

**Funding reform:** Flexible funding models that support value-based care. These include collaborative commissioning, pooled funding and shared savings models.

**Multidisciplinary team care:** Build on VPR to evolve general practice to be able to better coordinate multidisciplinary team care, enabled through one health system, shared and pooled funding models, and increased collection and analysis of integrated data

## Pillar 3: Continuous quality improvement, safety and future focus across the system, for consumers and providers

Ongoing governance; Leadership and change management; Data; Enabled by funding reform; Digital and virtual care; Research and innovation

### Pillar 3: Ongoing governance and implementation

Pillar 3 – Continuous quality improvement, safety and future focus across the system, for consumers and providers (recommendations 9, 15, 16, 17, 18 and 20)		
Ongoing governance; Leadership and change management; Data; Enabled by funding reform; Digital and virtual care; Research and innovation		(This pillar should support all other pillars)
Foundational short term (within 12 months)	Medium term (within three years)	Over the long term
<b>Ongoing governance and implementation (predominantly recommendation 20)</b>		
<p><b>Independent oversight group:</b> 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 (incl. ACCHs), government representatives from the Commonwealth, states and territories and independent expert advisors.</p>		
<p><b>Implementation, evaluation and refinement:</b> 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 through the NHRA Addendum 2020–2025 and the new National Agreement on Closing the Gap.</p> <ul style="list-style-type: none"> <li>• <b>Implementation Plan:</b> Co-design a stepped Implementation Action Plan with specific, measurable, achievable, realistic goals with specified timeframes. This should include a set of principles to allow local implementation based on community need, as well as enabling national evaluation.</li> <li>• <b>Monitoring and Evaluation Framework:</b> Co-design a Monitoring and Evaluation/research Framework for the 10 Year Plan, with accountabilities assigned and transparency on the effectiveness of program delivery assured. This framework should include targets in the new National Agreement on Closing the Gap.</li> <li>• <b>Data return:</b> Research teams should report back to communities where research has been conducted to enable community members to benefit from the research findings.</li> <li>• <b>Collaboration:</b> Collaborate closely with and ensure ongoing involvement of the broad range of leadership, institutions and organisations across the health sector, including:             <ul style="list-style-type: none"> <li>» Users of health services</li> <li>» Relevant professional bodies</li> <li>» Researchers</li> <li>» Community-based bodies, such as ACCHs (consistent with the National Closing the Gap Agreement, the Community Controlled Health Sector should be represented on the oversight committee and partnered with for implementation of the plan)</li> <li>» Private health care providers</li> <li>» Associated agencies, like the Australian Institute of Health and Welfare (AIHW), the Australian Digital Health Agency and the Australian Commission on Safety and Quality in Health Care (ACSQHC)</li> <li>» All bodies with a role in education and training of the primary health care workforce</li> <li>» The national network of PHNs</li> <li>» States and territories, through the NHRA and other cross-jurisdictional commitments.</li> </ul> </li> </ul>	<p><b>Monitoring and Evaluation:</b> 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.</p>	
<p><b>Concurrent reform:</b> Ensure current and ongoing alignment with other cross-jurisdictional reform priorities.</p>	<p><b>Funding reform:</b> Support current innovative funding models, share learnings and staged roll out of successful case studies.</p>	<p><b>Funding reform:</b> Systematically use data to inform funding changes and further reform. Introduce layered funding that supports service provision, integration of care, quality improvements, improved outcomes, efficient and effective use of resources, innovative and flexible care balancing the risks of unintended consequences.</p> <p>Reinvestment of shared savings to future funding decisions</p>
<p><b>Leadership and change:</b> Enable, with support from colleges and peak organisations, cultural change, leadership and change management by resourcing education for GPs, practice managers, nurses and allied health professionals on Medical Home/Coordinated Team Care through engagement with PHNs, peak organisations and colleges.</p>		

## Pillar 3: Leadership and change management

### Pillar 3 – Continuous quality improvement, safety and future focus across the system, for consumers and providers (recommendations 9, 15, 16, 17, 18 and 20)

Ongoing governance; Leadership and change management; Data; Enabled by funding reform; Digital and virtual care; Research and innovation

(This pillar should support all other pillars)

Foundational short term (within 12 months)	Medium term (within three years)	Over the long term
<b>Leadership and change management (predominantly recommendation 9 and across others)</b>		
<p><b>Inspire change, including showing what's worked and using current leadership:</b></p> <ul style="list-style-type: none"> <li>• <b>Successful examples:</b> Identify examples of successful leadership, innovation and change management around one system. For example, leadership within allied health practices with little resourcing, incentive and support.</li> <li>• <b>Framework for expansion:</b> Develop a framework to enable expansion of successful leadership, innovation and change management, linking in with the Australian Institute for Primary Health Care Research Translation and Innovation (see research pillar), PHNs, rural and remote bodies and peak organisations.</li> <li>• <b>Share learnings:</b> Increase performance transparency across the primary health care system, specifically identifying, rewarding and sharing successful examples of quality improvement, multidisciplinary teamwork and integrated care.</li> <li>• <b>Show benefits:</b> Create or collect data on how practices and patients can benefit from cultural change, for example regional co-commissioning. Collect case studies that underline the benefits to practices in changing the culture of their practice and the medical profession, including in relation to business sustainability and patient outcomes.</li> <li>• <b>Role models:</b> Use positive role models and local change champions.</li> <li>• <b>Cultural change:</b> Embed workforce, funding and other primary health care reforms into evolving models of care and training (see recommendation 9).</li> </ul>	<p><b>Inspire change, including showing what's worked and using current leadership:</b></p> <ul style="list-style-type: none"> <li>• <b>Successful examples:</b> Expand examples of successful leadership, innovation and change management, supported through staged implementation (see also data for sharing examples of using data).</li> <li>• <b>Show benefits and share learnings with providers:</b> Share successful examples and provide practices the data and evidence to interrogate for their own practice.</li> </ul>	<p><b>Inspire change, including showing what's worked and using current leadership:</b></p> <p><b>Shared learning and innovation:</b> Innovative thinking and ways of working that improve clinical and service outcomes are systematically supported, leveraged and disseminated, via awareness of best practice, use of data and research, and encouragement of service innovation.</p>
<p><b>Support change through effective change management:</b></p> <ul style="list-style-type: none"> <li>• <b>Well-resource contemporary change management:</b> Well-resourced nationally to roll out and locally to allow practices (all professions) the time and resources to upskill all staff members (practically and sustainably) – includes with additional resources (e.g. workforce), skills, knowledge and attitudes to achieve primary health care reform</li> <li>• <b>Business sustainability:</b> Provide reliable and predictable funding to support business commitment to change</li> <li>• <b>Fund change:</b> Use health pathways (see one system) and provide funding to support redesign of clinical workflow and team collaboration, for example through engagement with PHNs and block funding for team care.</li> <li>• <b>Resourcing:</b> Resource practices to be able to invest in essential changes, with flexibility that recognises challenges with limited resourcing, for example rural and remote areas.</li> <li>• <b>Targeted investment:</b> Consider targeted incentives for change.</li> </ul> <p><b>Existing support structures:</b> Leverage existing structures, such as PHNs, ACCHs, NACCHO and state and territory affiliates, 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.</p> <ul style="list-style-type: none"> <li>• <b>Professional body's role:</b> Immediate and ongoing leadership from professional bodies to support change management is crucial. A shared vision and constant support will be required to initiate maintain and consolidate change.</li> <li>• <b>PHN role:</b> develop and use a consistent methodology and framework for continuous quality improvement (for example 'the Model for Improvement') to foster a sustainable culture of QI within primary care practices.</li> <li>• <b>ACCH role:</b> NACCHO and state and territory affiliate role: To strengthen understanding of the ACCH model of care across the broader health system and continuously improve the delivery of comprehensive and culturally safe care to improve the health and wellbeing of Aboriginal and Torres Strait Islander people in all healthcare settings.</li> <li>• <b>Education and training sector role:</b> Immediate incorporation of interdisciplinary training and broadening it where it already exists will help to deliver a well-informed emerging health workforce better prepared for collaboration and multidisciplinary care.</li> </ul>	<p><b>Support change through effective change management:</b></p> <ul style="list-style-type: none"> <li>• <b>Clinician/consumer collaboration:</b> Adopt collaborative practices with consumers, carers and families and clinicians working together</li> <li>• <b>Incentivise models of collaboration and interdisciplinary training (see workforce pillar):</b> e.g. huddles, multidisciplinary collaboration. Support development of models that involve clear multidisciplinary collaboration on a daily basis to support patient care, for example through the WIP and RACCHOs.</li> </ul>	<p><b>Support change through effective change management:</b></p> <p><b>Business sustainability:</b> Business profitability and sustainability aligns with high quality patient outcomes.</p>
<p><b>Support change through fostering leadership:</b></p> <p><b>Early adopters:</b> Support and incentivise early adopters of change.</p>	<p><b>Support change through fostering leadership:</b></p> <ul style="list-style-type: none"> <li>• <b>Development opportunities:</b> Provide opportunities for evaluation, research and ongoing development, including encouraging and enabling primary health care to lead research and innovation, targeting aspects of the Quadruple Aim.</li> <li>• <b>Education and training:</b> 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, including in undergraduate curricula and early career professional transition.</li> </ul>	<p><b>Support change through fostering leadership:</b></p> <p><b>Leadership:</b> Leadership is fostered and supported in consumers, carers and their families, primary health care providers, practice managements, business owners, academics and the broader health and care system in delivering equity, continuous quality improvement and a whole-of-system focus.</p>

**Pillar 3: Data – benchmarking, linking and using**

**Pillar 3 – Continuous quality improvement, safety and future focus across the system, for consumers and providers (recommendations 9, 15, 16, 17, 18 and 20)**

Ongoing governance; Leadership and change management; Data; Enabled by funding reform; Digital and virtual care; Research and innovation

(This pillar should support all other pillars)

Foundational short term (within 12 months)	Medium term (within three years)	Over the long term
<b>Data – benchmarking, linking and using (predominantly recommendation 17 and across others)</b>		
<p><b>Culture of data driven improvement, supporting use of data by providers for quality improvement and reinvestment:</b> Set the foundation to build a culture of evidence-based quality improvement through using data, for people, providers and the system. Build confidence in privacy, safety, security and use of data for people and providers.</p> <ul style="list-style-type: none"> <li>Lessons learnt from LUMOS and collaborative commissioning in NSW to prime for the rest of the country</li> <li><b>Shared learnings:</b> Share/publicise examples of successfully using data for clinical improvement, for example stories from health care homes trial as well as other improvement collaboratives around the country</li> <li><b>Self-benchmarking and quality improvement:</b> Facilitate data drive self-benchmarking and quality improvement at the local and practice level               <ul style="list-style-type: none"> <li>Define clearly governance over and use of data that is collected and shared (see also governance below)</li> <li>Support, incentivise and educate practices about privacy, cybersecurity and maintaining data systems, linking in with the work of the Australian Digital Health Agency</li> <li>Undertake a survey that looks at current use of data, including number of practices who understand and use PIPQI data.</li> </ul> </li> </ul>	<p><b>Culture of data driven improvement:</b> Use data to justify further investment and build feedback loop to GPs to prove outcomes. 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.</p> <p><b>Equitable experience of care:</b> A report card should be developed linking investment with outcomes for people. Linked to the goal of person-led care, introduce PREMS that provide feedback on the collaborative team care experience for people</p>	
<p><b>Overarching and one health system data collection and use:</b> Develop, measure and use, in association with peak bodies, service data collection and meaningful use across settings and the care continuum – this includes quantitative and qualitative data that looks at patient recorded measures (e.g. PREMS/PROMs) and population health management.</p> <ul style="list-style-type: none"> <li><b>Governance:</b> Develop a robust governance framework for establishing standardised data assets and coding, integrating and linking data sets and analysing and translating data. This should include in relation to privacy, safety, security and use of data. Standardisation should consider relevance and variability across different contexts, with high commentary on the difficulties in drawing comparisons in the outcomes across different settings. Data should not be used for judgement and performance management but should be used for quality improvement by widely socialising local initiatives that have improved care. There should also be an appropriate process and supports in place to enable accurate analysis and translation of data into useable information, by providers and communities.</li> <li><b>Linkage:</b> Develop foundations for data linkage between currently collected datasets, including HeadsUPP, developing AIHW primary health care data set and others (e.g. Nurse Workforce Survey), as well as the separate needs analyses from PHNs, HWAs and state government databases, leveraging and building on what is currently available. Lift restrictions on utilising HeadsUPP data to enable appropriate sharing and use.</li> <li><b>Transparency:</b> Transparency of data to the community and at an individual practice level where appropriate on matters of safety (e.g. prescribing rates), quality (e.g. person-led clinical planning) and outcomes, as well as widgets (inputs like expenditure).</li> <li><b>Data and documentation:</b> 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.</li> </ul>	<p><b>Overarching and one health system data collection and use:</b></p> <ul style="list-style-type: none"> <li><b>Interoperability:</b> Drive National Health System Interoperability Standards, including standardised collection of data, secure exchange of data across multiple systems, standardised coding and consolidating and streamlining data provision to reduce administrative burden of data reporting.</li> <li><b>Use:</b> Use linked data to inform development, sustainability/business continuity and devolvement of services; research, innovation, planning, review and evaluation. This should lead to redistribution of funding towards high quality care, for example through the single medical destination. This redirection should be enabled at a practice, local, regional and national level, in line with one health system focus.</li> <li><b>Equipped workforces:</b> Bolster capacity and provide additional supports for providers and practice managers to use their data to continuously improve their services for people.</li> <li><b>Build on regional governance agreements (one system pillar):</b> <ul style="list-style-type: none"> <li>Build on the data governance framework through PHN/LHN regional governance agreements (one system pillar) and collaborative commissioning to over time better collect, integrate and share data across sectors, learning from the work of NSW.</li> <li><b>Patient reported measures:</b> Implement use of PROMs to demonstrate impact of quality improvement measures, building on regional agreements between PHNs and states. This should ensure PROMs data is reflective of Indigenous and other vulnerable populations.</li> </ul> </li> <li><b>Develop and introduce KPIs at all levels that support quality care:</b> <ul style="list-style-type: none"> <li><b>For example, clinical handover:</b> Measure and report on number of patients whose GP and/or allied health is contacted by the hospital on discharge and number of patients whose GP and/or allied health follows up after discharge. This information should be made transparent to people, potentially through a dashboard.</li> </ul> </li> </ul>	<p><b>Overarching and one health system data collection and use:</b></p> <ul style="list-style-type: none"> <li><b>Service planning:</b> Richer data flowing to support evidence-based population health resource allocation and service delivery improvements, including collecting and reporting data centrally to inform service planning, delivery, and workforce. Over the long term, fully integrated datasets should allow near real time policy, resource allocation and service delivery improvements nationally, regionally and locally, with data and outcomes transparent to providers and to patients. This is underpinned by the digital infrastructure.</li> <li><b>Expected outcomes:</b> improved experience care for people and communities, as well as justification for additional funding towards primary health care.</li> </ul>



**Pillar 3: Data – benchmarking, linking and using (continued)**

**Pillar 3 – Continuous quality improvement, safety and future focus across the system, for consumers and providers (recommendations 9, 15, 16, 17, 18 and 20)**

Ongoing governance; Leadership and change management; Data; Enabled by funding reform; Digital and virtual care; Research and innovation

(This pillar should support all other pillars)

Foundational short term (within 12 months)	Medium term (within three years)	Over the long term
<p><b>Primary health care specific:</b></p> <ul style="list-style-type: none"> <li>• <b>Allied health:</b> <ul style="list-style-type: none"> <li>» Develop an allied health primary health care minimum dataset, including staged implementation of data collection from allied health practice in conjunction with the AIHW primary health care data asset project. This would include scaling up data collection from allied health practices through PHNs over time.</li> <li>» Immediate commitment to resource AH practices to have consistent digital health capacity / solutions to capture data effectively and seamlessly.</li> <li>» Identify existing and potential new data sets for Allied Health, which capture intervention and patient outcomes data, to inform and support evidence concerning client pathways and quality service.</li> <li>» Identify allied health primary health care minimum dataset and data collection methodology and requirements. Post-scoping, further investment in 2022 Budget.</li> </ul> </li> <li>• <b>PHN Primary Health Insights:</b> Use and develop the PHNs Primary Health Insights initiative and platform to enable local level feedback to general practices for improvement and innovation, as well as feeding into service planning in collaboration with LHNs and other organisations (e.g. WA PHN, Western Sydney PHN, North Brisbane PHN)</li> <li>• <b>Complete data ecosystem:</b> Provide additional funding to build a complete data ecosystem to collect, validate and analyse data, building upon and aligning with the work undertaken by the Australian Institute of Health and Welfare to build a primary health care data asset, including the use of patient reported measures (PREMs and PROMs).</li> <li>• <b>Patient reported measures:</b> Implement use of PREMs to understand patient experience and use data to inform patient-centred care initiatives that are transparent to patients, facilitated by PHNs in collaboration with providers.           <ul style="list-style-type: none"> <li>» Education and socialisation in the community and consumers in relation to PREMs/PROMs.</li> </ul> </li> </ul>	<p><b>Primary health care specific:</b></p> <ul style="list-style-type: none"> <li>• <b>Allied health:</b> <ul style="list-style-type: none"> <li>» Integrate with primary health system-wide data and quality reporting ie AIHW Primary health care data</li> <li>» Ensure data integration of patient outcomes is embedded in an evidence-based and qualitative research framework to build upon an allied health research agenda and strategy.</li> </ul> </li> </ul>	<p><b>Allied health:</b> Interrogate allied health evidence and data to build future focused approaches, which strengthen preventative health initiatives</p> <p>Investigate how allied health data (including from local solutions) can contribute to AIHW primary care data asset project.</p>

## Pillar 3: Digital and virtual care

### Pillar 3 – Continuous quality improvement, safety and future focus across the system, for consumers and providers (recommendations 9, 15, 16, 17, 18 and 20)

Ongoing governance; Leadership and change management; Data; Enabled by funding reform; Digital and virtual care; Research and innovation

(This pillar should support all other pillars)

Foundational short term (within 12 months)	Medium term (within three years)	Over the long term
<b>Digital and virtual care (predominantly rec 15 and across others)</b>		
<p><b>Digital health care:</b></p> <ul style="list-style-type: none"> <li>• <b>Education and training:</b> Peak bodies, educational institutions and professional organisations to develop education, training and continuing professional development (CPD) resources to equip primary health care providers, including allied health, to use up to date technology in line with the preferences of people and communities. Build capacity of primary health care to expand and use digital infrastructure and developing clinical systems, including multidisciplinary providers, administrators and managers.</li> <li>• <b>Concurrent work:</b> Leverage the work of the Australian Digital Health Agency and align with the directions from the new National Digital Health Strategy to build the infrastructure and support for update of digital and virtual care.</li> <li>• <b>Digital infrastructure:</b> Provide financial subsidisation to increase digital health infrastructure for allied health practices.</li> <li>• <b>Prioritised funded provision of digital infrastructure and support in existing allied health practices, to achieve digital equity with other health providers.</b></li> <li>• <b>Telehealth:</b> Build a quality and safety clinical governance framework around the telehealth model.</li> <li>• <b>Consumer digital readiness:</b> Support digital readiness for people to embrace technology and digital modes of delivering care, as an adjunct for face to face services, including in relation to trust, social licence and capture of data. Educate consumers about their rights, as well as complaint and feedback processes.</li> <li>• <b>Patient supports:</b> Provide additional resources and supports for people, where required, to support equitable access to data and digital modes of care for disadvantaged populations, for example patient end telehealth supports (see pillar 2).</li> </ul>	<p><b>Digital health care:</b> Build infrastructure and support uptake of digital health</p> <ul style="list-style-type: none"> <li>• <b>Digital navigators:</b></li> <li>• <b>Digital educators:</b></li> <li>• <b>Digital infrastructure:</b> Establish funding pool for emerging/new AH practices and for take-up of new technologies as they are developed. All AH practices are digitally enabled.</li> <li>• <b>Remote monitoring:</b> support remote monitoring of people by GPs through bundled payments, use of regional based block/pooled funding and appropriate use of data.</li> <li>• <b>Use of technology:</b> As services and technologies become more viable and show improved, equitable outcomes and cost benefit they should be embedded into the system software, e.g. genomics, point of care testing and artificial intelligence, asynchronous health care.</li> </ul>	<p><b>Digital health:</b> People have equitable access to high quality digital health care.</p>
<p><b>Improved communication and multidisciplinary team care:</b> Develop digital platforms to support continuous quality improvement and multidisciplinary teamwork across the continuum of care, while reflecting on and addressing barriers experienced in the Health Care Homes trial in relation to shared care systems and My Health Record.</p> <ul style="list-style-type: none"> <li>• <b>Secure messaging and My Health Record:</b> Develop secure messaging and software infrastructure to support allied health communication with general practice and each other, 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.</li> <li>• <b>Provider Connect Australia:</b> Support the role out of Provider Connect Australia, developed by the Australian Digital Health Agency to improve the accuracy of provider databases to support accurate and timely communication between health care providers.</li> <li>• <b>e-prescriptions:</b> expand e-prescription capability, prioritising aged care.</li> <li>• <b>Shared care planning:</b> Learn from and build on work in NSW to support multidisciplinary shared care planning.</li> <li>• There should be 50% of allied health networked.</li> </ul>	<p><b>Improved communication and multidisciplinary team care:</b></p> <ul style="list-style-type: none"> <li>• <b>Secure messaging:</b> Promote meaningful use of secure messaging between providers to improve care access and quality.</li> <li>• <b>My Health Record:</b> Fetch and present relevant data from MyHR to fit in with clinical workflow e.g. Path and DI results requested by others, medications prescribed elsewhere alongside the local medication list. Share by default when a MyHR exists without extra workflow, e.g. a change to a medication list or an allergy or an update to a problem list.</li> <li>• <b>e-referrals:</b> Develop e-referral capability, with appropriate clinical system updates and supported by Provider Connect Australia.</li> <li>• <b>Shared care planning:</b> Invest in system integration and shared care planning, with a copy to be made available via the MyHR</li> <li>• There should be 100% of allied health networked.</li> </ul>	<p><b>Improved communication and multidisciplinary team care:</b> Multidisciplinary team and the health system is connected through digital infrastructure.</p>
<p><b>Clinical systems:</b> 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:</p> <ul style="list-style-type: none"> <li>• <b>Clinical Information Systems:</b> Support providers of Clinical Information Systems in primary health care, specialist, allied health, pharmacy and hospital systems to more fully integrate with My Health Record and health pathways via PHNs to display and share relevant coded data and assist clinical decision making through decision support.</li> <li>• <b>Allied health digital infrastructure:</b> Provide financial support to deliver a minimum level of digital health infrastructure and maturity for allied health practices.</li> <li>• <b>Data security:</b> Support practices to regularly update software and processes to maintain high levels of cyber resilience, e.g. software updates, screen timeouts, user authentication.</li> </ul>	<p><b>Clinical systems:</b> Develop integrated clinical systems to enable and support best practice clinical decision making, with real-time data collection and use:</p> <ul style="list-style-type: none"> <li>• <b>Telehealth:</b> Incorporate telehealth capabilities into clinical software (also in pillar 2).</li> <li>• <b>Coding:</b> Strengthen support for data coding and sharing.</li> <li>• <b>Clinical decision support:</b> (built on data and supporting pillar 2)– build decision support into GP software, ensuring this has good governance to support clinical decision making (rather than constrain, replace or command)</li> <li>• <b>Discharge summaries:</b> Flag discharge summaries in practice software to trigger an alert for follow-up appointments.</li> </ul>	
<p><b>One health system:</b></p> <ul style="list-style-type: none"> <li>• <b>Patient flow:</b> Scope/build digital infrastructure required to include primary and aged care in a whole of system approach to patient flow, building on currently available data, for example LHNs and ambulance services. This should support appropriate patient discharge from hospital by providing visibility to available GP appointments and aged care beds, improving patient flow and informing appropriate service planning.</li> </ul>	<p><b>One health system:</b></p> <ul style="list-style-type: none"> <li>• Strengthen the link between use and sharing of data and reinvestment of savings. Encourage and support implementation of coded/structured data or technologies, which will facilitate use of data (under proper data governance) for improvement of patient care locally (practice level), regionally and to prove benefits to patients and savings, which should be reinvested into primary health care (see also data).</li> </ul>	<p><b>One health system:</b></p> <ul style="list-style-type: none"> <li>• The health system is underpinned by high quality data that enables quality improvement, seamlessly underpinned by high quality and safe digital infrastructure and supports. Interoperable secure digital infrastructure across the health sector supports team-based care and connects services to improve transitions of care for people. This includes across primary and tertiary care, including general practice, specialist, allied health and pharmacy.</li> </ul>

## Pillar 3: Research and innovation

### Pillar 3 – Continuous quality improvement, safety and future focus across the system, for consumers and providers (recommendations 9, 15, 16, 17, 18 and 20)

Ongoing governance; Leadership and change management; Data; Enabled by funding reform; Digital and virtual care; Research and innovation

(This pillar should support all other pillars)

Foundational short term (within 12 months)	Medium term (within three years)	Over the long term
<b>Research, translation and innovation (predominantly recommendations 16 and 18, as well as others)</b>		
<p><b>Australian Institute for Primary Health Care Research Translation and Innovation (year 1):</b> Develop the specifications for an Australian Institute for Primary Health Care Research Translation and Innovation.</p> <ul style="list-style-type: none"> <li>Infrastructure – Specifications for Australian Institute for Primary Health Care Research Translation and Innovation (IPCRTI) completed. These should include broad roles and responsibilities, funding envelope and expected deliverables as well as identification of broad and appropriately qualified Board (max 9 members).</li> <li>The governance structure should effectively bind proven translational stakeholders and researchers together. CEO PD completed and available to Board.</li> <li>Overarching roles/responsibilities include:               <ul style="list-style-type: none"> <li>To provide thought leadership in driving a national translational research and innovation agenda involving primary/integrated care service delivery.</li> <li>To unite researchers, clinicians, executives, policy makers and consumers nationally in codesigning, embracing and promoting effective research and innovation throughout their networks and workplaces.</li> <li>To identify and engage international leaders in relevant research and service delivery innovation to inform and influence Australian research and service re-design.</li> <li>To inform appropriate policy development at regional, state and national level.</li> </ul> </li> <li><b>Collaboration:</b> 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.</li> </ul> <p><b>Translation of best practice:</b> Build on evidence base and enable coordinated integration and translation of best practice guidelines and evidence into primary health care (not only focused on translation in hospital setting), for example the ACSQHC Atlas of Healthcare Variation (e.g. preterm birth prevention in the fourth Atlas). This should focus particularly on disadvantaged people and communities.</p> <p><b>Process for continuous quality improvement:</b> 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.</p> <p>Reinstate previously defunded programs where they are deemed to have utility, to enable collection and use of longitudinal data, for example PHCRIS, BEACH and ReCEnt.</p>	<p><b>Australian Institute for Primary Health Care Research Translation and Innovation (year 2):</b></p> <ul style="list-style-type: none"> <li>Board established, and networking/partnership/communication strategy agreed. Board via CEO actively engaged with key research and service delivery stakeholders and utilising their regular and active input/ collaboration to design key pieces of work. Areas for commissioned research in health care reform and innovation involving primary health care agreed and tenders drafted. PBRN intersection and areas of interest identified. Opportunities for stakeholder contribution encouraged and identified both nationally and internationally. Relevant international partnerships identified.</li> <li>Training and support programs for early career and novice researchers developed and advertised.</li> </ul> <p><b>Research and teaching role models:</b> Support more primary health care research and teaching role models for medical students, including role models working in rural and remote areas. Directly link research to reaching interested practices and where relevant, building on these role models.</p> <p><b>Workforce capability and opportunities:</b> 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.</p> <p><b>Practice-based research networks:</b> 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.</p>	<p><b>Australian Institute for Primary Health Care Research Translation and Innovation (years 3–5):</b> Commissioned research commences and IPCRI uses networks to inform/increase momentum and maximise uptake/participation of translational research and care innovation nationally.</p>
<p><b>Allied health research and translation:</b> 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.</p> <p>Establish Allied Health Program within Australian National Institute for Primary Health Care Research Translation and Innovation. Establish allied health practice-based research network. Allied health represented in reinstated national governance framework.</p>	<p><b>Allied health research and translation:</b> Ensure there are at least five research partnerships involving allied health.</p>	
<p><b>PHN and ACCH facilitation:</b> Consider how research can be supported and facilitated through PHNs and ACCHs, NACCHO and state and territory affiliates, ACCH and RACCHO 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.</p>		
<p><b>Primary Health Care Nurses:</b> Build a PHC nursing data asset that would provide information on workforce planning and assist in the development of training and ongoing professional development.</p>		

## Pillar 4: Bolstering rural health

Pillar 4 – Bolstering Rural Health (recommendation 5 and across all others)		(This pillar should be supported by all other pillars)
Foundational short term (within 12 months)	Medium term (within three years)	Over the long term
<p><b>National Rural Health Strategy:</b> Develop an overarching framework for a National Rural Health Strategy, including;</p> <p>Scope: Workforce (e.g. models for single employer options, rural generalists, include fly-in-fly-out (FIFO) as model for continuity for 'difficult to recruit' places, expanding to full scope of role of allied health and nursing), models of care, funding arrangements, emergency preparedness and research. Emergency preparedness should include rural and remote clinicians in their community's emergency response, including local hospital, health professionals and ACCHs.</p> <ul style="list-style-type: none"> <li>• <b>Effective implementation:</b> An implementation plan and targets for improvement of health outcomes, a reporting framework against the targets and continuous evaluation and monitoring.</li> <li>• <b>Models of care:</b> Support innovative models of care that meet the particular needs of the local rural and remote communities with an emphasis upon community-controlled, rural generalist and multidisciplinary workforce, funding and service models that are place based. Possible models are further explored in the more detailed RACCHO principles document. Develop tools to support local communities to design local models of care, building appropriate workforce based on these models.</li> <li>• <b>RACCHOs:</b> Implement RACCHO models of care in rural communities, which nominate for participation, using the commitments outlined in the Addendum to National Health Reform Agreement to joint planning and funding at a local level with co-design of services and reorientation of health systems around communities.</li> <li>• <b>Local interprofessional approaches:</b> Build on, learn from and support current successful community collaboration and interprofessional approaches to rural health care.</li> <li>• <b>Community health centres:</b> Strengthen community health centres to support multidisciplinary team care, potentially providing salaried positions for providers to avoid siloing effects of MBS funding</li> <li>• <b>Funding arrangements:</b> Embrace all funding sources for the community, supported through actions to support one health system (see pillar 1). Innovative models of care need to emerge from innovative funding, be it pooled, blended or bundled including opportunities to leverage both state and Commonwealth sources of funding. Funding support to increase the investment in health access for rural and remote Australia – funding models that reflect the requirement of a different health workforce, that also need to include relocation, housing, travel etc for staff (medical, nursing, allied health, admin). Allow flexibility to be built into funding models to allow for 'peaks and troughs'. These elements are also essential considerations for the development of appropriate funding arrangements for RACCHOs. Also consider alternative business models such as the Business Council of Cooperatives and Mutuals (BCCM) model.</li> <li>• <b>Coordinated holistic care:</b> consider complexities and interactions with social determinants of health, mental health conditions, sociodemographic disadvantage and aged care to avoid potential siloed service delivery.</li> <li>• <b>Joint funding agreements:</b> Negotiate joint funding agreements with states and territory governments to support the funding of RACCHOs.</li> <li>• <b>Note the role of RACCHOs in addressing the workforce issues outlined below.</b></li> <li>• <b>VPR:</b> Include the establishment of RACCHOs as a feature to support the rollout of VPR.</li> </ul>	<p><b>National Rural Health Strategy:</b> Deliver rural strategies from the National Rural Health Strategy:</p> <ul style="list-style-type: none"> <li>• <b>Supports:</b> Design innovative and flexible supports for existing rural and remote general practices. For example, networked rural and remote practices sharing a virtual practice manager.</li> <li>• <b>Home monitoring:</b> Support widespread adoption of home monitoring of patients with chronic illness, unlocked through VPR, with additional assistance for purchasing of equipment.</li> <li>• <b>Workforce supports:</b> Create a mechanism to support seamless onboarding and management of locum support, facilitate CPD and training for rural colleagues, considering what rural workforce agencies are currently doing.</li> <li>• <b>Address lack of service availability:</b> Explore options to address additional and/or alternative investment to address rural and remote primary health care services where they don't exist or are unsustainable. Examples of options include salaried positions to prevent the need for GPs and other providers to take market risk, or through joint models of primary health care and public sector acute care.</li> <li>• <b>Innovative models:</b> Build on and expand innovative models that meet the particular needs of rural and remote communities, including community-controlled, workforce, funding and service models. This will build on the work of the National Rural Health Commissioner, for example, learning from and responding to evaluation of the Primary Health Innovative Multidisciplinary Model (PRIMM) program, together with the RDN NSW collaborative care models and wider evidence base.</li> </ul> <p><b>Regional governance arrangements:</b> Build on regional governance arrangements (see pillar 1) to support current services and needs assessments, and to develop solutions to address gaps in service.</p> <p><b>RACCHOs:</b> Scale up the implementation of RACCHOs following review and refinement of the model to communities across a range of rural settings.</p>	<p><b>Continue the staged rollout of successful appropriately funded models of care</b></p>
<p><b>Workforce:</b></p> <ul style="list-style-type: none"> <li>• <b>Incentivise primary health care medicine:</b> 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.</li> <li>• <b>Student clinical placements:</b> Provide adequate financial support for rural and remote settings.</li> <li>• <b>Rural generalist models:</b> refer to the National Rural Generalist pathway and the National Rural Health Commissioner – understanding of the rural generalist model, recognition as specialty with general practice, employment options that supports both the primary health care and the emergency department/in-patient/procedural aspect of skills, development of nursing and allied health models of generalism, appropriate recognition and respect.</li> <li>• Appropriate funding for training, acknowledging that training cost in rural and remote is greater than in urban areas.</li> <li>• Incorporate Aboriginal and Torres Strait Islander Health Practitioners and Aboriginal Health Workers.</li> <li>• Incorporate the allied health workforce appropriate to community needs.</li> <li>• Also potential for workforce enrichment and retention-quad aim.</li> <li>• <b>Local analysis, planning and coordination:</b> 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.</li> <li>• <b>Support existing services:</b> 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.</li> </ul>	<p><b>Workforce:</b></p> <p><b>Greater planning:</b> Develop more accurate supply and demand projections and increase supply of rural and remote training posts and student placements.</p> <p><b>Training pipeline:</b> 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.</p> <p><b>Supervision and supports:</b> Tailor supervision and supports for rural, remote and Indigenous training models.</p> <p><b>Community supports:</b> Improve community readiness, including professional and family support for people in rural practice.</p> <p><b>Fly-in fly-out workforce:</b> 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.</p>	



## Pillar 5: Aboriginal and Torres Strait Islander health

Pillar 5 – Aboriginal and Torres Strait Islander health (recommendation 4 and across all others)		(This pillar should be supported by all other pillars)
Foundational short term (within 12 months)	Medium term (within three years)	Over the long term
<p><b>Concurrent reform:</b> Align directions from the National Agreement on Closing the Gap July 2020, 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.</p>		
<p><b>Resource ACCHs:</b> 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. Aboriginal and Torres Strait Islander people should be supported to choose a practice or service that is culturally safe.</p> <ul style="list-style-type: none"> <li>Develop protocols for direct funding of ACCHs, with PHNs required to justify why funds are not being directed to ACCHs.</li> <li>Provide targeted support to ACCHs to build their capacity to generate Medicare income to fund additional primary health care services to their community/ies, while ensuring quality and safety of care.</li> </ul>		
<p><b>ACCH geographic coverage:</b> Support transitioning of government-run Aboriginal medical services to community-control where this will better meet the needs of communities and improve outcomes</p> <ul style="list-style-type: none"> <li>Identify all government-operated Aboriginal medical services across the country – this to be undertaken by state and territory Partnership Forums.</li> <li>Based on NT model, develop and agree with state and territories a National Framework for Transition of government-operated Aboriginal medical services to community control. The Framework to require state and territory Partnership Forums (see above) to develop and oversee implementation of jurisdictional plans/schedules for the transition of these services to community control.</li> <li>Undertake refresh of AIHW’s 2017 Report ‘Spatial variation in Aboriginal and Torres Strait Islander peoples’ access to primary health care’ to identify areas of poor access AND lack of ACCHs where new ACCHs or new Clinic sites for existing ACCHs could be established. This ‘refresh’ to take into account the needs of large urban and regional Indigenous populations – despite comprising the majority of the Indigenous population, 26% of the population in major cities have access to ACCHs compared to 97% in remote.</li> </ul>	<p><b>ACCH geographic coverage:</b></p> <ul style="list-style-type: none"> <li>Implement transition plan commencing in sites where ACCHs have capacity and community supports transition.</li> </ul>	<p><b>ACCH geographic coverage:</b> Full transition from government-run Aboriginal Medical Services to Aboriginal community-controlled services with demonstrated improvements in meeting the needs of communities and improving outcomes.</p>
<p><b>Integration of services within ACCHs:</b> Continue to invest in the ACCH model of comprehensive primary health care and minimise risk of fragmentation of medical care, including by supporting integration of non-prescribing pharmacists in ACCHs.</p> <ul style="list-style-type: none"> <li>Identify ACCHs with an interest/capacity AND secure funding for the employment of non-prescribing pharmacists within ACCHs.</li> <li>Review funding to PHNs (ITC, Mental Health) and other funds-holders/commissioners for key programs (i.e. MOICDP, RHOF) and identify opportunities for more integrated/targeted investment directly to ACCHs (i.e. rather than via PHNs) which achieve economies of scale/efficiencies, improved access AND integration of care/treatment for Aboriginal and Torres Strait Islander populations via regionally networked ACCHs.</li> <li>Develop/test new models of integration for ACCH delivery of primary health care, aged care AND disability services, consistent with the Government’s Response to the Aged Care Royal Commission’s Report/Recommendations.</li> </ul>	<p><b>Integration of services within ACCHs:</b></p> <ul style="list-style-type: none"> <li>Fund non-prescribing pharmacists within ACCHs.</li> <li>Test/stage implementation of direct funding to Networks of ACCHs to implement regional strategies for the delivery and integration of comprehensive primary health care to Indigenous populations within defined Regions, including support to those accessing mainstream/private GPs.</li> <li>Expand these Networks across the country.</li> <li>Expand integrated ACCH primary health care, aged care and disability services models across the country.</li> <li>Effectively resource/support ACCHs in priority Regions (ie. those with low levels of access) to expand their scope of services to include provision of home and residential aged care to Indigenous Elders and their families.</li> </ul>	<p><b>Integration of Services within ACCHs:</b> Integrated Aboriginal community-controlled primary health care, aged care and disability services scaled up and operating across the country.</p>
<p><b>Shared decision-making and co-design:</b> Recognise the ACCH Sector as a key plank of Australia’s primary health care system and require shared decision-making and co-designed structural reform nationally and regionally to improve Aboriginal and Torres Strait Islander health outcomes, supporting community engagement and empowerment, with stronger Integration of services across ACCHs, PHNs, LHNs, mainstream providers and hospitals.</p> <ul style="list-style-type: none"> <li>Use Closing the Gap shared decision-making structures (see below) to provide NACCHO, state and territory affiliates and Jurisdictional leadership and oversight of system performance/reform towards achieving health targets by 2031.</li> <li>Review/revitalise Aboriginal and Torres Strait Islander Health Framework Agreements AND Partnership Forums with states and territories to ensure consistency with new National CTG Agreement and strengthen commitment/s to community control, commitments and reform opportunities contained within the NHRA (2020-2025), and to implement joint regional planning processes underpinned by strong regional agreements between ACCHs, PHNs and Local Hospital Networks. Supported by NACCHO and state and territory affiliates. These Forums are to continue to be chaired by NACCHO Affiliates.</li> </ul>	<p><b>Shared decision-making and co-design:</b></p> <ul style="list-style-type: none"> <li>Regional Agreements/Partnerships in place between ACCHs, PHNs and LHNs and joint regional planning undertaken to identify priorities for system redesign/reform and new investment.</li> <li>Development/implementation of joint regional investment responses (including regional funds pooling) to priorities identified by joint regional planning processes.</li> </ul>	
<p><b>Improve mainstream services:</b> 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 healthcare services.</p> <ul style="list-style-type: none"> <li>All Peak organisations to support culturally safe care for all Aboriginal and Torres Strait Islander peoples through primary health care providers.</li> </ul>	<p><b>Improve mainstream services:</b></p> <ul style="list-style-type: none"> <li>Test/stage implementation of direct funding to Networks of ACCHs to implement regional strategies for the delivery and integration of comprehensive primary health care to Indigenous populations within defined Regions, including support to those accessing mainstream/private GPs.</li> </ul>	<p><b>Improve mainstream services:</b> Maintain mature CQI systems that are able to clearly assess and work to ensure Aboriginal and Torres Strait Islander people are receiving person-centred and culturally safe care through all mainstream providers.</p>

**Pillar 5 – Aboriginal and Torres Strait Islander health (recommendation 4 and across all others)**

(This pillar should be supported by all other pillars)

Foundational short term (within 12 months)	Medium term (within three years)	Over the long term
<p><b>Procurement and commissioning:</b> 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 ACCHs across the country supported by NACCHO and state and territory Affiliates. The aim should be to strengthen the ability and access of ACCHs 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 ACCHs 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.</p> <ul style="list-style-type: none"> <li>• Work with the Community Controlled Health Sector to codesign/ identify models for commissioning/procurement that could be tailored/tested within different regions, ensuring these models link with/directly inform broader commissioning and funds pooling work.</li> <li>• Identify investment/funding opportunities (mental health, chronic disease) and/or programs that could be commissioned through these models (MOICDP, RHOF).</li> </ul>	<p><b>Procurement and commissioning:</b> As part of broader regional funds pooling/ commissioning work, particularly the 10-15 vanguard initiatives <a href="#">reference to above</a>, fund and evaluate examples community controlled commissioning/ procurement models within urban, regional and remote regions. Those sights should focus on improving health outcomes for Aboriginal and Torres Strait Islander peoples, whether accessing services through ACCHs and mainstream primary health care services.</p>	<p>Broker Aboriginal-led solutions, with role in the regional integration of services using procurement and commissioning models that best suit communities and need.</p> <p><b>Procurement and commissioning:</b> Based on the outcomes of the evaluation of ‘vanguard initiatives’ scale-up and expand regional community controlled commissioning models to other regions supported by state and territory affiliates and NACCHO.</p>
<p><b>Data:</b> 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.</p> <ul style="list-style-type: none"> <li>• Co-designed with NACCHO and state and territory Affiliates, develop/implement targeted strategy to increase use of Indigenous PREMs and PROMs within ACCHs and mainstream providers.</li> <li>• Provide regular data on Indigenous access/use of mainstream GPs and other health services.</li> <li>• Explore potential for regional networks of ACCHs (above) to undertake CQI processes focused on integration of services across the health system, Indigenous patients accessing mainstream health services/GP.</li> </ul>	<p><b>Data:</b> Build effective Indigenous status and patient experience functions in all data sets and development of strong CQI processes for reflecting on data and driving necessary improvements to achieve quality access and care for Aboriginal and Torres Strait Islander people.</p>	<p><b>Data:</b> Require Indigenous status function in all data sets and development of strong CQI processes for reflecting on data and driving necessary improvements to achieve equality of access and care for Aboriginal and Torres Strait Islander people.</p>
<p><b>Digital infrastructure:</b> 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 ACCHs and patients.</p>	<p><b>Digital Infrastructure:</b> Demonstrated increase in the ability of ACCHs to maximise the use of telehealth as part of integrated care.</p>	<p><b>Digital Infrastructure:</b> Continue to ensure all ACCHs can maximise the use of telehealth as part of integrated care.</p>
<p><b>Workforce:</b> Develop and support the Aboriginal and Torres Strait Islander workforce to work to their full scope in delivering primary health, mental health, aged care, disability and family support services to communities over the next ten years. This includes ensuring ACCHs 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.</p>	<p><b>Workforce:</b> Deliver major workforce investments across all ACCHs leading to demonstrated increase in the number of Aboriginal and Torres Strait Islander Health Practitioners and Workers contributing at their full scope.</p>	<p><b>Workforce:</b> Major development of an internationally recognised Aboriginal and Torres Strait Islander health, aged care, disability services workforce.</p>
<p><b>Access to Medicines:</b> Update the 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.</p> <p><b>Medical/Health Technology:</b> 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.</p>	<p><b>Access to Medicines/ Health Technology:</b> Require National Medicines Policy, PBAC and MSAC processes to have matured to fully support improved access to effective medicines and health technologies for Aboriginal and Torres Strait Islander people.</p>	<p><b>Access to Medicines/ Health Technology:</b> Maintenance of world-leading National Medicines Policy, PBAC and MSAC processes ensuring effective medicines and health technologies for Aboriginal and Torres Strait Islander people.</p>

## Pillar 6: Health workforce

Pillar 6 – Health workforce (recommendations 10–14)		(This pillar should support and be supported by all other pillars)
Foundational short term (within 12 months)	Medium term (within three years)	Over the long term
<p><b>Workforce plan:</b> Develop an integrated and comprehensive health workforce plan that includes recruitment and retention to address workforce shortages and meet health system and population health needs; enabling providers work to full scope of practice; and ensuring an adequately skilled workforce through education initiatives, student placements and transition to professional practice (TPP) programs, supporting generalism. Capture training data to assist planning.</p> <p>Specific strategies include:</p> <ul style="list-style-type: none"> <li>• <b>Allied health:</b> Develop a coordinated National Allied Health Workforce Strategy covering planning and distribution across health, mental health, disability, early childhood intervention and aged care, with identification of measures to address workforce shortages and maldistribution, including education initiatives and student placements. <ul style="list-style-type: none"> <li>» <b>Student clinical placements:</b> Support and promote allied health student clinical placements within primary health, including within community health services, ACHs, private practice and as part of PHN programs. Consider the barriers, which negatively influence these opportunities</li> </ul> </li> <li>• <b>Nursing:</b> Develop a National Primary Health Care Nursing Strategy, including transition to professional practice (TPP) programs and capacity building programs such as the Nursing in Primary Health Care (NiPHC) Program, including NPs as part of the primary health care team and supporting student placements in primary health care. Embed the Career and Education Framework for Nurses in Primary Health Care – APNA to build capacity and support the transferability of nursing skills across primary health care settings (including facilitating a pathway for rural generalist nursing practice). <ul style="list-style-type: none"> <li>» <b>Scope of practice – nursing and midwifery:</b> Support fully utilising the appropriately trained and credentialed nursing and midwifery workforce to work within primary health care teams to their full scope, within integrated health pathways. This includes clearly defining a scope of prescribing capacity for nurses and midwives.</li> <li>» <b>Scope of practice/collaborative arrangements – NPs:</b> Review collaborative arrangements and establish scope of practice and credentialing frameworks for NPs.</li> <li>» <b>Models of care – nursing and midwifery:</b> 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.</li> <li>» <b>Models of care – NPs:</b> 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.</li> </ul> </li> <li>• <b>Midwifery:</b> Support the best models 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.</li> <li>• <b>Medical:</b> Align with directions of the National Medical Workforce Strategy, including development of the training pathway for rural generalism.</li> <li>• <b>Mental health:</b> Align with directions of the National Mental Health Workforce Strategy.</li> <li>• <b>Aboriginal and Torres Strait Islander health:</b> Align with directions from the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–31.</li> <li>• <b>Practice Management:</b> Training and support to improve practice management capability and understanding of the health system for all administrative staff.</li> <li>• <b>Non-traditional workforce:</b> 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. Ensure there are regulatory frameworks in place for all primary health care workforces, including: <ul style="list-style-type: none"> <li>» <b>Health assistance workforce:</b> Includes existing and emerging health assistant workforce, for example allied health assistants, assistants in nursing, personal care workers in aged care, mental health peer workers, disability support workers and physicians’ assistants.</li> <li>» <b>Unregulated:</b> Other unregulated health care workers, particularly in the aged care sector</li> <li>» <b>Traditional:</b> Traditional workforces, for example traditional Indigenous healers</li> <li>» <b>Patient support workers:</b> 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.</li> </ul> </li> </ul> <p><b>Single employer models</b> (also mentioned under National Rural Health Strategy and relevant to implementation of RACCHOs): Trial employment of primary health care professionals in areas of community need, considering rural and remote areas and low SEIFA areas.</p> <p><b>Enable mutual support and enablement for multidisciplinary team care:</b></p> <ul style="list-style-type: none"> <li>• <b>Educational reform:</b> Embed interprofessional education and collaborative practice across primary health care and secondary/tertiary care, including embedding interprofessional education and cross-professional student placements within the standards and curriculum of training programs of early career health professionals. Educational reform should contribute to a better understanding of the role of the different primary health providers across professions.</li> <li>• <b>Education and training:</b> 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.</li> <li>• <b>Mental health training:</b> Increase uptake of mental health training for GPs, nurses, allied health and other primary health care providers.</li> </ul>	<p><b>Workforce plan:</b></p> <p>Ensure plan is completed, and 50% of identified measures are implemented.</p> <p>Ensure at least 50% of medical graduates move into general practice (currently 16%).</p> <p>Regular review and evaluation of all workforce strategies with appropriate KPI’s. Incorporate flexibility within areas of workforce shortage to allow these issues to be prioritised – this is very important in rural and remote areas, and for general practice. Development of effective strategies to recognise and shift focus to ensure that ALL aspects of the workforce are improving.</p> <p>Work with funding bodies and authorities to enable student clinical placements, which provide direct client contact, e.g. need to change the funding and rebate rules of Medicare, PHIs and NDIS, which restrict student experiences in these services.</p>	<p><b>Workforce plan:</b></p> <p>Implementation completed within five years, evaluation is regular and ongoing, including evaluation of effectiveness of the National Allied Health Workforce Plan.</p>

**Pillar 6 – Health workforce (recommendations 10–14)**

(This pillar should support and be supported by all other pillars)

Foundational short term (within 12 months)	Medium term (within three years)	Over the long term
<ul style="list-style-type: none"> <li>• <b>Role and scope of all health professionals:</b> 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.</li> <li>• The nationally endorsed list is developed and NASRHP standards and regulation formally recognised as equal to AHPRA registration within 12 months.</li> <li>• <b>Flexible employment:</b> 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, ACCHs, public clinics, hospital, university (academic/teaching)).</li> </ul>		
<p><b>Strong clinical governance for allied health in primary health care:</b> Introduce national strategies and financial supports and incentives to ensure strong clinical governance for Allied Health in primary health care, including access to professional supervision and mentoring, professional development and career advancements. This may include specific supports and coordination of programs through PHNs, or other models of integrated services.</p> <p>Complete gap analysis and identification of best practice models and standards, including allied health in rural and remote areas and areas of disadvantage.</p>	<p><b>Strong clinical governance for allied health in primary health care:</b> A range of government financial supports, programs and incentives are in place enabling 50% of primary health allied health services to implement funded best practice clinical governance models and standards.</p>	<p><b>Strong clinical governance for allied health in primary health care:</b> A range of government financial supports, programs and incentives are in place enabling 100% of primary health allied health services to implement funded best practice clinical governance models and standards.</p>
<p><b>Capacity and sustainability:</b></p> <ul style="list-style-type: none"> <li>• Work with VET sector to promote and integrate VET trained health professionals to build health workforce capacity and sustainability, e.g. allied health assistants and other support workers.</li> <li>• Support allied health professions to work at their full scope, while working effectively with AHAs and others, under the appropriate delegation and supervision frameworks.</li> <li>• Create health professional education pathways for people across Australia that starts with community and children in schools seeing examples of others in their community taking on roles locally and having career progression opportunities.</li> <li>• 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.</li> </ul>		



# Appendices

## Appendix 1: 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 have met twenty times 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

Name	Member
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
- 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
- Evaluation of the measure.

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

## Appendix 2: Consultation process

The Steering Group Report has been informed by an extensive consultation process that has included:

- Engagement with the Primary Health Reform Consultation Group (in November 2019)
- Targeted consultation with patients with a 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 (from August 2019 to December 2020)
- Targeted consultation on the draft recommendation's discussion paper seeking feedback on the Steering Groups recommendations (from 15 June to 27 July 2021).

Following is a summary of these consultation processes and the feedback from each consultation.

### 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 to 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 primary health care system
- The role of allied health providers in 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 LGBTIQ+ community
- The health needs of people from CALD backgrounds
- Practice Managers, practice leadership and culture
- A future-focused roundtable, with an emphasis on new technologies such as genomics, point of care testing, telehealth, screening, and other innovative technologies.

### Consultation on the draft recommendations discussion paper

On 15 June 2021, the Steering Group released its 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 (Discussion Paper) seeking stakeholder views, particularly on the proposed direction and any challenges or omissions.

During the targeted consultation period, more than 420 organisations and individuals were invited to provide feedback on the Discussion Paper. The invitation to provide input was further disseminated through the professional networks of those originally invited.

In total over 200 submissions were received, many were substantial in both depth and coverage. They included peaks, consumer organisations a number of research entities, PHNs and state/territory governments and people with lived experience.

Overall, the comments were supportive of the broad direction of the discussion paper and the need to find innovative ways to deliver and fund primary health care. Many made considered suggestions and observations of value for the future of primary health care. These comments included:

### Access

- Support for engaging users of health services and people with lived experience in the co-design of changes and national, regional and local implementation actions.
- Support in addressing equitable access for disadvantaged groups and better understanding on how disability, aged care, justice systems can work together.

### Integration and person centred care

- A range of advice and suggestions on the scope and implementation of VPR, including clarity on the benefits for providers and their patients.
- Readiness to move to regionally based coordinated action or local solutions:
  - » Better understanding needed of the different health care needs and priorities, provider features and workforce environment in communities across MMM4-7 areas when compared with metropolitan-based primary health care
  - » To embed shifts to regionally or locally driven models: time is required to test and secure local engagement and trust across providers; ICT supports are essential; pooling of resources with accountability; government seed funding needed; and sustainable models embedded.

## Funding models

- Support for the development of innovative funding models, particularly to recognise the shift to preventive care, and meeting the needs of people requiring longer term or coordinated care and those who are disadvantaged.
- Support in addressing the challenges of funding complexity across jurisdictions, systems (such as aged care and the NDIS) and sectors (such as justice, child welfare and community health).
- Support for investing in primary health care but not through redirecting to reorienting funding from acute care, secondary or tertiary health care.
- Re-balance needed of fee-for-service and other forms of funding, moving to blended funding: fee-for-service GP funding model seen as a barrier for shifting more to prevention, coordinated care and continuity of care, supported by safe data sharing and digital technology and solutions.

## Workforce

- Suggestions on improving the training, education and continuing development of primary health care workforces in such areas as: culturally safe care for Aboriginal and Torres Strait Islander people; digital literacy; sensitivity to the needs of diverse populations and people with diverse lived experiences; capacity to be a research active and aware workforce.
- Support for multidisciplinary team-based care in primary health care settings, supported by funding models, and recognising the distinct role of nurses and allied health practitioners.
- Making greater use of the skills and scopes of practice of nurses and allied health practitioners.
- The role of allied health in primary health care needs to be recognised, incorporated and consistently applied, including: addressing barriers to MBS access; recognising their scope of practice as independent practitioners; access to digital infrastructure and clinical tools to support integrated care; participation in team-based care; recognition of specialist disciplines in allied health for maintaining wellness, preventing diseases and managing chronic conditions.
- Closing the Gap – support for furthering the coverage, adding to scope and funding security for community controlled organisations in line with national Closing the Gap commitments.

## Prevention







- Ensuring the role of primary health care in mental health is understood and linked with national, wider mental health and suicide prevention measures.

Some submission provided examples of innovative approaches, integrated service delivery or models, that have worked well or have proven to be sustainable, supported by evidence and data. Features have included:

- Partnerships approaches supported by good governance arrangements
- Starting with a well-structured pilot, evaluation, then build and scale up
- Use of seed funding provided by Australian governments
- Commissioning-type approaches, with committed participants having shared goals, either state-based level or in regional catchments and in sub-regions
- Coverage of specific population groups such as Aboriginal and Torres Strait Islander people
- Managing health care pathways for specific diseases or conditions, such as cancer, diabetes and Chronic obstructive pulmonary disease (COPD) linked with and avoiding hospitalisation
- Providing integrated place-based primary health care, articulated with community services
- Building new approaches to well-known barriers or challenges, such as making safe and trusted use of shared data across providers for quality improvement and to follow the person in their journey; digital innovations and nurse-led health service delivery.

## Appendix 3: 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
 Improving Access	Equitable access to the best available primary health care services
 Closing the gap	Improve health outcomes for Aboriginal and Torres Strait Islander people
 Keep people well in the community	Manage people's health and wellbeing in the community
 Continuity of care	Support continuity of care across the health care system
 Integration	Support health system integration and sustainability
 Future-focused	Embrace new technologies and methods
 Safety and Quality	Support continuously improving safe and quality primary health care services

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

<p><b>Patients</b></p> <p>Enhance patient activation, improve health literacy and shared decision-making.</p>	<p><b>Funding Reform</b></p> <p>Appropriate and sustainable funding reform that underpins the best models of care tailored to local circumstances.</p>
<p><b>Workforce</b></p> <p>A health workforce that works together, operating at top of scope and supported by education, training, and skills development.</p>	<p><b>Innovation and Technology</b></p> <p>Support innovation and new technologies to better manage care.</p>
<p><b>Leadership and Culture</b></p> <p>Foster leadership, inter-professional collaboration and co-design, and effective change management to ensure cultural shifts in the system.</p>	<p><b>Research and Data</b></p> <p>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.</p>

## Appendix 4: Outline of related Australian Government strategies, plans and reports

### Federal agreements

- Addendum to the National Health Reform Agreement 2020–2025
- Seventh Community Pharmacy Agreement

### Response to Royal Commissions

- Government's response to the final report from the Royal Commission into Aged Care Quality and Safety
- Government's response to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability

### Productivity Commission

- Innovations in Care for Chronic Health Conditions (March 2021)

### Strategies to address issues in relation to Aboriginal and Torres Strait Islander peoples

- The new National Agreement on Closing the Gap
- National Aboriginal and Torres Strait Islander Health Plan
- National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–31
- National Aboriginal and Torres Strait Islander Suicide Prevention Strategy

### Strategies to improve Mental Health

- Productivity Commission's Inquiry Report on Mental Health
- National Agreement for Mental Health and Suicide Prevention
- Vision 2030 for Mental Health and Suicide Prevention
- National Mental Health and Suicide Prevention Agreement
- National Rural and Remote Mental Health Strategy
- National Digital Mental Health Framework
- National Children's Mental Health Policy
- National Natural Disaster Mental Health Framework
- Being Equally Well: A national policy roadmap to better physical health care and longer lives for people living with serious mental illness

### Strategies to improve the capabilities of the health workforce

- National Medical Workforce Strategy
- Stronger Rural Health Strategy
- National Mental Health Workforce Strategy



### Other National strategies

- National Preventive Health Strategy
- National Digital Health Strategy
- National Women's Health Strategy 2020–2030; and domestic violence prevention
- National Roadmap for Improving the Health of People with Intellectual Disability
- National Safety and Quality Primary and Community Healthcare Standards (to be released on the 12 October 2021)

## Appendix 5: The principal providers in primary health care settings in Australia

There are numerous health care professionals that are involved in the wrap around care that patients require. Recommendation 2 aims to lay the foundation for a well connected multidisciplinary approach to care from these professionals. These include (but are not limited to):

- **Aboriginal Community Controlled Health Services:** ACCHs are community controlled organisations, which provide comprehensive primary health care for Aboriginal and Torres Strait Islander people, adding other services and supports to provide wraparound care. ACCHs considering the wider social, cultural, historical and economic determinants of health.
- **Aboriginal health workers and practitioners:** Aboriginal and Torres Strait Islander people who can work in either community controlled health services or undertake a wide range of mainstream health care roles.<sup>43</sup> They are independent practitioners who work alongside and collaboratively with other clinicians including doctors, nurses, midwives, allied health and oral health practitioners in a range of settings.<sup>44</sup> They provide clinical and primary health care for individuals, families and community groups including specialty areas of drug and alcohol, mental health, diabetes and eye and ear health.
- **Allied health practitioners:** With over 200,000 allied health professionals, allied health is Australia's second largest health workforce. Allied health professionals work across a diverse range of settings and sectors, providing services including diagnostic and first-contact services, preventive and maintenance-focused interventions for people with chronic and complex physical and mental illnesses, supporting pre- and post-surgical rehabilitation, and enabling participation and independence for people experiencing temporary or long-term functional limitations. Allied health also provides an essential bridge between the medical sector and social support systems such as aged care and disability, where it can represent the key formal health support in a person's life.

The allied health sector is extremely diverse with significant variation across and within professions. Allied health professionals include physiotherapists, exercise physiologists, occupational therapists, speech pathologists, podiatrists, optometrists, orthoptists, osteopaths, social workers, psychologists, creative arts and music therapists, rehabilitation counsellors, audiologists, orthotists and prosthetists, chiropractors, medical radiation practitioners, paramedics, genetic counsellors and perfusionists.

- **Pharmacy** covers community pharmacy and non-dispensing pharmacists. Pharmacy Agreements between the Commonwealth and the Pharmacy Guild of Australia have been in place since 1991, with their key purpose being to provide for the timely and equitable supply of PBS medicines across Australia.<sup>45</sup>
- **Dentistry and oral health:** Public dental services are provided by state and territory governments.<sup>46</sup> Oral health covers such aspects as impacts of oral disease, risk behaviours, preventive strategies, access to services, workforce and quality<sup>47</sup>, and agreed oral health promotion messages.<sup>48</sup> The Australian Government has been taking increased responsibility for the funding of oral health for specific cohorts and under a National Partnership Agreement on Public Dental Services for Adults.

<sup>43</sup> The Lowitja Institute (2014). Shifting gears in career: identifying drivers of career development for Aboriginal and Torres Strait Islander workers in the health sector: Policy brief. Melbourne: The Lowitja Institute.

<sup>44</sup> Australian Indigenous HealthInfoNet. See: <https://healthinfonet.ecu.edu.au/key-resources/health-professionals/health-workers/health-workers-registration/> (accessed 17 September 2021)

<sup>45</sup> The 7th Pharmacy Agreement applies from 1 July 2020-30 June 2025. See: <https://www.guild.org.au/programs/seventh-community-pharmacy-agreement> (accessed 17 September 2021)

<sup>46</sup> Healthy Mouths Healthy Lives. Australia's National Oral Health Plan 2015–2024.

<sup>47</sup> AIHW National Oral Health Plan 2015–2024: performance monitoring report. See: <https://www.aihw.gov.au/reports/dental-oral-health/national-oral-health-plan-2015-2024/contents/summary> (accessed 17 September 2021)

<sup>48</sup> The Australian Government has been taking increased responsibility for the funding of oral health linked to its involvement in chronic disease management, improving rural health, for specific cohorts such as Aboriginal and Torres Strait Islander children under 16 and under National Partnership Agreements Healthy Mouths Healthy Lives. Australia's National Oral Health Plan 2015–2024, Appendix 3 p81

- **Specialist General Practitioners (GPs):** can provide care in a variety of settings; home, practice, health service, outreach clinic, hospital or community. The characteristics of their discipline are: person centredness; continuity of care; comprehensiveness (not limited by age, gender, body system, disease process or service site); whole person care; coordination and clinical teamwork; Professional, clinical and ethical standards; Leadership, advocacy and equity; and continuing evolution of the discipline.<sup>49</sup>
- **Mental health practitioners:** Added to the role of the health professions already outlined, are the skills and expertise of practitioners in mental health and wellbeing, including psychiatrists, mental health nurses and psychologists. The focus on prevention, early intervention and continuity of care applies as much to mental health as physical health. Re-orienting health care and workforces to take advantage of digital technology, better data and integrated care all feature.<sup>50</sup> People living with mental ill-health are at higher risk of having physical health issues; being unemployed; being homeless; or being in prison.
- **Nurses (enrolled nurse, registered nurse, nurse practitioner) and midwives:** *for nursing*, community settings including the community controlled health services, the community health sector and roles within social service settings; general practice; residential aged care; domiciliary settings in the home, custodial/detention settings, boarding houses and outreach to homeless people; educational settings; occupational settings, occupational health and safety and workplace nursing; informal and unstructured settings including ad hoc roles in daily life, like sports settings and community groups.<sup>51</sup> *Midwives in community-based settings* are registered health professionals who care for women's health and wellbeing during pregnancy, birth and the first few weeks after birth.<sup>52</sup>

Working alongside health professionals are people in administrative and public facing roles, such as administration and receptionists, along with those tasked with basic level clinical support roles, for example medical practice assistants (MPAs).

Primary care also engages patient support roles, including translators, health coaches and service coordinators or care finders, e.g. in mental health or the Aged Care Finders.

Primary health care practice managers cover such functions as: financial management; human resource management; planning and marketing; information management; risk management; governance and organisational dynamics; business and clinical operations; and professional responsibility.<sup>53</sup>

New and emerging roles are developing within primary health care's changing environment. Rural generalist models and advanced practice models in nursing and allied health are being developed. There will likely be new roles in digital health, data analytics and the application of genomics in health care.

Making use of the full extent of scopes of practice will be fundamental in responding to the shifts in primary health care, for multidisciplinary care and integrated health pathways, particularly in nursing and midwifery and for Nurse Practitioner roles.

<sup>49</sup> RACGP What is general practice? See: <https://www.racgp.org.au/education/students/a-career-in-general-practice/what-is-general-practice> (accessed 17 September 2021)

<sup>50</sup> 2020 Productivity Commission Mental Health, Inquiry, Report no 95

<sup>51</sup> Australian Primary Health Care Nurses Association. See: <https://www.apna.asn.au/profession/what-is-primary-health-care-nursing> (accessed 17 September 2021)

<sup>52</sup> AIHW, Health topics, About nurses and midwives. See: <https://www.health.gov.au/health-topics/nurses-and-midwives/about> (accessed 17 September 2021)

<sup>53</sup> Australian Association of Practice Management, Definition of a Practice Manager. See: <https://www.aapm.org.au/Your-Profession/Definition-of-a-Practice-Manager> (accessed 17 September 2021) See <https://www.practicemanagersaustralia.com.au/> (accessed 17 September 2021)

## Appendix 6: Case studies and examples

### Case Study: Western Sydney NSW – The Western Sydney Care Collective.

The Western Sydney LHD and Western Sydney PHN have joined together to develop and implement a collaboratively designed model of care – called The Western Sydney Care Collective.

Collaborative Commissioning aims to collectively deliver 'one Western Sydney health system', which is value-based and patient-centred. The focus is on the delivery of care at the right time and in the right place. The program extends upon their strategic plan and highlights the need to continually evolve and enhance the way they work together. Collaborative Commissioning is one mechanism for achieving such enhancements, building on the foundations built over many years.

Priorities include:

- Moving from input and activity to outcome-based commissioning
- Consolidating and enhancing governance
- Scaling collaborative efforts to realise system-wide impacts
- Strategically focus on the levers of change
- Achievable focus on specific cohorts
- Engaging consumers and clinician.

Following a comprehensive co-design phase, the Western Sydney partnership exited the Joint Development Phase in December last year, and have now commenced implementation of their initial models of care: Cardiology in Community, high quality Urgent Care and Rapid Access to Care in the Community.

#### Successes:

- Rapid Expansion of Care in the Community model established partnerships between the LHD Integrated Community Health (ICH) team and local Patient Centred Medical Homes (PCMHs), to support the successful transfer of care of low risk COVID-19 positive patients to one of 4 general practices in the community. The process, supported by updates to HealthPathways and screening tools built into their shared care platform, has enabled vital support for ICH and the community
- Their PCMH portfolio has expanded from seven to 23 practices, laying the foundations for transformational practices that can support their Collaborative Commissioning models of care
- Established a shared care platform across their PCMH sites, with expansion occurring into local Residential Aged Care Facility acute care Support Service (RaSS) units and the wider healthcare neighbourhood
- Central Intake Line, remote monitoring and mobile diagnostic contracts in development to help support primary care and Hospital in the Home (HITH) physicians in minimising preventable hospital admissions.

(continued next page)

#### Next steps:

- Their immediate next steps are focused on driving the models of care at the ground level, with a number of test sites established across their 23 PCMHs to begin implementing components of their models of care, all aligned to 'The Western Sydney Care Collective'<sup>54</sup>
- The future lies in integration across different partners in the broader service system. By highlighting the benefits to patients and the system in these initial stages of Collaborative Commissioning, there will be opportunity to expand the services across other sectors. Their focus is now upon:
  - » **Commissioning services** with partner organisations that align with our vision for 'one Western Sydney health system'
  - » **Evaluation** and iteration of the model as needed
  - » **Regional planning** through partnering with the community and the wider healthcare neighbourhood to develop regional plans driven by local needs.

#### Case Study: WA Primary Health Alliance – Comprehensive Primary Care – Social Work Program<sup>55</sup>

##### Why was the service set up?

The Social Work Program was established to address:

- issues related to the social determinants of health (the 2019 Sustainable Health Review noted that only 16% of a person's overall health and wellbeing relates to clinical care<sup>56</sup>)
- the need for care coordination for complex patients between health systems
- psychosocial assessment and intervention for general practice patients
- reduction of Emergency Department presentations or hospital admissions for complex patients
- enhanced General Practice service through a multidisciplinary team approach and
- sustainability of Social Work services without PHN funding.

(continued next page)

<sup>54</sup> <https://www.wslhd.health.nsw.gov.au/western-sydney-care-collective> (accessed 16 September 2021)

<sup>55</sup> Source: Case Study provided by WA Primary Health Alliance

<sup>56</sup> Sustainable Health Review. (2019). Sustainable Health Review: Final Report to the Western Australian Government. Department of Health, Western Australia

#### The service

The program has contracted with a service provider to enable Social Workers to work within eight practices in metropolitan Perth for two days per week. The service provided by the Social Workers is determined by the needs of the community and practice in which they are working and includes:

- Psychosocial assessment of patients to assist patient centred holistic care within the practice
- Referral and engagement of patients with local community resources (204 community engagements in the first six months during COVID)
- Psychosocial assessment of patients to assist patient centred holistic care within the practice
- Referral and engagement of patients with local community resources (204 community engagements in the first six months during COVID)
- 32% of patients referred to the social worker with presenting issues of mental health; 12% family support and 11% social isolation. Psychological issues continue to be the most common presentations seen in general practice (RACGP Health of the Nation, 2020). Having a social worker embedded within general practice supports general practitioners to meet the biopsychosocial needs of their patients.

The service was established at the beginning of 2020 and ran until June 2021. The Social Workers remained in the practices for a period of 18 months (initially expected to be 12 months but given the COVID period the Social Workers continued in the current practices for 18 months).

##### Service findings/sustainability

The Social Work Program achieved high levels of satisfaction with patients and practice staff, as well as an average 18% improvement in patient reported outcome measures used to indicate improvement in the social determinants of health. Practice staff reported that they had more time to attend to their roles with the addition of the Social Worker in the team.

While there is little doubt of the value of the service, new funding mechanisms would need to be developed to support future program sustainability.

*'Having a Social Worker has provided a much-needed service for our patients. She has given the nurses and doctors support to deal with issues that are often overlooked in General Practice.'*

*'As a service providing care for disadvantaged youths the need for a social Worker service is of paramount importance to allow other clinicians to do the work for which they are trained and to facilitate even better outcomes.'*

### Case Study: South Eastern NSW Primary Health Network (PHN) – COORDINARE<sup>57</sup>

The Consumers Health Forum of Australia has pioneered Collaborative Pairs Australia, a joint leadership development program for consumers and clinicians based on the UK Kings Fund program. Consumers and clinicians nominate to participate as 'pairs', are instructed and coached by a trained consumer and clinical facilitator 'pair' and focus on a joint project. *Collaborative Pairs* has been shown through independent evaluation to accelerate service and system improvement.

In 2020, the South-Eastern NSW PHN (SENSWPHN) supported a pair to lead five health consumers and five health professionals to co-design a social prescribing service model that would meet the growing need for non-clinical care arising in the post bushfire, mid COVID-19 disaster fatigued communities.

In March 2021, a new social prescribing service was subsequently commissioned. Social prescribing is an emerging concept in Australia that involves enabling health professionals to refer people to a range of local, non-clinical services to improve social connectedness, self-management capacity and wellbeing.

Dianne Kitcher, COORDINARE's CEO commented 'We believe that problems are best solved with consumers at the centre of the process. What better way to design an initiative than facilitating a process where consumers can meaningfully engage with health professionals to shape a service to best meet their needs?'

The work of the Pairs led to the codesigned development of a social prescribing model from a concept to reality. The model now implemented is anticipated to achieve a sustainable community-based approach that continues to support people living with, or at risk of, chronic conditions in the South Eastern NSW region, by fostering social connection and enhancing self-management capacity in people.

Participants describe a positive experience with one commenting:

*'Thank you it was an interesting experience and I would be happy to participate in co-design projects again as I feel they value add to designing better health outcomes'.*

### Example: Characteristics Single Primary Health Care Destination<sup>58</sup>

Top Health Care is a practice with five GPs, a practice manager, six admin staff, two practice nurses, a community nurse/care coordinator, and part time diabetes educator, medical practice assistant and a non-dispensing pharmacist, cares for 5,200 registered patients and families across all demographics. All consenting patients have an up to date My Health Record, and secure messaging allows clinical handover and coordination with multiple external providers. The practice uses locally-developed Health Pathways to deliver optimal care and utilise relevant service delivery networks.

Care options include face-to-face and telehealth consultations (integrated into the practice software), email, app-based communications, health assessments, care planning, proactive coordination of care for complex patients with acute and community providers outside the practice, and virtual after-hours support for registered families. Patients receive SMS (and secure app based) reminders regarding important preventative or chronic care events. The practice also has an app available to patients through which they can engage with their care team. Patients use this app to help their care team track progress on preventative health activities such as their exercise levels, weight, blood pressure, and blood sugar readings (where relevant). The GP team use the app dashboard to track and remotely monitor their patient's progress. Automated notifications enable the monitoring of deteriorating parameters outside those set by the care team, enabling quick outreach to patients, and reducing the need for urgent care escalation.

Relevant practice team members meet weekly to proactively identify patients who may benefit from more structured care, and practice software alerts for patients at risk of avoidable hospitalisation. Data linkage with the tertiary sector also provides the practice team with a population approach to their patient cohorts to help identify service gaps and patients at risk of deterioration. The practice recommends and promotes local healthy lifestyle and support programs and encourages patient input by collecting patient satisfaction and experience measures, enabled by email or on a tablet available near the exit, as well as monthly service enhancement / quality and safety meetings. The practice website includes online booking and feedback opportunities as well as links to quality health information sources.

Patients are preferentially allocated to their nominated preferred clinician, or a subgroup of practitioners who 'team' together to cover practice opening hours. All patients are encouraged to provide their preferred provider details to any health/social care practitioner or organisation who may be delivering care so that all relevant clinical data can be received and coordinated by the team. For those that require complex care, regular case conferencing occurs between the practice team and allied health professionals (and patients and cares) involved with the care of the patient outside of the practice. Visiting specialists provide case conferencing opportunities to those that need it. Patient reported outcome measures are used to collaboratively develop care plans for these patients as well as to track progress.

The practice team meet monthly to use relevant practice-wide data for quality improvement, participate in benchmarking and look for opportunities to utilise practice data to improve outcomes. 'Mini quality improvement taskforces' are set up to constantly trial and test changes designed around quality improvement, which are tracked by the regular collection of data and made available to the team and on the practice website. The practice participates in relevant integrated care activities, supported and funded by regional co-commissioning. These include having social workers, peer support workers, mental health nurses, and non-dispensing pharmacists available to the practice, as well as collaboratively managing hospital in the home patients with the local hospital team.

<sup>57</sup> Source: Case study provided by the Consumer Health Forum

<sup>58</sup> Source: Professor Claire Jackson AM



## Case Study: Western Queensland – eConsultant Partnership Program

### Using digital health to support clinical integration: the eConsultant<sup>59</sup>

Limited local availability of specialist access means rural and remote patients in Queensland travel long distances to access specialist services. In addition, with increasing demand for specialist care across Australia, delays to input are increasing for both rural and urban patients, linked with subsequent deterioration in health. In 2017, a partnership between the University of Queensland (UQ) and University of California San Francisco, identified an evidence-based intervention to allow a remote consultant to respond asynchronously to family physician need, which in the US setting led to more timely assessment and reduction in outpatient department (OPD) demand. This provides a formalised, secure, efficient, and documented method for GPs to access remote specialist support in a way that is timely and convenient to both provider and patient.

The Queensland eConsultant Partnership Program (QePP) is a multi-partner program including the (UQ-MRI) Centre for Health System Reform and Integration (CHSRI); the Western Queensland Primary Health Network (WQPHN); Brisbane South Primary Health Network (BSPHN); Mater Health; Queensland Health and the Australian Digital Health Agency. It has progressed the program with practices across both PHNs in partnership with Mater consultants in South Brisbane.

Mean time for eConsultant to GP reply via secure messaging was two days, with a mean turnaround time for patients to discuss the specialist advice with their GP of 15 days. The eConsultant mean time to assess the Request For Advice (RFA) from the GP and respond via secure messaging was 27 minutes, well below the 60-minute OPD appointment booking usually allocated for new patient assessments. The partnership has achieved a 90% reduction in the need for a traditional OPD appointment, strong connection between the general practice community and a remote physician, and improved access to care for complex comorbidities for remote patients, including those utilising indigenous primary care. The model cements care within a continuity of care, patient-centred approach. The first publication includes author representation for all partners contributing content and has informed OPD and store-and-forward review at the Mater Hospital.

### Case study

<b>Day 1</b> Dr Jones (GP) to Dr Smith (eCons)	Mrs HJ, a 75-year-old widow, with aniridia and legally blind, has epilepsy, asthma, idiopathic lymphoedema, polyposis coli and a past history of paroxysmal atrial fibrillation (AF). She has had a normal ECG and been in sinus rhythm for over 12 months and has a CHADSVASC score of 2.  Major current concern is severe iron deficiency anaemia secondary to ongoing gastrointestinal blood loss despite normal endoscopies (Hb 76 NR110-160). She is on multiple medications for her chronic conditions include Rivaroxaban and Digoxin for her past AF  <b>Dr Jones has 3 RFA questions:</b> Is it appropriate to cease Rivaroxaban as Mrs HJ is in slow regular sinus rhythm and has been, as recorded by a number of ECGs, over the past 12 months? If so, is a replacement blood thinner needed? What is the role of Digoxin?
<b>Day 3</b> Dr Smith to Dr Jones	Has a capsule endoscopy has been considered? Appropriate to cease Rivaroxaban and Digoxin as CHADSVASC 2 and ECG in sinus rhythm. Little evidence for aspirin in paroxysmal AF. Monitor Hb, rate and rhythm and notify any further queries / concerns.
<b>Day 6</b> 6 months follow up	Dr Jones discusses advice with Mrs HJ at the follow up appointment. They accept all advice.  Mrs HJ remains in sinus rhythm with a normal Hb and no further GI bleeding.  <i>Feedback: The eConsultant was very responsive to the RFA &amp; recommendations very helpful. The avoidance of additional physical health visits appreciated.</i>

## Case Study: Rural Doctor's Network – Collaborative Care Workforce Models for remote and Rural Communities<sup>60</sup>

### What is the goal of the program?

The goal of the Collaborative Care Program is to develop sustainable solutions that will bring long-term benefits, and this will take time.

It is about communities coming together to cooperatively identify needs and share their resources, including flexible and innovative use of health professionals to fill care gaps, in a way that provides better primary health care access to everyone. This may include the rotation of health professionals between communities to deliver locally based care.

### Who is involved in the program?

The program works with local health professionals and communities to create a primary health care access model that fits their needs. It does this by bringing communities from neighbouring areas together to develop shared priorities and solutions, through a networked, multidisciplinary team.

It is the result of an ongoing collaboration between the Rural Doctor's Network and agencies that cooperatively administer the projects: Western NSW Local Health District, Far West NSW Local Health District, Murrumbidgee Local Health District, Western NSW Primary Health Network, and Murrumbidgee Primary Health Network. The coordinating organisations form a project team with local stakeholders, who guide their communities through the five planning phases shown below.

### What are the phases in the approach?

Phase	Actions	In plain English
<b>1. Investigate</b>	Research existing evidence of needs and primary health care workforce data to provide context for discussions.	<b>Do the homework:</b> What do we already know about the primary health care needs in these communities?
<b>2. Engage</b>	Seek community feedback to better understand their primary health care needs. <ul style="list-style-type: none"> <li>Connect with primary health practitioners to understand their perspectives.</li> <li>Invite relevant organisations at the local, state and national levels to provide input.</li> </ul>	<b>Listen and learn:</b> Hear the views of community members, health practitioners, and the organisations that support them.
<b>3. Co-Design</b>	Work together on a plan of action that will better address the needs of local communities. <ul style="list-style-type: none"> <li>Consider any tools or resources that are currently available.</li> <li>Set a realistic timeline and budget to begin implementing these changes.</li> </ul>	<b>Make a new plan:</b> Decide together how primary health care services could be shared among local communities.
<b>4. Implement</b>	Support health practitioners to work collaboratively across communities. <ul style="list-style-type: none"> <li>Communicate any changes to health services with local communities and organisations.</li> </ul>	<b>Get started:</b> Put the plan into practice and make sure communities know what to expect.
<b>5. Reflect and Learn</b>	Analyse how the new model of care is working and identify key learnings. <ul style="list-style-type: none"> <li>Compare the current evidence of primary health care needs against the needs that were identified at the start of the project.</li> </ul>	<b>See how it's working:</b> Look at what is working well and where improvements can still be made.

<sup>59</sup> Job J, Donald M, Borg, S, Nicholson C, Chaffey J, O'Hara K, Fagermo N, Jackson C 'Feasibility of an asynchronous GP to General Physician eConsultant outpatient substitution program: a Queensland pilot study' *Aust J Gen Prac*, November 2021.

<sup>60</sup> Collaborative Care Workforce Models for Rural and Remote Communities (nswrdn.com.au) (accessed 8 September 2021)

### Case Study: Far North WA – Kimberley Aboriginal Medical Services<sup>61</sup>

The Kimberley Aboriginal Medical Service (KAMS) is a longstanding and respected organisation, working across its seven networked members to deliver quality, culturally safe, primary health care services in the remote Kimberley region of Western Australia. KAMS independent members are the:

- Broome Regional Aboriginal Medical Service (BRAMS)
- Ord Valley Aboriginal Health Service (OVAHS)
- Derby Aboriginal Health Service (DAHS)
- Yura Yungi Medical Service (YYMS)
- Beagle Bay Health Services (KAMS Remote Clinic)
- Bidyadanga Community (KAMS Remote Clinic)
- Nirrumbuk Aboriginal Corporation.

'We are an organisation of Aboriginal people, for Aboriginal people, controlled by Aboriginal people. We are committed to providing and supporting the provision of effective holistic and culturally appropriate primary health care services for Kimberley Aboriginal people.' KAMS Strategic Plan

KAMS is an example of an effective networked Aboriginal Community Controlled Health Service in action. KAMS and its partners are achieving real wins for Kimberley Aboriginal people, improving the physical, social, emotional and cultural wellbeing of Kimberley communities and responding to new challenges, including management of the Kimberley response to the COVID-19 pandemic. The work of KAMS and its members is grounded in a holistic person-centred care that is, in many ways, at the forefront of future directions in primary health, delivering comprehensive services and health and wellbeing programs that go far beyond the primary health care services currently offered by many general practitioners in Australia.

The key to KAMS' success is building strong networks of staff across remote clinics and other partners KAMS has grown into one of the largest Aboriginal controlled organisations in the region, employing over 250 people. Staff work in practical and hands-on ways to empower remote clinics to develop local health and wellbeing strategies that work for their communities, respecting local knowledge and independence while providing effective workforce, training, communication, corporate and advocacy support. People in the KAMS network don't work alone but with communities and as part of flexible teams. That is the key to achieving better health and wellbeing outcomes for Kimberley Aboriginal people.

<sup>61</sup> Source: Case Study provided by National Aboriginal Community Controlled Health Organisation

### Case Study: South East Queensland – Institute for Urban Indigenous Health<sup>62</sup>

Established in 2009, the Institute for Urban Indigenous Health (IUIH) was a strategic response to the significant growth and geographic dispersal of Aboriginal and Torres Strait people in the South East Queensland (SEQ) region. It was founded by the region's four existing Community Controlled Health Services (CCHSs) as a regional 'backbone' organisation to enhance regional consistency, efficiency, and effectiveness and to drive transformational change to the way health services are delivered for urban Indigenous Queenslanders. The four founding Member Organisations are:

- Aboriginal and Torres Strait Islander Community Health Brisbane (South Brisbane region)
- Kambu Aboriginal and Torres Strait Islander Corporation for Health (Ipswich region)
- Kalwun Development Corporation (Gold Coast region)
- Yulu-Burri-Ba Corporation for Community Health (Bayside region).

Since then, IUIH has established the Moreton Aboriginal and Torres Strait Islander Community Health Service, a network of clinics in the Moreton Bay region. Collectively, these CCHSs comprise the IUIH Network and deliver services through 19 community controlled comprehensive primary health care clinics and four respiratory clinics.

Over 100,000 Aboriginal and Torres Strait Islander people reside in SEQ, now the largest and equal fastest growing Indigenous region in Australia. SEQ is home to 11% of Australia's, and 38% of Queensland's, Aboriginal and Torres Strait Islander population, and is projected to exceed 130,000 people by 2031. In 2009, only 16% of this population was accessing community controlled health care, and government policy and funding priorities wrongly assumed that proximity to mainstream health services would be sufficient to ensure participation in health care and achievement of improved health outcomes. The imperative to address these challenges drove the formation of IUIH and shaped the blueprint for a new regional community governance architecture, which enabled clinic expansion and brought culturally capable health care services closer to where people were living.

The IUIH Network is now one of the largest community health providers in Australia providing health care to around 40,000 people. It operates a consistent, regional system of care, which offers a 'one stop shop' suite of integrated services and programs to people across the life span. The IUIH Network ecosystem operates a 'no wrong door' approach to health care service provision, whereby an individual or family connecting with any program through any clinic can access the full range of medical, dental, allied health, social health, legal, care coordination, birthing, early childhood, and aged care services as required.

The IUIH Network System of Care is underpinned by:

- *Regional planning, data sharing and continuous quality improvement*, including through ongoing systems analysis, with rapid cycles of review and adjustment against specified targets
- *Governance*, which reflects a modern constitution and a mixed Board structure, underpinned by a Cultural Integrity Investment Framework that articulates traditional ways of being, doing and belonging, and which are embedded into the Network's vision, purpose, and operations

*(continued next page)*

<sup>62</sup> Source: Case study provided by Institute for Urban Indigenous Health

- *Regional network structure*, which supports consistency and location of services close to where people live and which eliminates barriers, promotes integration, and fosters business efficiency
- *Clinical governance* across the regional Network, through a structured clinical governance framework and a standardised toolkit for monitoring clinical quality and safety
- *A workforce strategy* that includes partnerships with universities and other tertiary institutions, in-house training and ongoing skills development that supports the IUIH system of care, thereby building a health workforce of Aboriginal and Torres Strait Islander people and non-Indigenous people capable of providing clinically and culturally safe care
- *Community engagement and empowerment* through ongoing consultation and feedback, and programs that build health literacy and promote healthy lifestyles
- *Shared IT and ITC systems*, including a single electronic health information system across the Network.

This regional ecosystem has allowed the IUIH 'backbone' to harness efficiencies through regionally scaled solutions. IUIH can leverage systematised approaches to maximising Medicare billing and achieve economies of scale through Network-wide funds pooling and internal sub-contracting arrangements. This enables an enhanced purchasing power that has delivered significant savings across the Network. Income and savings generated are then re-invested into additional services and programs; for example, this approach has enabled the establishment of a regional allied health and specialist workforce.

The IUIH Network has also established strong relationships and service delivery partnerships with mainstream providers across the region. Examples include the Birthing in Our Community partnership with The Mater Hospital, which received international recognition for closing the gap in pre-term births, rates of antenatal care in the first trimester, and babies born at optimal birthweight. A partnership with Metro South Hospital and Health Service enables IUIH to deliver wrap-around 'at the elbow' support for people requiring cataract surgery, from identification of need, to transport, advocacy and system navigation support on the day of surgery, to post-operative care, efficiently and at no additional cost to the system.

Finally, the regional structure of the IUIH Network allows for quick action and rapid response to emerging challenges, such as the COVID-19 pandemic. Using its Deadly Choices social media platforms and the network of clinics and services across SEQ, IUIH was able to activate targeted COVID-19 messages within 48 hours and establish four respiratory services within a few weeks.

The strength of the IUIH Network lies in its connectivity, its shared vision and purpose, its functional efficiency and systems-focus. The IUIH 'backbone' acts as a systems integrator, leading strategic planning, service development, business modelling, income generation, data analysis, clinical and corporate governance, quality improvement, performance monitoring, workforce development, cross-sector connectivity, and research, thereby enabling its Member CCHSs to focus on community connection and delivery of high quality health care at a local level.

## Appendix 7: Spectrum of payment models

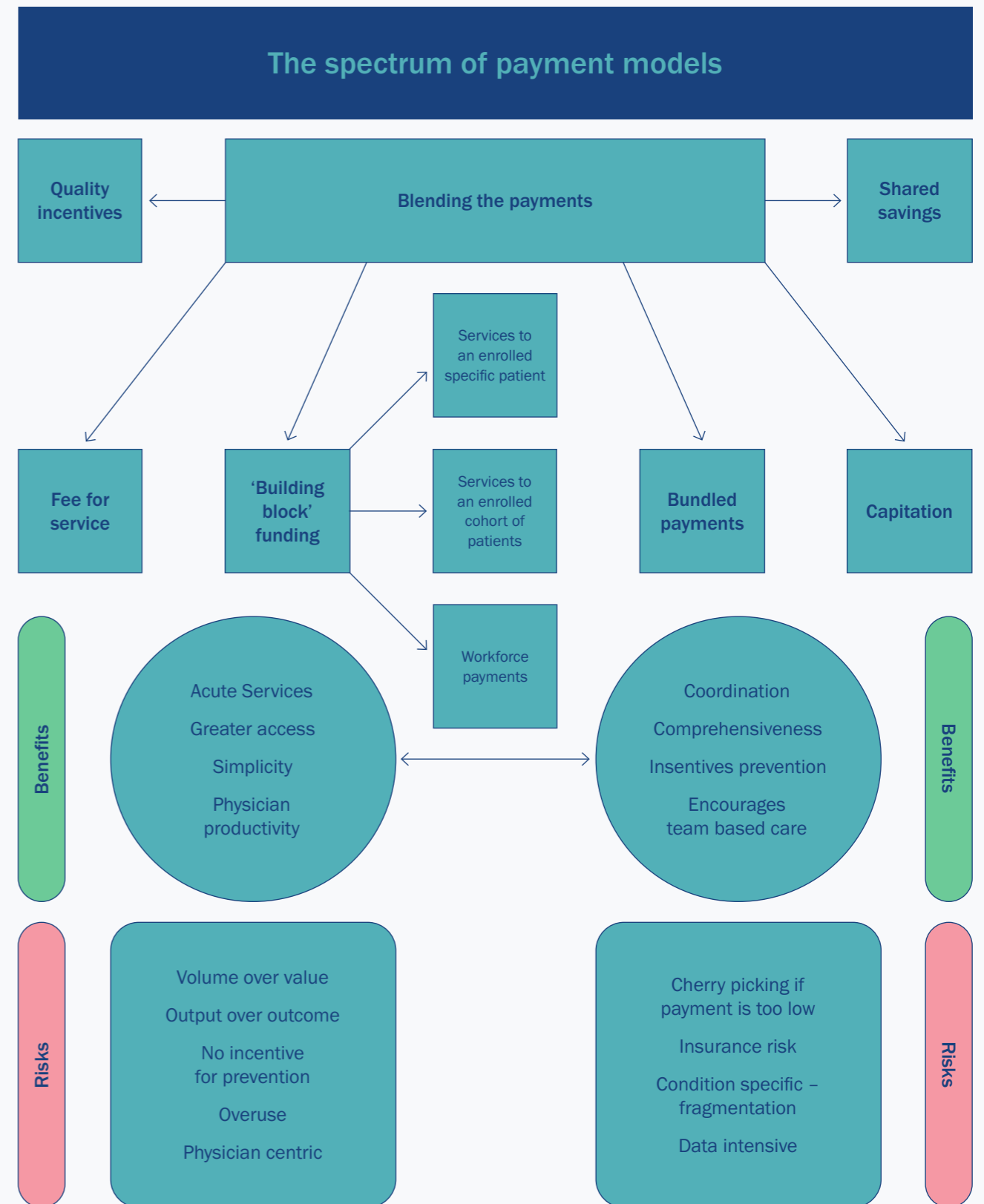


Diagram provided by Dr Walid Jammal based on Paresh Dawda, Australian Healthcare and Hospitals Association, "Bundled Payments: Their role in Australian Primary Health Care" (2015)

## Appendix 8: Abbreviations

<b>AAPM</b>	Australian Association of Practice Management
<b>ACCH</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>HITH</b>	Hospital in the Home
<b>LGBTIQ+</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 Scheme
<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>RaSS</b>	Residential Aged Care Facility Acute Care Support Service
<b>RERN</b>	Rural Emergency Response Networks
<b>RFDS</b>	Royal Flying Doctor Service
<b>VPR</b>	Voluntary Patient Registration
<b>WIP</b>	Workforce Incentive Program



## Appendix 9: 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 (ACCHs)</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 that 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</li> <li>• while not usually immediately life threatening, are the most common and leading cause of premature mortality.</li> </ul>

Definitions	Description
<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.</p> <p>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 three 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> <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>	<p>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.</p> <p>A Health Care Home is an existing general practice or ACCH that provides comprehensive primary health care, in the one place.</p>
<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

Definitions	Description
<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>HealthPathways</b>	HealthPathways 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>Hospital in the Home (HITH)</b>	Is clinical care that reduces the length of stay in hospital or in some instances can avoid an admission altogether. A range of clinical conditions can be effectively and safely managed without a person needing to stay in hospital.
<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 friends supporting someone. People with lived experience are considered experts on their lives and experiences. These insights of 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.

Definitions	Description
<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 Practice Incentive Program (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.
<b>Preventive health</b>	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>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>

Definitions	Description
<b>Primary Health Networks (PHNs)</b>	Primary health care organisations established as part of the National Health Reform 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.
<b>Residential Aged Care Facility Acute Care Support Service (RaSS)</b>	<p>Provides care in partnership with GPs and Residential Aged Care Facilities (RACFs) to increase patient choice of care setting and improves the quality and safety of care provided.</p> <p>If a patient becomes unwell, the GP or nursing staff at the RACF, can contact the RaSS for advice and support. The resident's acute care needs are assessed, and the most appropriate care delivery service is matched to these needs.</p> <p>If necessary, the RaSS can arrange for a specialist nurse or doctor to visit the RACF to provide ED substitutive care. This means the patient can receive care in familiar surrounds under a framework of patient quality care and safety. If transfer to hospital is required, the RaSS can ensure that the receiving emergency department receives high-quality clinical handover prompting activation of appropriate services for the arriving patient.<sup>63</sup></p>
<b>Risk Factors</b>	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.
<b>Social Prescribing</b>	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'.
<b>Workforce Incentive Program (WIP)</b>	<p>The Workforce Incentive Program (WIP) aims to build a sustainable and high quality health workforce, particularly in rural and remote areas, by providing better targeting incentives. Incentives include quarterly incentive payments to engage eligible health professionals, a rural loading of up to 50%, an annual loading for practices providing general practitioner services to Veterans' Affairs (DVA) Gold Card holders.</p> <p>The amount a practice gets depends on the practice size, type of eligible health professionals, average hours eligible health professionals work each week and type of practice and its location.<sup>64</sup></p>

<sup>63</sup> <https://clinicalexcellence.qld.gov.au/improvement-exchange/residential-aged-care-facility-support-service> (accessed 17 September 2021)

<sup>64</sup> <https://www.servicesaustralia.gov.au/organisations/health-professionals/services/medicare/workforce-incentive-program-wip-practice-stream> (accessed 16 September 2021)

