Primary Health Care Reform in Australia

Report to Support Australia’s First National Primary Health Care Strategy
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Acknowledgment

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Preface


The Report provides background for the Draft Strategy’s directions as well as providing evidence to support future investment in, and reform of, the primary health care system.

The Report also examines key issues that were raised under the ten individual Elements of the *National Primary Health Care Strategy Discussion Paper: Towards a National Primary Health Care Strategy*, which was publicly released on 30 October 2008.

The Australian Government Department of Health and Ageing received a large number of stakeholder submissions in response to the Discussion Paper. Submissions expressed a range of views on the key issues facing the Australian primary health care system and on possible priority areas for investment and reform.

All stakeholder views were carefully considered in the development of the Draft Strategy and Report. Submissions have supplemented analyses and research evidence from other sources to create the Draft Strategy and the Report.
1. Introduction

This Report provides, for the consideration of the Minister for Health and Ageing, presentation and analysis of the issues on which the Draft Strategy is based.

The Report and Draft Strategy have been prepared by the Australian Government Department of Health and Ageing, assisted by the External Reference Group (ERG), further informed by a large number of submissions and discussions, including with representatives from state and territory health departments.

The Draft Strategy is a high level action plan. This Report supports and expands on the issues which have determined the Key Priority Areas in the Draft Strategy.

Related reform processes

The Draft Strategy was developed in the context of the historic Council of Australian Governments’ (COAG) National Healthcare Agreement – Intergovernmental Agreement on Federal Financial Relations (NHA).¹

The NHA between Commonwealth and state/territory governments, announced in November 2008, is framed with the objective of improving health outcomes for all Australians and the sustainability of the Australian health care system. The NHA defines the objectives, outcomes, outputs and performance measures, and clarifies the roles and responsibilities that will guide the Commonwealth, states and territories in the delivery of services across the health sector. Importantly, the NHA recognises that primary health care involves Commonwealth and state/territory responsibilities but depends on the significant role of private providers and community organisations.

The NHA affirms the agreement of all governments that Australia's health system should:
- be shaped around the health needs of individual patients, families and their communities;
- focus on prevention of disease and the maintenance of health, not simply the treatment of illness;
- support an integrated approach to the promotion of healthy lifestyles, prevention of injury and diagnosis and treatment of illness across the continuum of care; and
- provide all Australians with timely access to quality health services based on their needs, not ability to pay, regardless of where they live in the country.²

The Draft Strategy is a priority reform area identified under the NHA which also sets the policy direction to better connect hospitals, primary and community care to meet patient needs, improve continuity of care and reduce demand on hospitals.

The development of the Draft Strategy has been undertaken alongside complementary health reform processes including the work of the National Health and Hospitals Reform Commission (NHHRC) and the National Preventative Health Taskforce.

Alongside these processes, initiatives in the 2009-10 Budget including those responding to the Maternity Services Review; the Rural Workforce Audit; the review of Commonwealth-funded rural health programs; and the review of rural classification systems, changes for nurse practitioners and the Closing the Gap National Partnership, contribute to primary health care reform in Australia.
Process

Development of this Report and the Draft Strategy has been informed through the release of, and stakeholder consultation on, the Discussion Paper. This Report draws on the information and views presented in the more than 260 submissions received in response to the Discussion Paper alongside other evidence and analysis. The Discussion Paper proposed 10 Elements for an enhanced primary health care system. These 10 Elements (Chapter 4) capture the directions reflected in the NHA.

The ERG, chaired by Dr Tony Hobbs, included a range of primary health care experts from around Australia: Mr Peter Fazey, Professor Mark Harris, Associate Professor Noel Hayman, Professor Claire Jackson, Ms Judy Liauw, Professor Lyn Littlefield OAM; Ms Anne Matyear, Mr Mitch Messer, Dr Vasantha Preetham, Dr Rod Pearce, Professor Hal Swerrisen and Dr Barbara Vernon.

External Reference Group

From left to right: Mark Harris, Claire Jackson, Tony Hobbs, Barbara Vernon, Lyn Littlefield, Noel Hayman, Rod Pearce, Peter Fazey, Mitch Messer, Judy Liauw, Anne Matyear (Note: Hal Swerrisen and Vasantha Preetham are not pictured above)

Further details regarding the ERG and the stakeholder consultation process are included at Attachment A.
2. Why is reform in primary health care needed?

Increasingly, both in Australia and overseas, there is recognition that strengthening and improving the way in which primary health care is provided is vital in determining how well the health system responds to current and emerging pressures.

Research shows that those health systems with strong primary health care are more efficient, have lower rates of hospitalisation, fewer health inequalities and better health outcomes including lower mortality, than those that do not.3,4,5 The recently released World Health Organization (WHO) Report, *Primary Health Care: now more than ever*, calls for a return to primary health care to help align health systems to deliver better performance and equity. The WHO Report found that where countries at the same level of economic development are compared, those that were organised around the tenets of primary health care produced a higher level of health for the same investment.6

There are a number of reasons why reforms to primary health care service provision and restructuring the health system to place greater focus on primary health care are needed:

- the first is the burden of disease, workforce pressures and effects on patient wellbeing from increasing rates of chronic disease;
- the second is to minimise the need for people to be admitted to hospitals and for people to spend less time in hospital by providing clinically appropriate care in the community; and
- a third reason is evidence that not all people are receiving equitable levels of primary health care services due to where they live, their ability to pay or their health condition.

Together these factors are placing growing pressure on our existing services and providers, and leaving more consumers with potential gaps in care. At the same time, growing fiscal pressure requires governments to ensure the investment of public funds is well targeted and cost-effective. Given long-term health expenditure trends, an important goal for primary health care reform must be to ensure the long-term financial sustainability of the Australian health system.

Around the globe, many nations are grappling with how best to address similar issues. In response, many industrialised countries including New Zealand (NZ), the United Kingdom (UK) and Canada have undertaken significant investment and reform processes directed at strengthening the primary health care sector.7,8,9 These reform processes have predominantly focussed on encouraging a population health focus, greater use of multi-disciplinary teams, increased accountability for performance, and improved access to services.

Across industrialised countries there is a shift towards payment structures which reflect broader system requirements and a move from general practitioner (GP) focussed fee-for-service payments to mixed (blended) payments incorporating elements of capitation, patient co-payment and incentive payments. The use of meso-level organisations (such as the Primary Health Organisations [PHOs] in NZ, Primary Care Trusts [PCTs] in the UK, and Divisions of General Practice in Australia) to coordinate and deliver health programs at the local level are also increasing. Patient enrolment with practitioner, practice or organisation has been considered appropriate in other countries, for example, new models of care in the Netherlands, NZ and the UK (and in some sections of the US system) require patient enrolment with privately run practices whilst retaining the ability to choose a family physician (who coordinates care including linkages with hospital and specialist care).
Looking forward, there are a number of challenges exerting increasing pressure on our health system generally and, in particular, on health care services delivered in the community, addressed below:

- demographic trends;
- burden of disease;
- changes in delivering care;
- increasing expectations;
- economic implications; and
- changes in the health workforce.

**Demographic Trends**

Australia’s population is growing. Increasing fertility rates and numbers of migrants has led to a significant increase in the Australian Bureau of Statistics (ABS) population projection, which has grown from 28.2 million people in 2051 (2004 estimates) to 34.2 million people (2006 estimates). This, together with demographic trends, suggests that while there will be a growing need for primary health care services targeted at children, teenagers and young families, the predominant influence will remain ageing, which will cause most change in the use of primary health care services.\(^{10}\)

The ABS projects that the proportion of the population aged 65 years and over could increase from 13.5% to 22.3% between 2009 and 2051. Older Australians are significant users of GP services, with the Bettering the Evaluation and Care of Health (BEACH) survey finding that people aged 65 years and over take up 29.7% of consultation time. Data from the survey suggests that people aged 65 years and over present to their GP with more problems than younger people, are prescribed more medications per visit and have longer average consultations.\(^{11}\) Older Australians are also major consumers of allied health and nursing services.

**Burden of Disease**

The prevalence and burden of chronic disease is significant and will increase with ageing of the population. Chronic diseases, including cancers, are estimated to be responsible for more than 80% of the burden of disease and injury.\(^{12}\) The WHO warns that the global burden of chronic disease is increasing rapidly and predicts by the year 2020 that chronic disease will account for almost three quarters of all deaths.\(^{13}\)

Increasing rates of chronic disease may place increasing pressure on health expenditure as well as reduce future labour force participation rates and productivity, thereby affecting economic growth. Diabetes, for example, is projected to increase from around 5% of the total burden of disease in 2003 to 9% by 2023, primarily due to increasing obesity rates.\(^{14}\) The 2007-08 National Health Survey (NHS) found that 24.8% of the adult population were obese compared to around 18.7% in the 1995 National Nutrition Survey. The Treasury and the Department of Health and Ageing are currently undertaking a project on the economic impact of chronic disease and the economic benefits of a greater focus on prevention in health care.
Figure 1 shows that the burden of disease is expected to increase in the coming decades, especially for older people.\textsuperscript{15}

**Figure 1: Increasing burden of disease**

![Graph showing increasing burden of disease](image)

Source: AIHW, The Burden of Disease and Injury in Australia, 2003

Not only is the incidence of chronic disease on the rise, but a large number of people suffer from more than one chronic health condition at the same time. Data on 9,156 GP patients in 2005 from the BEACH survey was used to estimate the number of people with multimorbidities, based on having one or more of the following conditions: vascular, musculoskeletal, psychological, asthma, upper gastrointestinal diseases, cardiac, diabetes, cerebrovascular and malignant neoplasms. Table 1 shows that after adjusting the sample to reflect the GP patient population, 28.3\% of people had more than one condition.\textsuperscript{16}

**Table 1: GP patients with more than one condition, 2005**

<table>
<thead>
<tr>
<th>Number of conditions</th>
<th>Estimated percent of GP patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>47.7</td>
</tr>
<tr>
<td>One</td>
<td>24.0</td>
</tr>
<tr>
<td>Two</td>
<td>13.7</td>
</tr>
<tr>
<td>Three</td>
<td>7.8</td>
</tr>
<tr>
<td>Four</td>
<td>3.8</td>
</tr>
<tr>
<td>Five</td>
<td>1.8</td>
</tr>
<tr>
<td>Six</td>
<td>0.8</td>
</tr>
<tr>
<td>Seven or more</td>
<td>0.4</td>
</tr>
</tbody>
</table>

Source: BEACH survey data
Changes in delivering care

The acute care sector is increasingly characterised by high technology, high throughput and reducing lengths of stay, leading to pressure on post acute, step down and convalescent care. Resulting trends towards shorter hospital episodes of care, including an increasing number of day surgery procedures, means that patients, on discharge, require greater and more complex care from primary health care providers. In addition, some care which has traditionally been provided in hospital is now able to be provided in the community including within the patient’s home (eg dialysis and chemotherapy). Other factors over the last two decades, such as changes to mental health services, have increased the demand on primary health care services to provide ongoing care in the community for people with complex needs.

Increasing expectations

Better knowledge of what constitutes best practice care, both at the consumer and health provider level, combined with new technologies which can change the way services are provided, have meant that expectations regarding health and the health system have also risen.

A common theme throughout this Report is the uneven provision of primary health care services in Australia. The WHO has identified the inverse care law as one of the common shortcomings of health care delivery. Inverse care suggests that people with the most means – whose needs for health care are often less – consume the most care, whereas those with the least means and greatest health problems consume the least. Public spending on health services most often benefits the rich more than the poor in both high and low income countries alike. Discussions around gaps in service provision are discussed under Element 1 and through other Elements where relevant.

Economic implications

The Australian Government published the second Intergenerational Report (IGR2) in 2007. The Report projects that if policy settings in 2007 were maintained, Australian Government health spending would increase as a proportion of Gross Domestic Product (GDP) from 3.8% in 2006-07 to 7.3% in 2046-47. IGR2 found that the greatest cost pressures on health spending by the Australian Government over the next 40 years are demographic factors such as ageing and non-demographic factors such as the listing of new medicines on the Pharmaceutical Benefits Scheme (PBS) and greater use of diagnostic procedures and new medical technologies. Modelling is based on trends from historical data and a continuation of current service models; it does not take account of new service models or changing patterns of disease or chronic conditions. The third Intergenerational Report will take into account analysis of the growing burden of chronic disease.

Changes in the health workforce

The 2006 ABS Census of Population and Housing reported that there were 548,400 health workers in Australia. An analysis of published data on occupation and industry setting shows that 52% of health workers are employed in hospitals and residential care, 25% in primary care, 5% are specialists, 4% are employed in community non-primary care, and 14% are employed in other health occupations. The primary health care workforce, based on people employed in general practice medical services and community-based dental, allied health and pharmacy services, including nurses, is around 137,600 as shown in Table 2.
Table 2: Primary Care Workforce, Australia, 2006

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Community Primary Care</th>
<th>Health and Community Services</th>
<th>Primary Care %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical practitioners</td>
<td>26,900</td>
<td>57,000</td>
<td>47</td>
</tr>
<tr>
<td>Nursing workers</td>
<td>23,800</td>
<td>222,100</td>
<td>11</td>
</tr>
<tr>
<td>Allied health workers</td>
<td>24,700</td>
<td>65,300</td>
<td>38</td>
</tr>
<tr>
<td>Dental workers</td>
<td>24,900</td>
<td>29,600</td>
<td>84</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>12,400</td>
<td>15,300</td>
<td>81</td>
</tr>
<tr>
<td>Complementary therapists</td>
<td>12,900</td>
<td>16,400</td>
<td>79</td>
</tr>
<tr>
<td>Medical imaging workers</td>
<td>900</td>
<td>10,500</td>
<td>9</td>
</tr>
<tr>
<td>Other health workers</td>
<td>11,100</td>
<td>132,200</td>
<td>8</td>
</tr>
<tr>
<td>Health workers</td>
<td>137,600</td>
<td>548,400</td>
<td>25</td>
</tr>
</tbody>
</table>

Source: AIHW, Health and community services labour force, 2006

The AIHW also reported that there were 17,700 specialists in Australia, with 41% working in hospitals, 33% in specialist offices and 20% working in primary care settings.

The Primary Health Care Research and Information Service (PHCRIS) estimate that there were 7,261 general practices in Australia in June 2008, with 22,965 practising GPs. There has been a trend in recent years towards larger practices - in the last four years, the number of solo GP practices has fallen from 42% to 38% while the number of practices with six or more GPs has increased from 15% to 18%.21

Of the 23,800 community nurses shown in Table 2, the AIHW reported that 5,700 were employed in general practice medical services, 5,000 in allied health services and 13,100 community nurses were reported in ‘other medical and health care services’. The number reported under general practice medical services varies from data from different sources which totalled 8,575 practice nurses in 2007-08. The number of practice nurses more than doubled in the four years to 2007-08. Around 53% of practices reporting to Divisions employed practice nurses in 2007-08, up from 39% in 2003-04. Furthermore, in 2007-08 44% of metropolitan practices employed practice nurses compared with 76% of rural and remote practices.22 This distribution has been encouraged by the availability of Practice Incentive Program (PIP) incentive payments to employ practice nurses and/or Aboriginal Health Workers in rural and remote areas, and eligible areas of urban workforce shortage. Practices in eligible urban areas of workforce shortage can employ allied health workers instead of, or in addition to, practice nurses. Also important is the increasing range of MBS items for services provided by practice nurses for, and on behalf of, a GP.

The health workforce is ageing, with 16% aged 55 years and older in 2006, a rise from 9.2% in 1996.23,24,25 The average age of people employed in health occupations in 2006 was 42 years, 3 years older than other people in the workforce.26 Data from the BEACH survey suggests that for GPs patient age mirrors the age of the GP, finding that older GPs see patients aged 65 years and older at more than double the rate of the youngest GPs.27
The health workforce is also predominantly female, with females making up 75.7% of health workers, ranging from 91.3% of nurses to 32.2% of dentists and 37.2% of GPs (cf 32.3% in 1996). GP data from the BEACH survey shows that when compared with male GPs, female GPs see more female patients, provide longer consultations and write more prescriptions; female GPs also work an average of 13.6 fewer hours per week than male GPs.28

At the same time as our health workforce is ageing, there continues to be a mal-distribution of health professionals in all states and territories and in all major health professions, with the possible exception of nursing.29 Regional and remote Australia has experienced medical workforce shortages for a considerable time, particularly in terms of general practice services. Increasingly, workforce shortages are being experienced in disadvantaged urban areas. Workforce distribution is considered further under Element 1.
History

In considering the current status of health care in Australia and what changes may be required, it is useful to understand how the primary health care sector has developed in recent years - its role and function, component parts, how they perform and interact, and the role that primary health care has played in the broader health system.

Primary health care in Australia is delivered through a mix of Commonwealth, state and territory government funding and private funding, and publicly and privately delivered services. While many primary health care services are delivered through privately provided general practice, supported by patient access to Medicare rebates, it is recognised that a range of other programs have developed to address some service gaps as they have emerged.

In considering the recent history of primary and community health care arrangements in Australia, the starting point is Medicare.

Medicare was introduced in October 1984 with the intent to provide a simple, fair and affordable insurance system that provided basic health cover to all Australians, building on the existing fee-for-service billing arrangements. The then Health Minister, Dr Neal Blewett, outlined the four key attributes of the Medicare insurance scheme:

- **Simplicity:** “…the simpler we make a health scheme the more chance it has of delivering the services to those who need the most.”
- **Affordability:** “…everyone will contribute towards the nation’s health costs according to his or her ability to pay. Under Medicare people will not have to worry about falling behind in their payments and being caught with substantial bills.”
- **Universality:** “…Medicare will provide the same entitlement to basic medical benefits, and treatment in a public hospital to every Australian resident regardless of income. In a society as wealthy as ours there should not be people putting off treatment because they cannot afford the bills. Basic health care should be the right of every Australian.”
- **Efficiency:** “…one of the Government’s major objects through the Medicare program is having the maximum number of health dollars spent on delivering health services rather than administering them.”

A fifth attribute, Access, was subsequently articulated with reference to public hospital care in the *Medicare Agreements Act 1992*, and was explicitly applied to primary health care services in the 2008 National Healthcare Agreement.

Under Medicare, which applied to in- and out-of-hospital services, privately practising doctors were able to elect to take the Medicare benefit as full payment for a service from a patient (a practice known as bulk-billing), and those patients who wanted to receive private treatment in a public or private hospital were able to insure against such costs – but there was no requirement, compulsion or incentive for anyone to take out private health insurance. Private health insurance cover has not generally been available for treatment covered by Medicare.
Medicare was seen as:

- providing universal access to a set rebate;
- being well suited to episodic care of illness and ill-health; and
- enabling patient choice of health provider.

Since its introduction the Medicare Benefits Schedule (MBS) as applied in general practice has been highly successful in meeting the original Medicare aims of affordability (with almost 80% of GP services being provided free of charge to patients in 2009) and universality (with the same basic rebates available to all patients). Under Medicare there is no compulsion for doctors to charge the schedule fee. In practice around 20% of GP services and 30% of non-GP services are billed at or above the schedule fee.

At the same time however, the profile of care in both the primary health care and the acute care sector has changed, and the boundary between the sectors has blurred.

**Related Commonwealth initiatives**

Commencing in the early 1990s Medicare, a universal scheme to provide a rebate for episodic health care, has been used to address particular health issues and policy objectives and to overcome perceived problems in service access. This has raised tensions between the original design of Medicare and the MBS as a universal patient insurance scheme providing rebates for episodic health care and the different needs of newer services focussed on ongoing care, care for specific population groups and care involving other health professionals.

These amendments have been introduced with the best of intentions, albeit at times in an ad-hoc manner, and have generally had good results in meeting some of the gaps facing patients in accessing primary health care services – but may have come at a cost, in reducing efficiency, affordability and accessibility. They have also introduced significant complexity in Medicare arrangements for providers and patients, have somewhat distorted the original principles of Medicare (including universality), and have compromised the design of newer models of care in order to fit them into a Medicare framework. It should also be noted that the MBS (and Medicare more widely) is not the only tool available to achieve behaviour change and improve patient outcomes and service delivery.

The Australian Government introduced the General Practice Reform Strategy in 1991 to overcome problems in the primary health care system which had arisen as the Commonwealth retained responsibility for primary health care services via Medicare GP funding and the states and territories retained responsibility for community health care with funding coming via the Medicare block grants. The Strategy aimed to address some specific issues facing general practice in Australia, focusing on workforce initiatives; the development of a primary care accreditation system; and remuneration strategies to more appropriately reward quality care in general practice.

In 1992-93, the Australian Government committed funding for the establishment of the Divisions of General Practice to support GPs to work with each other and with other health professionals to improve the quality of service delivery at a local level. Over the last decade the role of Divisions has evolved to a focus on achieving program and policy outcomes through a move to outcomes-based funding. The introduction of the More Allied Health Services program in 2000 and the Access to
Allied Psychological Services (ATAPS) Program in 2006 have also broadened the role of Divisions to include fund-holding and provision of allied health services. Support for allied health and other health professionals has now developed to be a core role for some Divisions.

Commencing in 1996, alternatives to MBS funding for GPs were introduced in an effort to mitigate the key shortcoming of the MBS through a shift towards a ‘blended payments’ model of funding. Initially introduced as the Better Practice Program (1996), and subsequently the Practice Incentives Program (PIP) (1998) and the General Practice Immunisation Incentives Scheme (1998), these were intended to allow the Government to ‘purchase’ particular quality improvement activities and reduce overall financial risk by increasing the share of GP funding which was capped rather than demand driven.

The PIP has evolved since its inception to include a range of new incentives including several outcome-based incentives, disease-specific incentives and an incentive to support practices to employ practice nurses and allied health workers. More recently, incentives have been introduced for rural and remote general practices which provide procedural services and act as a referral point for domestic violence services.

The introduction of these types of targeted funding streams has resulted in significant gains within the health sector, and has complemented and enhanced the original attributes of Medicare (universality, affordability, simplicity and efficiency). However, over recent years these types of approaches have been comparatively neglected in favour of increased investment in MBS fee-for-service approaches to the provision of health services.

- The Enhanced Primary Care (EPC) MBS items were introduced in 1999-2000 to improve the health and quality of life of older Australians, people with chronic conditions and those with multi-disciplinary care needs. The EPC items provided a Medicare rebate for GPs to undertake or participate in health assessments for older people, and care planning and case-conferencing services for patients with chronic conditions and complex needs. Since that time additional health assessment items have been implemented incrementally to cover additional targeted populations including Indigenous people, aged care residents, refugees, people with intellectual disabilities and 45 year olds at risk of developing chronic disease.

- In 2004 MBS items were introduced for a limited range of services provided by practice nurses when acting for, and on behalf of, a GP.

- In 2004 MBS rebates for a range of allied health and dental services were also introduced for patients with chronic conditions and complex care needs being managed by their GP under a multi-disciplinary care plan. Patients were eligible for up to 5 allied health services and 3 dental services every 12 months. A more extensive schedule of rebates for dental services was subsequently introduced along with a cap on the Medicare benefits received for dental care in any two-year period.

- Chronic Disease Management (CDM) items were introduced in 2005 to replace the existing EPC care planning items. The CDM items were developed to better enable GPs to manage the health care of patients with chronic medical conditions, including patients who need multi-disciplinary care. The capacity for referral to MBS eligible allied health services was maintained under these items.
A range of bulk billing incentive items were introduced in 2004 to encourage GPs to bulk bill concession card holders and children aged under 16. Higher incentives were available for rural and remote areas and certain eligible urban areas. In 2005 the rebate for most GP services was increased from 85% to 100% of the Medicare schedule fee. Collectively these initiatives increased rebates for GP services and reversed what had been a long term decline in bulk billing rates for GP services, particularly in rural and remote areas.

In 2006 MBS items for GP mental health plans and associated psychological therapy items were introduced as part of the Better Access to Psychiatrists, Psychologists and GPs program through the MBS to improve consumers’ access to high quality primary mental health care.

Alongside changes to general practice funding and the introduction of the Divisions Network, a range of targeted programs to address specific service gaps, for example in Indigenous health and rural health, were also introduced.

In Indigenous health, Aboriginal Community Controlled Health Organisations (ACCHOs) have played a significant role in the delivery of primary health care. ACCHOs are primary health care services initiated and operated by the local Aboriginal community to deliver holistic, comprehensive and culturally appropriate health care to the community through a locally elected Board of Management.

Services to rural and remote areas are provided through the Regional Health Services (RHS) and MAHS programs. In addition, the 2009-10 Budget announced that, from January 2010, a new Rural Primary Health Services Program (RPHS) would be established to consolidate a range of existing programs and introduce greater flexibility into primary health care service provision in rural and remote communities.

State and territory government services

State and territory governments are also important in the funding and delivery of primary health care services in Australia. In addition to general practice services, some primary health care has always been delivered through states and territories through other arrangements.

In 1973 the Australian Government established the Community Health Program. The Program aimed to develop a coordinated national network of facilities and services for primary health care, designed as locally managed health centres operating on a social model of health and comprising multi-disciplinary teams that would respond to all types of community health problems. Primary medical care was one aspect of the program, provided by just over one third of the 161 main community health centres across Australia.

From 1976 to 1983 the government introduced a less centralised model and by 1981 had rolled up community health funding into block health grants to the states and territories, ending Commonwealth involvement in the Program. The role played by some community health centres providing access to primary medical care for low income people was made redundant in 1984 with the establishment of Medicare and bulk billing for GP services.
Medicare Agreements with states and territories have been premised on states and territories maintaining their primary health care service levels. This requirement has been made more explicit in the National Healthcare Agreement (November 2008) which recognises that primary health care involves both Commonwealth and state/territory responsibilities but depends on the significant role of private providers and community organisations. Under the NHA the Commonwealth will:

- seek to ensure equitable and timely access to affordable primary health care services, predominantly through general practice;
- assist in reducing pressure on hospital emergency departments through the provision of funding for primary health care services; and
- seek to ensure equitable and timely access to affordable specialist services.

Under the Agreement states and territories will provide public health, community health, Home and Community Care (HACC), and public dental services, deliver vaccines purchased by the Commonwealth under national immunisation arrangements and provide health promotion programs.

States and territories provide a range of community health services including maternal and child community health services, parenting support, early childhood nursing programs, disease prevention programs, women’s health services and men’s health education programs. The Report on Government Services (RoGS) defines community health services as multi-disciplinary teams of salaried health and allied health professionals who aim to protect and promote the health of particular communities. The services may be provided directly by governments (including local governments) or indirectly through a local health service or community organisation funded by government. State and territory governments are responsible for most community health services. The Australian Government’s main role in community health services is in health services for Indigenous people, as well as providing support to improve access to community health services in rural and remote areas. The RoGS has found that there is no national strategy for community health and there is considerable variation in the services provided.

The range of available community health services varies across Australia. States and territories fund, or deliver for the Commonwealth, community health programs that include:

- primary health care programs targeted at Indigenous people, men, women, schoolchildren, youth, homeless people, people living in remote areas, people born overseas, refugees, prisoners and people in residential aged care facilities;
- mental health assessment, treatment and rehabilitation;
- aged care assessments;
- HACC services (40% state and territory funded, 60% Australian Government funded);
- cancer screening programs;
- community nursing;
- school dental and oral health programs; and
- community midwifery programs.
State and territory governments are also increasingly focussed on funding a range of programs targeted towards improved primary health care and hospital avoidance. These include programs such as the Hospital Admissions Risk Program (HARP) in Victoria. An important focus of programs such as Primary Care Partnerships (PCPs) in Victoria and the Connecting Healthcare in Communities (CHIC) initiative in Queensland is to improve integration between jurisdictional services, to reduce fragmentation and improve the patient journey. Other state programs focussed on integrated primary health care service delivery models include the NSW HealthOne initiative and South Australia’s GP Plus initiative.

State data suggests that between 45% and 51% of regional emergency department presentations in Victoria could be classified as ‘primary health care’ presentations. This is of particular concern when it is noted that Victoria has reported an 18% increase in these types of presentations over the last five years. Amongst these presentations is a high proportion of young people driving the growth in primary health care service delivery through emergency departments, with anecdotal reports that these patients do not have a connection to, or are comfortable with, accessing general practice services.

**Conclusion**

The complex, fragmented and often uncoordinated delivery systems that operate across primary health care have implications for the services individuals receive, how they pay for them, and how care providers interact and provide care. These relationships are further developed in this Report in the context of the 10 Elements.

While the primary health care sector delivers services that meet the needs of most people requiring treatment for isolated episodes of ill-health, it is less successful at dealing with the needs of people with more complex conditions or in enabling access to specific population groups that are ‘hard to reach’.

Over recent years, primary health care reform has attempted to meet these more specialised needs using a case-by-case approach, largely through existing financing and organisational frameworks. These frameworks have not always been well suited to certain models of care and the result of ad-hoc changes over time has been to create a complex system for patients and providers. The primary health care sector has also proven to be relatively inflexible, not able to readily adapt to changing demands, opportunities and pressures nor to reflect on its own performance and engender change. As a consequence, primary health care tends to operate as a disparate set of services rather than an integrated system.

In meeting the ongoing and future needs of the Australian population, the Draft National Primary Health Care Strategy aims to build on the undertakings agreed through the National Healthcare Agreement to improve the level of cooperation, coordination and integration of service delivery across Commonwealth and state and territory governments and to refocus the primary health care system on meeting the needs of individual patients, being responsive to changing population needs, and operating effectively in a broader social system.
How does Australia compare internationally?

In terms of overall health, according to Australia’s Health 2008, Australia’s level of health continues to improve overall. Moreover, in most aspects of health, Australia matches or leads other comparable countries (those from the Organisation for Economic Co-operation and Development [OECD]).

Little comparable data is available on the importance and specific contribution of primary health care to the overall health of a nation, as most data is presented on total health spending. Figure 3 for example compares life expectancy and Gross Domestic Product (GDP) spending on health services and shows that the proportion of an economy devoted to health care varies considerably across countries and suggests that there is not a simple and consistent relationship between higher spending and life expectancy.

Figure 3: GDP on health and life expectancy, 2005-06

Source: OECD Health Data, 2008

Figure 3 shows that Australia’s spending on health in 2006, as a proportion of GDP, was in the mid-range of OECD countries, and health outcomes in terms of life expectancy were high.

International data shows Australia to be near the middle of comparable countries for the provision of health professionals. Table 3, looks at a number of health occupations across a number of comparable countries to Australia, but still only provides data for the health system rather than primary health care. This workforce data gives an indicative picture of supply, but there may be limits to how it is interpreted as it is a headcount and gives no indication of the person’s workload.
Table 3: Number of health professionals in selected countries

<table>
<thead>
<tr>
<th></th>
<th>Aust</th>
<th>UK</th>
<th>US</th>
<th>Can</th>
<th>NZ</th>
<th>Neth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>25</td>
<td>23</td>
<td>26</td>
<td>19</td>
<td>21</td>
<td>37</td>
</tr>
<tr>
<td>Nurses/midwives</td>
<td>97</td>
<td>128</td>
<td>94</td>
<td>101</td>
<td>89</td>
<td>146</td>
</tr>
<tr>
<td>Dentists</td>
<td>11</td>
<td>10</td>
<td>16</td>
<td>12</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>7</td>
<td>5</td>
<td>9</td>
<td>8</td>
<td>10</td>
<td>2</td>
</tr>
</tbody>
</table>


Funding for primary health care

Until recently, no estimate has been available on primary health care expenditure in Australia. The AIHW has published an estimate from 2004-05 that $35.5 billion was spent on primary health care services in Australia – 44% of total health expenditure – a similar amount to total spending on hospital care and residential aged care. However the definition of primary health care used by the AIHW included medical services, medications, dental services, community and public health services, non-admitted hospital services, aids and appliances, other health practitioners and patient transport. This definition would cover the workforce occupations shown in Table 2, but is likely to cover a broader range of health care workers than those included in that table. The expenditure data is not reported in sufficient detail to allow a more accurate matching with workforce data. The data also covers areas which may not generally be considered primary health care such as non-admitted hospital services and patient transport.

Figure 4 shows the indicative source of AIHW-estimated primary health care funding. Just under half of primary health care funding (47%) is provided by the Australian Government. Almost half is for medical services and one third for medications. States and territories contributed 17% for community health and non-admitted hospital patients, and non-government/private health insurance/individuals contributed 36% mainly for dental services, medications, medical services and aids and appliances.

Figure 4: Indicative source of primary health care funding, Australia, 2004-05
A significant proportion of primary health care services in Australia are funded through the MBS. In 2007-08, Medicare subsidised a total 279 million medical services at a cost of $13 billion, close to 13% of total health spending. 43% of MBS services and 37% of benefits paid were for primary health care services. 92% of MBS primary care services are provided by GPs.

In recent years, the number of primary health care services provided under Medicare has been growing at well above the rate of population growth (1.4% a year). The number of primary health care services grew by 5% a year between 2003-04 and 2007-08 while MBS benefits paid increased from $2.9 billion to $4.8 billion over the same period, an average annual growth rate of 13.8% a year.

**Definitions of primary health care**

Primary health care is commonly viewed as a first level of care or as the entry point to the health care system for consumers. It can also be taken to mean a particular approach to care which is concerned with continuing care, accessibility, community involvement and collaboration between sectors. From a theoretical perspective, primary health care is sometimes regarded as a spectrum ranging from comprehensive primary health care to selective primary health care to the medical model of primary health care. For the majority of Australian health consumers, however, primary health care is a term that is not widely used or even understood with most people simply distinguishing between the health care they receive in the community and the health care they receive in hospital.

The World Health Organization (WHO) Alma-Ata declaration of 1978 defined primary health care as:

> Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

In the Australian context, a commonly used definition from the Australian Primary Health Care Research Institute (APCRI) is:

> Primary health care is socially appropriate, universally accessible, scientifically sound first level care provided by health services and systems with a suitably trained workforce comprised of multi-disciplinary teams supported by integrated referral systems in a way that: gives priority to those most in need and addresses health inequalities; maximises community and individual self-reliance, participation and control; and involves collaboration and partnership with other sectors to promote public health. Comprehensive primary health care includes health promotion, illness prevention, treatment and care of the sick, community development, and advocacy and rehabilitation.
The WHO wrote that:

_The service delivery reforms advocated by the PHC [Primary Health Care] movement aim to put people at the centre of health care, so as to make services more effective, efficient and equitable. Health services that do this start from a close and direct relationship between individuals and communities and their caregivers. This, then, provides the basis for person-centredness, continuity, comprehensiveness and integration, which constitute the distinctive features of primary care._

Table 4 summarises what the WHO sees as the differences between primary care and care provided in conventional settings such as in clinics or hospital outpatient departments or through the disease control programs that shape many health services in resource-limited settings.43

**Table 4: Aspects of care that distinguish conventional health care from people-centred primary care**

<table>
<thead>
<tr>
<th>Conventional ambulatory medical care in clinics or outpatient departments</th>
<th>Disease control programs</th>
<th>People-centred primary care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus on illness and cure</td>
<td>Focus on priority diseases</td>
<td>Focus on health needs</td>
</tr>
<tr>
<td>Relationship limited to the moment of consultation</td>
<td>Relationship limited to program implementation</td>
<td>Enduring personal relationship</td>
</tr>
<tr>
<td>Episodic curative care</td>
<td>Program-defined disease control interventions</td>
<td>Comprehensive, continuous and person-centred care</td>
</tr>
<tr>
<td>Responsibility limited to effective and safe advice to the patient at the moment of consultation</td>
<td>Responsibility for disease-control targets among the target population</td>
<td>Responsibility for the health of all in the community along the life cycle; responsibility for tackling determinants of ill-health</td>
</tr>
<tr>
<td>Users are consumers of the care they purchase</td>
<td>Population groups are targets of disease-control interventions</td>
<td>People are partners in managing their own health and that of their community</td>
</tr>
</tbody>
</table>


Barbara Starfield has written extensively on the importance of primary health care noting that:

_Evidence of the health-promoting influence of primary care has been accumulating ever since researchers have been able to distinguish primary care from other aspects of the health services delivery system. This evidence shows that primary care helps prevent illness and death, regardless of whether the care is characterized by supply of primary care physicians, a relationship with a source of primary care, or the receipt of important features of primary care._44

Changes in acute care leading to shorter stays, earlier discharges and more day surgery procedures also requires better integration between hospital services, community-based support and ambulatory care specialist services.
Scope of primary health care for the Report and Draft Strategy

A number of submissions proposed that the National Primary Health Care Strategy needed to encompass a broad definition of comprehensive primary health care including consideration of the social determinants of health.

Whilst recognising the importance of the social determinants of health, the Draft Strategy does not attempt to actively address the range of non-health issues which impact on health outcomes and inequalities. At the same time, the Social Inclusion Principles identified as part of the Social Inclusion Agenda adopted by the Australian Government, are an important aspect in guiding this reform. The Australian Government's Women's and Men's Health policies are also considering these broader issues.

The Draft Strategy that accompanies this Report does, however, recognise and adopt key characteristics of a people-centred primary health care model including a strong focus on addressing inequities in access to health services; a focus on disease prevention rather than just the episodic treatment of illness; and a greater use of population health approaches including being responsive to the needs of local communities.

The focus of this Report is primarily on services delivered by GPs, nurses, allied health providers, Aboriginal health practitioners, and pharmacists. In addition, primary health care is increasingly being seen as all health care services provided outside the hospital, with the linkages between these health professionals and the services provided by specialists and consultant physicians also being an important consideration.

While dental health is an important part of primary health care, issues around access to dental services are being considered through other forums and are not covered by this Report. Similarly, maternity services are not considered in detail in this Report and will be addressed through the forthcoming development of the National Maternity Services Plan.

In many areas involving primary health care, there are existing processes for the planning, delivery and governance of health care services where the National Primary Health Care Strategy could serve as an overarching framework with which these areas can integrate and link, for example the Fourth National Mental Health Plan and the Fifth Community Pharmacy Agreement, both of which are currently being developed. The interface between primary health care services and aged care services is also significant.

What the submissions said

Over 260 submissions were received in response to the Discussion Paper from a wide range of health professionals, governments, academics and researchers, public health groups and consumer organisations. Feedback from stakeholders supported the government's commitment to develop Australia's first National Primary Health Care Strategy and many submissions supported the 10 Elements of an enhanced primary health care system that were identified in the Discussion Paper as an appropriate framework. A brief summary of submissions across key stakeholder groups follows:
Submissions were received from the majority of state and territory governments which welcomed the development of the Strategy, with one of the highest priorities raised being improving access to primary health care services for the most disadvantaged groups, particularly Indigenous Australians. They were generally supportive of workforce redesign and innovation, particularly stressing the importance of team-based care arrangements in primary health care. Flexibility at the local level (in funding and models of care) was also a recurrent theme as was the use of voluntary patient enrolment for targeted populations or specific services.

Many of the consumer groups agreed that the Strategy needed to examine coordination and integration across sectors, highlighting the value of shared electronic health care records and a role for chronic disease coordinators. Equity, choice and affordability were of high importance as was incorporating consumer participation in service planning, resource allocation, service delivery and evaluation. Some consumer groups discussed voluntary enrolment and GPs as gatekeepers, identifying possible impacts on patient choice and affordability.

Midwives, nurses and their representative organisations were broadly supportive of team-based primary health care and sought recognition and expansion of their current role, particularly in prevention activities and care coordination. These groups also raised their desire to be involved in independent and collaborative work with other health professionals, access to MBS and PBS rebates, and access to and training for eHealth.

Common themes raised by submissions from allied health professionals were the need for an increase in the number of Medicare subsidised allied health consultations to improve access to care and for an electronic shared health care record to better facilitate multi-disciplinary care. Other key themes included a desire for inter-disciplinary health learning, increased incentives for working in rural and remote areas and an expansion of their responsibilities, particularly in the prescription of medicines and the ability to order tests. Many of these groups also supported team-based interventions with respect to chronic disease management, with greater scope for preventive services.

Key GP groups discussed the role of GPs in coordinating team-based care arrangements. They also stated their preference that fee-for-service remain the core funding arrangement but sought an expansion of practice nurse incentives, increases in the cap on allied health visits and a broader scope for MBS items. These submissions were also supportive of an increase in the number of training places for GPs, nurses and allied health professionals and there was some support for use of blended payments, capitation and patient enrolment. Across GP groups, there was variation in views on the extent of reform warranted.

A number of common themes were also present in submissions received from groups with an interest in pharmacy. Overwhelmingly, these submissions indicated the need for improvements to be made in managing patients as they transition from one care setting to another (eg pre/post-admission to hospital) and for pharmacy to play a role in this process. Other key issues included the role that eHealth can play in reducing adverse reactions to medications and prescribing behaviours, the importance of improved data collection and the need for pharmacists to be included as part of the primary health care team.
Aboriginal and Torres Strait Islander representatives and organisations universally supported a holistic approach to primary health care including support for social and emotional well-being and increased levels of support and involvement of the community sector. Submissions also discussed the biggest obstacles in accessing primary health care services, i.e., the availability of effective, culturally safe and timely services. Options to address this issue included increased support for Aboriginal Health Workers and ACCHOs. The impact of chronic disease was also raised as a major concern with suggestions that the Strategy should include a focus on prevention.

Submissions received from organisations in the research, safety and quality sector recommended prioritising investment in health care research for planning and quality improvement. It was suggested that this be supported through better information management including through the eHealth agenda. These submissions also highlighted the importance of building an evidence-based framework for preventive care which they suggested could provide significant benefits in avoiding chronic disease. Many groups also focussed on equity in access and resource allocation including the issues facing many Indigenous Australians. Issues such as patient-centred care, awareness of patient rights and building health literacy were also discussed.

Education and training organisations indicated their support for greater investment in clinical training in the community setting to allow development of infrastructure and to acknowledge the time commitment involved for supervisors/teachers. Their views around increasing support and incentives for inter-professional collaboration, facilitated by horizontal integration of medical, nursing and allied health training activities, were also discussed. These groups also highlighted the importance of a generalist approach and the need for vertical integration across undergraduate, postgraduate and vocational medical training. Increasing remuneration and incentives, and support for primary health care students, was also raised.

Whilst submissions from the many other key organisations and individuals were divergent, the common themes included a focus on better addressing disadvantage and inequity in access, and the view that the current system would benefit from better integration and a stronger emphasis on team-based care arrangements. Other key issues seen as significant objectives included the importance of improving access to health care in rural and remote areas with support for regional planning, the development of eHealth and improving health literacy in individuals.

4. Key Issues for Primary Health Care Reform in Australia

This section of the Report draws on the 10 Elements for an enhanced primary health care system identified in the Discussion Paper and identifies the key issues for each Element. From these issues, the Key Priority Areas identified in the Draft Strategy have been developed:

- improving access and reducing inequity;
- better management of chronic conditions;
- increasing the focus on prevention;
- improving quality, safety, performance and accountability.

Underpinning these Key Priority Areas is the recognition that a patient-centred focus (Element 2), strong eHealth system (Element 6) and well educated and distributed workforce (Elements 8/9) are key underpinnings to all future reforms in primary health care. Equally, issues of financing and in particular, ensuring changes are fiscally sustainable, efficient and cost-effective (Element 10) are key to defining many of the reform directions identified in this Report and the Draft Strategy.

At the same time, as recognised in the Draft Strategy, while issues of financing are an important element in determining possible reform directions, this would be insufficient on its own. An effective reform strategy requires action on multiple fronts including careful planning of implementation and consideration of change management requirements.
Elements of an Enhanced Primary Health Care System

In our future primary health care system all Australians should have access to primary health care services which keep people well and manage ill-health by being:

1. Accessible, clinically and culturally appropriate, timely and affordable;
2. Patient-centred and supportive of health literacy, self-management and individual preference;
3. More focussed on preventive care, including support of healthy lifestyles;
4. Well-integrated, coordinated, and providing continuity of care, particularly for those with multiple, ongoing, and complex conditions.

Service delivery arrangements should support:

5. Safe, high quality care which is continually improving through relevant research and innovation;
6. Better management of health information, underpinned by efficient and effective use of eHealth;
7. Flexibility to best respond to local community needs and circumstances through sustainable and efficient operational models.

Supporting the primary health care workforce are:

8. Working environments and conditions which attract, support and retain workforce;
9. High quality education and training arrangements for both new and existing workforce.

Primary health care is:

10. Fiscally sustainable, efficient and cost-effective.
Element 1: Accessible, clinically and culturally appropriate, timely and affordable

Objective: All Australians have access to required primary health care services, which are clinically and culturally appropriate to their needs and circumstances, and are delivered in a timely and affordable manner.

Key Points

At the core of an effective and high performing health care system is good access to clinically appropriate services. Essentially this means being able to see the right health professional, at the right time, in the right place, and in a manner that is affordable and culturally appropriate.

While many Australians experience good access to primary health care services, there are a range of areas and populations facing significant access gaps. Of particular concern is that those individuals with high health needs or facing significant disadvantage most often experience difficulties in accessing necessary services.

These access gaps can be categorised to four broad groups, noting that some individuals experience a combination of issues across these categories:

- **Location and workforce availability**: Where workforce availability restricts access to health services in a local area or where specialised service delivery arrangements are needed to support highly dispersed populations.

- **Service delivery**: Where individuals requiring a range of services are prevented from accessing them as a result of poor integration across the health system and inflexible service delivery arrangements.

- **Affordability**: Where individuals are unable and/or unwilling to access primary health care services due to their capacity to pay privately or meet out-of-pocket costs for subsidised services.

- **Specialised needs**: Where individuals with specialised health needs and/or among disadvantaged and/or marginalised populations face physical or cultural barriers in accessing appropriate services.

Where are we now?

The population nationally averages 5.1 MBS subsidised GP visits per year\(^7\) and experience a high level of access to GPs with 80% of Australians visiting their GP at least once a year.\(^8\) However, primary health care is more than the provision of services by a GP through Medicare, and also includes specialists, nurses, pharmacists and other allied health workers, providing publicly and privately funded services.

Despite this level of access there is a proportion of the population who are unable to access primary health care services when and where they are needed.
Primary health care is also generally the entry and exit point to and from hospital care, in that patients who require hospital care for acute treatment are usually cared for in a primary health care setting before entering hospital and immediately after being discharged. This aspect of primary care can exacerbate the existing access issues, while also demanding a more organised response from the primary health care system.

**Location and Workforce Availability**

Workforce distribution is one of the major determinants affecting access, with estimates that 74% of Australia is currently considered to be experiencing health workforce shortage (affecting 59% of the population).49

- While only 68% of the Australian population live in major cities, this is where the majority of Australian health professionals are located, including specialists (85%), dentists (81%), GPs (77%), allied health workers (77%) and pharmacists (76%).50

*Figure 5: Primary health care workforce by remoteness per 100,000 people, 2006*

Source: AIHW, Health and community services labour force, 2006
• This workforce shortage in rural and remote areas is further compounded by the logistical challenges of servicing highly dispersed populations over wide and diverse geographical areas.

• Workforce availability is also an issue in many outer metropolitan areas. For example, in examining the equity of access to general practice by remoteness the Family Medicine Research Centre at the University of Sydney estimated that for 2005-06, outer metropolitan areas were undersupplied by 1,303 GPs.51

• The availability of specialists is also an issue for areas facing health workforce shortage. Increasingly specialists are playing a role in the delivery of primary health care services – particularly in managing transition arrangements between different care settings. They are also providing more services out-of-hospital which may have once been provided through the acute sector, which now need to be integrated and coordinated under a primary health care setting. At the same time, access to specialist services in rural and remote regions has been enhanced through the More Specialist Outreach Assistance Program visiting specialist arrangements.

The 2008 Report on the Audit of Health Workforce in Rural and Regional Australia52 and a review of rural programs examined the issues for rural and remote Australia and responded with a major package of initiatives in the 2009-10 Budget, which will improve the recruitment and retention of rural and remote doctors.53

Workforce availability is also a key factor in the provision of after-hours services by GPs. This can be particularly acute in rural areas where complementary health services may not be available.

• Despite more than 80%54 of general practices having arrangements to provide after-hours care, many Australians report problems in accessing general practice services after hours. The Commonwealth Fund55 reported that 64% of adult Australians found it difficult or very difficult to access care on weeknights, weekends or holidays without going to a hospital emergency department.

The availability of established infrastructure may also act as an additional incentive to attract health providers to under-serviced areas. As such, governments are investing in the development of primary health care infrastructure. For example:

• The National Rural and Remote Health Infrastructure Program (NRRHIP) provides opportunities for partnerships and multi-disciplinary approaches in delivering health care in rural and remote communities through access to funding for infrastructure.56

• The positive response57 towards the Australian Government GP Super Clinics Program indicates that there is significant interest to improve the capacity of the primary health care sector through investment in capital infrastructure.

• State and territory governments also provide capital infrastructure support through a range of initiatives improving access to primary health care, for example the South Australian GP Plus,58 NSW Health One,59 and Queensland North Lakes60 initiatives.

A range of other workforce issues are discussed under Elements 8/9.
**Nursing in the primary health care sector**

As illustrated below in Figure 6, nurses have become increasingly involved in the delivery of primary health care services:

- The Australian General Practice Network (AGPN) reported in 2007 that 58% of general practices employed one or more practice nurses.\(^{61}\)
- Nursing is one of the major features of community primary health care service delivery models.\(^{62}\)
- Nurses have the potential to improve workforce capacity, with claims that practices employing a nurse can see over 800 more patients per year.\(^{63}\)

**Figure 6: Number of practice nurses and number of Medicare practice nurse claims**

![Graph showing the number of practice nurses and Medicare practice nurse claims over years](image)

Source: PHCRIS and Medicare

The 2009-10 Federal Budget extended access to the MBS and PBS for nurse practitioners.\(^{64}\) While only a relatively small proportion of the total nursing workforce, this initiative represents a significant step forward in recognising the skills and expertise that nursing brings to the provision of primary health care services.

**Allied health in the primary health care sector**

Allied health professionals are also important to the provision of primary health care. However accessing these services is an issue for many patients.

- Historically, the majority of allied health services (including psychologists, physiotherapists and dieticians) have been funded through state and territory government community health and outpatient clinics or through private arrangements (including private health insurance).
Over recent years, the Commonwealth has invested in supporting allied health through a number of targeted programs. For example, the Better Access initiative provides a range of Medicare services for eligible people with a diagnosed mental disorder (including services provided by GPs, psychiatrists, psychologists, social workers and occupational therapists). Since 2006, this program has been accessed by over 1.4 million patients, although it is estimated around 60% of those in the community with mental health issues are not accessing the services they need.

The MBS also provides some direct funding to patients receiving allied health services. However in order to access these services an individual must have a chronic and complex condition, and be a patient of a GP who has prepared an Enhanced Primary Care (EPC) Management Plan. Unfortunately, not all GPs provide these types of services to all patients for whom there would be a benefit. For example, while 89% of GPs provide at least one care plan service a year, only 34% of GPs provide more than one care plan a week. MBS care planning arrangements are further discussed under Element 4.

Service Delivery

For many individuals, the health system is complex and fragmented. For example, a patient may be required to access Medicare, a state-funded service and utilise their private health insurance for the treatment and management of one health condition. For many individuals, access to primary health services largely relies on factors including their health condition, geographical location, level of private insurance cover and ability to pay privately.

In many ways, this variety of funding mechanisms and associated lack of integration, coordination and collaboration has put the service delivery model ahead of the needs of the individual, in that it is the patient that often has to adapt to the way services are delivered, rather than service delivery models responding to the needs and circumstances of patients.

This is also true for health care providers – who are increasingly expected to navigate multiple health service purchasers implementing and modifying large numbers of new programs (with associated reporting and eligibility requirements) to provide the most effective and evidence-based services to a growing number of patients.

In addition to these issues of fragmentation and integration, the traditional organisation of health care, based on a clear divide between general practice medical care and more specialised care provided on referral by consultant physicians and specialists, is increasingly out of step with the needs of both patients and health professionals.

This is largely due to the fact that many patients now receive a mix of services provided out-of-hospital – including GPs (for ongoing primary health care), allied health, specialists or consultant physicians (as required for more specialised treatment). For example, a patient diagnosed with diabetes in general practice will (as their condition progresses) benefit from investigation and management of aspects of their condition from a variety of health professionals, including nursing professionals, diabetes educators, endocrinologists, podiatrists, urologists, dieticians, nephrologists, pharmacists, neurologists, and/or cardiologists. All of these services are being provided as part of primary health care, along with the patient’s ongoing care as provided by their GP. However, the patient may not have the means to access all of these services, and in obtaining these services the providers themselves may be unaware of the full range of services the patient is accessing (risking duplication of effort).
Under current arrangements, matters such as access, location of services and availability of information about the patient’s needs have historically tended to reflect the separation of different medical and health professions rather than the provision of integrated care. There is increasing recognition of the need for better integration of the services provided across the full spectrum of primary health care, including effective shared care arrangements between general practice, allied health and specialists.

The different service delivery and funding models between sectors, providers, and governments can act as a barrier to patients accessing services. Through greater integration and coordination of investment in primary health care, patients will have access to more efficient and effective services, and governments will achieve higher cost benefit outcomes. For example:

- increased collaborative efforts between health purchasers, such as the co-located GP clinics program and the delivery of Medicare services to Aboriginal and Torres Strait Islander patients through the state-funded community health sector;
- ensuring that funding and service delivery models retain flexibility to take account and make best use of technological advances, such as the potential for telephone, email and internet technologies to play a role in providing access to primary health care services for some patients; and
- integrating and coordinating the use of information tools, such as ensuring the use of Individual Electronic Health Records is consistent across care settings, jurisdictions and health professionals. Issues associated with eHealth are discussed in detail at Element 6.

Affordability of services

Australians generally have good access to affordable health services – particularly those provided through general practice, community care and the hospital sector. However there are disparities across the country for different services and locations in accessibility of affordable primary health care services.

- Nationally (in 2007-08), 79.2% of MBS-funded GP and practice nurse services were provided with no cost to the patient (or ‘bulk billed’). However, this is not the experience of every patient as there is significant regional disparity in accessing bulk billed primary care services. For example, regionally aggregated GP bulk billing rates vary from under 50% to almost 100%.
- In 2007-08, there were 23.2 million GP and practice nurse services charged above the schedule fee, incurring $480 million in out-of-pocket costs, an average of $20.11 per non-bulk billed service.
- 2007-08 bulk billing rate for MBS allied health services was 47.2% nationally, incurring $49 million in out-of-pocket costs, an average of $37.04 per non-bulk billed service they access. Individuals accessing non-MBS allied health services experience out-of-pocket costs (including services accessed through private health insurance) or face waiting lists in accessing services through the hospital sector.
- 2007-08 bulk billing rates for specialist services provided out-of-hospital was 32.1% nationally, with out-of-pocket gaps averaging $44.91.
- Some of these out-of-pocket expenses are partially offset by the Medicare Safety Net, the Extended Medicare Safety Net and the net medical expenses tax offset.
The ABS 2003–04 Household Expenditure Survey found that on average, for all households,$^{79}$ $2,381 was spent annually on medical care and health expenses, which equated to 5.1% of total household expenditure. Spending was further broken down to health insurance ($918), health practitioner fees (GPs, specialists, dentists, etc, $746), pharmaceutical products ($599) and other spending ($118).$^{80}

These issues have a relatively high impact on the decisions of individuals in accessing health services. For example, the Commonwealth Fund survey 2007$^{81}$ found that in Australia 26% of adults said that in the last year they either had not filled a prescription or skipped doses, had a medical problem but did not visit the doctor or skipped a test, treatment or follow-up due to cost. This rose to 36% in the 2008 survey of adults with chronic conditions.

This is of particular concern when considering individuals from low-socioeconomic backgrounds. For example, the 2007-08 National Health Survey (NHS) reported that the most disadvantaged$^{82}$ populations in Australia face a higher prevalence of health issues compared with less disadvantaged populations, as illustrated below:

Table 5: Health conditions experienced by individuals from different socio-economic populations

<table>
<thead>
<tr>
<th></th>
<th>Most disadvantaged</th>
<th>Least disadvantaged</th>
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<tbody>
<tr>
<td>Has arthritis</td>
<td>23.0</td>
<td>16.4</td>
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<tr>
<td>Has asthma</td>
<td>15.9</td>
<td>9.6</td>
</tr>
<tr>
<td>Has diabetes</td>
<td>7.0</td>
<td>3.3</td>
</tr>
<tr>
<td>Has heart, stroke and vascular diseases</td>
<td>9.3</td>
<td>4.5</td>
</tr>
<tr>
<td>Has mental and behavioural problems</td>
<td>18.9</td>
<td>13.1</td>
</tr>
<tr>
<td>Has profound or severe activity limitation</td>
<td>25.2</td>
<td>12.5</td>
</tr>
<tr>
<td>Has a sedentary lifestyle</td>
<td>46.7</td>
<td>24.4</td>
</tr>
<tr>
<td>Is overweight/obese</td>
<td>65.7</td>
<td>56.3</td>
</tr>
</tbody>
</table>

Source: Australian Bureau of Statistics, 4364.0 National Health Survey: Summary of Results, Australia, 2007-08

This poses particular challenges for the health sector in that the longer a health issue is undiagnosed or untreated, the higher the costs associated with eventual treatment. For example, while early interventions can reduce the risk of the onset of diabetes by up to 70%, the average health cost (direct plus indirect) for people with diabetes was $5,325 a year.$^{83}$ Furthermore, the cost for individuals with diabetes complications was 2.4 times higher than in people who were effectively managing their condition.$^{84}$

Patients with specialised needs

Despite our overall strong health outcomes, there are disparities within the population which can be influenced by access to appropriate health services. This is particularly the case when individuals with the highest health needs also face poor access to primary health care services. These access barriers can generally be summarised under two main categories: physical and cultural barriers.
It is also important to note that one of the major roles fulfilled by primary health care is the provision of high quality family care, child-specific and ‘generic or routine’ health care services. It will be necessary to ensure good quality care to patients requiring these services while also providing additional emphasis on the provision of services to marginalised and disadvantaged populations, or disproportionately on disease-specific initiatives.

While this section focuses on a number of key areas and populations, it is recognised that these examples are not exhaustive. As such, it should be noted that discussion under this section is not intended to exclude any such group and that examples are merely illustrative.

**Physical Barriers**

*Patients in residential aged care*

- As noted earlier, Australia has an ageing population.
- Some residents of aged care facilities may have difficulty in accessing primary health care services from a GP, with data reporting that almost 60% of Australian GPs do not actually provide any MBS services to these patients and that only 12% provide more than 100 services annually to such patients.85
- Innovative solutions to improving access to primary health care services for these patients and avoiding hospitalisation are being developed across Australia. For example, preliminary research from Western Australia86 has identified that up to 32% of all transfers from residential aged care homes to a tertiary hospital emergency department are potentially avoidable if improved primary health care services were available. This has resulted in the provision of a WA Health-funded outreach nursing service which works closely with GPs servicing the area to provide acute care assessment and management with residents in their facility. Economic analysis indicates this service is providing significant cost savings to the hospital sector.

*Patients dealing with disability*

- According to the 2003 ABS National Survey of Disability, Ageing and Carers, 3.9 million Australians, or 20% of the population, had a disability.87
- People with physical and intellectual disability often experience difficulty in accessing primary health care services.88 Data indicates that people with intellectual disability die prematurely and often have a number of unrecognised or poorly managed medical conditions as well as inadequate health promotion and disease prevention.89
- Following de-institutionalisation, general practice has played a key role in the provision of health care to people with intellectual disability (which constitute about 2% of Australia’s population), but this care is often inadequate due to many contributing reasons.90

**Cultural Barriers**

*Indigenous Australians*

- The health issues and access gaps associated with some Indigenous populations are well established, including that Aboriginal and Torres Strait Islander peoples have higher rates of chronic disease, more disability, and greater exposure to risk factors (such as smoking and alcohol misuse).91
All Australian governments have committed significant funding to improve Indigenous Australian health outcomes in response to the Closing the Gap Statement through the COAG National Healthcare Agreement – National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes.

Part of this commitment included a statement of intent to work together in achieving equity in health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians by the year 2030.

Individuals from Culturally and Linguistically Diverse (CALD) backgrounds

Australia has one of the largest proportions of immigrant populations in the world.

Although governments have produced a number of health resources in multiple languages, there is limited information in regard to the availability of translation services when a patient is visiting a doctor.

Under current Medicare arrangements, there is a provision for the medical practitioner and patient to use the services of a translator by accessing the Australian Government’s Translating and Interpreting Services (TIS) and the Doctors’ Priority Line:

- The TIS only provides free services for non-English speaking people receiving Medicare rebateable services from a privately practising provider (or pharmacies dispensing PBS medications).
- For ineligible individuals, the telephone translation costs range from $23.10 to $36.95 per 15 minutes which could act as a significant barrier for individuals, their families and carers seeking access to translated medical services.
- Furthermore, it might be reasonably assumed that the involvement of a translation service could add to the consultation time required and complexity associated with provision of a service. As such, a practitioner may choose not to provide such a service for the perceived risk of financial penalty and/or inappropriate claiming.

Other concerns for this population which are not necessarily resolved through the availability of translation services extend to safety and quality aspects, and the sensitivity, awareness and diversity of the primary health care workforce.

What the submissions said

The limitations of our current system in dealing with the health care needs of special needs, marginalised and disadvantaged populations was a recurrent theme in submissions.

Patients with special needs require intense, time consuming care which is difficult to provide in a standard consultation under the present funding model.

Strategies put forward to address these issues included greater focus on cultural competencies in training and accreditation frameworks, enhanced use of interpreters and greater involvement of communities in health service development and greater resourcing for outreach and support services which could address the needs of specific high need population groups.
It is high time that all health professionals have specific training, education and professional development, within existing training structures, in cultural safety that fits within a broad framework of cultural respect. Such training must be mandated for all health professionals and service providers on the health, history and cultures of Aboriginal and Torres Strait Islander people. This demand is based not on geographical location of health professionals, service type or funding source, but on the need to recognise the significance of poor knowledge and the flow-on effects to Aboriginal and Torres Strait Islander service users.\textsuperscript{99}

Many submissions noted that funding inflexibilities were a key barrier to the provision of clinically and culturally appropriate primary health care services. A range of views were presented on preferred funding models which included moving from fee-for-service to population or service-based approaches, greater use of blended payments or salaried arrangements, ‘cashing-up/out’ the MBS, and adopting regional-based ‘funds pooling’ of health services. A consistent theme across many submissions was the need for financing models that allow for local flexibility to meet a specific community’s requirements and the need for inter-sectoral collaboration.

The funding model … has a population based approach within local communities, provides targeted funding aligned to services offered, including preventative services, and is then weighted based on population. The model should allow for consultations with a range of health care practitioners in a variety of settings that best meets the local need. In doing so, the model must adequately sustain a primary health care team approach to delivering services and builds in incentives for targeting services to clients with chronic and complex needs and those from marginalised communities to reduce the disparity in wellness amongst the population.\textsuperscript{100}

The out-of-pocket costs associated with accessing private primary health care services were consistently identified in submissions as being a major inhibitor to access.

In regional, rural and remote areas, only 51% of doctors bulk bill, and doctors should be urged to bulk bill. This is the reason patients flock in great numbers to casualty/emergency centres, because they know that there will be no cost to them - charged under Medicare, when they cannot afford to pay doctors’ fees.\textsuperscript{101}

Submissions noted the disparity in access to certain services and therapies on the basis of geographical location.

There are strong regional variations in medicine use in Australia – and these must, in part, reflect problems that these patients face in accessing health professionals in primary care. For example, in 2007 the AIHW reported: ‘Compared to those in major cities, people in rural and remote areas have higher death rates from cardiovascular disease, but are dispensed these medicines at half the rate in rural areas [and] about one-thirtieth the rate or less in remote areas’.\textsuperscript{102}

Many submissions commented on the accessibility of pharmaceutical services through the network of established community pharmacies.

With its network of over 5,000 pharmacies in urban, regional and rural communities throughout Australia and its highly trained workforce, community pharmacy is the most accessible of all health services, and is well placed to play a constructive and dynamic role in the provision of effective primary health care.\textsuperscript{103}
A number of submissions commented on the funding arrangements for practice nurses and how these arrangements impact on practice nurses’ ability to operate at their full capacity. In particular a number of submissions commented on the task-oriented ‘for and on behalf of’ funding.

*The general practice nurse role could be substantially developed and enhanced through greater investment and commitment to developing the general practice nurse practitioner role. This autonomous advanced practice role, particularly with independent access to MBS and PBS, would provide a significant support to the general practice and enable medical practitioners within general practice to concentrate on more clinically complex health care management. Furthermore, it provides a career trajectory for general practice nurses and enhances and strengthens the layers of health care service available in the PHC [primary health care] sector.*

**What is the way forward?**

It is vital that Australia’s primary health care sector is able to effectively and efficiently provide an appropriate level of clinically relevant services including to the most disadvantaged in our communities.

At the same time, any reform of the primary health care system needs to acknowledge that the current system is working reasonably well for the majority of Australians and for many health care providers, but that it could work better for all Australians. In considering a way forward, there needs to be consideration and examination of where fundamental changes at a system level are required, and where the strengths of the existing primary health care system should be retained, amended and built upon.

This will identify the potential for the Australian primary health care system to:

- make best use of the available workforce in providing clinically and culturally appropriate services across public and private sectors;
- better support primary health care professions in delivering effective and efficient services through innovative and flexible service delivery models;
- improve the level of integration across the primary health care sector to improve the patient’s experience of the primary health care system; and
- address service gaps including the care needs of marginalised and disadvantaged populations.
Summary – Key Future Directions

A National Primary Health Care Strategy will provide a framework to guide future priorities for changes to support greater access to clinically and culturally appropriate, timely and affordable primary health care services.

In this context, strengthening and better integrating the mainstream primary health care system is a key starting-point for reducing current gaps in service delivery and improving outcomes for disadvantaged population groups.

At the same time, specialised or targeted programs linked to individual patient needs will remain an important component of service delivery.

Consideration of future changes is likely to involve a re-examination of the balance between existing universal fee-for-service arrangements and alternative approaches to service delivery and funding for both the mainstream system and specific targeted programs.

Importantly, these changes need to be informed by the specific policy objectives and priorities involved.

Compared to current arrangements, changes are needed to:

- improve access and reduce disparities in access to services for disadvantaged populations and in under-serviced areas;
- develop and implement effective and integrated models of care in delivery of primary health care services;
- support and encourage greater flexibility in service provision including through opportunities afforded by technology;
- develop infrastructure to support and expand comprehensive primary and ambulatory health care to facilitate effective primary health care; and
- ensure service changes are monitored and evaluated.
Element 2: Patient-centred and supportive of health literacy, self-management and individual preference

Objective: Primary health care services respond to the individual preferences and circumstances of patients, their families, and carers, and actively support them in achieving best possible health outcomes.

Key Points

Although the Australian primary health care system serves many patients well, it has not been designed specifically to cater for the particular health needs and cultural requirements of groups such as people from CALD backgrounds, and disadvantaged and marginalised populations. These groups may find it difficult to access appropriate services within the system, and know which services to access and when.

It has been suggested that one way of improving these populations’ access to primary health care services, and ultimately health outcomes, is to address their health literacy. It will be a challenge to develop accessible health information sources and supports that are clinically and culturally appropriate. This will involve cooperative work from a range of sectors other than health.

A key part of the health information these groups require will be on self-management of health conditions. This will be particularly important if rates of chronic disease continue to rise in Australia; sharply among certain populations.

It has also been suggested that there is not sufficient integration of self-management in the teaching of primary health care providers. It will be essential to develop teaching of self-management in the educational, clinical and workplace settings, in order for health professionals to provide useful instructions to patients.

Overall, it is vital that patients feel engaged and empowered to manage their health, are proactive about their health, and are more aware about primary health care services. Importantly, services need to be developed to cater for the cultural requirements and preferences of different groups.

Element 2 is about a primary health care system which is designed around supporting the individual, their family and carers to be in control and actively supported in their care. It is also about a system which is easy for them to access the care they need and which helps them to manage their health care needs and stay as healthy as possible.
The priority issues, identified through the Discussion Paper and confirmed through submissions, were the need to:

- develop a ‘person-centred’ approach to health care, enabling consumers to be at the centre of their own care;
- improve the support provided to health consumers, particularly those with low health literacy, through more appropriate information, self-management programs and other supports;
- enhance health provider skills to better support their patients; and
- improve linkages between primary health care providers and others, such as non-government organisations (NGOs), providing support to individuals, their families and carers.

**Where are we now?**

A lack of socially and culturally appropriate services is a contributor to poor access to primary health care services for a number of disadvantaged groups. This can be compounded by low levels of health literacy and self-management capacity and skills, all of which can contribute to lack of follow through which contributes to poorer health outcomes.

**Patient rights in health care**

Putting individuals, and their families and carers at the centre of care is fundamental in designing health system changes.

In Australia, the Australian Commission on Safety and Quality in Health Care (ACSQHC) has developed the ‘Australian Charter of Healthcare Rights’ which was endorsed by Australian Health Ministers in July 2008. The Charter, which was developed after wide consultation, specifies the key rights of patients and consumers when seeking health care services. These rights are Access, Safety, Respect, Communication, Participation and Comment.105

Underpinning the Charter is the concept of ‘person-centredness’ in health care. The Picker Institute has identified eight dimensions of patient-centred care: respect for patient-centred values, preferences and expressed needs; coordination and integration of care; information, communication and education; physical comfort; emotional support and alleviation of fear and anxiety; involvement of family and friends; transition and continuity; and access to care.106 The WHO draws together research evidence which suggests a person-centred approach to health care improves treatment intensity and quality of life, leading to better understanding of psychological aspects of a patient’s problem, improved patient confidence, satisfaction and treatment adherence.107

**Health literacy**

Putting individuals, their families and carers at the centre of their own care will enable them to engage with the health care system and make decisions about their own health. In practice, the extent to which health professionals address patients’ concerns, beliefs and understanding, and share problem management with them can be limited and declines with disadvantage. Underpinning
this are patient skills and expectations, provider skills and opportunities, and the availability of tools and other supports, particularly those which are tailored and culturally appropriate. From the patient perspective, Jordan et al introduced a hierarchy of critical components that range from:

- access to health information;
- knowledge, education and empowerment;
- self-management; to
- command – with health literacy being an initial component.\(^{108}\)

Health literacy refers to the ‘ability of individuals to gain access to, understand and use information in ways which promote and maintain good health.’\(^{109}\) Health literacy is a product of the population’s knowledge and skills gained from education and experiences. The relationship between a generally poor level of literacy and health status is now well recognised and understood.\(^{110}\) Data from many developed nations shows a relationship between low literacy levels and declining use of available health information and services.\(^{111}\)

The literacy levels of the population vary according to a number of factors including income and ethnicity.\(^{112}\) However, even those with advanced literacy skills may not have a high level of health literacy. To have a good level of health literacy, individuals must not only understand health information but be able to access and use this information. At present, Australia does not have a single, comprehensive source of health information for individuals, their families and carers and the resources that are available can be difficult to navigate.

The direct results of an improvement in health literacy include:

- an understanding of the benefits of preventive measures;
- the early detection of illness and disease;
- access to the most appropriate form of health care; and
- improved management of chronic disease.\(^{113}\)

Currently, the levels of health literacy in Australia are lacking. Health Literacy Australia reports that 59% of the Australian population aged 15–74 did not achieve health literacy skill level 3 (out of 5) or above which is the minimum required to effectively engage with the health system and manage their own self-care.\(^ {114}\)

Greater health literacy at a population level can be an effective tool to increase awareness of, and reduce stigma and discrimination often associated with, health conditions such as mental illness.

The 2007 National Survey of Mental Health and Wellbeing found that one in five Australians continued to experience mental illness in a given year. Approximately two-thirds of people (around 2.2 million) who were sufficiently unwell to meet diagnostic criteria for a mental disorder did not use any health services for their mental health problems. When asked about their perceived need for help (medication, talking therapy, skills training, social interventions and even information), the majority (85.7%) of people with mental disorders reported that they had no need for any kind of help, suggesting the need for new strategies to assist people to recognise the symptoms of mental illness and access appropriate services.
Self-management

One of the key positive outcomes from building health literacy is improving a patient's ability to self-manage their condition. Self-management is about people being proactive in the care process, optimising their capacity to acquire the needed skills and having confidence to manage their own health and wellbeing.115

A broad definition of self-management is involving individuals working in partnership with their families/carers and health professionals so that they can:

- know their condition and various treatment options;
- negotiate a plan of care (ie care plan and review/monitor the plan);
- engage in activities that promote and protect health;
- monitor and manage the symptoms and signs of the condition;
- manage the impact of the condition on physical functioning, emotional and interpersonal relationships; and
- have confidence in their ability to use support services.116

There is a growing body of evidence supporting the efficacy of self-management, particularly in relation to preventing and managing chronic disease including improved adherence to agreed treatment plans and actions, enhanced quality of life and an overall reduction in the burden of chronic disease.117 A systematic review of chronic disease management undertaken by APHCRI in 2006 found that self-management support was the most commonly used intervention described in the 145 Australian and international studies reviewed and also the most effective intervention. Within self-management support, the most effective interventions were educational sessions for patients and patient motivational counselling. Distribution of educational materials in association with patient education and motivation produced positive outcomes for patients’ use of services and risk behaviour.118

It could be suggested that many Australians are not aware of the aspects of self-management or its benefits,119 or do not have the necessary skills required to self-manage their disease. The Commonwealth Fund measured doctor-patient communication and found that while Australia rates highly compared with other countries, a significant proportion of patients did not feel well supported.
Table 6: Doctor-patient communication

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<th>Aust</th>
<th>UK</th>
<th>USA</th>
<th>Can</th>
<th>NZ</th>
<th>Neth</th>
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<td><strong>2007</strong></td>
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<tr>
<td>Doctor always explains</td>
<td>79</td>
<td>71</td>
<td>70</td>
<td>75</td>
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<td>71</td>
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<td>things so you can</td>
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<td>understand</td>
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<td>Doctor always tells you</td>
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<td>54</td>
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<td>67</td>
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<td>treatment decisions</td>
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<td><strong>2008 (chronic conditions)</strong></td>
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<td>Doctor always tells you</td>
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<td>treatment decisions</td>
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<tr>
<td>Clinician gives you a</td>
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<td>manage care at home</td>
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</table>

Source: Commonwealth Fund, 2007 and 2008 surveys

All of these contribute to low levels of patient follow through on recommended treatment plans and, as a result, can impact on the levels and severity of chronic disease, ill-health and, in turn, health expenditure. This is demonstrated by an Australian study which revealed that up to 50% of those surveyed on long-term medications taken to prevent or treat Cardiovascular Disease (CVD), stop taking them within two years.120

Not all individuals have access to the range of services that might help them self-manage their health conditions. For example, The Australian Lung Foundation estimates that less than 1% of those with Chronic Obstructive Pulmonary Disease (COPD) who would benefit from pulmonary rehabilitation have access to it,121 despite evidence that it is a proven self-management program which is effective in improving quality of life for those with COPD and reducing hospital admissions.122 Access to allied health professionals can also be important to support self-management. The 2000 Chronic Diseases survey: Diabetes Prevalence and Management Report found only 19% of those whose characteristics indicated they should have attended a diabetes educator in the last 12 months had actually done so.123

Health professionals play a key role in providing self-management support to their patients. This includes supporting patients to optimise their capacity to manage the risk or impact of chronic disease over their lifespan and along the care continuum including following care plans developed in partnership with their health professionals.124 Importantly, for individuals, this is an ongoing process which may need to deal with circumstances when planned and agreed strategies don’t work. However, health professionals do not all have the necessary range of skills required to support patients in the self-management of their chronic disease or to support related behavioural changes. Survey results show that on the other hand, two-thirds of Australian health professionals report
that techniques known to be effective in supporting self-management and behaviour change (such as health promotion approaches, stages of change, structured problem-solving, reasons for non-adherence, and goal setting) are of use within their practice with patients. The key challenge is for the system to provide the structures for these things to happen as a matter of course.

**Person-centred care for Indigenous Australians**

Improving the person-centredness of mainstream health services will be a key part of the Government’s commitment to Close the Gap between Indigenous and non-Indigenous Australians. Aboriginal and Torres Strait Islander peoples are almost twice as likely as non-Indigenous people to report fair or poor health.

The culture of Aboriginal and Torres Strait Islander peoples is such that the concept of ‘health’, and more specifically ‘primary health care’, can vary greatly from traditionally GP-focussed care.

‘Health’ to Aboriginal peoples is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity.

Enhancing person-centred care in Indigenous communities will be a priority. As part of the COAG Closing the Gap National Partnership, alongside increasing the number of trained health workers skilled to deliver self-management programs tailored to meet the particular needs of the local Indigenous community, plans are underway to recruit and train Indigenous healthy lifestyle workers to provide healthy lifestyle sessions and activities tailored to participating communities. These prevention and self-management activities will improve the health literacy of Indigenous Australians, preventing development of a chronic disease, supporting better management of chronic conditions and, overall, begin to place the patient in the centre of their own care.

**What the submissions said**

The experiences and needs of consumers, carers and providers are not always aligned, and acknowledging this is a strength of the Discussion Paper.

The ‘Australian Charter of Healthcare Rights’ developed by the ACSQHC was seen as key.

A National Primary Health Care Strategy should be underpinned by the ‘Australian Charter of Healthcare Rights’ developed in 2008 through the Australian Commission on Safety and Quality in Healthcare and agreed on by Australian Health Ministers. This Charter acknowledges the need for a genuine partnership between consumers and providers to achieve best health outcomes.

The need to address health literacy and the gaps in availability of appropriate information and supports for consumers, especially those with low health literacy, was a common theme.

In terms of health literacy, there are no national standards or supports to ensure that all Australians, regardless of background, have the ability to understand and navigate the Australian health system, and are therefore empowered to make appropriate choices regarding their own health and that of their families. This is particularly important for people who come from backgrounds which have had extremely basic health services, and so have limited understanding of how to access and use the Australian health system.
Many submissions expressed concern about health professionals’ training needs to provide them with the necessary skills and tools to be effective in supporting their patients in the self-management of their health and wellbeing.

At present, medical practitioners in particular are not educationally prepared to encourage and support patients in self-management strategies... Where possible have an integrated curriculum that shares core courses/units with a range of healthcare professionals at the undergraduate and postgraduate levels.¹³¹

Particularly important for many submissions was the need for the time involved for health professionals in educating and supporting their patients to be adequately resourced.

The facilitation of patient self-management is not currently encouraged or recognised in the MBS. [Allied health professionals] AHPs and specialist nurses, as well as GPs, are well placed to provide education and assist patients to develop their capacity for self-management... This should also cover services that are provided via a range of communication means that best meet the patient’s needs such as the telephone or email.¹³²

Other submissions talked about the need for the most appropriate health professional or organisations to be involved in supporting individuals in self-managing their health and wellbeing, and the importance of improved linkages.

[voluntary sector organisations] …have a proven track record in supporting patients’ self-management, improving health literacy and understanding individual preferences in seeking treatment and other services option. Cancer Councils also provide high levels of supportive care; improved primary care linkages with Cancer Councils would increase patient access to these services.¹³³

There needs to be closer linkages, referral pathways and identification of people during acute episodes of sickness to ensure they are referred [to] and attend self-management intervention.¹³⁴

Submissions also highlighted the important role played by carers and the need to ensure this was considered.

…some people will not [be] able to take responsibility for their health decisions. In this case there should be a program to identify carers to assist the individual along with the trusted clinician.¹³⁵

The primary health care system needs to engage carers better, both as partners in the care of persons they care for, and as individuals, who require physical and emotional support in their caring role.¹³⁶

Many submissions identified the potential to reward or provide incentives that are consumer based, for example:

Care systems and processes should be changed to reinforce the above approach (of the individual taking responsibility). Where possible the systems should reward such action with financial incentives. There may be lessons to be learnt from the UK where attendance at gyms results in financial reward through reduced premiums.¹³⁷
What is the way forward?

Person-centredness, based on a patient’s rights to access, safety, respect, communication, participation and comment, as set out in the Australian Charter of Healthcare Rights, must underpin primary health care reform.

Within the Australian context, improving health literacy, especially for disadvantaged and marginalised populations, is an area where effort is needed.

Many aspects of improving health literacy are outside the domain of primary health care providers and need to involve, for example, the education sector. At the same time, primary health care does have an important, ongoing role in supporting individuals, their families and carers, and communities to be better informed about health-related issues and assisting them in accessing and using a range of health information and other consumer-focussed supports.

Levels of health literacy will also be dependent upon the context of each individual’s medical history. The ability to ‘access, understand and use’ health information will be different for a pregnant mother and a cancer patient. A more useful term may be ‘health literacies’ based on the variety of needs in the population.

Improvements to self-management support including multi-media are needed to support an improved focus on person-centred primary health care. Advances in technology which will allow greater diagnostic assessment and self-monitoring of a patient’s condition, accompanied by internet and telephone support, is but one area.

In this context, there is scope to improve the information sources and supports available, and to increase primary health care providers’ awareness of them, including the opportunities provided through the existing infrastructure of the National Health Call Centre Network together with HealthInsite. For example, this existing infrastructure could provide a vehicle for a range of tools to assist in educating consumers about the health care system and health information quality.

Primary health care providers also have an important role in self-management services. A recent Medical Journal of Australia supplement on chronic disease management proposed the way forward for chronic disease self-management support for Australia as:

- Self-management and self-management support are key aspects of optimal chronic disease care and are effective if implemented appropriately.
- Health literacy is the foundation of self-management programs and should be fostered for the whole population.
- We should invest in research and evaluation of self-management because the evidence base is underdeveloped and inherently difficult to expand.
- Because patient, carer, clinician and organisational engagement with self-management support programs are uneven, we need to prioritise activities designed to engage known hard to reach populations.
- We should strive to improve integration of self-management into clinical, educational and workplace contexts.
- Education and psychological theories can help guide self-management support.
Self-management programs and interventions include a range of activities, supported by professionals or peer leaders, which aim to achieve one or more of the following outcomes:

- improvements in healthy lifestyle behaviours;
- improvements in health status; and
- reductions in unplanned health service utilisation.\(^{140}\)

Additional benefits of self-management programs include: improved life control and activity; improved resourcefulness and life satisfaction; improved communication with physicians and other health care providers; and enhanced quality in the doctor-patient relationship.\(^{141}\)

Within general practice, types of self-management support that could be undertaken include self-management education, mentoring and phone support, use of patient-centred decision support tools, undertaking self-management assessment and care planning, linking with community organisations (referring individuals to local consumer self-management programs, support groups, local physical activity groups), and practice-level changes such as use of multi-disciplinary teams, patient registers, recall and reminder systems, and diabetes clinics.\(^{142}\)

For example, telephone based models for self-management have had positive impacts on participants. A Western Australian program has shown positive changes in behaviours which could be expected to contribute to longer-term decreases in hospitalisations. Similarly, the Coaching patients on Achieving Cardiovascular Health (COACH) program which uses the telephone and mail to provide regular coaching sessions to patients after discharge from hospital, has been highly effective in reducing total cholesterol and many other CVD risk factors in patients with coronary heart disease.\(^{143}\)

**Summary – Key Future Directions**

A National Primary Health Care Strategy provides a key opportunity to better orientate the primary health care system towards the needs of individuals.

Compared to current arrangements, changes are needed, particularly for disadvantaged and marginalised populations:

- to improve individual’s rights to a person-centred approach to their health care;
- to improve health literacy and the availability of accessible and appropriate information and supports to help maximise patient involvement in shared decision-making and appropriate use of health services; and
- to improve the capacity of primary health care services to address the needs of different groups and more effectively support self-management and health literacy, through a range of tools and supports.
Element 3: More focussed on preventive care, including support of healthy lifestyles

Objective: All Australians are supported to stay healthy through a stronger focus on wellness, prevention and early detection, and appropriate intervention to maintain people in as optimal health as possible.

Key Points

In Australia, certain populations have significantly higher rates of disease and risky health behaviours, are more at risk of developing particular health conditions, and have lower life expectancy than other populations. More preventive health activities through primary health care services could assist in improving this situation, and in behavioural change. Currently however, there is no systematic approach to preventive health care in the Australian primary health care setting although Divisions of General Practice and states and territories have their own initiatives in place.

At present, the range of preventive care MBS items available, such as health checks, are confined to a limited number of groups. Further, the uptake of these health checks across Australia is uneven, reflecting the different levels of primary health care service across the country, and variable item usage by providers. The use of health check items also does not necessarily indicate that more preventive care is actually being provided.

Currently, general practice and primary health care are not supported or funded to implement population health approaches to risk reduction and management across local communities and populations. Further barriers to the provision of more preventive care include the fact that GPs already have heavy workloads, and associated time constraints. Even when Royal Australian College of General Practitioner guidelines on preventive care are provided it is a challenge to ensure these are universally taken up by general practice.

GPs could perhaps be better supported to provide preventive health care through further skills training, IT system support and financing. There is also potential to expand the role of nurses, community pharmacists, and allied health professionals in preventive health care provision.

Ideally, preventive health activities in primary health care would take a whole-of-life course perspective that highlights the importance of healthy lifestyles and of health promotion, early detection, timely treatment and management of risk factors and early stage disease at every age. As prevention is most required for high needs and disadvantaged groups it will be important to also improve their access to primary health care services.

Element 3 is about a primary health care system that promotes good health and provides expanded access to preventive care interventions including supporting individuals with the behavioural changes required to reduce the risks of disease.
Prevention is defined as ‘action to eliminate or reduce the onset, causes, complications or recurrence of disease’. Prevention is often conceptualised as being primary, secondary or tertiary, as follows:

- Primary prevention reduces the likelihood that a disease or disorder will develop.
- Secondary prevention interrupts, prevents or minimises the progression of a disease or disorder at an early stage.
- Tertiary prevention focuses on halting the progression of damage already done.

The priority issues, identified through the Discussion Paper, and confirmed through stakeholder feedback are the need to:

- extend the current scope of prevention to adopt a more systematic and integrated process to guide preventive care;
- better address lifestyle risk factors in the primary health care setting;
- remove current barriers that prevent opportunistic preventive care including time constraints, lack of practice infrastructure, lack of robust evidence base to support preventive activities;
- re-examine workforce roles and responsibilities in the context of which primary health care professionals are best placed to deliver preventive care; and
- provide appropriate practice and system supports, flexible financing arrangements and linkages and partnerships to support the workforce to engage in preventive care.

Where are we now?

Scope of prevention in primary health care

General practice already undertakes a range of targeted and opportunistic preventive care activities including immunisation, some risk factor identification and screening for certain diseases. For example, an estimated 22.4% of all clinical treatments provided by GPs in 2007-08 involved types of health advice, education and counselling that could be considered preventive (eg advice about general lifestyle, smoking, alcohol, exercise and diet).

The nature of the existing financing and service delivery framework, however, means that virtually all preventive health care in general practice is focussed on the individual patient when they present to the practice. General practice is not supported or funded to implement population health approaches to risk reduction and management across local communities and populations. Internationally, several countries have adopted voluntary or compulsory patient enrolment schemes in conjunction with the establishment of Regional Primary Health Care Organisations to support the collection and monitoring of local population health data.

Quality improvement programs including the Australian Primary Care Collaboratives program and Healthy For Life in the Aboriginal Community Controlled Health Organisation (ACCHO) sector have to some extent improved knowledge and understanding of a practice population. There is, however, in Australia no nationally consistent model for data collection and reporting on the delivery of preventive interventions in primary health care.
A range of programs, initiatives and tools are available for general practice to use in the delivery of preventive health care. For example, the RACGP’s *Guidelines for preventive activities in general practice (the Red Book)*, *Putting prevention into practice: guidelines for the implementation of prevention in the general practice setting (the Green Book)* and *SNAP: A population health guide to behavioural risk factors in general practice*.147

The Divisions Network has also been actively supporting preventive health activity through its support for the Life Scripts program, support for practice and Divisional-based population health activity (including through the promotion of data extraction tools) and other locally targeted initiatives.

At the same time state and territory governments through community health, support for Non-Government Organisations (NGOs) and other avenues are undertaking a range of activities. For example, the Victorian PCP Integrated Health Promotion (IHP) Strategy involves local private and public agencies working in collaboration to use a mix of health promotion interventions and capacity building strategies to address priority health and wellbeing issues.148 A recent independent evaluation of the PCP IHP Strategy found clear evidence of the success of the partnership approach to improve integral health promotion.149

But despite, or as a consequence of, the range of initiatives and approaches, while preventive health care activity has increased, it could not be said that there is a systematic and integrated approach to preventive health care in the Australian primary health care setting. There is fragmentation across the country and uneven uptake of guidelines (e.g. RACGP ‘red and green books’) and initiatives (e.g. MBS health checks).

**Prevalence of behaviour risk factors**

As noted by the National Preventative Health Taskforce, smoking, obesity, and harmful use of alcohol account for a large part of the differences in health status between rich and poor Australians and between city dwellers and rural and remote Australians.150 Similarly, the burden of disease caused by smoking, obesity and harmful use of alcohol makes up a significant part of the considerable gap (10-12 years according to recent data)151 in life expectancy between Indigenous and non-Indigenous Australians.152

National data (Table 7) from the 2007-08 National Health Survey indicates higher rates of risk behaviours (with the exception of risky alcohol consumption) in the most disadvantaged group compared to those with the highest socio-economic status.

*Table 7: Comparison of risk behaviours across the most and least disadvantaged group*

<table>
<thead>
<tr>
<th>Risk Behaviour</th>
<th>Most disadvantaged areas (%)</th>
<th>Most advantaged areas (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>current daily smoker</td>
<td>27.8</td>
<td>11.0</td>
</tr>
<tr>
<td>risky/high risk alcohol consumption</td>
<td>11.2</td>
<td>13.3</td>
</tr>
<tr>
<td>sedentary</td>
<td>46.7</td>
<td>24.4</td>
</tr>
<tr>
<td>overweight/obese</td>
<td>65.7</td>
<td>56.3</td>
</tr>
<tr>
<td>inadequate fruit/vegetable consumption</td>
<td>95.0</td>
<td>93.4</td>
</tr>
</tbody>
</table>

Source: Australian Bureau of Statistics, 4364.0 National Health Survey: Summary of Results, Australia, 2007-08
But despite disadvantaged population groups having lower life expectancy, higher rates of chronic disease and behavioural risk factors relative to advantaged individuals, they are less likely to access or receive appropriate preventive care.153

**The gap between recommended and usual preventive health care in modifying risk behaviours**

There is evidence that brief interventions can be effective in modifying risk behaviours. In this context, the 5As approach (Ask, Assess, Advise, Assist, Arrange) has been used internationally and adopted in Australia by the RACGP, for example, as part of its smoking cessation guidelines.154 However, in part reflecting constraints in the current system, as stated above, RACGP guidelines are not being taken up universally by general practice. For example, fewer than one in five individuals are routinely asked about their drinking,155,156 while two-thirds are asked about their smoking,157 only up to a third are asked about exercise and physical activity,158 and around 15-30% of individuals get some form of dietary advice.159

**Barriers**

Self reported data from general practices in Australia indicate that factors influencing the gap between evidence and practice in preventive care include:

- clinician age and gender;
- personal lifestyle behaviours;
- beliefs and attitudes, in particular, confidence to intervene and perceived effectiveness; and
- lack of knowledge, skill and confidence on the part of practitioners.160

Other barriers to delivering preventive health care cited within general practice include:

- competing pressures on the time of both GPs and their patients;
- lack of system support;
- limited referral options; and
- the need for specific funding to support assessment, training and counselling.161

The increasingly high workload of GPs and associated time constraints are often cited as major barriers to expanding preventive health care in general practice. It is estimated that 7.4 hours per day would be needed by the typical GP to implement known best practice in prevention.162

**Health checks**

There is also the question of whether relying on discussion between GPs and their patients is the most effective way to influence and improve the behaviours of individuals, or whether population-based approaches and opportunities, ideally targeting people in the workplace, the community and at various points of the health system, will achieve more far-reaching results. Many of these issues were raised in submissions and are further discussed below.

Commencing with the introduction of the Older Australians’ Health Check in 1999, the Australian Government has introduced a range of structured health checks aimed at improving preventive health care delivered through primary health care services.

However, the range of available MBS health checks remains confined to a limited number of groups and with varying timing conditions, meaning that some population, age and disease groups benefit while others miss out.
As already noted, and highlighted in Figure 7 below, uptake of the MBS health checks across Australia is uneven, reflecting different service levels according to the target population and variable usage by providers. Figure 7 also shows that the Indigenous health check items have been widely used in remote areas. These data complement a recent report which indicates that the adult health check for Aboriginal and Torres Strait Islanders aged 15-54 years is a viable vehicle for evaluating health status, identifying chronic disease risk factors and for implementing preventive health care.\textsuperscript{163} At the same time, however, those living in remote Australia have the lowest service utilisation of standard health check items, possibly reflecting that GPs can be hard to access or are absent in these regions.

Figure 7: Medicare funded health checks by remoteness, 2007-08

![Graph showing Medicare funded health checks by remoteness, 2007-08](image)

Source: Medicare data

It is important to note that the Government has undertaken a review of primary care items in the MBS with a view to, \textit{inter alia}, streamlining the range of health check items to make them simpler and more equitable, as well as clarifying the arrangements for using longer standard consultation items for preventative health activity. The outcomes of this review will be implemented later in 2009.

\textbf{What the submissions said}

A key area of consensus across the submissions was the support for, and importance of, an increased focus on preventive health care in primary health care.
The importance of using every opportunity to provide preventive care was emphasised by many stakeholders.

_A future national primary health care strategy … should embrace the position that prevention is: integral to primary health care; everyone’s business (including beyond the health system); and that every encounter between a health care consumer and provider, however brief, represents an opportunity for health promotion._164

**Barriers**

Despite widespread support for the notion of opportunistic preventive care, some submissions pointed to difficulties in carrying this out. Time constraints were frequently cited as a barrier to the provision of opportunistic preventive care.

_Medical consultations are already crowded with immediate needs. Behaviour change attempts must be well down the list if only because they have very limited success. There has been a tendency on the part of academic GPs to ‘over-egg’ the prevention pudding when talking about what can reasonably be expected from a 10 or 15 minute consultation._165

Lack of practice infrastructure was another barrier cited by many submissions.

_Infrastructure in the practice poses issues in many practices. Risk factor counselling needs to be done in a private area and many practice nurses do not have access to a consulting room._166

Lack of certainty about the effectiveness of preventive activities in primary health care was another barrier to participation in preventive activities. The importance of developing a robust evidence base to support preventive activities was highlighted in many submissions.

_Further evidence and ‘pathways of evidence’ should be developed in multiple areas to ensure targeting of money into successful health promotion interventions. Change is costly and should be limited to situations where there is a genuine evidence based reason to do so._167

**Workforce roles and responsibilities**

Issues relating to workforce constraints including the consideration of current and/or new roles and responsibilities around prevention were key themes in the submissions. Some submissions raised the question as to whether GPs were the most appropriate primary health care practitioner to undertake preventive care.

_GPs do not have the time for counselling and the monitoring and follow up that is required and is probably not best use of their time other than their part in the direct medical component._168

Submissions commented on the potential role of nurses, allied health and pharmacists in preventive care. The role of the practice nurse in behavioural risk factor modification was supported by evidence provided in submissions.

_Practice nurses and allied health are often better placed to carry out the detail of this process. General Practitioners are ideally placed to set individual targets, and protocols for healthy change parameters against guidelines, tailored to the individuals needs._169

Submissions noted that a range of primary health care professionals in addition to GPs such as dentists, pharmacists and Aboriginal Health Workers could also link people with risk factor modification and lifestyle-related programs.
Education and training

While there is widespread support for prevention as core business in primary health care, many practitioners acknowledged that they lack the skills required to undertake preventive care effectively.

Health Professionals need much more training in motivational interviewing and some GPs may be interested in upskilling specifically in areas of motivational interviewing, weight reduction and exercise, smoking cessation etc being remunerated for their extra skills and providing a source to refer to by other GPs. There is no point talking about lifestyle modification if the GP lacks the skills to help their patients or there are no cheap, effective programs including up skilled GPs to refer to. 170

Education and training in preventive health throughout the career of primary health care professionals including a core unit on prevention during undergraduate training was suggested, as was the rollout of a comprehensive national inter-professional learning program for the primary health care workforce to embed the multi-disciplinary team approach around prevention. There was some support for including motivational interviewing and lifestyle modification in continuing professional development programs.

System supports

Submissions highlighted the need for additional support at the primary health care system level to enable practitioners to fully embrace a greater focus on prevention. Upskilling practitioners to undertake preventive care was considered unlikely to be successful without system supports such as availability of up-to-date information, risk assessment tools and guidelines, the development of referral pathways, electronic recall and reminder systems and other tools, as well as appropriate funding mechanisms.

The Divisions Network identified its current and potential future role in determining local prevention priorities and to devise targeted interventions to address them in conjunction with other local health services and providers.

The Divisions Network has played a key role in developing and implementing a number of successful preventative health care programs across Australia - from national programs in immunisation and chronic disease management (many of which have been adapted locally to target specific population groups) to more locally specific innovations such as Pitstop, a successful prevention and early intervention health program specifically targeted at men. 171

Other stakeholders indicated that there was clearly scope to strengthen the role of regionally-based organisations and networks in providing support for prevention initiatives.

Greater collaboration and localised planning and prioritisation is required between Divisions of General Practice and state-funded health promotion and public health services in the direct provision of more prevention and health promotion programs, and also in assisting individual general practices to deliver such programs. 172

The importance of establishing partnerships and networks at the local level to support primary health care's role in preventive care was frequently raised. Local partnerships were seen as essential to reinforcing health-promoting behaviours.
To facilitate greater integration the NPHCP [National Primary Health Care Partnership] recommends the establishment of local consortia for prevention at regional levels. These would draw together local stakeholders with an understanding of local health risk factors and the capacity to promote health at the local level, to support the tailoring of universally targeted health promotion initiatives to local contexts in a manner that enables a cross-community approach to reinforcing health-promoting behaviours.  

Issues relating to referrals were frequently raised. Submissions demonstrated a clear need for the development of referral pathways to support behaviour change. It was pointed out that primary health care professionals may not always be aware of the referral options that are available in a local area, particularly referral options to allied health providers such as dieticians and certain options for physical activity, eg gym programs suited to certain ages or abilities. Work needs to be done to develop, and make available to practitioners, a more comprehensive network of referral services and programs.

Periodic health checks were generally regarded as a useful way of delivering preventive care and for encouraging people to take responsibility for their own health. However, opinions differed on the optimum ages for when health checks should be undertaken. Many submissions referred to the complexity of assessments and the need to rationalise health checks.

A recent systematic review found that health check visits were likely to improve the quality of preventive care … but the number and complexity of preventive assessments and interventions makes a structured systematic approach necessary.

The issue of voluntary patient enrolment or registration was raised in the context of a greater focus on prevention in primary health care. Submissions endorsed the concept of voluntary patient enrolment as a means to enabling a population health approach to prevention.

The NPHCP support voluntary enrolment with a key primary health care provider as one option to support a proactive approach to primary and secondary preventative health care where a key provider, aided by recall and reminder and health monitoring systems, assumes coordination of an individual’s preventative health care.

It was pointed out that defining a practice population for the purposes of preventive health would need to be supported with systems to identify at-risk individuals, to coordinate or refer individuals to evidence-based services, and to manage patients via established written or telephone feedback from professionals.

Financing arrangements

The funding of preventive care in primary health care was a key theme in the submissions. A range of views was presented with many stakeholders believing that preventive care could be addressed through enhancing the current MBS fee-for-service financing arrangements and others recommending alternative funding mechanisms. Suggested changes included increasing the scope of the MBS to:

- include item numbers to enable GPs and practice nurses to provide educational group sessions, both in the practice and in community settings;
• include items for thorough and ongoing preventive health activities based around developed and evidence-based tools of age-appropriate primary care prevention; and
• allow greater access to nurses and other health professionals who can provide individuals with lifestyle modification advice.

There was some support for practice-level remuneration along the lines of the PIP that would allow the implementation of systems to support individual practitioners in providing preventive care, for example the introduction of recall and reminder systems.

Scope of prevention in primary health care

While there was general acceptance of the role of primary health care practitioners in lifestyle risk factor modification, and the focus of the above discussion is on how this could best be achieved, other aspects of prevention were also raised in submissions as essential components of primary health care. For example, many submissions referred to the importance of early childhood intervention and the crucial role of primary health care in establishing the foundation for subsequent good health in the early childhood years.

There is good evidence that access to early childhood services, including home visiting, parent education, and breast feeding support through primary health care services can improve the health of disadvantaged populations. … While general practice play an important role in the provision of ante and post natal care and preventive health care for infants and young children, including health checks and immunisation, they are not well linked in with early childhood services or programs that support home visiting, parent education and breast feeding.  

As stated above, many submissions raised the broad nature of prevention and the need for a whole of society approach which involves councils, town planners and industries as well as primary health care in developing a cohesive approach. Many cautioned against over-emphasising the degree to which prevention can be addressed by primary health care. However, the role of primary health care practitioners as advocates for measures to improve health was generally supported.

Primary health care professionals have a role to advocate for measures such as changes to regulation and taxation which will improve health.

In addition, the need for primary health care services to be more involved with local communities was frequently emphasised.

Primary health care could better support prevention by incorporating an ‘upstream’ focus on the social determinants of health and not just addressing the high prevalence of risk factors. Taking this approach would mean that primary health care services are more involved with local communities and environments, that they link their service users with community activities and networks that support healthy lifestyles, and that they build the capacity of and advocate for the health and wellbeing of their communities.

What is the way forward?

Primary health care has an important role to play in helping individuals lower their risk of disease and in preventing, delaying the onset or reducing the severity of many health conditions including the complications or recurrence of disease. This potential is currently only partially fulfilled and would
benefit from greater integration, both within the primary health care sector, and between primary health care and other areas.

Whilst treatment of episodic sickness remains core business for primary health care, the promotion and maintenance of health and wellbeing are assuming greater importance as key functions for primary health care. Re-orienting the primary health care system towards prevention is a key objective of health care reform processes internationally and is considered a key element in tackling health inequalities. At the same time, resources (financial and health professional time) devoted to preventive activities need to be balanced against those needed to support the care of those individuals managing illness.

An expanded role for nurses, community pharmacists, and allied health professionals in preventive health care is increasingly supported internationally. For example, a recent European study has demonstrated that nurses providing preventive education and monitoring in general practice reduced dietary saturated fat and increased fruit and vegetable consumption, increased physical activity and reduced cardiovascular disease (CVD) risk. While in Australia, general practice nurses also have a role in preventive care, this work has limited recognition in current funding arrangements.

There are a number of other international examples that could be drawn upon when considering options for an increased emphasis on preventive health care. As published in the recent UK White Paper on the future of pharmacy in England, there are a number of preventive health and public health programs delivered through local pharmacies (as well as through a number of other primary health care settings), including a men’s health check, targeted public health campaigns, vascular checks, diabetes testing and lifestyle risk assessment testing. Similar population specific options could be considered within the Australian context.

It is commonly identified that prevention activities in primary health care need to take a whole-of-life course perspective that highlights the importance of healthy lifestyles and of health promotion, early detection, timely treatment and management of risk factors and early stage disease at every age.

**Reaching high risk groups**

The primary health care setting is appropriate for both episodic/opportunistic preventive advice/counselling of individuals as well as for more systematic/pro-active approaches to the health of all members of the practice population. But for those populations at high risk and who are hardest to reach, a whole-of-population approach needs to be complemented by targeted preventive measures – which may be appropriate and also more cost-effective.

One area to further explore is the possible use of a tiered model of primary health care to ensure that early intervention and prevention services (among other services) are targeted appropriately according to patient need. For example, researchers from the Centre for Health Equity, Training, Research and Evaluation (CHETRE) outline a ‘four tiered model’ as follows:

- **Tiers 1 and 2** are classed as generalist tiers and provide most of the care for common time limited health problems, the ongoing care of multiple chronic health problems, anticipatory preventive care, and early detection of, and intervention for, risk factors.

- **Tiers 3 and 4** are classed as specialised and provide services for individuals/families/communities with specific health conditions or more complex and multiple needs, and the criteria for accessing these services is restricted to people who are at-risk or are affected by the condition.
A similar four-tier system of service provision in Child and Adolescent Mental Health has been used successfully in the UK where Tier 2 service providers were able to address unmet need, provide short focussed interventions to families, and release specialist Tier 3 staff to concentrate on complex, chronic problems. The success of such models do however, rely on well integrated service provision within and across tiers; lack of integration can limit access by consumers and compromise the quality of care provided.

**Workforce implications**

A greater focus on prevention necessitates making optimum use of the primary health care workforce and utilising team-based approaches where appropriate. Consideration of the appropriate roles and skills of different members of the primary health care team (eg general practice nurse, nurse practitioners, community pharmacists, allied health professionals and Aboriginal Health Workers) is a key factor. There is also scope to explore the potential of new emerging roles in the practice setting such as service coordinators.

Improving current education and training arrangements is another key priority so that health care professionals have the necessary skills/competencies (eg in techniques aimed at behaviour change such as brief interventions and motivational interviewing) to undertake preventive health care and work in multi-disciplinary teams.

Preventive care requires approaches that are informed by evidence, are systematic and sustainable. There is a particular need for further research into the appropriate role of primary health care in addressing the lifestyle risk factors for chronic disease. Areas for further research could include cost-effective interventions and the most appropriate primary health care practitioners to deliver them.

**System supports**

There is scope to improve support at the practice-level to better enable practitioners’ engagement in preventive care and to develop population health approaches. This could be facilitated through, for example:

- access to information systems that record and monitor patient risk factors and which can also collect and analyse data on the practice population at the local, community and regional level;
- installing recall and reminder systems and disease registers;
- initiating quality improvement activities related to prevention activities; and
- identifying assessment and educational tools to assist with risk management.

Such eHealth tools have the ability to ensure that prevention activities can be appropriately targeted and implemented, and also improve the ability to track progress and monitor performance related to community-based prevention activities. Importantly, a systematic approach could also support multiple identification and referral points.

At the local or regional level, support for community-based approaches is also required to embed prevention activities in everyday life, guided by community-driven principles as outlined by the National Preventative Health Taskforce.
Financing arrangements

Limitations of the current fee-for-service financing arrangements in supporting preventive health care for GPs, practice nurses and other primary health care professionals have been identified. This is particularly in regard to prevention activities aimed at marginalised and disadvantaged groups, and to the length of consultation, as shorter consultations have been shown to include less preventive activities and more prescribing of medications.\(^{184}\)

For the GP, in particular, given the time constraints, there is often a concern of overloading the individual consultation by providing health prevention advice both from the practitioner’s and the patient’s perspective. There is also a clear question about how much preventive advice, especially around lifestyle related issues, would be more effectively provided by others in the primary health care team, and what funding mechanisms might be most effective and efficient.

A population-based approach to preventive care implies a defined population either at the geographical or practice-level. Patient enrolment, at a geographic or practice level, is therefore, an option to be considered in the context of engaging primary health care in prevention activities.

Linkages and partnerships

The prevention of disease and injury and the promotion of good health are broad issues extending well beyond primary health care and impacted by a number of sectors, therefore necessitating inter-sectoral approaches.

Primary health care has an important role to play in supporting broader regulatory, legislative, social marketing and other measures to address the behavioural risk factors for disease and injury.

Primary health care needs to forge effective linkages with wider community services and programs. In addition, in certain cases, knowledge of the primary health care needs of the community may make a useful contribution to advocacy for changes in wider community circumstances.

The existing role of Divisions, and other regional organisations, in providing support for prevention activities could be strengthened, particularly in regard to determining local prevention priorities and devising interventions to address them in conjunction with other local health services and providers.
Summary – Key Future Directions

A National Primary Health Care Strategy provides a key opportunity to strengthen the existing framework for the promotion of health and wellbeing, prevention and early intervention in primary health care.

Key building blocks for such a framework and areas where change is needed include:

• encouraging more systematic and evidence-based approaches including whole-of-population preventive approaches and targeted initiatives to better address the needs of high risk groups, and support individuals in preventing or slowing disease progression;

• making optimum use of the workforce and improving education and training arrangements to support preventive care activities;

• providing practice-level support to improve adoption of electronic tools and information systems that support primary health care practitioners to optimise preventive care;

• improving referral pathways between primary health care and other (particularly community) services;

• consideration of more flexible funding arrangements including possible consideration of voluntary patient enrolment schemes; and

• fostering linkages and partnerships across agencies from both the public and private sectors, and at local, regional and national levels, to better integrate primary health care services and the broader prevention effort, and minimise duplication.
Objective: All Australians, particularly those with multiple, ongoing and complex conditions, experience primary health care services which are coordinated across multiple care providers, with transitions across health sectors actively managed and continuity of care supported.

Key Points

The prevalence of chronic disease is placing an increasing burden on patients and their carers, and on the whole Australian health system and its service providers. For patients, especially those with multiple chronic diseases, lack of service coordination and assistance in transitioning between health services and sectors can lead to poor continuity of care, resulting in potentially avoidable negative health outcomes such as hospitalisation.

It has been suggested that a ‘medical home’ for patients, complemented by voluntary patient enrolment, can allow for better population health planning as well as strengthen integration, coordination, management and continuity of care for patients.

To some extent, introduced MBS items have been effective in improving coordination and continuity of care for Australians with chronic diseases by providing care plans and access to allied health professionals. Nevertheless, there is an ongoing need to reduce the complexity of these items, and how to improve the education of GPs about the use of items and how to provide quality chronic disease care. Reviewing and improving education opportunities for GPs and decision making systems may better enable GPs to provide optimal care for patients.

It has also been suggested that the different business arrangements and funding models under which different health services operate impact on communication pathways between health services and consequently on a patient’s transition across health sectors. One level of government assuming responsibility for all of primary health care has been suggested as one way to drive better service integration in this space.

Regardless of funding responsibilities, a viable proposal is to increase the number of integrated care models which would allow patients to access a range of closely located specialist, nursing, GP and allied health professionals in one location. Further, such models may enable patients to become more involved in self-management of their health condition and improve their health literacy.

Due to the widespread nature of chronic disease in Australia, changes to its management need to involve development of care models based on the best Australian and international examples, that are evidence-based, targeted for different populations, and involve service delivery system design and greater health professional and patient education.
For all health consumers, but especially those with multiple chronic conditions and complex care needs, their interactions with the health system need to be well integrated with effective and coordinated transitions between different health services and health providers and continuity of care.

The priority issues identified through the Discussion Paper, and confirmed through stakeholder feedback, are the need to:

- improve integration, coordination of and accountability for care, particularly for those with complex care needs;
- improve the targeting and quality of care provided to patients with complex care needs; and
- improve access to available workforce to better support integration of care.

**Where are we now?**

The growing burden of chronic disease is one of the major challenges facing health systems across the world, as noted in Chapter 2. For those living with chronic disease, it can affect nearly every aspect of their life. Over time, it can reduce their participation in work and other activities, and place increasing burdens on their families and carers. Chronic disease is also associated with anxiety and depression.

When well-managed, the health impacts of chronic disease are reduced, progression of disease is delayed, quality of life is improved, there is a positive impact on carers, workforce participation is maintained or increased, and downstream expenditure on health services can be reduced.

In contrast, when disease is poorly managed, it will almost always be associated in time with more complications, acute exacerbations and unplanned and avoidable hospitalisations.

In Australia, the different business arrangements and funding models under which services operate impact on communication pathways between health services and can confuse or dilute responsibility and accountability for individual patient care and service delivery, for example, between Commonwealth subsidised and state/territory government services. They can also reduce flexibility and adaptability at the service delivery end as well as contribute to higher administration costs and increased risk of errors at handover of care.

Individuals, their families and carers can experience increasing frustration and difficulties navigating their way unassisted to access health care from different providers and across different care settings, each operating under different arrangements and with different costs. Health professionals can be unaware of the range of local services that their patients can access or the basis on which they can access them, which can severely restrict the design and implementation of multi-disciplinary care plans or treatment options. Private providers, particularly GPs, also express frustration about the difficulties in obtaining access for their patients to state-funded services.

The National Chronic Disease Strategy (NCDS) endorsed by Health Ministers in 2005 provided national direction for improving chronic disease prevention and care. The NCDS included a strong focus on improving the integration and coordination of care for those Australians with, or at risk of developing, chronic disease. While there has been investment across all levels of government (including through COAG) in a range of initiatives to improve chronic disease management, and by health insurers, evidence suggests that chronic disease in Australia can be poorly managed and highly variable, particularly for disadvantaged sub-population groups.
Potentially preventable hospital admissions

Poor management of chronic disease shows itself through potentially preventable hospital admissions.\textsuperscript{185,186} Potentially preventable hospitalisations are those conditions where hospitalisation is thought to have been avoidable if timely and adequate non-hospital care had been provided. Importantly, as discussed under Element 2, individual behaviour can be an important determinant of health outcomes for individuals with chronic disease, for example, through adherence to treatment regimes or aspects of lifestyle.

The importance of these issues to the effective operation of the entire health system has been recognised in the National Healthcare Agreement (NHA) which has identified a reduction in potentially preventable hospital admissions as a performance benchmark for primary health care.

The AIHW reported that 731,000 hospital separations in 2007-08 (9.3\% of all separations) were potentially avoidable, a rate of 33 per 1,000 people. The majority of potentially preventable hospitalisations, 58\%, were related to chronic conditions such as diabetes and asthma, with 40\% relating to acute conditions (eg appendicitis) and 2\% to vaccine-preventable conditions (eg measles).

The rate of potentially preventable hospitalisations was higher in lower socioeconomic areas (42 per 1,000) than in higher socioeconomic areas (25 per 1,000), and was also higher in remote areas (74 per 1,000) than in major cities (30 per 1,000). Figure 8 shows the major potentially preventable hospitalisations related to chronic conditions by type of condition – diabetes complications account for 52\% of potentially preventable hospitalisation chronic conditions.\textsuperscript{187}

**Figure 8: Potentially preventable hospitalisations for chronic conditions, 2007-08.**

![Diagram showing potentially preventable hospitalisations for chronic conditions](source: AIHW, Australian hospital statistics, 2007-08)
The concepts of ‘medical home’ and ‘patient enrolment’

In terms of integrated and coordinated care, the concept of a ‘medical home’ or regular provider is increasingly recognised internationally as an important component of improving health care. The Commonwealth Fund 2007 survey found that 96% of Australian adults surveyed have a regular doctor or place of care (or a ‘medical home’). The Survey reported that for those Australians with a medical home, defined as having a ‘regular provider who knows you, is easy to contact and who coordinates your care’, 87% rated the care they received as ‘excellent’ or ‘very good’ compared with only 60% of those who do not have a ‘medical home’. It also found that Australian adults who have a regular provider were significantly more likely to have a written care plan, receive reminders for preventive/follow-up care, experience less medical errors and report that they receive excellent or very good care from their doctor.

This survey-based measure of ‘loyalty’ or continuity of care is higher than relevant figures derived from Medicare data. From Medicare data, of the individuals who had more than one in-surgery consult, 47.8% (6.5 million) had all of their surgery consults with a single provider or in a single practice. The rate climbs to 84% if patients who visited only two practices or two providers are classified as ‘loyal’ but then declined as the number of surgery consultations for a patient increased: dropping below 50% by four surgery consultations, about 33% by 12 consultations and under 20% by 50 consultations.

Both the survey and MBS data suggest that a high proportion of Australians have either one or two ‘home’ providers of primary (medical) care; whether these correspond to the concept of a ‘medical home’ (eg in terms of a place that coordinates the patient’s care) is less clear.

While the ‘medical home’ concept can bring potential benefits to the whole population, it is particularly applicable in the management of chronic disease. In international experience, the ‘medical home’ is also coupled with some form of voluntary or compulsory patient enrolment. Internationally, enrolment for particular health conditions or populations is being used as a mechanism for improving the continuity, coordination and integration of care.

Establishing an ongoing relationship with a health service through enrolment or registration has potential advantages in terms of continuity of care. It can encompass oversight and coordination of care for an individual patient including responsibility for maintaining information about that individual and active engagement in transitions between care settings.

A voluntary registration arrangement is included as a component of the recently announced COAG Indigenous National Partnership. This arrangement does not limit an individual’s access to services from other providers but actively encourages an ongoing relationship between the practice and the patient.

The use of MBS chronic disease management items

Within the MBS, Chronic Disease Management (CDM) items were introduced in July 2005 to help improve coordination and continuity of care for Australians with chronic diseases. The introduction of these Medicare items which replaced the original Enhanced Primary Care (EPC) case planning items first introduced in 1999, acknowledged the value of multi-disciplinary care planning. From November 2004, these items have also served as a gateway to a range of allied health services which are rebated through the MBS for patients with chronic conditions and complex needs. In 2007-08,
1.322 million allied health services were claimed with $63 million MBS benefits paid at an average of $48 per item claimed.

Since the introduction of these items, care planning activity has increased compared to the original EPC multi-disciplinary care plan items. There has been a significant increase in the number of individuals receiving care planning services (now comprising both GP and team care) subsidised through these items and in the number of providers using (at least one of) the items. In 2007-08, 2.064 million GP CDM items were claimed with $203.8 million MBS benefits paid at an average $99 per MBS service claimed.

The impact of the CDM items is, however, open to question. As Table 8 shows, coverage of the eligible population would seem to be uneven, given as usage is concentrated on a small number of GPs. Table 8 provides a measure of concentration for selected GP MBS items based on data from 20,600 GPs who claimed more than 1,000 services in 2006-07. It shows that while most doctors use some of the items, a small number of doctors make most of the claims. For example, while 86% of those GPs who claim more than 1,000 services a year use the care plan items, only 34% claimed them more than 50 times a year and the 10% of GPs who claimed most care plans accounted for 54% of all care plans claimed.

Table 8: GPs claiming new MBS items, 2006-07

<table>
<thead>
<tr>
<th></th>
<th>Care Plans</th>
<th>Health Assessments</th>
<th>Mental Health</th>
<th>Aged Care</th>
<th>After Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Make at least 1 claim</td>
<td>86%</td>
<td>69%</td>
<td>83%</td>
<td>58%</td>
<td>71%</td>
</tr>
<tr>
<td>Make more than 50 claims</td>
<td>34%</td>
<td>13%</td>
<td>14%</td>
<td>26%</td>
<td>37%</td>
</tr>
<tr>
<td>% claimed by top 10% of GPs</td>
<td>54%</td>
<td>41%</td>
<td>50%</td>
<td>63%</td>
<td>59%</td>
</tr>
<tr>
<td>% of GPs where these items make up at least 5% of their total claims</td>
<td>8.0%</td>
<td>0.3%</td>
<td>1.5%</td>
<td>16.8%</td>
<td>24.8%</td>
</tr>
</tbody>
</table>

Source: Medicare data

A recent review of the MBS care planning items noted the need for greater education of GPs in the appropriate use of those items. A Medicare Australia audit which fed into that review found that only 64% of items claimed were compliant with MBS requirements.

There are also concerns that the quality of care provided is unknown and that the objectives of coordination and continuity of care may not be being achieved. Over 2005-07, only around 30% of patients with a GP Management Plan received an MBS review item and only 20% of patients with a Team Care Arrangement received an MBS review item.

Correspondence to the Department of Health and Ageing from the Professional Services Review (PSR) has highlighted the risk of these higher rebated items being accessed more for business than clinical considerations. In particular, the PSR is concerned that plans are being opportunistically generated, based on system driven templates, that do not reflect the patient’s actual needs and that are not necessarily shared with or even provided to the patient. Concerns have also been expressed that care
plans are being provided to individuals whose clinical condition could readily be managed by ‘normal care’ and that while a benefit is payable for the preparation of a care plan, there is no requirement that the plan is actually delivered or is even capable of being delivered. The PSR raised these issues in their 2005-06 Annual Report.  

In summary, the CDM items have been criticised in relation to complexity and ‘red tape’/paperwork, time constraints, eligibility requirements, overlap and duplication, and lack of understanding, support and remuneration for the roles of other team members within the multi-disciplinary team. The EPC items, and current MBS funding arrangements for primary health care more generally, have also been seen by some as contributing to fragmentation of primary health care with the number and complexity of separate items being a cause for confusion amongst health professionals and patients.

**Improving the quality of care for people with chronic disease in general practice**

Other than specific issues with the CDM items, evidence suggests that about half of general practice care for chronic illness, in general, does not meet optimal standards. This has been demonstrated in the care of children with asthma and adults with type 2 diabetes or hypertension. Factors contributing to the gap between optimal and current practice include the method of financing, the availability of other disciplines to participate in team care, limited engagement with self-management education, and lack of information and decision support systems.

Access to health professionals is discussed under Element 1. However, access to a multi-disciplinary health care team is also key to chronic disease management. Multi-disciplinary team care has been shown to have positive effects on both provider behaviour and some patient outcomes, particularly for diabetes, hypertension and lipid disorders. However, a 2006 survey indicated Australian GPs were less likely than primary health care doctors in the UK, Netherlands, Germany or NZ to use a multi-disciplinary team approach to the management of chronic conditions.

Chronically ill patients are most likely to suffer the consequences of poor care coordination and transition between care settings. This is because they are required to have multiple contacts with the health care system and often see a range of specialists and primary health care professionals to manage their more complex needs in the course of an acute episode of care. Significant care coordination problems (with high potential for errors and adverse events) are also experienced when individuals transition across health sectors or stages of care provision (for example: from inpatient to ambulatory care; or acute to long-term care, including residents of aged care services).

In response to these issues, there are a growing number of integrated models of care whereby patients with chronic disease receive a suite of specialist, GP, nursing and allied health services in the community setting, close to where they live. For example, the Chronic Obstructive Pulmonary Disease (COPD) Community Linkage Service in Perth, Western Australia, offers community-based care for people with a primary diagnosis of COPD via a respiratory specialist, community nurse, and physiotherapist, who work in conjunction with the patient’s GP. The service essentially provides a ‘one-stop’ shop in the community that includes specialist assessment and review, access to spirometry, pulmonary rehabilitation, self-management education and social support for patients with COPD.

Building on the Coordinated Care Trials, which demonstrated both improved health outcomes and reduced costs of care, there have also been a number of examples of explicit funding of care
coordination support for individuals with chronic and complex care conditions, including work by GP Partners for the Queensland Government and Medibank Private, and work undertaken by McKesson, for the Department of Veterans’ Affairs (DVA).

What the submissions said

There was general recognition that some target groups needed assistance in navigating the system and accessing services, with a role for care coordination.

The key target groups that would benefit from a more coordinated approach to their care are those with complex chronic disease and the frail elderly. … We believe practice nurses could take on a liaison role for general practice clients requiring care coordination or assistance with navigating the health care system.\textsuperscript{201}

Some stakeholders saw GPs and the general practice as the most appropriate location for coordinating the care of individuals with multiple, ongoing and chronic conditions.

The Australian primary health care system should be based around patients’ health care needs, enabling patients to receive timely and appropriate coordination of their care. In order for this to occur, the system requires support for general practitioners to coordinate the care of their patients, particularly the care of patients with multiple, ongoing and complex conditions… General practitioners should be recognised and funded for their integral role in coordinating and supporting patients when implementing patient centred strategies.\textsuperscript{202}

The general practice team is central to care coordination and ongoing holistic care. Referral from the GP should remain the entryway to specialist care.\textsuperscript{203}

The coordination of care is best managed in the general practice environment …. It essential that the [care coordination] role be performed within the practice so that established relationships and communication mechanisms can be best leveraged.\textsuperscript{204}

The capacity of practice nurses and nurse practitioners to provide a range of functions, including care coordination, was emphasised in some submissions.

Practice nurses are critical in ensuring general practice delivers well-integrated and coordinated care in a way that promotes continuity of care. A growing role for nurses in primary health care, which makes full use of their existing nursing skills, is that of working with patients with multiple, ongoing and complex conditions. Everyday practice nurses see patients who are in great need of support in navigating our complex health and social services system…This is a role which fully uses the wholistic approach of the professional nurse in clinical and service coordination and we would support a clearly autonomous role for nurses in this capacity within the general practice team…Non-clinical service coordination models which sit outside the practice do not seem to take advantage of the health professionals within the practice working together to provide a coherent service and plan of care for the patient.\textsuperscript{205}

The changing population needs mean that not every patient needs a medical specialist to manage their care, and nurse practitioners are recognised as effective in the integration and coordination of care across all aspects of the health sector, particularly between primary care and hospital services.\textsuperscript{206}
A number of submissions included suggestions for ways in which to ensure better continuity of care across a number of different care settings, including use of universal processes and eHealth solutions.

*Transition points in care are a high risk area for preventable adverse medicines events. Universal processes are needed to ensure accurate communication of information about the consumer’s medication history to all health professionals involved in his/her care. This will require a systems approach across the entire medication management pathway and in all sectors of the health system.*

*E-Health and the Individual Electronic Health Record (IEHR) have the potential to improve continuity of care and health literacy, to provide useful prompts for different interventions such as a medication review or prevention education, and to provide information and educational resources and tools at the point of consultation and/or decision-making.*

Some submissions described a model and function for coordination with implications for how the function could be designed.

*The objective of this revised primary health care system is to increase access for people requiring timely and targeted evidence-based interventions especially to address chronic disease and other health issues by enabling self-referral and referral via a triage type system to allied health providers. This system could be provided by a range of health professionals. Under this model the GP remains at the core of the consumers’ primary health care treatment with this role being maintained via communications systems rather than referral pathways.*

The importance of matching care coordination services to the target population and to their specific needs, for example, in relation to the Indigenous population, was identified.

*…using the expertise of Aboriginal community controlled health services through coordinator positions established within NACCHO [National Aboriginal Community Controlled Health Organisation] Affiliates…ACCHSs [Aboriginal Community Controlled Health Services] are best placed to coordinate local and regional service provision to Aboriginal peoples.*

**Box 2: Overview – response to selected Discussion Paper questions**

**Question:** Would there be advantages in patients having the opportunity to ‘enrol’ with a key provider? (p.24, Discussion Paper)

61 submissions addressed this issue - of these 82% were generally in favour of voluntary patient enrolment. Enrolment was recommended particularly for patients with chronic/complex disease and young families, but it was noted that enrolment should be voluntary and flexible. It was also suggested that an electronic health record would have similar benefits. The benefits of voluntary enrolment mentioned by submissions included continuity of care, better coordination, and greater patient participation. The problems with voluntary enrolment identified by submissions included lack of choice, favouring of urban areas, and the lack of inclusion of disadvantaged populations.
There was a general view that patient enrolment offers a number of potentially significant benefits for individual patients, communities, service providers and funders. Advantages to patients include clarification of expectations and greater coordination of care.

Voluntary enrolment for patients with specific chronic disease prevention and management needs in a single practice offers the potential to encourage a more proactive and coordinated approach to patient management by reducing fragmentation and duplication of service provision...²¹¹

At the level of individual patients, the most basic advantage would be to clarify the mutual responsibilities and expectations of providers and patients, and in the Australian context remove the fear that active follow up would be seen to [be] soliciting for business. This could provide a basis for the development of more actively coordinated systems of care, ranging from better follow up and reminder systems to the redesign of models of care, particularly if enrolment were accompanied by some form of capitation payment that created a predictable flow of funds.²¹²

Many submissions pointed to the potential of voluntary patient enrolment to enable more systematic approaches to preventive care.

Patient enrolment would also allow effective monitoring and evaluation of preventative health initiatives for national reporting. Registers of patients within a practice with particular risk factors or chronic conditions which are the target of population based preventative health programs would identify the target groups for implementation of appropriate interventions.²¹³

It was pointed out that individuals are already enrolled with practices to some extent, particularly in rural areas.

However, support for patient enrolment was by no means unanimous with many stakeholders highlighting the importance of choice and several submissions emphasising the role of eHealth as a means to improve coordination of care.

The freedom of patients to choose their doctor and for doctors to choose not to treat particular patients is paramount.²¹⁴

Given that one of the key objectives to developing a primary health care strategy is making the patient the centre of decision making, there is merit in a system where consumers have the ability to decide which health practitioner they access rather than being tied to any one key provider. Effective sharing of information via safe and secure eHealth networks has the potential to overcome any information gaps in a patient’s health history rather than insisting a patient enrol with a key provider.²¹⁵

The Consumers Health Forum, in particular, was opposed to the proposal.

Consumers do not want to register or ‘enrol’ with a particular coordinator or managed care team as such arrangements can limit access and choice, for example, in relation to consumers seeking a second opinion. Such a system also fails to recognise or cater for those with transient lifestyles or personal circumstances that make enrolment impractical or impossible. … such as the homeless, Indigenous populations, those with mental health issues and those with limited incomes.²¹⁶
What is the way forward?

International work identifies key elements of an effective chronic disease management model. This model includes an efficient delivery system design; evidence-based and patient-centred decision support; clinical information systems to facilitate efficient and effective care; self-management support through patient empowerment; and mobilising community resources to meet patient needs. Effective chronic disease management is also greatly facilitated through readily accessible, accurate and up-to-date patient information (for example, through an Individual Electronic Health Record).

There is also a growing body of literature around chronic disease management interventions and their effectiveness. While current evidence is inconclusive, there is increasing understanding and acceptance of the broad features required for interventions to improve chronic disease management. In particular, there is growing consensus of the need for stratification or grouping of individuals based on complexity of disease, needs and capacity to self-manage, and the broad nature of interventions appropriate for different categories.

This approach divides the population into four groups or risk categories in relation to chronic conditions (Figure 9). People in each of these risk categories require a different response from the health system.

Figure 9: Chronic disease risk distribution

Very High Risk – Patients have multiple, complex health care needs, are at a very high risk of experiencing an acute event and need help managing their condition and coordinating services.

High Risk – Patients are, or are at high risk of being, frequent presenters to emergency department, have recently experienced a major health event, have multiple care gaps, often need pain management, medication coaching or biometric monitoring.

Lower Risk – One or more chronic conditions and some identified care gaps. May need help understanding treatment plans and likely to benefit from education and support to encourage healthy behaviours.

Well Population – Basically healthy with no detectable chronic disease. Focus on prevention screening and healthy behaviours. Low intensity strategies to prevent or reduce incidence of health events through broad dissemination of information and tools to help individuals understand their health conditions, risks, treatment options and available resources.
The Kaiser Permanente approach to chronic disease care estimates that of the group of at-risk individuals approximately 3-5% of patients with chronic conditions require case management, 15-27% require care management, and 70-80% can be managed with supported self-care (corresponding to the very high, high and lower risk categories in Figure 9).

The percentage of the Australian population covered by these categories cannot be quantified in exact terms given variations in applying criteria based on need and risk. However, estimates based on multiple hospital admissions or on prevalence of major chronic diseases suggest that in broad terms around 10-16% of the Australian population could be covered by the top three levels of the pyramid (ie very high, high and lower risk). For a well population, primary prevention is promotion of healthy behaviours and environments across the life course, and universal and targeted approaches. For the at-risk population, secondary prevention and early detection are vital. This includes screening, case finding, periodic health examinations, early intervention, and control of risk factors such as lifestyle and medication. For populations with established disease, treatment and complications management (including acute care) may be required. For populations with controlled chronic disease, continuing care, maintenance and rehabilitation may be required. Self-management and support for patients’ capacity to self-manage are relevant to different degrees across all levels.

As part of an effective chronic disease management model for individuals with established disease, optimal uptake of care planning requires:

- clarification, definition of, and appropriate funding for, the roles of different multi-disciplinary team members;
- changing patterns of interactions between care providers;
- an understanding of local services and supports;
- alignment of roles and work practices (including active and structured facilitation of teamwork);
- changes to organisational arrangements, especially for those under the care of specialists;
- clarification of the patient’s role in care; and
- training for individuals, their families and carers as well as health professionals in team-based care.

Collectively, these factors can work together to support increased collaboration and integration between providers and streamline transitions of care. At the same time however, there is increasing recognition of the importance of reducing avoidable hospital admissions and ensuring that individuals are receiving health care services closer to home. Integrated chronic disease management models provide the opportunity for GPs, supported by specialists and other health professionals, to manage complex and chronic diseases in the community setting. Such models also offer the potential to improve access to specialist medical care closer to people’s homes, strengthen the interface between GPs and specialists, and to build capacity within general practice through the provision of mentoring, support and education on best practice management of specific diseases (eg CVD, COPD or diabetes). Clearly this is an important priority for consideration under the Draft Strategy.

In relation to the current operation of the MBS arrangements, there is potential for improving chronic disease management, through options such as:

- better targeting services to needs;
- encouraging more ongoing care through review activity;
• providing greater flexibility for multi-disciplinary teams and allied health services; and
• supporting quality improvement through promotion, awareness and clinician education activities.

Further developments in eHealth will also be significant to improving coordination of care for those with chronic disease. The OECD has identified that better integration of care across health sectors and care modalities can be supported by enhanced information transfer across providers and payment models which encourage cooperation across sectors and reward multi-disciplinary care. 221

Effective communication including timely transfer of information between providers and across health settings is integral to the provision of effective team-based care, particularly in referral and collaboration. Technology solutions supporting efficient monitoring and follow-up of patients have potential to support prevention approaches and individualised care coordination. Research indicates that countries with better information flow report higher rates of referral from hospitals back to primary care and improved coordination in the provision of longer-term multi-disciplinary care.222

In the Australian context the experience of patients with chronic disease can be further complicated by both Commonwealth and state/territory governments having responsibility for aspects of primary health care and state/territory funding for emergency departments and outpatient services which can often form one part of a broader primary health care service system. One response to the multiplicity of funders in this space is for one level of government (the Commonwealth) to take full responsibility for primary health care. While this option is not developed fully in these papers, the types of benefits that could accrue include improved connections across primary health care services, removal of perverse incentives on how services are funded and how that can impact on an ‘ideal’ patient journey and assist patient transitions.

Regardless of funding responsibilities between levels of governments, introducing a new model of chronic disease management would need to address a range of complex design and funding considerations including the need to determine:
• targeting of populations for different levels of chronic disease management and how this would operate in practice;
• range of services to be publicly funded, funding mechanisms to be adopted and how these could interact with existing mechanisms such as MBS rebated services, HACC services etc;
• voluntary patient registration or enrolment arrangements which might be associated with a chronic disease management program, at what level these would occur and what conditions would apply to registration (noting that any arrangement would need to allow for patients’ ability to change practices/providers); and
• integration across primary, specialist and acute care settings.

Before making an increased investment in chronic disease management, governments would also need to consider where this investment could be most effectively placed. Ideally, the goal of effective chronic disease management should be to ‘upstage’ or ‘upstream’ the impact of the disease – to slow or even halt the progression and ratchet back to more amenable intervention at an earlier stage. Targeting only that part of the population at the furthest end of the disease pathway will at best only shift the setting or place of care, not the type of care needed. It will also not reduce the continuing need for such care from new cohorts of patients nor the expense of treatment or the sequelae effects.
Evidence suggests that improved chronic care services focussed only on the high end/high need group provide limited overall benefit to the health system. Furthermore, interventions used earlier in the disease process may be more effective in preventing or at least delaying deterioration in health and hospitalisation.

Self-management and other support provided by health advisors (e.g., at the time of or shortly following diagnosis of a chronic condition) can help individuals better manage their health through improved understanding of their condition, proactive identification of care gaps, influencing health behaviours, and actively monitoring patient health to help patients achieve their defined goals. Elements 1 and 2 also discuss important aspects of improved chronic disease management.

In the long-term, an effective model of chronic disease management would see stratification of the population with chronic disease and at risk of declining health to enable delivery of chronic disease care tailored to the particular needs, conditions and circumstances of individuals.

Summary – Key Future Directions

A National Primary Health Care Strategy provides the opportunity to strengthen and enhance existing arrangements to improve the continuity and coordination of care, particularly for those with complex care needs. Options include:

- introduction of voluntary enrolment arrangements to encourage greater continuity and increased accountability for ongoing care;
- development of clinical governance protocols to guide effective multi-disciplinary team care – to ensure teams understand individual roles and responsibilities;
- support for adoption of evidentiary best practice – to encourage greater standardisation of care in line with evidence;
- improved assessment tools and processes to improve targeting of available services according to individual clinical need;
- greater flexibility in service delivery arrangements to most effectively tailor available services to individual need; and
- most effective use of available workforce and support tools based on community need.
**Element 5: Safe, high quality care which is continually improving through relevant research and innovation**

**Objective:** All Australians have access to safe, high quality primary health care services that deliver evidence-based care and accountability for outcomes, support continuous quality improvement, and reward research and innovation.

**Key Points**

There is very little information currently available to Australian consumers, health care professionals and governments about the quality of care provided in primary health care. While there is a range of mostly voluntary quality assurance mechanisms and accreditation standards available for primary health care professionals, these vary in comprehensiveness across professional groups and in uptake by individual clinicians. There is also a limited evidence base to support accreditation and standards as quality assurance mechanisms for primary health care and there is mixed evidence in regard to the financial and health outcomes impacts of accreditation.

A variety of primary health care indicators are being developed across a range of processes. However, currently available information does not provide a comprehensive picture of the primary health care sector and is not well suited or accessible to primary health care providers for the purpose of improving performance. This is in part due to the scarcity of good quality data on care provision and information systems to support data collection, analysis and reporting at the clinician, health service and policy levels.

Many countries are experimenting with pay-for-performance schemes that tie a portion of provider payments to performance measures of quality, patient experience and outcomes. In Australia, pay-for-performance in primary health care is limited to the Practice Incentives Program (PIP), in general practice, with a number of other initiatives, such as the Australian Primary Care Collaboratives Program, also supporting quality improvement in primary health care. While the PIP includes outcome-based incentives, moving significantly towards payments based on patient health outcomes will require further development of performance indicators that are both meaningful and usable by health professionals.

It is widely acknowledged that evidence-based policy and practice are fundamental to an effective primary health care system. In Australia a range of factors including limited funding, research capacity and representation in research governance, as well as the complexity of primary health care presentations, have been barriers to effective research and uptake of proven research interventions. Recent initiatives have led to some progress in the development of a well trained primary health care research workforce, a stronger research culture in general practice and uptake of primary health care research. However, research capacity and infrastructure remain fragile and there is an ongoing need to broaden the scope, and improve dissemination of, primary health care research.

There is a clear need, and support, for a stronger framework for safety, quality and performance improvement in primary health care to be developed in consultation with consumers and the primary health care professions. Potential building blocks for the framework have been identified and there will be a need to ensure consistency with the National Strategic Framework for Safety and Quality being developed by the Australian Commission on Safety and Quality in Health Care.
Where are we now?

Safety and quality

There is currently very little information available about the quality of care provided in primary health care and limited monitoring of patient experiences in primary health care in Australia. Aspects of quality of care that are reportedly important to patients include continuity, coordination and integration of care, respect for their values and preferences, information and education, physical comfort, emotional support and involvement of family and friends in their care.225

One of the few available sources regarding patient experiences in Australia is the 2007 Commonwealth Fund survey, which outlines the following findings in respect to its Australian respondents:

- 20% reported experiencing a medical, medication or lab error;
- 10% reported that their doctor had ordered tests that had already been done;
- 14% reported often receiving conflicting information from different health professionals;
- 36% reported that they received quality and safe care; and
- 51% reported that their regular doctor coordinates care received from other health care providers.226

A similar survey conducted by the Commonwealth Fund in 2005 indicated that of Australians who reported experiencing medical mistakes or medication errors, 37% of respondents indicated these occurred in the hospital setting.227

Within primary health care, health care professional associations have developed a range of quality assurance mechanisms for the professions they represent but these vary in comprehensiveness and uptake by clinicians. One example is the Royal Australian College of General Practitioners (RACGP) A Quality Framework for Australian General Practice228 which aims to provide a dynamic and flexible quality management tool for use in a range of primary health care settings.

The Australian Commission on Quality and Safety in Health Care is charged with leading and coordinating improvements in safety and quality in health care in Australia by identifying issues and policy directions, recommending priorities for action, disseminating knowledge and advocating for safety and quality. The Commission is currently developing a National Strategic Framework for Safety and Quality in all health care settings with a consultation process underway. The Commission’s primary health care committee is focussed on issues of quality and safety for primary health care.

Accreditation

Accreditation is often used as the key indicator of safety and quality in health care. Accreditation for most primary health care services is voluntary and coverage varies across professional groups. Since general practices must be accredited or registered for accreditation to participate in the PIP, data from this program are broadly representative of the number of accredited general practices. In 2007-08 PIP practices provided over 81% of GP care in Australia. In part, this reflects the PIP incentives compensating (or partially compensating) practices for the costs associated with accreditation. There is thought to be limited coverage of dental practices (less than 1%), physiotherapy private practices (1.9%) and optometry practices (approximately 2.2%).229 Around 98% of community
pharmacies are registered to participate in the Quality Care Pharmacy Program; of these 67% have been accredited against the Quality Care Pharmacy Program Standards. By contrast, 100% of hospitals, surgical day procedure centres and pathology laboratories are accredited due to mandatory requirements.

The range of external organisations that provide accreditation for primary health care organisations and services use different standards. This is a particular issue for primary health care reform where care is increasingly focussed on delivery through multi-disciplinary teams involving individual health professionals working effectively together.

Accreditation reports are often limited to whether an organisation is accredited or not and when the accreditation expires. There is no detail provided of the health service organisation’s weaknesses or areas of concern identified by the accreditation process. Current accreditation standards are also focussed on processes, with little emphasis on clinical aspects and patient outcomes. In this regard, Australia lags behind other countries such as the UK where comprehensive data on individual facilities is provided on the relevant Healthcare Commission website.

In addition, the evidence base to support accreditation and standards as quality assurance mechanisms for primary health care is limited.230 The results of research studies are mixed in regard to the financial impact of accreditation, the relationship of quality measures to accreditation and whether accreditation delivers better health outcomes.231

**Performance indicators and data for primary health care**

Although significant progress has been made over the past decade in developing and refining healthcare performance measures both internationally and in Australia, considerable further work needs to be done to develop valid and reliable measures of the performance of the primary health care system.

Currently, a range of different processes are considering performance measurement for the health care system including primary health care. These include:

- National Healthcare Agreement (NHA) and National Partnership Agreements;
- Divisions’ National Quality Performance Service (NQPS);
- Australian Commission on Safety and Quality in Health Care (ACSQHC) Quality Framework;
- Australian Primary Care Collaboratives Program;
- National Prescribing Service (NPS);
- Report on Government Services (RoGS); and
- The Indigenous Healthy for Life program.

Related to the development of effective systems of performance measurement is the scarcity of current data collections in primary health care including how primary health care systems record quality of care:

- the poor quality of recorded data which may be related to the lack of feedback provided to those collecting it and perceptions around usefulness;
- a lack of automated data extracted from primary health care services; and
- considerations of privacy, time and coding.
In general practice, higher levels of computerisation can support greater use of data, though other primary health care services may be less advanced in this regard. Importantly, improvements in data collection and monitoring, at the clinician and practice level, especially when associated with peer review, has been shown to drive performance improvement.

In addition, compatibility of software and data linkage from different sources is limited. Overall, this restricts the capacity and effectiveness of information systems to support analysis, reporting and quality improvement changes, at all levels. Further discussion about information management in primary health care is provided under Element 6.

**Pay-for-performance**

Many countries are experimenting with pay-for-performance schemes that tie a portion of provider payments to performance measures of quality, patient experience and outcomes. In Australia, the PIP provides a range of targeted incentives (which complement fee-for-service payments) for accredited practices that encourage general practices to improve the quality of care provided to patients – including outcome-based payments.

The incentive payments that specifically focus on health outcomes relate to cervical screening and diabetes management. These two incentives follow a similar pattern of payments, in that they both provide:

- a sign-on payment: where practices are rewarded for either engaging with their local Cervical Screening Register, or implementing a Diabetes register and recall/reminder system;
- an outcomes payment: where payment is made to practitioners (working within a PIP practice) who provide specific services to a certain proportion of a subset of their patients; and
- a service incentive payment: where a payment is made to providers (working within a PIP practice) for either providing cervical screening to high-risk individuals, or for the completion of an annual cycle of diabetes care.

The provision of these incentives directly encourage and reward general practices in undertaking best-practice care for their patients, while also targeting major health issues at a practice population level.

Alongside the PIP, a number of initiatives have supported quality improvement in general practice. For example, the Australian Primary Care Collaboratives Program was established to provide a generic quality improvement model for use in the primary health care setting. General practices are given practical support to help them close the gap between current and best practice and make practice-level changes to improve clinical outcomes, help maintain good health for individuals with or at risk of chronic and complex conditions, and improve access to care.

Evaluation of the first phase has shown that general practices made measurable improvements in patient care and health outcomes. For example, in participating practices, there was a 105% increase in patients with diabetes who have appropriate cholesterol levels and a 45% increase in patients receiving recommended medications after a heart attack.
Research and knowledge transfer

Evidence-based policy and practice are fundamental to a high quality, fully functioning primary health care system. The literature states that there are several reasons why research is needed in the primary health care sector, it:

- improves patient care;
- is important for teachers of general practice, providing an evidence base for best practice; and
- stimulates critical thinking.\(^{234}\)

McAvoy (2005) also states that ‘primary care research is the missing link in the development of high quality, evidence-based health care for populations’. In Australia, as in other countries, primary health care research accounts for a relatively small proportion of health research expenditure (around 4% in 2002-03).\(^{235}\)

Although there is increasing recognition of the complexity of primary health care, there still remains limited participation by primary health care researchers in the governance of national research bodies and a low level of rigorously designed studies in primary health care research compared to other medical disciplines. In addition to clinical research, there is a need for health services research to underpin planning for primary health care service delivery.

Health services research needs to be relevant to primary health care in Australia to recognise the specifics of delivery in the Australian context. Also important for the primary health care context is that most presentations are ‘undifferentiated illness’ with significant co-morbidities or associated factors. Currently the complexity of primary health care patients is a barrier to either effective clinical research and/or uptake of proven research interventions.

A number of schemes have been established over the last decades to specifically support primary health care research, including the General Practice Clinical Research Program, the Health Services Research Program and the Primary Health Care Research, Evaluation and Development (PHCRED) program. As part of PHCRED, initiatives such as the Australian Primary Health Care Research Institute (APHCRI) have encouraged quick response research activity against targeted priorities. In Indigenous research, the Cooperative Research Centre (CRC) for Aboriginal Health has developed an approach which includes a ‘facilitated research development approach’ where the CRC for Aboriginal Health mediates relationships between researchers, the Aboriginal health sector and government agencies to set research priorities and develop research projects.

While the last decade has seen improvements in developing a research culture in general practice, some other primary health care disciplines lag behind. For example, developing a research base to underpin the discipline of practice nursing is at an early stage and few practice nurses have training in conducting or evaluating research. Engagement of consumers, health economists and other health professionals is also needed to expand the scope of research in primary health care.

Translating research into practice

Evidence-based practice is ‘the conscientious, explicit and judicious use of the current best evidence in making decisions about the care of individual patients’.\(^{236}\) However, for primary health care practitioners struggling with time constraints and large caseloads, keeping up-to-date with the current best evidence is a perpetual challenge, especially as it needs to cover a very broad field.
The latest research findings relevant to primary health care are scattered across hundreds of different international scientific journals and other publications. The use of systematic reviews of the scientific literature, clinical practice guidelines and decision support systems can assist all practitioners to ensure that their clinical practice remains consistent with internationally recognised good practice. For example, the Primary Health Care Field Group of the Cochrane Collaboration is concerned with the quality, quantity, dissemination, accessibility and applicability of Cochrane systematic reviews relevant to people who work in primary health care.

There has been a proliferation of guidelines and their authorship, currency, status and quality may not be clear to health care practitioners. Guidelines do not necessarily adhere to accepted best practice guideline development standards, such as those set by the National Health and Medical Research Council (NHMRC), and have tended to be disease-specific and, as such, are often not relevant or useful for managing the complex needs of patients with multi-morbidity.

To be effective, guidelines must:

- be based on the best evidence available (e.g., supported by the National Institute of Clinical Studies);
- have transparent methodology;
- have clearly identified priority areas and recommendations;
- have current, active implementation plans;
- be adequately disseminated to end users; and
- recognise cultural and traditional values.

Professional associations have a role to play in assisting health care professions to access high quality guidelines relevant to their practice.

The use of integrated information technology (IT) systems, incorporating knowledge support systems and their potential to improve compliance with clinical guidelines, reduce errors and provide an audit trail in primary health care is covered in more detail under Element 6.

Improved dissemination of the latest research findings to primary health care practitioners and policy makers is necessary for research to be embedded into practice. The evidence shows that research transfer is likely to be favoured in situations where research is valued, there is critical debate of research methods and results, and there is managerial support for change processes.

An example of a national primary health care practice-based network that is translating research into practice is the Cancer Australia national cooperative clinical group. Australia has 12 national cancer cooperative groups involved in clinical trials. The research emphasis is about improving the survival of cancer patients, contributing to a reduction in premature death and disability, and improving the evidence behind cancer care.

A range of interventions has been developed aimed at translating research findings into practice. These include educational outreach visits, decision-support systems, interactive educational meetings, audit and feedback, local consensus processes, mass media interventions based on social marketing theory, the use of local opinion leaders, patient-mediated interventions, educational sessions, financial incentives and penalties, and administrative interventions.\(^{237}\)
In general, submissions recognised the need for greater accountability of primary health care and the need for consumers to have confidence that primary health care operates within a safe, outcome-focused quality improvement framework. Performance monitoring was generally seen as crucial as an agent for change, for service improvement and as a catalyst. Those submissions that did comment in regard to quality improvement emphasised the importance of embedding quality improvement approaches into ongoing organisational service delivery, planning and development.

It is crucial to build a continuous improvement process into all initiatives related to safety and quality so health services always strive to be better, with better outcomes for consumers.288

It was generally recognised that for this to happen there would need to be a culture change at every level of primary health care. Organisational development was suggested as the way to enable this culture change to occur.

What the submissions said?

Safety and quality

Box 3: Overview – response to selected Discussion Paper questions

Question: Who should be responsible for developing and maintaining a performance framework? (p.27, Discussion Paper)

From the submissions, there were 51 responses to this question. 55% of these mention the Commonwealth or a national body, supplemented by stakeholders or experts, as the best option to be responsible for developing and maintaining a performance framework. The alternatives to a national body included professional colleges, experts, stakeholders and universities.

Question: Would there be advantages in linking patient health outcomes and quality of care provided to incentives for health care professionals? (p.27, Discussion Paper)

55 Submissions responded to this question. These responses held mixed views. It was mentioned that this approach may not work for disadvantaged groups or ‘non-compliant’ patients, and would be influenced by factors outside the GPs’ control. It was suggested that it may be easier to link to a process that leads to the desired outcome (eg pap smear reminder system). Some submissions also suggested consideration of providing incentives for patients.

Divisions of General Practice are increasingly providing opportunities to promote best practice particularly to practice nurses and GPs. However, this activity is variable and does not address the needs of the wider range of health care practitioners working in primary health care.
Our experience suggests that few organisations focus on the use of organisational development (OD) as an effective strategy to achieve improvement in practice. Performance in healthcare organisations is inextricably linked to leadership, culture, climate and collaboration which can be improved by OD.  

Several submissions also highlighted the need for a systematic and universal approach to managing quality and safety in primary health care.

**Barriers to quality improvement**

Submissions also highlighted a number of barriers to the implementation of quality improvement across the primary health care system that would need to be overcome. The lack of skills and competence in quality management is one such barrier.

The workforce responsible for service quality and CQI [Continuous Quality Improvement] is often seconded from embedded clinical work and has little or no exposure to quality theory in undergraduate training. There is a need to dedicate resources to develop the competencies of the quality workforce in primary healthcare.

For this reason, practitioners require considerable support and assistance to build their competence in this field. It was suggested that regional primary health care support organisations could play an important role.

Other submissions pointed to time constraints and financing models that hinder participation of practitioners in quality improvement activities.

The current fee for service system does not support systematic team building and quality improvement activities, and funding and financing models that support the engagement of general practice in QI [Quality Improvement] activities is strongly encouraged. Fee for service does not allow for time out to reflect and improve.

**Accreditation**

Few submissions commented on issues relating to the accreditation of primary health care services but those that did emphasised the importance of accreditation for maintaining and improving quality of care as long as organisations were not required to undertake several different accreditation processes.

We strongly support the need for all health services to be accredited, but this should not result in us being required to undertake multiple systems of accreditation.

Several submissions referred to the need to extend accreditation to cover clinical care as well as administrative processes.

Some submissions also highlighted the need for primary health care services that cater for groups with special needs to have the flexibility to choose accreditation packages that are appropriate to their requirements.

While headspace supports the current primary health care accreditation system, greater flexibility is needed to allow parallel accreditation programs to be developed for specialty primary health care services. Many of these services, like headspace, target disadvantaged groups and employ sessional general practitioners, as well as other health professionals and social/vocational staff, placing them largely outside the guidelines for accreditation under AGPAL [Australian General Practice Accreditation Ltd] and limiting access to MBS income.
The submission from Australian General Practice Accreditation Limited/Quality in Practice sets out a proposal for a profession-led quality improvement framework.

**Performance indicators**

The importance of developing performance measures that are meaningful and appropriate to clinicians was highlighted.

> Thrusting inappropriate and unworkable performance indicators onto general practice only serves to demoralise and frustrate the GP workforce.

Various lists of suggested performance indicators were provided in the submissions. These are too numerous to detail here. Some examples are:

[Suggest these areas could be monitored and reported against:] Access; timeliness; out-of-pocket costs; appropriateness; affordability; patient centred; health literacy; opportunities for self-management; preventive care; integration with other services; coordination of care; safety; quality; use of health information technologies; flexibility; sustainability (e.g. staff turnover, patient/consumer satisfaction); effectiveness; cost-effectiveness; evidence of collaboration; extent to which partnerships in care are being developed; equity; universality.

Aspects of quality that were particularly highlighted in the submissions as important to measure include consumer satisfaction, holistic care, equity of access in relation to need and equity of outcomes and chronic disease risk factor reduction.

Submissions from consumer groups emphasised that consumers have an essential role to play in continuous quality improvement and that obtaining feedback from consumers should be an integral part of the quality improvement process. This is rarely the case for the Australian primary health care system where few mechanisms currently exist for consumer feedback to be effectively utilised to improve health outcomes.

> Health Issues Centre believes there is an important role for consumers and carers in continuous quality improvement (CQI) approaches. Consumer and carer participation in quality improvement should be implemented through establishing meaningful and non-threatening feedback mechanisms for individuals and involvement of consumers and carers in organisational complaints’ management systems.

Several submissions referred to the UK where the establishment of ‘critical friends groups’ between clinicians, practice managers and patients has been shown to improve the overall running of practices. Patient feedback is also utilised to guide clinician training in advanced communication and interpersonal skills development. It was suggested that similar approaches could be useful in the Australian context.

> Experience from the UK suggests system supports can enable practices/services to strengthen their effectiveness through the routine application of validated and evidence based instruments and training to assist both clinicians and services in improving their capacity to improve both the quality of patient experience and health outcomes for the communities they serve...Australia needs to follow suit by establishing its own mechanisms to enhance the interactions between clinicians and health consumers.
**Data systems**

Many submissions highlighted the inadequacies of current primary health care data collection.

...significant investment is required to improve the capacity and quality of recording activity in primary care. Several barriers exist to achieving this at present, not least the variability of clinical software systems in general practice in their ease to record data in a systematic way. We recommend implementation of a minimum set of standards for clinical software systems that would promote simple, systematic recording of healthcare data in practice.²⁴⁸

Many submissions emphasised that it is essential that any additional data collection builds on existing data collection capabilities and does not interfere with practitioners’ capacity to deliver clinical care.

**Pay-for-performance**

The potential for the current PIP to be extended as a funding vehicle, to encourage improvements in quality and safety across the primary health care sector, was highlighted.

...the NPHCP [National Primary Health Care Partnership] supports a blended funding system for primary health care that includes payments that recognise quality improvement activities across members of the multidisciplinary care team. This could extend Practice Incentive Program (PIP) style-payments, currently only available to general practice, to recognise quality improvement in services provided outside general practice by allied health practitioners. This may, for example, acknowledge and incentivise the uptake of eHealth systems.²⁵⁰

At the same time, submissions highlighted the need to proceed with caution. The main concern, mentioned in many submissions, was that perverse incentives could adversely affect patient care and potentially increase health inequalities. It was pointed out that ill-conceived incentive payments may actually deter practitioners from working with consumers who have complex needs or are from disadvantaged backgrounds.

Pay for performance targets...could cause inequality of care for patients and discrimination against practices with the most medically disadvantaged patient populations. Performance targets will actively discriminate against GPs who like to tackle difficult patients and reward those who pick and choose. It may stop GPs working in certain areas or not wanting to see certain patients or not ordering certain tests.²⁵¹

Some submissions highlighted the potential for pay-for-performance incentives to adversely affect the morale of practitioners; the consumer’s right to exercise choice regarding treatment options; and the overall holistic/person-centred approach to primary health care.

Concern was also expressed that the development of performance monitoring systems might take resources away from the provision of direct patient care.

[The Australian Medical Association] would caution against placing benchmarks and performance pay systems and structures above the need for more resources for direct patient care. Performance reporting must be set at the system wide level and be used as an indication of the need for more funding and resources and not used to impose penalties when benchmarks are not achieved. Performance indicators must not encourage perverse incentives that could detrimentally affect patient care.²⁵²
Research and knowledge transfer

Submissions highlight the importance of primary health care being informed by relevant evidence but raise many issues that need to be addressed before this ideal can be realised.

Many submissions emphasise the differences between primary health care research and traditional bio-medical research.

Furthermore, the relatively limited available funding for primary health care research was seen as focusing on general practice and clinical research, rather than health services research or research relevant to the wider primary health care workforce.

... there is very limited investment in primary health care research that does not involve general practice. As a means to improve the targeting of primary health care research, the option of allocating a greater proportion of the available research funds to proactively commissioned research in primary health care will be vital.253

The urgent need to develop a research culture among primary health care practitioners was frequently raised in submissions.

A lack of research skills and training in research methods among current primary health care practitioners was a constant theme in the submissions. This was seen as one of the major barriers to the development of a research culture across primary health care. Other barriers cited were funding constraints and the time available to practitioners.

We need to identify strategies that support healthcare professionals at the coalface to be research literate and also become involved in research. The current funding models of primary care are mainly based on the small business model with financial disincentives to participating in research. GPs often give a great deal of time to research studies and are penalised by loss of income as a result...254

Translating knowledge into practice

It was pointed out that knowledge transfer or translation research is a growing field and that more evidence is becoming available about what is needed to ensure the successful uptake of evidence into practice.

The Australian evidence points to four key elements in the successful uptake of evidence into practice: consultation and engagement of practitioners at all stages of the evidence development, needs assessment in their practice, ability to trial the change in their practice and evaluation and feedback.255

The need to overcome information overload is a key issue for many and clinical practice guidelines were seen as one method for addressing the problem of information overload. However, opinions varied regarding the value of clinical practice guidelines. Submissions also highlighted the need for national guidelines to be customised for local circumstances.

...care needs to be taken to ensure that guidelines are of high quality and that they are implemented effectively. This requires adaptation for a local setting and tailoring evidence based implementation strategies to local factors. However, guidelines will not address all the uncertainties of current clinical practice and should be seen as only one strategy that can help improve the quality of care that clients receive.256
There was widespread support in the submissions for the development of partnerships, networks, linkages and collaborations between academic researchers and practitioners, policy makers and consumers, to assist in translating research findings into practice and nurture research skills.

Some submissions suggested that all primary health care practices should be affiliated with an academic institution and many submissions referred to the Canadian model of academic practices with funded research and teaching time as one that could be considered for adaptation in the Australian context.

Many submissions highlighted the approach taken by the APHCRI as a successful partnership model that could be emulated.

Research models such as that employed by APHCRI support ongoing communication between policy makers and research to help ensure that research is meaningful to policy development and that research outcomes are fed back to policy makers. The expansion of models with a similar aim and outcome to other research institutions should be facilitated by linking their uptake to funding contracts for research institutes.\textsuperscript{257}

Other submissions put forward the NPS model of localised academic detailing, quality education and resource services as successful in assisting to translate research into practice. Some submissions also saw a key role for Divisions of General Practice in encouraging GPs to become involved in research and supporting research projects.

**What is the way forward?**

There are several key issues which come through the various components of this Element. These are:

- the need for policy clarity around what is being measured;
- the need for good quality data to inform quality improvement; and
- that any change in this area needs to deliver real improvements to patients, help health practitioners to do the best job they can, and improve the overall quality of the primary health care sector in Australia.

For this to happen, change needs to be clear and involve minimal compliance costs for all participants.

**Safety and quality**

There is a need for a stronger framework for safety, quality and performance improvement in primary health care to be developed in consultation with consumers and the primary health care professions based on the building blocks identified.

**Accreditation and quality improvement**

Accreditation for primary health care services needs to be streamlined and relevant to the practice in order to simplify the plethora of processes currently in place for different components of service delivery.

In light of the support for comprehensive primary health care services there is also a need for expanded accreditation standards to cater for this expanded service system, including a greater focus on patient outcomes and the requirements for effective integrated multi-disciplinary care.
Performance indicators

There is a need to streamline the existing processes for development of primary health care performance indicators and develop a more strategic approach to quality measurement in primary health care that incorporates national, regional, practice and individual practitioner requirements.

Consumer access to safety, quality and performance information will drive improvements in primary health care services and improved health for individuals, their families and carers.

Reports on primary health care services focusing on issues of particular concern to consumers which are widely available, in formats which are accessible and meaningful to consumers, will be core to meeting the need for this information.

To assist primary health care services, there could be value in developing national guidelines for the development of health reports for the public.

Aspects of patient-centred care are considered in more detail under Element 2.

Data systems

There is a need to develop an agreed minimum data set and data collection methodology for an appropriate national data collection in primary health care that could better inform the development of a systems approach at a later date.

Issues relating to electronic data systems in primary health care are covered in more detail under Element 6.

Pay-for-performance

In developing pay-for-performance incentives, consideration will need to be given to the performance indicators which are within the scope of practitioners to achieve. Incentives can be based on achievement as well as exclusions for non-performance as long as they are based on an agreed set of performance indicator benchmarks.

There may be scope to introduce pay-for-performance through the PIP. However, in recognition of the concerns raised in some submissions, pay-for-performance initiatives would need to be developed in consultation with the professions.

Issues relating to pay-for-performance incentives and the potential for extending the PIP are covered further under Element 10.

Research and knowledge transfer

In the future, it will be important that primary health care research is well placed to inform, and respond to the information needs of, decision makers in primary health care policy and practice. Key directions will need to:

- support a broader, more comprehensive conceptualisation of primary health care;
- develop a systematic approach to setting research priorities that are adaptable and responsive to the changing health environment and emerging issues;
- improve integration and coordination of research efforts; and
- increase engagement and knowledge transfer between researchers, practitioners and policy makers.
In moving forward there is also scope for the NHMRC’s existing structure, support mechanisms, broad networks and funding schemes to include a stronger focus on primary health care. This is recognised by their proposal to make primary health care a central part of their strategic plan which is to commence in January 2010. This would allow for an immediate expansion of Australia’s primary health care research effort through facilitating discussion between a range of health professionals involved in primary health care and effective connection to other forms of clinical and health services research.

**Summary – Key Future Directions**

A National Primary Health Care Strategy provides a key opportunity to establish a strong framework for safety and quality in primary health care in Australia.

Compared to current arrangements, the key building blocks for such a framework could include:

- improved mechanisms for measuring and feedback of service delivery outcomes, consumer experience of primary health care, and greater transparency for consumers on the quality of standards for primary health care services;
- further development of appropriate and affordable accreditation systems and improved participation in quality improvement across primary health care practices with a view to requiring all primary health care practices to be accredited over time;
- progressive development of performance indicators for primary health care building on existing processes at the national, regional and local level and linked as appropriate to performance indicators for other health sectors;
- development of data systems to support collection of data for reflective practice as well as an agreed minimum data set and data collection methodology for an appropriate national data collection in primary health care;
- progressive introduction of pay-for-performance arrangements which are linked to improvement of patient health outcomes to support participation in the framework and continual quality improvement activities; and
- continued development of high quality and relevant primary health care research expertise and evidence base, knowledge exchange between researchers, practitioners and policy makers, and culture of continuous quality improvement across primary health care.
Element 6: Better management of health information, underpinned by efficient and effective use of eHealth

Objective: Consumers and providers benefit from greater sharing and improved access to health information, clinical knowledge resources and emerging technologies to better support patient-centred care.

Key Points

eHealth and other technologies are key enablers for change in primary health care and are integral to the changes proposed under other Elements. eHealth will allow information to be available when and where a patient needs care, reduce the risks of adverse events for consumers and reduce costs.

Electronic information exchange, including electronic health records, will also support multi-disciplinary primary health care collaboration and enable efficient exchange of information between the primary health care, community and specialist health care settings. This would be a significant improvement on the current situation for clinicians and consumers, particularly those with complex or chronic health conditions.

As Australians increasingly access online information and services through mobile and e-technologies, they expect that the health sector will operate as does other sectors, affording them similar access and efficiencies. Consumers expect to be involved and active in their health care management and should have access to tools to enable self-care and assist them to navigate the health system maze effectively.

Consumers and clinicians both seem supportive of eHealth and expect it to be available to them as soon as possible. Currently, the availability and usage of eHealth tools varies considerably across the primary health care sector and other health sectors.

eHealth is a fundamental building block for improvements in patient experience and outcomes in primary health care.

For all consumers, better management of their health information is integral to the safety and quality of their health care. Making relevant health information available electronically when and where it is needed is seen as essential to support change in primary health care services leading to improvements in the quality of care. The availability of clinical information electronically also has the potential to add to workforce productivity and provide economic efficiencies across the primary health care sector. Fundamental is the availability of personal health information such as medications, pathology results and discharge information which will contribute to significant improvements in consumer health outcomes.

Although discussed specifically in this Element, the value of electronic enablement in primary health care is acknowledged across this Report.
Currently in primary health care, an individual’s health record is either paper-based or held in multiple, isolated clinical information systems. Consumers need to remember what has happened to them and when, what tests and treatment they have received and what medication they are on. Not only is this frustrating, it means there is often incomplete information available for their chosen carers, adding to the risks of adverse events for consumers and the costs of their health care. This also creates significant challenges for primary health care providers by increasing the time required to obtain patient information and hampering the efficient communication between providers involved in an individual’s care.

The development and use of nationally compatible eHealth systems, including Individual Electronic Health Records (IEHRs), will support multi-disciplinary primary health care collaboration and enable efficient exchange of information between the primary health care, community and specialist health care settings. It would also allow information to be available when a patient needs care, including after hours, or if seen by someone who is not their regular carer. This would be a significant improvement on the current situation for consumers and clinicians.

For consumers an IEHR means that, over time, their information would be able to travel with them, be seen by them and be available to their chosen health and family carers when and where they need it. This is of particular benefit in primary health care where the vast majority of Australians receive most of their care and especially to people with complex and chronic health conditions whose health is likely to be managed by a variety of health care providers.

Consumers expect access to online health knowledge and self-management tools to assist them to actively participate in their health care and to inform discussions with their providers. Clinicians want additional opportunities for knowledge support and professional education through e-applications. Consumers and clinicians want remotely accessible services such as e-consultation and video case-conferencing. This would be especially valuable in assisting consumers and primary health care clinicians in rural and regional Australia who often have limited access to services. Primary health care business management and reporting can also be improved through electronic infrastructure, giving providers more time for clinical care and/or work/life balance.

While consumers and clinicians appear supportive of eHealth, they would like to have these systems available to them as soon as possible. The key issues to ensure the efficient and effective use of eHealth to support patient-centred primary health care are:

- promoting eHealth across the breadth of the primary health care sector;
- establishing a robust shared electronic health records system to support information availability; and
- supporting consumers to be active in their health care management.

**Where are we now?**

**Promoting eHealth across the breadth of the primary health care sector**

eHealth in primary care requires health care providers to have reliable information and communications technology (ICT) tools, know how to use them and see value in them. Additionally, they need to be able to exchange information within and across organisations.
Availability and usage of ICT varies considerably across the primary health care sector. Although 96% of general practices are computerised in part reflecting the Australian Government’s considerable investment through the PIP, the use of computers for clinical purposes still lags a little behind their use for business purposes. While there are some limited examples of general practices using ICT to analyse data to monitor and plan service delivery, this has raised the issue of data quality and the need for agreed standards.

Although general practice has been assisted to use ICT with training and support programs conducted through the Divisions of General Practice, the ICT capability of other key areas in the primary health care sector is relatively immature.

Community pharmacies are almost completely computerised and connected, with capabilities supporting nearly all of their business and clinical operations. Aged care services are reasonably well connected with basic business capability but very few clinical services. Most allied health service providers have little computing or communication capability.

The story of mixed capability also holds for those areas of the health system with which primary health care regularly interacts. Pathology and radiology services are well advanced and some non-GP specialists use computers to record clinical information but their ability to safely exchange clinical information is limited. Hospitals, both public and private, have a high degree of variability in their ICT capability. Initial work on advancing the ICT capability of the community care sector has resulted in some improvement but it is still limited.

But even with good computerisation at practice levels, information about any individual patient is likely to be held in each provider’s separate system and not available to all of that individual’s carers. This means clinicians are often working blind to important care information, relying on the patient’s ability to remember what happened to them when. Both are frustrating and have the potential to reduce patient safety and increase costs of care.

Chronically ill patients are most likely to suffer the consequences of poor care coordination and transition between care settings. This is because they are required to have multiple contacts with the health care system and often see a range of specialists and primary health care professionals to manage their more complex needs in the course of an acute episode of care. Significant care coordination problems (with high potential for errors and adverse events) are also experienced when patients transition across health sectors or stages of care provision (eg from inpatient to ambulatory care; from acute to long-term care, including residents of aged care services).

A 2005 Commonwealth Fund survey reported:

Table 9: Care coordination in Australia

<table>
<thead>
<tr>
<th>Problem reported in the last two years</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test results or records not available at time of appointment</td>
<td>12</td>
</tr>
<tr>
<td>Duplicate tests: doctor ordered test that had already been done</td>
<td>11</td>
</tr>
<tr>
<td>Percentage who experienced either coordination problem</td>
<td>19</td>
</tr>
</tbody>
</table>

Source: Commonwealth Fund survey, 2005
Building the capability for clinical information exchange between primary health care providers has been driven through locally initiated eHealth solutions and government funded programs. There are some successful regional systems with electronic transfer of referrals, pathology results and hospital discharge summaries, however these are not based on national standards and are not easily scalable to a national level.

**Establishing a robust shared electronic health records system**

Currently in Australia there are approximately 80,000 Australians with some form of shared electronic health record. These people are located around Katherine, western Sydney, the Hunter region and north Brisbane. These specific implementations, resulting from the HealthConnect initiative, have provided important lessons in preparing for a national electronic health record system. The Royal Flying Doctor Service (RFDS) has recently rolled out an electronic medical records system which is available twenty four hours a day, seven days a week.

The National E-Health Transition Authority (NEHTA) foundation work funded by the Council of Australian Governments (COAG) is developing the common language and standards critical to enabling reliable health information exchange across the system. The NEHTA clinical packages’ work programs are focussed on medication management, transfer of images and pathology results, referrals to and discharge and transfer in and out of hospitals, rehabilitation and aged care settings.

Uptake of secure, business-grade broadband is a key foundation for secure clinical information exchange. As a result of the Broadband for Health Program, general practice take up reached 63% while community pharmacy take up reached 96%. The new Practice Incentive Program (PIP) eHealth incentive aims to help improve the security of patient health records by encouraging general practices to adopt a secure electronic messaging capability. There is also work underway by the software industry to develop data interchange standards for general practice.

A national health information regulatory framework is being developed to address the key issue of consistent health information privacy law. This is being addressed through work by all governments in response to the Australian Law Reform Commission’s review of privacy law.

Released in December 2008, the National E-Health Strategy provides an appropriate basis to guide the development of eHealth and proposes the incremental adoption of IEHRs.

**Supporting consumers to be active in their health care management**

Currently consumers are largely responsible for coordinating the sharing of their health information but in most cases have poor or limited access to health information retained by their care provider. As Australians increasingly access online information and services through mobile and e-technologies, they expect that the health sector will operate as does other sectors, affording them similar access and efficiencies.

Commonwealth and state/territory-based resources such as HealthInsight and Better Health Channel, and the COAG investment in the National Health Call Centre Network healthdirect Australia website, provide trusted and reliable sources of online information. The emergence of personal health record systems are increasing consumers’ expectations in relation to recording and storing of personal health data and access to information held in other systems.
All Australians have access to health call centres through either the National Health Call Centre Network or jurisdiction-based services. These services provide nurse-based telephone triage services. There are also some isolated examples of telehealth services which are assisting consumers to access services remotely. These are of value to both consumers and clinicians but are disparate and usually isolated from other clinical information systems. Clinicians are also seeing the value in these technologies for time efficient e-consultation and counselling, professional e-learning and case-conferencing. While there are technical system issues to be addressed, clinicians express frustrations at the current funding barriers they face in progressing this way of providing primary health care.

Consumers have little or no access to information held about them in their health carers’ records. And, while consumers may keep their own records of home monitoring and access online health knowledge resources, there is little opportunity for them to share this with their providers. Their ability to self-manage their conditions, especially those with chronic complex conditions or in areas where workforce is not available locally, is limited by their lack of access to person-centred eHealth tools and electronic health information exchange systems.

There is little or no automatic data extraction currently available in the primary health care setting. Most data collation for reporting and evaluation is still done as a separate administrative function. There are some examples of embedding guidelines and evidence resources into clinical applications but this is not robust and is currently application-dependent. The General Practice Sidebar initiative in South Australia is showing some value across the primary health care team as it applies nationally agreed standards and is clinical application-independent.

**What the submissions said**

Of the 265 submissions received on the Discussion Paper, nearly half provided specific comment on this Element. Consumers and clinicians appear both supportive of eHealth and demanding in their expectations that it be available to them as soon as possible.

*Consumers are supportive of e-health initiatives that will improve health outcomes, improve access to services, develop stronger partnerships and reduce disadvantage.*

*Better management of health Information underpinned by effective use of E Health would be the greatest thing since the stethoscope for better health management.*

*A robust e-health infrastructure would support better care coordination and provide more timely access to available technologies that can deliver better patient outcomes. … True patient centred care requires a comprehensive approach to the development [of] a robust e-health system that supports all aspects of patient care.*

*…the use of eHealth is fundamental to primary health care. Health care professionals require access to information in a timely manner and consumers of care need to know that these professionals have access to this information…*

*The whole area of eHealth is an area which in Australia has been very slow to develop …. It is imperative that the current hurdles impeding progress are addressed so that greater advancement in this crucial area is achieved.*
There was a strong message across submissions that all involved in primary health care, not just GPs, need access to and support with electronic enablement. Consumers want to be involved and their care providers increasingly support this. Organisations want eHealth infrastructure and systems used to support staff competency, consumer safety, new service models and systems monitoring. Submissions were supportive of promoting eHealth use and training across primary health care. The key matters raised in relation to electronic enablement were the:

- need to address variability in infrastructure and workforce capability;
- importance of medication management, knowledge support and recalls, as part of eHealth in primary health care;
- need to ensure support for evaluation, research and monitoring of the primary health care system; and
- need to facilitate new care models which take advantage of ‘e’ (eg tele-medicine and e-consultations) and provide access by different modalities (eg mobile phones and personal digital assistants).

The following are a selection of the submissions which identified the need to support adoption of eHealth across all primary health care professionals and clinical settings.

**Crucial to the full scale introduction of eHealth systems into primary health care is attention to building computer literacy capacity amongst [all] health care professionals.**

**AHPA [Allied Health Professionals of Australia] strongly believes that an integrated and universally accessible electronic record system is imperative to team-based multidisciplinary patient centred care. This would allow for sharing of agreed information with other team members in real time, improving patient care and outcomes.**

**Divisions [of General Practice] are well placed to support other private health care providers, such as allied health professionals and specialists, as these professions become increasingly computerised.**

Many submissions identified the importance of key clinical applications as part of eHealth in primary health care but also raised the need for software standards.

**Effective patient management systems must include recall and reminder systems, preventative and screening practices and clinical decision support tools. Quality data that is clean, accurate and complete can be used for benchmarking, peer review, clinical outcomes assessment and to offer more tailored packages of care.**

**ACT Health would support a universal eHealth record in place for all people registered with Medicare. Health care organisations and health care professionals should be required to comply with national standards to implement the system in a timely way.**

**NPS [National Prescribing Service] has conducted research on the quality of drug interaction support in clinical software and found considerable variability. The lack of national guidelines or standards for pharmaceutical decision support tools is a major contributor to the inconsistencies and limitations in Australian clinical software.**
A national knowledge base for clinicians is needed. The availability of knowledge resources by clinicians is variable in terms of access and the quality of the resources. While most states provide access to knowledge resources in public hospitals there is no national equivalent for community-based health practitioners. A national library of accredited knowledge resources is needed for access and use by all.\textsuperscript{281}

Submissions noted the need to address evaluation, research and monitoring to support the sustainability, efficiency and effectiveness of primary health care.

\textit{Intelligent use of data generated by e-health systems will also enable better research on the effectiveness of health care interventions for individual patients, at a practice or community level and at a whole of population level.} \textsuperscript{282}

\textit{Systems need to be designed which can incorporate monitoring and data collection functions for the range of professional groups using the system to allow for expanded clinical and quality audits and to contribute to research in the area of primary care.} \textsuperscript{283}

\textit{[There is a need for additional] discussion of better use of health information, particularly in terms of policy/program analyses, or statistical uses, of the data for monitoring, reporting and evaluation purposes, and with which to form health policy and undertake service planning. Such data are also essential to enable assessment of whether primary health care is financially sustainable, efficient and cost effective (Element 10).} \textsuperscript{284}

Many submissions noted the opportunity for education support and new service delivery methods in primary health care through electronic enablement.

\textit{Rural Australia in particular stands to benefit from e-health in a number of ways… [including] through its potential contribution to professional development, peer support and decision tools that assist all health professionals in their work.} \textsuperscript{285}

\textit{Professionals and consumers require education regarding the potential role of technology in the provision of health care and an understanding that quality care may be available through means other than just face to face contact. At the same time however, it is imperative that due consideration be given … to the ethical and logistical challenges that will inevitably arise through the use of telehealth and e-technology.} \textsuperscript{286}

\textit{We believe that e-health has many potential applications in the remote context, including videoconferencing, remote patient monitoring and use of the internet to facilitate access to information, thereby increasing health literacy.} \textsuperscript{287}

Submissions strongly supported the introduction of a shared electronic health records system. There was a strong thread in submissions that not only should consumers have access to their records, the record itself should be designed to be person-centred. Submissions were generally clear that establishing a national IEHR for Australia should be a high priority for governments. The key matters raised were:

- a high level of acceptance for a national electronic records system;
- the imperative to make it happen;
- to provide access for consumers not just clinicians; and
- support for progressive rollout – delivering value along the way.
The sharing of information on the individual electronic health record between health professionals is an essential contributor to the benefits that will flow from an IEHR. The sharing of that information with the consumer is as critical to deriving the enormous benefits as sharing between health professionals. Access to the shared record and the data it contains is a strong matter of principle for health care consumers. The details of how and what and how data can be varied are all details for negotiation further down the track – the critical element is the consumer access to the data.

ACCHSs [Aboriginal Community Controlled Health Services] have been early adopters of the use of electronic health records. The main ongoing problem is that of information-sharing across health systems.

For general practice nurses who play a key role in initial assessment, chronic disease management and coordination of patient care, access to an electronic health record is essential. For patients to have access and ownership of that record is very congruent with the partnership approach to care in nursing and we strongly support such an enabling resource for patients.

Privacy must be a central feature of an IT strategy as required by law. Consumers, communities and general practices need to have trust in the system before it can be successfully and widely embraced.

The [Pharmacy] Guild supports ... The need to implement eHealth systems to support the secure use and transfer of health information. ...Community pharmacy is ready to embrace a wider use of eHealth to enhance community pharmacy between health professionals.

[While supportive of IEHRs that provides information] to an authorised healthcare provider to whom the individual gives permission, .... [the Network does] not consider there is sufficient protection in any IEHR, whether this is opt in plus the ability to withhold information, to obviate the need for the sensitivity label. Many of us would want to have an IEHR for all the benefits this would provide, but need to be very assured that any information about our mental illness would be quarantined if that was determined by us.

Submissions made it obvious that consumers expect to be involved and active in their health care management, and should have access to tools to enable self-care and assist them to navigate the health system maze effectively. They want their providers well informed and care options to be well researched and cost-effective. Providers not only want to improve the information flows about their patients with each other across multi-disciplinary teams to improve the health outcomes for consumers, they also want to be able to communicate more effectively with their patients, and many put forward electronic service delivery as a way of helping this happen.

The effectiveness of e-health will be greatly influenced by consumers’ ability to understand and make decisions on the information available. This will be dependant to a large extent on improved health literacy and education of health consumers; improved information flows, including explanations, between consumers and practitioners; and the readiness, willingness and ability of health care agencies and health care professionals to listen to and consult with health consumers.

A valuable benefit that should flow from eHealth is the strengthening of the information base available to consumers, that can inform the consumer and their carers, and empower them in discussions with health professionals.
Understanding that [an IEHR is a] major initiative [which] will take some time to come into effect, consumers would like the following e-health initiatives to be pursued now: electronic medication lists; electronic save my life data; electronic discharge summaries, and information to help consumers navigate Australia’s health system… CHF [Consumers Health Forum] has developed ‘Consumers and E-health project principles’ that reflect consumer needs and expectations in this area.295

The development of a web based information system similar to that used in the United Kingdom (NHS Direct) that provides authoritative health information and advice on navigating the health system would enhance the individuals’ knowledge of, and ability to, interact with the health system. This facilitates personal responsibility, and with a limited impact on health system capacity.296

Web-based information allows health care professionals to direct clients to particular sites for information, either through use of computers set up in the primary health care facilities or to refer to at home.297

Consumers need access to appropriate resources to support their journey through the health system, including shared electronic health records and appropriate knowledge and resources to support decision-making.298

eHealth… permits health care organisations to… provide patients with access to their own health information to assist them to understand their medical treatment…[and] provide patients with access to the same health record as their participating healthcare providers, thus supporting collaborative care…299

What is the way forward?

The National E-Health Strategy, endorsed by Health Ministers in December 2008, provides a framework to take this work forward. It emphasises the need for engaging all stakeholders to support the uptake and continuance of eHealth solutions that improve consumer access, health outcome quality, and primary health care workforce productivity and economic efficiency. While there are important key foundations and infrastructure being developed through NEHTA on identifiers, terminology and standards, building on these foundations to support the better use of health information in primary health care requires a number of streams of work to be advanced. These include:

- Getting key eHealth infrastructure in place across primary health care. Specifically there needs to be attention given to increasing the use of electronic enabled clinical tools and solutions while acknowledging the ongoing participation costs for primary health care providers.

- Building the capacity of the primary health care workforce to use electronic health information as part of their clinical practice. This needs to be provided through health training and ongoing professional development programs to address basic computing and general health information skills. Health care organisations will need to provide application-specific training relevant to the systems in use in the workplace.

- Developing and delivering clinical applications that are of high value and priority for primary health care clinicians and supporting emerging models of primary health care service delivery, eg through telehealth.
• Providing safe and secure information exchange in primary health care and connection across sectors to support referrals to and transfer in and out of hospitals, rehabilitation and aged care settings. While the work of the NEHTA on foundational infrastructure is important, adoption of standardised secure messaging and authentication services by provider organisations is the key. Areas requiring further work in the primary health care sector include allied health, community care and aged care services. Outside primary health care, the messaging capability of non-GP specialists and hospitals also requires further work to strengthen communication across sectors.

• Enabling primary health care monitoring, planning, research and evaluation through use of electronic systems to collect and aggregate health data. This will need to be supported through improvements in data quality and also in establishing robust privacy protections.

• Ensuring privacy of personal information while allowing the health care benefits that can be gained through better sharing of health information.

Acknowledging that any national electronic health records system will take time to implement, primary health care will benefit from incremental steps which provide opportunities for the exchange of information both among themselves and with the acute sector. The introduction of scalable and nationally interoperable eHealth solutions including ePrescribing, eReferrals, eCare Plans and electronic test ordering and results capacity will be important to primary health care providers and their patients. This will help prepare the way for a national IEHR by embedding clinical terminologies, providing secure messaging capability and supporting clinicians to use electronic work practices. It will also need to be supported by the implementation of national identifiers, robust security and authentication models, and appropriate regulatory requirements.

As primary health care is a key point of access to health care for Australians, it is important to ensure primary health care providers are supported and ready to embrace an IEHR system. To achieve this, work will need to continue on laying the foundations for its adoption by primary health care providers.

While it is envisaged that consumers will have access to their records, consumers will also need support to understand, amongst other things, what a national electronic records system will offer them, how they can access it and how they can authorise their carers to participate. The primary health care setting is likely to play an active role in this education and support process for most Australians.

The National Health Call Centre Network provides opportunities to support consumers in being more active in their health care management. For example, the healthdirect Australia website could be used as a national web platform to provide access to a range of creative e-tools constructed to encourage consumers to self-assess their health, plan and join self-managed health improvement programs including life coaching, self monitoring or personal response monitoring. This would be similar to the progression of National Health Service (NHS) Direct in the UK which has evolved from the original health call centre concept into a full consumer-centric health delivery service, providing an interactive website, health information channel on digital television, printable self-help guides and an online enquiry service.
Summary – Key Findings and Directions

A National Primary Health Care Strategy will provide the opportunity to facilitate better health information availability and management to support patient-centred care. Key steps include the need to:

- identify the priority eHealth solutions, knowledge support and service delivery tools that will improve consumer access, health outcome quality, and primary health care workforce productivity and economic efficiency;
- encourage uptake and availability of eHealth tools and support the associated change management required across the primary health care sector;
- ensure the scalability and standards of eHealth solutions in primary health care meet the national requirements for interoperability;
- enable the secure and reliable exchange of health information electronically across the primary health care sector and key care interfaces with other sectors; and
- support consumers to access their own electronic health records, accredited online health knowledge sources and e-resources which assist them in being active partners in their primary health care management.
Element 7: **Flexibility to best respond to local community needs and circumstances through sustainable and efficient operational models**

Objective: Primary health care services in Australia operate with an accountability and governance framework which is responsive to local needs, and is sustainable, flexible and well-integrated with other non-health services in local communities.

**Key Points**

Over time, Australia’s primary health care system has become increasingly complex, currently comprising a range of governance and financing mechanisms that can be difficult for patients and providers to navigate. This has led to duplication of services, wastage of effort and resources, as well as gaps and underservicing. The system has little flexibility in being able to respond effectively and efficiently to localised needs and priorities.

The establishment of strong Regional Primary Health Care Organisations is one way to address these issues. The potential benefits of regionally-based organisations include:

- reducing the overall complexity and fragmentation in current arrangements for patients, providers and health sectors;
- building and strengthening service networks and referral pathways across the providers and services in an area to deliver more comprehensive and integrated care to individuals, their families and carers; and
- facilitating change in, and improved planning and monitoring of, local service delivery to better address local level health issues and gaps.

One of the main features raised in discussion around Regional Primary Health Care Organisations is the role that targeted fund-holding might play, particularly in terms of the potential for pooling funds from a range of existing narrow programs to increase the efficiency and effectiveness of programs and improving the responsiveness of the primary health care system to better meet the needs and circumstances of different regions.

While there are already existing Commonwealth and state/territory-funded regional health organisations, there have been limits to how far organisations can play a role in the broader primary care system due to the variance in their sizes, funding systems, performance and function in their roles, governance arrangements and membership.

A new structure of Regional Primary Health Care Organisations needs to consider a range of issues, including administrative efficiency, the governance and other performance and accountability structures under which such organisations would operate, funding arrangements and the implications for existing regional organisations. Such a change would need to be well planned and developed in close consultation with the community.
The priority issues, identified through the Discussion Paper, and confirmed through stakeholder feedback, are the need to:

- enhance the capacity and responsiveness of regional organisations; and
- improve service planning to meet local needs and circumstances, particularly in terms of integration of services.

Underpinning Element 7 is the idea of a future primary health care system which works more closely with local communities, including non-health services where relevant, to effectively plan, target and deliver primary health care services which are responsive to the needs and priorities of their local community.

**Where are we now?**

As discussed throughout this Report, primary health care in Australia is characterised by a mix of service delivery and funding models through investment from the Australian and state/territory governments and private arrangements, which has resulted in an often times fragmented and complex system – which is perceived as chaotic and uncoordinated. This is also the case for regional health infrastructure.

From a Commonwealth perspective, investment in regional infrastructure has been through the Australian Divisions of General Practice, which is comprised of the Australian General Practice Network (AGPN), 111 individual regionally-based Divisions (each with their own board of governance) and 8 State Based Organisations. The Divisions have been relatively successful in bringing together general practitioners as a group, as it is estimated that around 90% of the total GP population are members of the Divisions Network. Such coverage of one of the key health professional groups in the primary health care sector would seem to place the Divisions Network in an ideal position to be heavily involved in any introduction or expansion of the role of regional organisations in service planning and delivery. However, as highlighted earlier in this report, primary health care is about more than services delivered by GPs – and is constantly evolving. While some Divisions have been highly successful in improving the provision of general practice services and localised initiatives, they focus on and are generally run by GPs.

The role of Divisions within the primary health care system is further complicated by activities undertaken by state/territory-funded regional health services and community health services. While some of these services have strong links with the local Division, it is more often the case that activities are undertaken exclusive of each other. This is despite the fact that programs will often target similar issues within the primary health care sector – although to different groups of providers, which may be driving a further gap between health professionals delivering the most integrated and coordinated services to a patient.

It has been suggested that one of the ways of improving the level of coordination and integration of primary health care service delivery is to establish broad regional infrastructure, responsible for a wide range of primary health care services in a region (not isolated to either Commonwealth or state/territory-funded services). The responsibilities of such organisations could range from planning and coordinating services to allocating resources for health service delivery. Ideally, such organisations would be well placed to ensure the types of services being delivered were appropriate, necessary
and delivered as effectively as possible, while allowing for local flexibility. The governance of these structures would need to be responsive and accountable to the local community for the health services delivered in their region, and could include representation of patients and providers.

What the submissions said

Box 4: Overview – response to selected Discussion Paper questions

Question: What advantages/disadvantages would there be if regional organisations were responsible for purchasing some primary health care services for their communities, that is, should they ‘hold funding’ for health services? (p.33 Discussion Paper)

There were 48 responses to this issue and these held mixed views on the advantages and disadvantages of regional fund-holding. The Divisions of General Practice were evenly split in their views. The benefits mentioned by submissions included a better ability to target local needs and a reduction in duplication of services. However, there were also a number of problems identified including bureaucracy, rationing of funds, the need for funder/provider split and that this structure would not be ideal for an Indigenous population. Some suggested that regional organisations could operate alongside MBS and others suggested the consideration of a new type of Regional Primary Health Care Organisation structure. It was suggested that a staged introduction be considered if this mode proves its value.

Many submissions commented on the need to streamline the current planning, resource allocation, funding and monitoring systems between the different tiers of government and providers. Such observations essentially confirmed and acknowledged the widespread duplication and wastage of effort inherent in the current fragmented primary health care system which the Draft Strategy seeks to improve.

There are simply service and cost inefficiencies inherent in all tiers of government that must not be further entrenched – it is not just health services that need to strive for efficiency gains.\textsuperscript{300}

Successfully coordinated and effective planning and delivery mechanisms are lacking in Australia due in part to fragmentation and different agenda of the various stakeholders.\textsuperscript{301}

Regional organisational structures

A common theme raised in submissions related to regional organisations. Submissions were generally supportive of the idea behind the need for some type of regionally-based structure, or meso-level organisation, to bridge the gap between national planning and policy directions and local needs and circumstances. Such commentary regularly included an examination of international health systems that utilise such structures and organisations, and their applicability to the Australian primary health care system.
Evidence from recent systematic reviews suggests that regional mid-level PHC [primary health care] organisational structures such as Primary Care Organisations (PCOs) in New Zealand and England can play an important role in the planning, development, delivery and organisation of PHC services. The devolution of responsibility to PCOs for contracting/commissioning the full range of PHC services gives them the required leverage to influence the range and availability of PHC services.\(^{302}\)

The involvement of well resourced and appropriately auspiced regional organisations were seen as having an important role in enabling greater involvement of communities and consumers in the planning process of health services as well as providing a greater capacity to address the social determinants of health and greater equity of access. It was noted that such organisations may also assist in maximising efficiencies in service delivery and avoiding duplication as well as increasing the capacity for population-based approaches to health priorities.

It should be noted, however, that while the establishment of regional organisations was viewed as having potential advantages, concern was also raised that their widespread introduction might also generate additional layers of bureaucracy and red tape, thereby exacerbating the very problems they are being established to address.

Having been involved in the failed regionalisation of health in Queensland we have some concerns about another roll-out of regionalisation. There is a risk of wasteful duplication of administration and insufficient funds for actual service delivery as each region builds their own structures. The economies of scale, population characteristics, and adequate funding of the regions are critical factors.\(^{303}\)

Opinions were also divided as to whether existing organisations could effectively take on the roles and functions that would be expected and required of Regional Primary Health Care Organisations.

Presently there are no organisations that could effectively undertake responsibility for planning and delivery of health care services. State area health boards and regions would claim to do so however the constant restructuring of such bodies indicates shortcomings with the ability to plan and deliver new services.\(^{304}\)

The challenges facing regional level organisations are multi-faceted, and should not be underestimated. The current proposals of a regional organisational structure, with responsibilities for primary care services, are not achievable at this stage due to insufficient information and data on the prevalence of disease and health outcomes within each given community.\(^{305}\)

As already indicated, one such existing organisation that may have the potential (albeit with significant restructuring) to take on additional responsibilities envisaged of Regional Primary Health Care Organisations is the Australian Divisions of General Practice Network. In their submission to the development of the Strategy, the AGPN identified that:

All Divisions could contribute to a regional enterprise with different levels of involvement:

- Become the regional enterprise with broader representation and responsibilities.
- Act as one of several voices at the table of these new organisations or of existing regional structures which expand their roles and responsibilities.
- Sit beneath these new organisations as service providers which operate in a contestable environment, competing for funds held by these new regional enterprises.
The Network goes on to say that: `the Divisions’ Networks preferred outcome is for high capacity divisions to evolve into regional enterprises and then work with other divisions and relevant organisations within their region’. 306

Interestingly, there are differing views between individual Divisions and the AGPN on this issue. Almost half the individual Divisions made submissions on the Discussion Paper and they were evenly split for and against the concept of Regional Primary Health Care Organisations.

The content and views presented in submissions diverged further when it came to the role that fund-holding or fund-pooling could theoretically play (or in some circumstances is already playing) in such organisations to better meet localised health service needs.

The principle of having regional level bodies who can pool the funds available for primary care is supported. We believe that the above sources of funding – to GPs and Practices need to continue through the current Medicare system. Other activities funded through different government sources – state, federal and local would be better pooled, managed locally according to local needs and resources.307

North and West Queensland Primary Health Care for example has [already] pooled funds from a variety of sources to employ 75 primary health care professionals, including dietitians, psychologists, occupational therapists and a pharmacist, to address the needs of a dispersed population with limited primary health care access.308

That is not to say that fund-holding and fund-pooling are not without risk, particularly when proposals involving cashing out (or even ‘cashing up’) of the MBS are involved to the point where the very idea was presented as too risky for government to contemplate and should be dismissed.

Possible disadvantages could include fragmentation of the health system from a national perspective due to regional variation, difficulty in measuring (especially at national level) their outcomes when models differ from region to region, and rationing of services in order to fit within budgets.309

Fund holding would be appropriate but only once the organisation has proved itself to be accountable and effective, in terms of its advocacy and responsiveness to community health needs.310

Though pooling resources may appear attractive at a superficial level, there is a high potential for distortion and conflict of interest in a small market for health services where the funds available may be insufficient to provide quality care across the region.311

While some submissions viewed the existing Divisions Network as the obvious leverage point for a broader role in localised health planning and primary health care service delivery, others raised issues around the inherent conflict of interest in the current Divisions’ structure (ie they generally represent one component of the primary health care sector and operate without representative community governance). Concerns were also raised around the disparity in effectiveness of some Divisions, that business and operational processes are well entrenched across the Network, and that achieving fundamental culture and attitudinal change would be unlikely.

Irrespective of the potential benefits that might be delivered from the establishment of new organisations or by expanding the role and focus of existing organisations and networks, there was no clear prevailing view across the submissions as to the best way forward. Furthermore, where
Regional Primary Health Care Organisations were discussed, concerns (and accompanying opinions and viewpoints) emerged including high level issues around the perceived benefits, boundaries and size of organisations, to specific models including governance structures and how to appropriately resource any such organisations to meet localised needs. In terms of the submissions, stakeholders agreed that a ‘one size fits all’ model is no longer appropriate for the primary health care sector and that jurisdictional issues need to be recognised and accounted for.

**What is the way forward?**

Table 10 illustrates some of the range of possible approaches to Regional Primary Health Care Organisations which have been canvassed.
Table 10: Alternative models for primary health care regional organisations

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<th>Model</th>
<th>Description</th>
<th>Possible functions</th>
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| Enhanced regional partnerships | Collaborative (MOU) arrangement of existing service delivery and regional organisations. | • monitoring and reporting of local health outcomes  
• planning and coordination of services among members of partnership  
• delivery of supplementary services through some members of partnership | Similar to existing PCPs and CHIC models                                                                         |
| Separately constituted organisations | …with incremental service planning and purchase responsibility | • monitoring and reporting of local health outcomes  
• planning and coordination of local services within funding scope  
• intervention into local service delivery where needed  
• fund-holder for some local primary health care services  
• advocate for local area to funding providers  
• peer support and education (based on evidence/data) | A number of governance issues would need to be addressed including:  
• legal structure of new collaborations or organisations;  
• the relationship between the regional organisations and local service providers; and  
• the level of control and accountability of the organisations.  
It would also need to be decided whether funding and accountability for these organisations will be to the Commonwealth, state level or joint. |
| Regional Primary Health Care Organisation | … with pooling and consolidation of existing program streams | As above, with additional levels of responsibility due to increased funds. Also, there would be increased accountability to ensure funds are being allocated appropriately. |                                                                                              |
|                               | … with all non MBS/ PBS funding allocated on a ‘needs based’ capitation formula | As above, with an increased need to represent the needs of the region to funding providers and to manage funds responsibly. |                                                                                              |
|                               | … with the responsibility for all primary health care (including MBS/PBS) funding | As above, with a significant increase in the level of funding provided. Monitoring and reporting standards would need to be established and maintained by the regional organisation to ensure the regional management of funds results in improved health outcomes. |                                                                                              |

NB: The highest level of reform would see the development of Regional Health Care Organisations – separately constituted organisations with service planning and purchasing responsibility for all health services.
Existing regional infrastructure organisations

In considering the introduction of integrated Regional Primary Health Care Organisations there must also be an examination of what jurisdictions and existing organisations are already doing and what are the lessons learned. In order to truly maximise efficiencies, there will need to be national consistency in many areas, while also providing flexibility for jurisdictional variances in others acknowledging the different pressures and issues faced by communities across the country in relation to primary health care. Importantly, the administrative costs associated with any new structures will need to be carefully monitored and minimised, to ensure service delivery funding is not diverted to administrative overheads.

Any reform in the way regional organisations might build local flexibility and integration in the delivery of primary health care, including governance arrangements, would need to carefully consider the future role of the Divisions Network.

The AGPN has acknowledged that the Divisions’ Network currently lacks the capacity and expertise to immediately take on a broader regional governance role. They advise that they are keen to ‘step up’, believing the Network has the capability of transitioning into this expanded role. However, issues of how such a transition might occur in practical terms are of concern, particularly in terms of change management, governance, performance, and current geographic boundaries.

State and territory views on this issue, in addition to their existing relationships with and engagement of Divisions, is also variable and is an essential consideration.

A key step in the consultation and planning process for Regional Primary Health Care Organisations would be to ensure that new models do not simply introduce an artificial structure on top of existing structures, thereby further complicating funding and service delivery models.

Size and coverage of Regional Primary Health Care Organisations

Any new regional organisational entities would need to have explicit responsibility for clearly defined populations, though there are divergent views on how large a population might be appropriate, with estimates ranging from 300,000 to 1 million people. The size of the population covered by each new Regional Primary Health Care Organisation needs to be carefully considered across both numeric and geographical proportions to ensure a balance is struck between:

- being large enough for the organisation to assume responsibility for the majority of health risks (particularly important if the organisation was to take on a service purchasing role); and
- being so big that an organisation risks losing its clarity of purpose, is unavailable (through distance) to constituent practices and is unable to effectively engage health care practitioners in meeting organisational goals.

A further consideration is that size and coverage of Regional Primary Health Care Organisations would need to be able to adapt to future needs and pressures as a result of population and demographic shifts, and changing clinical practice and service delivery challenges, within their boundaries.
Fund-holding/pooling

The suggestion of introducing fund-holding and funds-pooling across sectors and providers under Regional Primary Health Care Organisations is a further possible area for reform.

For fund-holding organisations to have sufficient purchasing and service delivery power, pooled funds generally comprise prospective and aggregated averaged payments or capitation arrangements in respect of enrolled individuals. The largest and most available funding sources within the primary health care sector are the MBS and PBS, but opening these structures up to fund-holding and fund-pooling (for enrolled populations) pose some risks.

For example, one of the potential uses of fund-holding/pooling through Regional Primary Health Care Organisations is potentially through targeting the management of patients with chronic and complex conditions by providing highly integrated funding and service delivery pathways for patients electing to enrol under such a program. Such a model has the potential to improve the level of access to funding for currently underserviced populations – but also risks exceeding allocated funding.

Arrangements such as these are far removed from the current model of a universal health insurance scheme, where there is a relatively good level of understanding and high levels of support across the community. The introduction of such arrangements may therefore be considered controversial, and will require considerable development and discussion in consultation with the community to explore their potential benefits, as well as ensure that targeting and governance is effective in improving health outcomes.

There are, of course, many other primary health care programs and elements of the MBS where funds could potentially be accessed, such as the Practice Incentives Program (including Service Incentive Payments) and the MBS Chronic Disease Management items, as well as from various programs and projects that involve both Commonwealth and state/territory investment. However, it is not clear whether the funding allocated under these programs would provide the necessary capital and capacity for organisations to be effective in meeting their aims.

These issues require careful consideration in consultation with the community, noting the strong potential benefits for at-risk or high needs patients to be able to access regionally organised and delivered services responsible for their ongoing care.

Concerns have been raised that fund-holding could disadvantage patients and providers, particularly if patients’ access to health care according to need is undermined or rationed and the professional autonomy of individual doctors is limited. Regional purchasers would need to have continuing close contact with relevant health care providers and community organisations to ensure that purchasing of services is well targeted and responsive to regional requirements. This would be further complicated if the regional organisation was to have no responsibility for the hospital and acute sector in their area as more careful management of the patient in the transition between care settings (home to hospital, hospital to aged care facility, etc) needs to be an essential component of the health system particularly in terms of team-based care arrangements.
Governance

The introduction or enhancement of strong regional organisations in primary health care is not a ‘silver bullet’. The same inherent risks around perverse incentives are still likely to exist and would need to be carefully monitored and addressed. Such risks include:

- under-servicing of the patient population if the fund-holder benefits from underspends in budget;
- over-provision of services to low severity individuals; and
- under-provision of services to individuals with the most complex needs, ie potential to discriminate against high cost users.

In addition, there are issues relating to governance (particularly community involvement, liability/indemnity, information/data management and the quality of care) that would need to be assessed and addressed.

Improving integration and planning of service delivery

Alongside the Divisions’ Network, there are a number of emerging models of integrated service planning, development and delivery that rely on better integration and partnership arrangements at the regional level (such as Primary Care Partnerships) that are worthy of consideration and perhaps could also be the base for future regional primary health care development. Over recent years, a range of measures have been introduced, aimed at addressing the current system fragmentation, lack of integration and impacts this has on patient experience and outcomes:

- Australian Better Health Initiative Primary Care Integration Program, Primary Care Partnerships and the Connecting Healthcare in Communities initiatives have focused on improving networks and information sharing and care protocols (including some standardising of assessment – for example, the Primary Care Partnerships initiative has successfully implemented a single suite of tools used by over 500 agencies) between different providers at the regional level.
- GP Super Clinics and NSW Health One initiatives are focused on an integrated service model which encompasses clinical, functional and administrative integration of a range of services and service providers including GPs, nurses, allied health providers and community health.
- Clinical networks activities, for example in WA where 18 clinical networks currently operate including the recently formed Primary Care Health Network.

Internationally, there is a move to building networks and formalising partnerships between health care providers to enable the delivery of more comprehensive and integrated care, and to support greater continuity of care over the life-course. Health care professionals are also recognising the value of working more closely with their peers.

When many health professionals are involved in a particular patient’s care, the issue of who is responsible for clinical management and/or coordinating the care can lead to either conflicting information being provided to patients or, in some instances, no-one taking responsibility.

To address this issue, internationally there has been a shift towards increased collaboration and integration between providers including establishing networks of doctors, integrated medical groups or integrated networks in which ambulatory practice groups are often linked to a hospital.
The reorganisation of primary health care services into ‘networks of care’ has potential to transform services to provide more integrated care. The provision of integrated care requires general practices, allied health services, community health, specialist providers, hospital outpatient departments, consumer organisations, self-help groups, social supports and the community sector to form effective long-term working relationships focussed on providing patient-centred care to their communities. Formalising networks has potential to build and enhance long-term relationships and communication amongst these groups. Individuals, their families and carers are also more likely to take up services if comprehensive or better integrated care is offered.

The Draft Strategy has identified this as a potential area for reform. In order to be truly effective, it is important for all parties involved to come to a common understanding and agreement on how such structures might be most effective and reduce risk (including financial) as far as possible. A staged approach to dealing with this issue including a rigorous and comprehensive planning process and community consultation on design and implementation is needed to move forward. As a first step, the future role of, and related changes to, the Divisions’ Network needs to be a consideration.

Summary – Key Future Directions

A National Primary Health Care Strategy will provide the opportunity for new organisational and governance structures for primary health care, including the potential for comprehensive Regional Primary Health Care Organisations to:

- support collaboration and integration between service providers at the local level;
- undertake service planning and monitoring, to drive improvements in patient outcomes; and
- enable delivery of supplementary programs to address service gaps.

As a fundamental change to primary health care delivery, implementation would need to take place in close consultation with the community.
Elements 8/9: Working environments and conditions which attract, support and retain the workforce, and high quality education and training arrangements for both the new and existing workforce

Objectives: Primary health care professionals work in environments which support a team-based approach and a work/life balance, with conditions that attract, support and retain a strong local workforce.

The current and future primary health care workforce is provided with high quality education (undergraduate, postgraduate, vocational and continuing) and clinical training opportunities that support inter-disciplinary learning.

Key Points
While there has generally been growth and positive development in overall primary health care workforce capacity, distributional problems prevail. Attracting and retaining primary health care professionals to work in some parts of Australia remains a key challenge. Using the existing workforce more effectively, maximising the scope of practice in which practitioners can safely practice and examining alternative models of service provision are possible solutions to help tackle workforce supply and demand issues.

At the same time, Australians’ health care needs and the service systems designed to deal with them have shifted markedly in recent decades. There is an increasing focus on keeping patients well rather than treating ill-health, and recognition of the value that integrated, multi-disciplinary care can bring to preventive health and management of chronic disease. In addition, the changing nature of clinical practice and advances in technology has meant that community-based services have grown in scope and complexity. Despite this, many practices lack the infrastructure to facilitate teamwork in these areas and the workforce continues to operate on a fairly traditional basis, unable to easily adapt to new challenges.

In terms of clinical education and training of health professionals, there is a relative lack of inter-disciplinary learning opportunities, or horizontal integration of curriculum. In addition, there is still a heavy focus on preparing primary health care students to work in hospitals which does not encourage or prepare them to work in the primary health care setting should they choose this career path.
Improvement of the current primary health care system, to meet the health needs of all Australians, including those living in rural and remote areas, in disadvantaged communities and in metropolitan and outer urban areas, can only be enabled through developing and sustaining the current and future health workforce. To do this means addressing key issues facing the workforce, assisting those who are part of it, and optimising their use.

Priority issues identified through the Discussion Paper in relation to the primary health care workforce, and confirmed through stakeholder feedback, are:

- the need to address workforce distribution issues including attracting and retaining the existing workforce;
- enabling health professionals to use their skills, training and knowledge to their full potential, through possibly expanding current roles and responsibilities/scope of practice or introducing new professions;
- supporting teamwork and alternative models of care (such as co-located, walk-in/walk-out, hub and spoke and/or virtually-integrated service structures) where appropriate; and
- putting in place clinical education and training opportunities that will adequately and appropriately equip new graduates, including a focus on community-based clinical training and inter-disciplinary learning.

Where are we now?

**Workforce distribution, attraction and retention of the workforce**

A well distributed, appropriately trained workforce needs to underpin the future primary health care system and arrangements. As noted under Element 1, this has a direct impact on the availability of services, and patient access to these services.

In order to improve distribution of the primary health care workforce, it is essential to ensure that there is an adequate workforce supply. This supply is met through sufficient numbers of medical and health students moving into and through primary health care streams within the tertiary education system, vocational training sector and clinical training systems. But as noted under Element 1, the current health workforce is poorly distributed resulting in a shortage of health professionals in some rural and remote areas, a challenge that has faced Australia for more than forty years.313

The decisions made by GPs on where to establish their private business and how they interact with their client groups are likely to be at least partly influenced by the need to ensure the financial viability of their businesses, in turn reflecting population distribution and ability to pay for care. This has contributed to a mal-distribution in the GP workforce, where the majority of services are not necessarily located where the need is greatest.

Of the approximate 21,250 nurses currently working in Australia, this workforce appears to be relatively evenly distributed across the country, yet there are still variations across jurisdictions.314

The supply of other health professionals such as dental practitioners, as a ratio of professional to population, is low to poor in rural and regional areas.315 This disparity relates to dentists and equally to other dental health professionals, including dental therapists, hygienists, prosthodontists and dental assistants, among others. Most dental care and the workforce who provide it work privately and in
metropolitan settings. Access to public dental health care is constrained by the relatively small public sector dental workforce and their reliance on generally metropolitan-based infrastructure. Given the implications dental health has for people's broader health outcomes, improving access to affordable and timely dental health care would address a substantial gap in primary health care coverage.

The *Report on the Audit of Health Workforce in Regional and Rural Australia* identifies that allied health professionals (which includes pharmacists in this Report) are also mostly based in major cities. An analysis of census data regarding allied health professionals demonstrated that people living in outer regional centres have access to only about half as many allied health professionals as people living in metropolitan centres.

It is widely acknowledged that distribution problems can stem from difficulties in attracting health professionals to work in rural and remote areas and getting them to remain there. Research indicates that it is the total employment experience including non-remunerative benefits and not salary alone that impact on recruitment and retention. For primary health care professionals working in rural and remote Australia, key challenges can include:

- the inability to take leave;
- limited availability and cost of locums;
- social isolation and lack of inter-professional support;
- lack of employment opportunities for partners, particularly where the non-health professional partner is male;
- limited training and education, mentoring and career development opportunities – this includes lack of access to face-to-face Continuing Professional Development (CPD) which is often costly and inconveniently located; and
- lack of appropriate/stable remuneration.

Other issues that are generally more relevant to GPs include:

- high patient volume;
- lack of access to specialists and other support services; and
- lower remuneration levels compared to other medical specialties.

As the proportion of Australian graduates entering general practice has declined, there is an increasing reliance on International Medical Graduates (IMGs), previously referred to as Overseas Trained Doctors. IMGs currently constitute 41 per cent of doctors working in rural and remote Australia. In terms of those working in Aboriginal Medical Services, IMGs make up 38 per cent of the workforce, which means that they are a significantly represented group of health workers among hard to service populations. There has been criticism about whether there has been sufficient support and recognition of the training needs of IMGs in Australia. Particular issues identified as affecting their long term retention in rural and remote areas, once their service obligations are completed, include the lack of:

- acknowledgement of their status as a doctor, long-term career planning, training opportunities;
- orientation to the Australian health care system, cultural mentoring and briefing about working in Australia and with different communities;
• recognition by the Australian medical accreditation organisations of prior education and training and work experience.324

In addition to the issues noted above, other factors which influence the attraction and retention of nurses in general practice, particularly in rural and remote general practice areas, include:

• lack of career opportunities and a career structure;
• inability to use nursing skills to full potential;
• lack of recognition of ability, skills and training by doctors;
• nurses may not work in a purely nursing role;
• the billing structure through Medicare and the ‘for, and on behalf of, a GP’ item - registered nurses and nurse practitioners are not recognised through the current billing structure for their ability to perform higher duties; and
• lack of recognition for prevention work under the current funding models or workforce arrangements.

Given that 77% of the allied health workforce is female across both major capital cities and rural and remote areas, lack of child care and child care allowances is another factor cited as affecting the decision on whether or not to work in rural and remote areas. For pharmacists, a community’s involvement in welcoming them, and the ability of the pharmacist to extend their scope of practice, was cited in a NSW study325 as being incentives to moving to work in rural and remote areas and remaining there.

Many of the factors which impact on the attraction and retention of other health professionals in rural and remote areas also apply for dental health professionals. However, the extent of mal-distribution in the dental workforce appears to be exacerbated by structural issues that inhibit training opportunities and subsequent practice across sectors and locations.

Workforce roles, responsibilities and scope of practice

An important issue to note and which cuts across most of the non-medical professions working in rural and remote Australia, is that without a GP in the vicinity, these health professionals may be unable to work, or be restricted in what work they can do. For example, one study on pharmacists stated that if doctors ‘decide to leave [the country], the [pharmacy] businesses are worth nothing’.326

Given current pressures, there is considerable support for making best use of the existing workforce, and utilising the full capacity of existing health professionals. However, there are a number of barriers, legislative and financial, which prevent some health professionals from working at the full extent of their training and experience in all sectors and settings. Often there are variances between what a professional may be authorised to do in a public hospital setting compared to what they are able to do in a private setting, such as prescribing under standing orders.

As noted above, community pharmacists are increasingly providing professional services and advice as well as traditional dispensing services, but their full scope of practice is being under utilised and activities are variable across the sector. Similarly, concerns have been expressed by the nursing fraternity that registered nurses with additional skills (such as asthma education or wound management) or nurse practitioners with advanced primary health care skills may not be fully utilised or be supported to provide services that are fully within their skills and capacity to provide. These
issues may contribute to hindering nurses entering practice and workforce attrition, in addition to confusion around clinical governance, delegation and supervision in relation to these nurses.\textsuperscript{327}

In addition to support for some expansion of workforce roles and responsibilities, there is an emergence of new professions, such as the rural generalist role in Queensland and physician assistants, being trialled in Australia. To date, this has been done largely on a limited and localised basis. Expansion of these sorts of models would need to address current financial and legislative constraints, including registration requirements.

**Teamwork and alternative service delivery models**

Primary health care services are delivered in a range of settings in the community from solo or group practices, to health centres and emergency departments. The type of primary health care service model in place in a particular area can act as an incentive or disincentive for health professionals to get involved in the service.

Across primary health care professions there has been a shift towards greater use of service models involving teams and the delivery of multi-disciplinary care. As noted under Element 4, this model can have proven benefits for both providers and patients, particularly in the management of chronic diseases.\textsuperscript{328} However, there are a range of barriers which currently limit the extent to which multi-disciplinary teams can operate effectively. These can include lack of necessary physical and Information Technology (IT) infrastructure; medical indemnity and insurance cover; integrated clinical governance; shared care protocols and defined scopes of practice; and practice management/administrative resources.

Data\textsuperscript{329} on GPs currently in the workforce indicates that there remains a significant proportion of GPs in solo practices. However, the next generation of GPs are moving more towards group practices and team-based approaches.\textsuperscript{330,331} Generational and other lifestyle changes have prompted this shift, with fewer professionals prepared to work in isolation, and maintain long and inflexible work hours, or be on onerous on-call arrangements. An increasing number of graduates are also seeking part-time work.\textsuperscript{332} For example, in relation to the 2006 GP workforce, 15.3% of men and 38.5% of women worked less than 35 hours per week.\textsuperscript{333}

An increasing number of GPs are also not as prepared to establish or buy into a practice. The emergence of ‘walk-in/walk out’ or ‘easy entry/gracious exit’ models of attracting health professionals are gaining popularity, where community or university investment in practice capital and infrastructure elements is utilised to attract doctors who wish to be free from practice management and ownership responsibilities.\textsuperscript{334} ‘Fly in/fly out’ models also allow primary health care professionals to provide services in hard-to-service or remote locations without needing to be permanently based in the region.

Other innovative models are also gaining increasing recognition as potential solutions to overcome current workforce supply issues, including remote access to health practitioners and mobile health service delivery. Another example of such a model includes ‘hub-and spoke’ arrangements for delivering services to smaller localities, where health professionals may visit smaller communities for short periods within a defined catchment area, but utilising the support structure provided by a larger practice.\textsuperscript{335}
Clinical education and training

In Australia, there has been an increase in tertiary training places for medical and health students for some time, yet clinical training capacity has not kept pace with this. Major increases in health training positions are also being implemented through the Vocational Education and Training (VET) sector. Current arrangements also limit the availability of appropriate and adequate clinical training and the settings in which training can be provided.

As health professional education and training has been traditionally structured around an illness model, clinical training of health workers has continued to be largely dependent on acute inpatient services. The changes in case-mix and an increased focus on treating more complex acute conditions in tertiary facilities has reduced the breadth of clinical training possibilities available in the public system.

The growing complexity of care provided in the community setting, and the need to provide more preventive and disease management care, requires that education and training of students and health professionals is better incorporated at all levels, in appropriately resourced multi-disciplinary community-based settings. However, for medical, nursing and allied health students and current health professionals, arrangements to date have offered limited opportunities and support for team-based learning including inter-disciplinary training. For example, there is no integration of specialist trainees into community training. While general practitioners are required to undertake a range of compulsory hospital rotations during their training, the reverse situation, where specialist trainees undertake general practice rotations, does not occur.

Another issue raised by various stakeholders is the growing need to support the role of ‘generalism’ in educational curriculum, to ensure that those health professionals who go on to work in rural and remote areas particularly are able to provide holistic care and have procedural skills if they desire, rather than be limited by skills in one sub-specialty.

In relation to nurses, while their role in primary health care and general practice has expanded, this has not been accompanied by an equivalent expansion of education and training opportunities in primary health care. Undergraduate training opportunities for nurses in community and in general practice settings remain limited. Postgraduate opportunities for practice nurses are only just emerging and need further development, which can lead to frustration for nurses wanting to develop their role but having no defined scope of practice.

Also important to note is that general practices often do not have the training infrastructure required, and practice nurses who are involved in teaching others are usually not trained for this role, nor are they remunerated for their teaching role.

For allied health professionals, clinical training opportunities in primary health care have also been limited – with most clinical training occurring in the acute setting. There is also no rural pathway available to support students who wish to pursue this particular career path (unlike in medicine where a structured rural pathway exists).

The impact of the recent COAG Health Workforce package

Australian governments recognised the importance of addressing the education and training issues through the COAG announcement of 28 November 2008. The resulting COAG Health Reform
Initiative involves a comprehensive package of measures to support Australia’s health workforce now and in the future. The measures contained in the health workforce package include:

- increasing the clinical training subsidy for all pre-professional (eg undergraduate) entry students;
- expanded supervisory capacity to deliver training;
- greater use of simulated learning environments in clinical training; and
- the establishment of a national Health Workforce Agency (HWA) which will be established by early 2010 and will have responsibility for implementing the majority of these measures.

Funding for the package is $1.6 billion – $1.1 billion in Australian Government funding and $540 million in state and territory funding.

This builds on COAG’s Intergovernmental Agreement on health workforce which was signed on 26 March 2008 to create, for the first time, a single national registration and accreditation system for thirteen health professions. The new arrangement will help health professionals move around the country more easily, reduce red tape, provide greater safeguards for the public and promote a more flexible, responsive and sustainable health workforce.

The Australian Government, which funds GP training and determines the numbers entering the Australian General Practice Training program, has recently made several announcements, one through COAG, which will result in an increase in commencing registrars from 675 in 2009, increasing to just over 800 from 2011 onwards. It will be important to ensure that a national distribution of these GPs is maintained through this growth phase of the program.

What the submissions said

Workforce distribution, attraction and retention

A key area of consensus across submissions was that distribution of the primary health care workforce, particularly for rural and remote Australia, needs to be addressed urgently.

> Health workforce shortages are now the single largest risk to the rollout of programs to improve the health of people living in rural and remote Australia. It is therefore imperative that planning for services and programs incorporates workforce plans.

Some submissions also suggested that for the many IMGs, who comprise a significant proportion of the rural health workforce, there are few non-financial incentives offered to them, to assist with their integration and retention:

> [IMGs] …do not receive any induction to the Australian health care system and are given little community support. They often work in challenging environments where access to professional support and up-skilling is very limited. Providing these doctors with more support will enhance their contribution to patient care and will also encourage many of them to seek a permanent place in the Australian general practice workforce.

One submission mentioned that generalist practitioners may be very useful in rural and remote areas but that education must assist in shaping generalist careers:

> Queensland has developed specific training and career pathways for ‘rural generalists’ which reflects the importance of broad procedural and cognitive skills and is supported with attractive remuneration.
For allied health professionals and for nurses, it emerged that the lack of non-financial incentives such as skills recognition, role definition and career pathways particularly, are barriers to working in primary health care.

It is also crucial to educate medical practitioners and health administrators as to the capabilities of registered nurses to ensure that their knowledge and expertise is respected and that their working conditions are satisfying, including appropriate remuneration, flexible education structures and continuing education.  

A large number of submissions suggested that non-financial incentives such as CPD and training opportunities are vital, particularly to attract and retain health professionals to certain areas:

…whilst accredited courses for practice nurses exist in Australia, the current practice environment provides nurses with little incentive to undertake additional training unless their role is allowed to develop to apply these new skills. Continuing professional development (CPD) and opportunities to maintain a strong knowledge base, develop further skills and meet with other professionals in a learning environment contributes to a GP’s commitment to rural towns.

Other non-financial incentives to attract students to primary health care were flagged:

…the [general practice] profession [needs] to improve its image with medical students and those thinking of studying medicine and be more flexible in training and working hours to attract young professionals.

There could be use of incentive programs rather than punitive measures such as bonded medical places. Incentives where teams of professionals are moved to areas of need and collocated together to reduce isolation.

Workforce roles, responsibilities and scope of practice

Enhancement and development of the practice nurse role was flagged as a key priority in several submissions:

Nurses in primary health care will not replace other health professionals but will (and do) provide a unique service that they are already well prepared and qualified to offer. Extending this service will enable the community to access a level of primary health care that is currently not available to the Australian population.

More generally, the impact of broadening workforce roles on primary health care teams, and where advanced roles could be most beneficial was also raised in some of the submissions:

A common thread in many of the APHCRI [Australian Primary Health Care Research Institute] reviews is the need for adequate quality assured training, sensitive development of roles, mutual trust and respect between team members leading to effective communication and collaboration amongst the primary care team.  

Making greater use of (and, where necessary, incentivising) other health professionals, such as pharmacists and nurse practitioners in delivering prevention interventions.

Many submissions noted the current role of a pharmacist in the primary health care team, and outlined the core skills that can be contributed by the pharmacist workforce and network of community pharmacies.
The potential for an enhanced role of community pharmacy has been recognised in the United Kingdom, where the Government has issued a White Paper setting out a vision for ‘building on the strengths of pharmacy, using the sector’s capacity and capability to deliver further improvements in pharmaceutical services over the coming years...’ (‘Pharmacy in England: Building on Strengths, Delivering the Future’, Department of Health, United Kingdom, 2008). The paper describes ways in which pharmacists will work to complement GPs in promoting health, preventing sickness and providing care that is more personal and responsive to individual needs. The views around introducing new roles into the primary health care workforce, to assist current health professionals, were mixed.

The World Health Organization (2008) suggests that primary care requires teams of health professionals including physicians, nurse practitioners, and assistants with specific and biomedical and social skills.

The evidence base for the introduction of new models of care or roles is insufficient to support their introduction at this time... just expanding services or introducing new categories of workers will at best be a short term bandaid solution.

**Teamwork and alternative service delivery models**

Submissions suggested that the right infrastructure is important in order to assist health professionals to work in teams and for clinical education purposes.

The existing funding systems are not designed to adequately provide for the proper working and training space of GPNs [General Practice Networks] and offer little support in the training of new GPNs.

Also noted in submissions were the enablers needed to make multi-disciplinary teams work, for example:

A number of enablers are required to enable team members to work together [including] ....e-Health tools ...[the development of] multidisciplinary models ...funding mechanisms ...[and] education and training at all levels...

Several submissions identified alternative service delivery models that are operating in rural and remote areas, recommending that, where appropriate, these be promulgated more broadly:

The Geraldton Regional Aboriginal Medical Service Diabetes model is another success story in Western Australia. This model involves one General Practitioner and up to four allied health professionals (e.g. dietician, podiatrist, diabetes educator) travelling together by bus to rural and remote areas in the Mid West to provide diabetes screening and mentoring.

The RFDS [Royal Flying Doctor Service] ‘hub and spoke’ model of service delivery is able to provide regular and frequent services to otherwise inaccessible communities. Flexibility in visiting schedules enables visits to be set depending on community size and health needs. The model assists in retention of health professionals enabling a workable lifestyle in the RFDS base ‘hub’ usually in a larger regional centre.
Clinical education and training

Many submissions supported more horizontal integration in education, including inter-disciplinary clinical placements to encourage multi-disciplinary care teamwork. Some commented that this would require funding to support universities to develop this and funding to create inter-professional bodies.

The future education of the primary health care workforce should actively facilitate the development of functional primary health care teams. A starting point would be to increase inter-professional health care education and clinical placements. This is currently extremely difficult to achieve due to poor vertical integration of undergraduate-postgraduate training as well as almost no horizontal integration of medical, nursing and allied health training. Improving integration will be an additional cost to universities which provide medical and nursing training. First steps forward should include supporting the development of inter-professional primary health care organisations and providing targeted funding to universities to improve integration.356

Many submissions suggested that an important component of inter-disciplinary learning is teaching health students what the roles and skills are of all types of health professionals.

One of the greatest barriers to multidisciplinary approaches and patient centred care in the primary health care setting is the lack of awareness of various professional groups about the skills and potential contributions of other health professionals.357

Another submission suggested that clinical training for non-medical students needed to be more focussed on the primary health care sector and be funded for this.

Clinical placement in the private primary care setting is currently a difficult proposition due to financial and indemnity insurance barriers. There is support for medical students and this should be extended to other primary health care professions. Currently all professional placements for dietetics are in the public sector and this does not equip graduates for primary care roles in the private sector with many being reluctant to enter this area and those who do so often struggle. The development of regional primary health care organisations may assist in supporting this and in developing a multidisciplinary approach to professional placement.358

Various stakeholders supported the idea of vertical integration to make all levels of medical education more cohesive and coherent.

In Australia… [basic medical curriculum through to the vocational general practice curriculum] have traditionally been delivered separately by Universities and vocational training organisations respectively. This has largely prevented the natural integration and progression of curricula and training resulting in confusion at the recipient end and a waste of resources.359

However, some submissions were supportive of vertical integration but only under certain conditions.

The concept of vertically integrated teaching assumes that a single teacher can simultaneously support learners at different stages. Although this is possible for a few skilled educators it is a demanding expectation for professionals whose primary role is patient care.360

To assist with vertical integration, suggestions were made to provide single accreditation for training providers for undergraduate to postgraduate and CPD.
The regional training network supports the concept of a single accreditation process for training sites which can be applied across the training spectrum. The accreditation should be targeted at the highest level (specialist college accreditation) therefore enabling any practice to deliver training from undergraduate to vocational without the need for multiple certification.\(^{361}\)

Many submissions suggested that in order to engage primary health care providers in clinical training for health students, particularly in rural and remote areas, strong financial incentives are required.

… to truly support and recognise the role of teaching would be through a Medicare item for teaching consultations. At the very least, we believe that the teaching PIP requires a significant increase, at least by 50%, if it is to truly be an ‘incentive payment’ and reflect the critical importance of undergraduate education in general practice.\(^{362}\)

Several submissions noted the difficulties associated with providing clinical placements in the primary and community health care setting including problems associated with lack of infrastructure, human resourcing, and remuneration issues.

Community student placements require extensive teaching and infrastructure resources due to the need for high teacher to student ratios and close supervision. These are currently very poorly remunerated, which has created an enormous barrier to recruitment and retention of quality GP teachers, with the conflicting demands of their busy practices. This has been recognised through recent funding from the Federal Government for the Crescent Project, which is establishing two community clinical schools in northern and western suburbs of Melbourne. This recent development provides an exciting opportunity to develop a high quality and relevant community-based medical training and is a useful model for future funding initiatives.\(^{363}\)

What is the way forward?

As noted above, there have been significant changes in the delivery of health services, with an increasing emphasis on the primary health care sector to manage a range of complex care needs and chronic disease in the community.

Health outcomes depend on the availability of a skilled health workforce. For many Australians, having timely and affordable access to the services provided by skilled primary health care professionals remains difficult. As the preceding comments demonstrate reforming the system to improve supply, access and health outcomes will require a multi-faceted approach. We need to:

- create appropriate practice environments that function effectively as both service delivery and training precincts for multi-disciplinary teams;
- provide training for all health disciplines in the environments in which services are delivered. This will need to also consider the implications of our current mixed funding of primary health care services, including patient contributions;
- provide suitable infrastructure and professional capacity for all health professionals to ensure appropriate teaching opportunities, research and evaluation of primary health care programs can be achieved; and thereby
- create workplaces which are attractive and relevant to students, which creates sustainability within the primary health care sector.
Workforce distribution, attraction and retention of the workforce

Significant consideration needs to be given to improving the current discrepancy between supply and demand for primary health care services, and the factors contributing towards attracting and retaining workforce in hard to service areas.

There is an ongoing need to consider the effectiveness of the current range of initiatives available to encourage the workforce to less attractive areas/populations, and how these could be built upon in the future to better distribute the primary health care workforce. The 2009-10 Rural Health Budget measures include the establishment of a National Rural Locum Service in addition to other initiatives that will seek to improve retention and provide greater support for the rural primary health care workforce.

In relation to better recognising the role played by IMGs, the Rural Health Workforce Measures announced in the 2009-10 Budget are a significant first step to addressing these challenges. The newly recruited IMG will face many of the same education and support needs of the newly graduated Australian-trained doctor, with additional needs due to cultural and language differences and lack of knowledge of the Australian health care system.

Through these new Budget measures, development of standardised induction programs and cultural mentoring will assist in supporting newly arrived IMGs through ongoing support, for them and their families. Access to locum relief will also be crucial factors in retaining these IMGs in rural and remote locations. These support services will also become available for other overseas trained primary health care professionals, such as nurses, allied health and dentistry, through the expansion of funding agreed by COAG for international recruitment (under the National Partnership Agreement on Hospital and Health Workforce Reform).364

Workforce roles, responsibilities and scope of practice

There is considerable support for using the existing workforce more effectively, through, for example, broadening the current roles and responsibilities of primary health care professionals. Primary health care service delivery models that rely heavily on nurse-led services are increasing in number. For example, the Walwa Bush Nursing Centre is run by a nurse practitioner and staffed by advanced practice nurses who work to their full capacity and thereby ease the workload for medical staff who can address more complex cases.365 The recent Budget decision to provide access to the MBS and PBS to nurse practitioners working in primary health care, and advanced midwives providing care from November 2010, provides opportunities for new models of care to develop in collaborative partnerships, and for a new career pathway to open up.

Making optimum use of the workforce can also involve consideration of changing current scopes of practice, for example, in relation to prescribing arrangements through implementing delegated prescribing models. Under such a model, the GP would be able to authorise other health professionals working in a collaborative team to prescribe certain medications or authorise repeat prescriptions as appropriate to the skill level, experience and knowledge of that individual. Changes to some of these structural barriers may free up resources to enable more effective service delivery within the primary health care sector.
Teamwork and alternative service delivery models

Research indicates that a healthcare system that supports effective teamwork can improve the quality of patient care, enhance patient safety, and reduce workload issues that cause burnout among healthcare professionals.\textsuperscript{366} Evidence shows that for teams to work most effectively, they need to have a clear purpose; good communication; co-ordination; protocols and procedures; and effective mechanisms to resolve conflict when it arises.\textsuperscript{367}

Greater acknowledgement of the value of teamwork, particularly in managing chronic and complex conditions, is a clear priority for the Draft Strategy. This will need to include looking at how current financial arrangements can be made more flexible to ensure that multi-disciplinary teams are properly supported in service delivery. At the same time, there are considerable issues to overcome in terms of how practices can be supported to establish the necessary infrastructure required for delivering multi-disciplinary care (eg additional consulting rooms and office space) – as discussed under Element 4.

Alternative primary health care service delivery models (such as remote access to health practitioners and ‘hub and spoke’ arrangements) will be key in considering how quality health care can be delivered sustainably into the future, in light of shifting service demands resulting from demographic changes, changing clinical practice, and other factors. In this context, a model that has growing support in Australia is the use of inbound/outbound call centre networks to assist the general population or provide services to targeted groups. The COAG initiative, healthdirect Australia, takes inbound calls while selected jurisdictions and some private health insurers provide inbound/outbound telephone support for patients with chronic disease.\textsuperscript{368}

Clinical education and training

Importantly, there is a need to develop more training to complement where health care is being delivered and underpin the most appropriate areas where it should be developed. Careful consideration will need to be given to how to best facilitate moving more training of primary health care professionals into the sector in which they will be working, while acknowledging the mixed nature of funding of primary health care services at present, including patient contributions.

The health workforce reform package announced by COAG will support a significant expansion of clinical training opportunities within the primary health care setting, in both the private and public sector, by providing specific funding for all major health professions to assist them to meet the costs associated with providing clinical training to pre-professional entry students, which many submissions noted was a significant barrier.

As the clinical training subsidy is linked to individual students regardless of health discipline, there will no longer be funding barriers between health professionals in terms of providing clinical training experiences. For example, students from nursing or allied health will be funded if they have clinical training in a general practice setting. This provides an opportunity to further some of the work engaged in by some universities to reflect the growing multi-disciplinary approach to primary health care.

This initiative should have a significant effect in increasing the number of clinical training places available to students in primary health care settings, thereby exposing students to the range of issues and challenges that face primary health care practitioners. Early exposure and positive learning experiences are linked to specialty choices of students.\textsuperscript{369,370}
The use of Simulated Learning Environments (SLEs) has increased particularly for training of procedural skills in rural and regional environments. The COAG workforce package contains additional funding to assist in the establishment of new SLE centres, focussing on rural and remote provision of training. With an increasing demand for clinical training, further use of SLEs could take some of the demand for clinical training off the clinical service delivery environment. Rural clinical schools have already demonstrated that the use of SLE facilities can provide great value in augmenting patient-centred clinical training experiences. Further investment in video-conferencing facilities and live web-based educational delivery also has the potential to alleviate a lack of dedicated physical training capacity.

**Inter-disciplinary learning and competency-based assessment**

It is likely that the clinical training arrangements put in place through the HWA will be administered through a regional partnership for all relevant professions. This provides an opportunity for further consolidation of inter-disciplinary learning (or horizontal integration) of pre-entry health professionals. It would be feasible, using the opportunity presented by the new clinical training arrangements, to streamline organisational infrastructure at the regional level with one university-based regional structure and one prevocational/vocational structure. Such an arrangement would require close cooperation and sharing of resources between professional organisations, Divisions, Regional Training Providers, universities and other stakeholders, but may result in a significant release of resources to facilitate multi-disciplinary training for both students and established professionals within a region. This would particularly be the case if individual accreditation requirements for specific professions could be streamlined by accreditation authorities and universities, thereby simplifying the requirements for primary health care providers who train students from a variety of disciplines.

Expanding multi-disciplinary training infrastructure would also need to be coordinated with a revision of curriculum to ensure that all health professions are able to provide the increasingly complex primary health care, including multi-disciplinary team-based care and preventative health care. Most health disciplines have closed and single pathways of training with little cross-discipline recognition of learning or competency-based assessment. Through cross-discipline learning, health professionals would be equipped with a thorough understanding of each profession’s skills and expertise, which would ensure maximum use of each person’s competencies in the multi-disciplinary team.

In addition, emerging models of new primary health care will need to be underpinned by appropriate and implementable education and training. Development of core competencies in primary health care will assist this process. It is important to note, however, that establishing competency-based training presents a number of challenges, particularly in determining a means of assessing some of the skills and personal attributes needed for successful primary health care service, with its emphasis on diagnostic skills, chronic disease management and patient communication.

**Vertical integration of education and training**

There may also be value in further investment and coordination at the regional level to test different operational models of vertically integrated training. The opportunity most readily presents itself in general practice settings, where vocational training is already organised on a regional basis, as is proposed for clinical training of medical students under the new funding arrangements proposed for HWA. While there is clear agreement between stakeholder groups of the value of providing
integrated career pathways, barriers to the successful implementation of practical models still need to be removed and greater collaboration between professional organisations needs to be encouraged.

**Infrastructure support for community-based learning/teaching**

Underpinning these initiatives, there needs to be consideration of infrastructure issues, both in terms of capital development of training facilities, and in terms of the ‘human capital’, that is support for supervisors and teachers. Current initiatives, such as GP Super Clinics which allow inter-disciplinary learning opportunities will be a key component, as will the infrastructure development opportunities presented through the Australian Government’s capital funding provided in the COAG package, and more broadly through the Health and Hospitals Fund.

It will be important to ensure that the available infrastructure funding is focussed on projects which maximise the opportunities for training a variety of health professionals, both pre-entry and continuing professional development. This is particularly the case for the additional funding available for SLEs, which have a strong focus on providing training for rural and remote health professionals.

To address the issue of a clinical training capacity shortage, COAG also agreed funds to train approximately 18,000 nurse supervisors, 5,000 allied health and other supervisors and 7,000 medical supervisors. Supporting adequately the supervisors of primary health care health students, however, requires reconsideration of the funding arrangements for primary health care, as previously noted. The clinical training subsidy arrangements under the COAG workforce agreement are an important step in this direction, and will defray some of the costs of teaching, but full integration of teaching in all aspects of the primary health care sector will require some significant rethinking of the current arrangements.

**Capacity to address needs of Indigenous Australians**

For particular groups, notably Aboriginal and Torres Strait Islander peoples, whose needs have not been addressed adequately by the existing health system, improvements in the capacity of the health workforce, in primary health care and other spheres, will be critical to close the gap in life expectancy and other key measures, identified as a priority by the Australian Government. If Indigenous health is to be addressed effectively, it will depend on a fundamental shift in the capacity of the health workforce to meet their needs. This will mean:

- increasing the awareness and understanding of Indigenous health across the health workforce generally;
- incorporating effective content and standards into health course curricula;
- increasing the number of health practitioners providing appropriate and ongoing care to Indigenous people; and
- substantially increasing the representation of Indigenous people in the health workforce, including in the tertiary trained sector, where they are most under-represented.
Summary – Key Future Directions

A National Primary Health Care Strategy provides a key opportunity to establish a strong framework to support a highly skilled primary health care workforce.

Key building blocks for such a framework, and areas where change is needed, include:

- Implementation of COAG Health Workforce package including consideration of the following issues:
  - ensure that students experience clinical education in primary health care, early and often, in a supportive working environment;
  - support inter-disciplinary learning across primary health care professions through streamlining organisational infrastructure at the regional level;
  - testing models of vertically integrated training whereby different stages of clinical training are aligned;
  - infrastructure requirements for community-based clinical training (where appropriate) and boosting teaching capacity; and
  - financing arrangements that can better support training of primary health care professionals within the sector.

- Address current workforce supply, attraction and retention issues to better meet the needs of our rural, remote and under-serviced populations, through considering options such as:
  - recognising the important role of IMGs – considering induction (including competency in the Australian health care environment), support services, and continuing education through appropriate agencies;
  - using the existing workforce more effectively through reskilling or upskilling, multi-disciplinary care, or maximising the scope of practice which practitioners can safely practice;
  - supporting alternative models of service provision such as remote access to health practitioners, mobile health service delivery, and hub and spoke models; and
  - developing more dispersed service delivery and training capacity, to include areas of chronic shortage, such as dental care in the rural and regional settings and potentially throughout the public system.
Element 10: Fiscally sustainable, efficient and cost-effective

Objective: All Australians have a primary health care system which is efficient, including making the best use of the available workforce, and is cost-effective, fiscally sustainable for governments and affordable for individuals and families.

Key Points

Efficient and cost-effective provision of services will be essential to the long term sustainability of the primary health care system in Australia for governments and for consumers alike. Developing the right information will be key to determining the most effective allocation of funding across the health system and across Australia and the appropriate mechanisms to ensure the right health professionals can provide the right services at the right time.

While there is some support for more radical change there is broad agreement that there should be a shift from the current emphasis on the acute care sector to more preventive care and early intervention in the community and from the MBS with its inherent limitations to increased use of other funding mechanisms.

Availability of information on resource allocation methodologies and the comparative effectiveness of assessment, intervention and treatment options across the health sector is critical. This will enable governments to provide the right incentives to drive change toward the right balance of funding across health sectors, and ensure best value for health expenditure.

Developing this information and embedding assessment and review into all primary health care programs is the long term goal but in the short term there is scope within current financial arrangements to increase support for prevention, improved chronic disease management, pay-for-performance incentives, research and quality improvement activity and inter-disciplinary training and practice.

Where are we now?

Current funding arrangements for primary health care service delivery in Australia include:

- Commonwealth benefit payments (MBS/PBS, Department of Veterans’ Affairs);
- publicly-funded services either delivered by states and territories such as hospital outpatient, community and public health services or delivered through non-government organisations (NGOs) such as the Royal Flying Doctor Service, More Allied Health Services Program and Access to Allied Psychological Services Program;
- private health insurance (ancillary tables plus limited services through broadened hospital tables); and
- private patient contribution including some services delivered through NGOs.
Possible reform of financing arrangements for primary health care in Australia is a recurrent theme in submissions and in broader discussion of primary health care reform.

While not the sole issue, the limitations and strengths of the MBS as a financing mechanism for primary health care have been raised in the context of other Elements, in particular under Elements 1, 3 and 4.

While many of the submissions to the Draft Strategy reinforce this view, it is not universal with a small number of submissions suggesting radical changes to financing arrangements and a move away from MBS arrangements.

More generally, in the primary health care context the need for changes to current financing arrangements is acknowledged. However, there is a range of views on the optimal structure of, and priorities for, changes to financing for primary health care service delivery in Australia.

While simplified, the dimensions of debate over public funding, particularly Commonwealth funding for primary health care, identified through the Discussion Paper, and confirmed through stakeholder feedback, could be summarised as covering:

- how do we allocate funding across the health system?
- how do we allocate funding geographically and across population groups?
- which health professionals do we fund?
- how do we pay our health professionals?

**How do we allocate funding across the health system?**

Discussion in this area is around the distribution of funding between primary health care and other health care sectors, particularly hospitals and between different activities within primary health care. Internationally, there is renewed interest in investment in primary health care. Primary health care can provide better long term value than alternative investments in health care; through continuity of care it can result in reduced use of expensive pathology, emergency services and hospitalisations.

A 2004 article from WHO stated that ‘Despite the evidence for primary care, resource allocation in most countries still favours hospitals and specialist care. This is partly due to perceptions about what PHC [primary health care] is, what it has to offer, and its development as a control function to reduce costs or access to secondary care, rather than its positive contribution to health gain. This explains the paradox of the attractiveness of primary care on empirical grounds and its lack of appeal to national policy-makers and healthcare professionals, who see it as a low-grade activity with little effect on mortality and serious morbidity and a predominant role in triage of access to hospitals.’

In submissions, there was a particular emphasis on the role of primary health care in prevention; the difficulty primary health care faces in fulfilling this role within current funding mechanisms; and the benefits of prevention and early intervention activity (see Element 3).

A key challenge in primary health care is how to make the health care system adjust to focus on the most effective and cost-efficient approaches to caring for an individual patient or a population:

- in the face of pressures from each sector of the system (particularly hospitals, which are large resource consumers);
- the propensity of individual providers to focus on their own specialty, rather than patient outcomes across the system;
financing rules that narrow rather than broaden the range of treatment possibilities; and
emerging technologies and new information that can change accepted clinical practice.

An example of the treatment of back pain is outlined in Box 5, below.

**Box 5: Example: Lack of evidence of comparative effectiveness of prevention or early non-medical intervention strategies over surgical or medical (including imaging) intervention in acute and chronic lower back pain.**

Lower back pain is a commonly presenting condition in general practice accounting for around 5% of all consultations.\(^\text{373}\)

While there are NHMRC guidelines for assessment and management of lower back pain\(^\text{374}\) overseas evidence indicates that the ‘usual care’ of back pain is often poorly recorded, inconsistent and may not follow guidelines.\(^\text{375}\) In the face of this variability it is not surprising that patient health outcomes are also inconsistent.\(^\text{376}\)

The American Pain Society has recently issued new guidelines for lower back pain which recommend the use of non-invasive therapies supported by evidence before consideration of interventional therapies or surgery. The guidelines indicate that evidence on many interventions was mixed and specifically advises against some interventions while recommending shared decision making with patients on other interventions given the risks involved and limited benefits.\(^\text{377}\) Recent evidence also indicates that, while some practitioners routinely use lumbar imaging, without indication of serious underlying conditions it is not associated with improved health outcomes.\(^\text{378}\)

There are many other intervention and treatment options available including physiotherapy which can play a role in non-specific back and neck pain\(^\text{379}\) and has proven positive impacts on health outcomes over usual care but with uncertain mechanisms of action.\(^\text{380,381}\) There are also preventive activities such as back strengthening exercises, risk factor modification and educational sessions but there is limited evidence of their comparative effectiveness.\(^\text{382}\)

In Australia, public funding is available for medical assessment and treatment including a range of diagnostic tests, operations, pharmaceutical and other therapies while non-invasive therapies including physical therapies are not publicly-funded in many cases. What is needed is comparative effectiveness research to provide better information about the costs and benefits of different treatment options across all health sectors. This could enable better targeting of public funding and result in improved health outcomes with the potential for lower health care spending.\(^\text{383}\)
How do we allocate funding geographically and across population groups?

As discussed under Element 1, the current primary health care system struggles to provide equitable access to appropriate services for a number of population groups and areas of the country which can often contribute to a lower level of health status for these individuals. Examples of the types of populations that fit into this category include Indigenous Australians, refugees, Australians from non-English speaking backgrounds, and people living in remote and regional Australia. Underpinning this is the fundamental impact which workforce distribution has on the availability of services. While a small number of submissions suggested somewhat radical approaches to addressing workforce distribution such as geographic provider numbers or radical realignment of pooled funding, most commentary sought optimal ways to organise funding to supplement basic Medicare arrangements.

Several themes emerged from submissions:

- the need to reduce the current fragmented service delivery and funding arrangements to produce a more coherent nationally consistent primary health care system and address inequities in access;
- the need to increase local flexibility to identify and better address the needs of under-serviced/disadvantaged populations;
- the scope to consolidate and rationalise existing funding streams to reduce administrative impost and support greater local flexibility to meet the needs of at-risk and under-serviced populations (see Element 1); and
- the possible role of enhanced Regional Primary Health Care Organisations as fund-holders and purchasers of supplementary services at the regional level (see Element 7).

Which health professionals do we fund?

The potential for other non-medical health professionals to take an expanded role in the delivery of primary health care services is a key issue in financing deliberations.

The current primary health care system is relatively fragmented when it comes to providing access to multi-disciplinary care for patients. Some public funding is provided through Medicare for individuals with chronic and complex conditions to access a limited range of services. States/territories also fund a range of services. The amount and effectiveness of team-based care seems largely determined by a GP’s motivation and capacity to develop and maintain team-based care arrangements and by a patient’s ability to pay/access subsidies or rebates.

The need to improve the level of teamwork in primary health care, encourage greater integration and improve affordable access to a range of non-medical services is well accepted, although there is debate around where the GP sits in the team. There are also some clinical needs that can be addressed through allied health services but that do not necessarily require or involve team-based care.

The most complex issue in reforming current arrangements to better support multi-disciplinary teams is funding for allied health service delivery (currently a combination of state/territory government, community health including private health insurance - ancillary and hospital, MBS and other Commonwealth programs).
A further issue is how to target the support of allied health services to clinically relevant health care services.

This proliferation of funding sources is confusing and difficult for individuals, families and carers but also leaves some with gaps in access to affordable clinically relevant and necessary services. At the same time, the levels of unmet and patient demand for subsidised services are unknown but could be significant.

A key underlying question in this area is what will be the scope, mechanism and extent of public funding for clinically relevant health services provided by nurses, allied health professionals, pharmacists and dentists.

How do we pay our health professionals?

Financing arrangements for public sector primary health care services in Australia include a complex range of mechanisms. While the majority of funding is provided through MBS patient rebates (often referred to as fee-for-service), there are also a large number of targeted health programs, with some based on pay-for-performance and capitation payments as well as salaried arrangements for services provided through community health centres and Aboriginal Medical Services (AMS). Each of these financing mechanisms provide different incentives (with different arrangements and rules) for both providers and patients.

There are a number of issues in this area: firstly the significance of Medicare fee-for-service and its limited suitability for supporting some models of care, and secondly the lack of information about what happens in primary health care and the incentives to promote quality improvement.

There is widespread agreement that the Australian health care system, in common with many other countries, does not provide the highest quality care for the money spent. Inherent in the current financing mechanisms are disincentives for professionals to supply quality, efficient care side by side with incentives to provide expensive, inefficient care irrespective of health outcomes.

While the universality of Medicare makes it a readily accessible mechanism for most individuals and providers, the MBS patient rebate for an episode of treatment also has a number of potential weaknesses which are summarised along with the strengths and weaknesses of a range of other funding arrangements in Table 11.

In addition to these limitations, the MBS has been used to finance an increasing range of new service delivery models, some of which are significantly different to the types of care for which it was originally intended. There is a tension between the principle of universal access based on clinical need and the need to manage demand for more specialised services (with higher rebates) within a public insurance system.

Some recent changes have focussed on the types of care that extend beyond an episode of ill-health, for example the chronic disease management (CDM) items focus on ongoing care for patients with chronic conditions. Other MBS items have also been developed which trigger incentive payments to providers for other purposes or other programs (eg the PIP Service Incentive Payment items and bulk billing incentives). Inclusion of these newer models of care has both complicated the MBS and distorted MBS provisions beyond its original purpose of providing a universal patient subsidy for the costs of treatment for episodes of ill-health.
However, targeted health programs continue to be widely used to fill the gaps in ‘mainstream’ services under Medicare or through community health and hospital outpatient clinics. These programs can provide incentives for specific behaviours or health outcomes but are often time-limited and capped.

Pay-for-performance incentives currently form only a relatively small part of the financing arrangements in primary health care but there have been some notable achievements including improved rates of immunisation and computerisation in general practice. Difficulties with identifying suitable health outcome indicators, data collection issues and professional resistance around the need to continually align incentives with desired outcomes have limited the use of these incentives to date. However, there is scope for these types of incentives to play a much larger role in achieving improved health outcomes (see Element 5).

Salaried arrangements support provision of primary health care services through Aboriginal Medical Services (AMSs) and state/territory funded community health centres and hospital outpatient clinics. While salaried arrangements enable more attractive remuneration for some health professionals, particularly in rural and remote areas, there has been significant professional resistance to Commonwealth direct employment of medical practitioners particularly in general practice relating to constitutional conscription issues dating back to the establishment of Medibank in the 1970s. The dominance of independent private businesses in primary health care and the changing work culture, particularly in younger GPs, has also led to increased participation in corporate practices which can also include aspects of salaried and contractual arrangements for service delivery.

While there are examples of fund-holding or quasi-fund-holding arrangements including the More Allied Health Services (MAHS) program and Aged Care Panels programs through the Divisions Network which have demonstrated flexibility in providing primary health care services, the limited timing and scale of funding, high reporting and administrative burdens and variability in the management capacity of fund-holders has restricted the use of fund-holding more broadly.

Across the primary health care system, the various financing mechanisms used are largely unassessed at the program or initiative level as to their effectiveness or efficiency in any particular context. While some assessment occurs during the evaluation phase, it is generally only in terms of implementation parameters. Often these do not consider many alternative funding mechanisms and have lead to a ‘business as usual’ approach to funding with only peripheral changes to existing mechanisms such as the MBS.
Table 11 - Relative strengths and weaknesses of current and proposed funding arrangements

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
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<tbody>
<tr>
<td><strong>Fee-for-service</strong></td>
<td>• Focuses more on treating ill-health, not on keeping healthy.</td>
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<tr>
<td>• Supports patient choice.</td>
<td>• May provide insufficient incentive for quality/prevention - promotes focus on presenting</td>
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<tr>
<td>• Encourages throughput, although can lead to</td>
<td>patients not those that don’t attend.</td>
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<tr>
<td>overservicing (with an emphasis on shorter</td>
<td>• Leads to fragmentation and potentially</td>
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<td>consultations).</td>
<td>duplication by paying individual providers.</td>
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<tr>
<td>• Any costs to patient are associated with a</td>
<td>• Tends to increasing complexity as more, and more complex, services need to be itemised for</td>
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<tr>
<td>particular health need/episode and provide a</td>
<td>episodes of care.</td>
</tr>
<tr>
<td>disincentive for overuse.</td>
<td>• Not necessarily well suited to flexible team-based approaches nor to potential new modes</td>
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<tr>
<td>• Strong professional support - decisions about</td>
<td>of care.</td>
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<tr>
<td>patient care (once the patient has presented)</td>
<td>• Structured around acute, episodic care, less well suited to conditions requiring ongoing,</td>
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<tr>
<td>are being made by doctors rather than</td>
<td>pro-active, coordinated care and management.</td>
</tr>
<tr>
<td>bureaucrats.</td>
<td>• Can lead to under-capitalisation and under-servicing in some areas or for particular</td>
</tr>
<tr>
<td>• Administratively efficient.</td>
<td>populations.</td>
</tr>
<tr>
<td></td>
<td>• Uncapped-demand driven.</td>
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</table>

<p>| <strong>Pay-for-performance/incentives</strong>             |                                                                                             |
| • Can be targeted at particular priority areas.| • Can lead to non-rewarded activities being ignored and keeping incentives aligned with    |
| • Promotes focus on outputs/quality instead of | goals can require considerable bureaucratic resources.                                      |
| just throughput.                               | • Difficulty identifying and agreeing suitable indicators; collecting data is resource      |
|                                                | intensive.                                                                                 |
|                                                | • Difficulties in attribution for more outcome focussed indicators.                         |
|                                                | • Insufficient share of total income to engage professions.                                |
|                                                | • Potential professional resistance.                                                       |</p>
<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
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<tbody>
<tr>
<td><strong>Fund-holding – capitation and other</strong></td>
<td>• Requires risk allocation arrangements and demand management strategies.</td>
</tr>
<tr>
<td>• Can support flexibility and local solutions including best use of available workforce.</td>
<td>• Can lead to ‘cherry picking’.</td>
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<tr>
<td>• Allow reallocation to priorities.</td>
<td>• Potential for high administrative cost proportion.</td>
</tr>
<tr>
<td>• Can be targeted to populations/under-serviced areas.</td>
<td>• Incentive to reduce service provision unless outputs are measured meticulously.</td>
</tr>
<tr>
<td>• Incentive is to keep people healthy and using the system efficiently.</td>
<td></td>
</tr>
<tr>
<td>• Can support patient registration and population health approaches.</td>
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<tr>
<td><strong>Salary</strong></td>
<td>• Can discourage throughput.</td>
</tr>
<tr>
<td>• Attractive to some health professionals.</td>
<td>• Professional resistance.</td>
</tr>
<tr>
<td>• Medical workforce more responsive to priorities of funder.</td>
<td></td>
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<tr>
<td>• Funder has greater control over their expenditure.</td>
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<tr>
<td><strong>Health program grants/ targeted programs</strong></td>
<td>• May be seen as too directive by health professionals.</td>
</tr>
<tr>
<td>• Can be tailored to specific circumstances.</td>
<td>• As time limited, capped programs, may be subject to arbitrary cuts and changes.</td>
</tr>
<tr>
<td>• Not an incentive for inputs or types of clinical care; can specifically relate to outcomes.</td>
<td>• Funding allocation to nominated fund-holder.</td>
</tr>
<tr>
<td>• Time limited and specific in purpose.</td>
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</table>
What the submissions said

How do we allocate funding across the health system?

Many submissions commented on the role that a stronger primary health care sector could play in keeping people healthier, delaying the onset of chronic disease and reducing avoidable hospital admissions with support for additional funding for primary health care:

Governments must significantly invest in this sector (primary health care) to see greater health cost sustainability overall, appreciating that investment in a sustainable future must be long term – results may not be measureable within the short term.\textsuperscript{386}

However at the same time there is mixed support for where this funding should be sourced, either through a change to the balance of funding within the health system or through new funding:

Australia has a strong political focus on hospitals and on high level clinical activities. A better balance between preventative and remedial services would ultimately lead to reduced hospital admissions and to savings in government expenditure.\textsuperscript{387}

Yes, more community-based, preventive and early intervention care is required in order for ensure the health system is sustainable, but will resources be taken away from hospitals in order to set up and support a more robust community care system, particularly when any improvement in outcomes will be long tem and not readily demonstrable for some time.\textsuperscript{388}

Funding should be equitable and efficient. To answer this question, we first need to undertake a national audit of current health expenditure and health need – including barriers to equity – to determine what the current mix is before we can identify what an ‘appropriate’ mix is. Ultimately the Australian people should be able to decide on this, possibly through mechanisms like citizens juries.\textsuperscript{389}

The appropriate mix of private and public funds should be that which supports a sustainable health system and quality outcomes whilst ensuring equity of access and care. Determining this mix will require additional research and consultation with consumers, health professionals, policy makers and health service agencies.\textsuperscript{390}

How do we pay for our health professionals?

A recurrent theme in many of the submissions was that impacts resulting from the limitations of current financing mechanisms underpin many of the shortcomings of the primary health care system. While the submissions focussed on the benefits and disadvantages of various financing mechanisms there was general consensus that there needs to be consideration of adjustments to the current mix of blended payments.

The National Primary Health Care Strategy should be linked to a payment system which aligns the payment modality (fee for service, capitation, blended payments) with the expected outcomes. The College agrees with the evidence that suggests blended methods lead to efficiencies as they can out perform pure fee-for-service and pure capitation.\textsuperscript{391}

The guiding principle to be applied to consideration of funding models is that no one model will be appropriate for a health system as a whole. In order to expand the scope for innovation, funding models must be adaptable to reflect local circumstances and should have the capacity to be applied and modified on a sub-jurisdictional or local basis.\textsuperscript{392}
Most submissions considered the primary health care system funding should include some mix of fee-for-service, pay-for-performance, capitation and salaried arrangements. However there was no clear and consistent view of the most appropriate mix to provide for the long-term sustainability of the primary health care system. Following is a thematic analysis of what the submissions said about each of the main financing mechanisms identified.

**Fee-for-service**

A recurrent theme from submissions was that mainstream fee-for-service arrangements do not meet the need for access to primary health care services for disadvantaged groups such as Indigenous Australians, refugees, the intellectually disabled and Australians from low socio-economic backgrounds. There was support for the idea that the MBS provides disincentives for practitioners to provide care for these consumers who tend to take longer to care for due to their more complex health problems and communication needs.

Many submissions presented various alternatives including moving to a population-based approach, making greater use of blended payments, salaried arrangements, ‘cashing up/out’ the MBS or adopting regional-based funds-pooling for primary health care services. However, there was some acknowledgement that the MBS works well for straight forward episodes of care and should be retained for these simpler types of services. A consistent theme was the need for financing models to allow for local flexibility to meet the needs of the community.

Similarly, there was broad coverage of the limitations of current MBS arrangements for access to allied health services through the Enhanced Primary Care (EPC) items including issues relating to referral requirements, service cap and rebate levels. There was mixed support for individuals having direct access to subsidised allied health services.

There was also some support for better utilisation of the MBS to support a broader range of professionals in providing preventive care including health promotion, educating and supporting individuals, their families and carers in self-management through covering support services provided via email or telephone and including provision for longer consultations. However there was recognition that the MBS does not often remunerate practitioners who have additional training or experience which may be required to provide this care.

A number of submissions were not supportive of further expanded roles of medical practitioners within fee-for-service arrangements given the perceived time constraints in medical consultations resulting from treating the urgent care needs of patients. A few submissions also suggested that the time constraints implied in the fee-for-service model provide strong disincentive for medical practitioners participating in research.

Many submissions noted that inequities in current MBS funding arrangements are a barrier to participation in true multi-disciplinary care for individuals with complex chronic disease, particularly for allied health professionals. Many submissions called for allied health professionals to have direct access to MBS items and specialist referral. Another issue raised with the current team care arrangements was that they are not available for early interventions which are considered effective for many conditions.

Several submissions also cited the limitations of the MBS in allowing coordination of care by appropriate team members. Many proposals also included various options for ‘cashing up/out’ the
MBS to finance other funding mechanisms for provision of coordinated multi-disciplinary care for people with chronic conditions and complex care needs including resourcing for collaboration and care coordination.

**Pay-for-performance/incentives**

There was support for various practice-level remuneration such as incentives for using accredited frameworks which support team-based care, participation in patient registration/enrolment or for implementation of systems to support practitioners to provide preventive care such as recall and reminder systems.

There was also significant support for extension of the PIP practice nurse incentive.

A few submissions supported the introduction of performance payments in combination with other financing mechanisms such as capitation payments based around patient enrolment in order to encourage effective and efficient service provision while maintaining flexibility.

**Fund-holding – capitation and other**

A number of submissions supported targeting of services based on data at the level of individual general practices to enable monitoring of the outcomes of the services provided at a local level. This implies fund-holding at least at the practice-level or higher.

Several submissions supported funds-pooling in combination with patient enrolment, and in some cases pay-for-performance incentives, as an effective means for engaging primary health care in prevention and improved care coordination and planning activities. There is also some support for pooling of public funding from national and state/territory-based chronic disease programs as a first step in improving integration between the public and private sector provision of primary health care.

Many submissions have espoused regional organisations with responsibility for purchasing/commissioning primary health care services as being able to better plan for the health service and training needs of local communities. However there are also many submissions which identify potential risks around the funding levels, scale, insufficient population-level information and the lack of organisations ready to undertake such roles.

There is also some support for partial pooling of funds at the local level for more complex care combining national, state/territory and local government funding while maintaining the MBS for routine episodic care.

**Salary**

Teamwork and care coordination were identified as being strongly supported by the utilisation of salaried service provision and block funding of multi-disciplinary community health centres. Aboriginal Community Controlled Health Organisations were also supported as a salaried model which promotes continuity of care particularly for vulnerable groups such as Indigenous Australians.

There was also recognition that health workers require time to learn research skills and conduct research projects and that this required supporting salaried professionals in further study.
Health program grants/targeted programs

Health program grants and targeted programs were seen as more able to accommodate flexibility for disadvantaged groups such as Indigenous Australians, rural and remote populations and people with intellectual disabilities through providing specialised services for target populations. This includes programs for direct service provision through block funding, prevention and early intervention, promotion of health literacy and self-management.

There was also some support for the utilisation of targeted programs in implementing change in the workforce particularly to encourage participation in research activities as well as to promote workforce up-skilling and re-distribution.

Comments on the way forward

There was however strong support for the need for evidence of effectiveness and efficiency of financing mechanisms, as much as the model of care employed. Indeed the Royal Australian College of General Practitioners in their submission stated the need to choose the financing mechanism most suitable to achieving the expected health outcomes in any particular area.

As a step towards achieving this goal many submissions identified the need for investment in primary health care research to identify appropriate evidence in determining the benefits and effectiveness of both models of care and the most appropriate financing mechanisms.

In order to have a sustainable primary health care system, evidence of benefit and effectiveness is needed. A strong investment in primary care research, including research into overseas studies, would enable the identification of evidence and its effectiveness. Investment in research should be a pillar of the National Primary Health Care Strategy.

What is the way forward?

There is general agreement that there are complex issues around making substantial changes to the way resources are allocated across health, how these are targeted across Australia and different population groups, and through what mechanisms they are distributed. It has been suggested that there needs to be a clear view on the future demands of the health system and a plan for how to efficiently align the financial incentives to meet that demand.

To make significant changes to the price, location, volume and quality of care requires informed debate, including with the community, on how to pay providers. Many health economists, in considering how to achieve efficient, effective and sustainable improvements, have espoused the need to consider what fundamental changes are required in current financing arrangements and if any incremental rewards or penalties could be added to encourage the changes sought. Many of the pay-for-performance programs are about adding a new layer of rewards and incentives on top of current payment systems but there is a growing consensus that this alone is not enough to address the disincentives inherent in payment systems. This is borne out by many submissions which support investigation of major changes to the payment mechanisms alongside implementation of incremental changes.

In the USA, there are moves away from fee-for-service arrangements with the Commonwealth Fund Commission on a High Performance Health System recommending policies to enhance payment systems to encourage adoption of the medical home model of care to ensure better access, care coordination, chronic care management and disease prevention and to correct price signals in health care to improve alignment with value.
In the UK, while the majority of services are still provided by salaried professionals, there have been many financing reforms over the last decade. The introduction of Primary Care Trusts, Payment by Results, the Quality Outcomes Framework and practice-based commissioning have all been major reforms in their own right and the evidence is still being gathered on the effectiveness of these changes in driving improvements in quality, efficiency and effectiveness.398,399

There are no quick and easy answers. Governments and health organisations in most countries continue to struggle with a lack of information about what mechanisms will achieve desired health outcomes in a sustainable way. There is increasing evidence that while reimbursement models influence some aspects of practitioner behaviour there is a lack of evidence about the impacts on health outcomes. Indeed Glazier et al suggest that there is no single model which can achieve the full range of policy objectives and information to support decisions around blending of different elements and the incentives and disincentives outside the model to achieve improved access is extremely limited.400,401

Fundamental reform requires a new approach to resource allocation, not simply based on the population or the size of the problem which are as old as the principles of the Resource Allocation Working Party developed in the UK in the 1970s. The concepts around ‘needs-based funding’ have been canvassed in a number of submissions to the Draft Strategy and the National Health and Hospitals Reform Commission (NHHRC).

In an attachment to his submission to the NHHRC, Professor Mooney takes these concepts a step further providing some new insights into making the most of public funding based on the ideas of populations ‘capacity to benefit’ from additional resource allocation and the need to recognise that some jurisdictions/regions function better around allocation of resources. This new methodology overcomes many of the limitations of existing methodologies and indeed he notes that aspects of this methodology have been incorporated into the UK’s NHS Plan. Professor Mooney also recognises that much more research is needed to allow measurement of capacity to benefit and variation across jurisdictions and populations. Consideration could then be given to investigating the appropriateness of this and other developed resource allocation methodologies in consultation with consumer and professional representatives.

In addition to developing new ways to distribute resources, there is also a need to ensure new programs and initiatives make the most effective and efficient use of public funding once allocated through identifying key evidence-based measures against which they all can be measured. These can then also be applied to existing programs and initiatives.

This will enable:

• assessment of health outcomes and quality of care comparative to other modalities of care including broader preventive initiatives addressing social determinants of health;

• consideration of broader financial implications including improvements in workforce participation, cost reductions in other parts of the health system, and impacts on social determinants of health; and

• additional investment in comparative health outcomes research to further improve evidence-based assessment of programs/initiatives.
To make the most of any gains, evidence-based measurement of efficiency and effectiveness will need to be embedded in publicly funded programs. This will require development of mechanisms for regular review and adjustment of financing arrangements to ensure that programs/initiatives remain consistent with government priorities and community health needs as well as promote continual improvement in efficiency and effectiveness.

The Government has already started down this path through a commitment to funding the *Medicare Benefits Schedule – a quality framework for reviewing services* initiative in the 2009-10 Budget. This initiative will include the development of a framework for the Department of Health and Ageing to review services listed on the MBS and to inform, when necessary, appropriate amendments or removal of existing MBS items.  

Under the new arrangements, services will be evaluated and aligned with contemporary evidence to ensure clinical relevance and appropriate pricing. New services will be evaluated three years after being listed. This will improve health outcomes for individuals, their families and carers and contribute to maintaining the financial sustainability of the MBS.

The challenge for the future is assessing the most appropriate financing arrangement for particular objectives and initiatives, and ensuring a balance of financing methods to achieve the changes in service delivery arrangements sought and in light of other considerations including broader fiscal considerations.

While funding decisions will need to be supported by available evidence, equally the gaps in the current evidence base for primary health care need to be recognised.

In the longer term, a similar approach could be incorporated across all primary health care funding mechanisms to improve health outcomes for all Australians by ensuring publicly provided or subsidised services remain efficient, effective and sustainable.

**Summary – Key Future Directions**

A National Primary Health Care Strategy provides a key opportunity to ensure:

- financing arrangements and service delivery changes are informed by considerations of cost-effectiveness and relative efficiency at different approaches across the spectrum of care options including self-management;
- MBS arrangements remain a central tenet of primary health care financing arrangements – to support those things they were designed to support, and do well, ie access to episodes of health care;
- other funding mechanisms such as blended payments and targeted programs are used to complement MBS and deliver specific outcomes; and
- improving the evidence base for assessing cost-effectiveness and efficiency in primary health care is a priority for research and program evaluation.
5. Summary and conclusions

Primary health care is an integral part of the Australian health care system. At a broad level, the outcomes look good and compare well internationally:

- long life expectancy;
- affordability of GPs.

Primary health care in Australia is delivered by a mix of public and private, Commonwealth and state/territory services. It is best described as a sector, rather than a system. Hence, as other parts of the health system such as acute care have changed and evolved, the primary health care sector has not been able to respond effectively in a coordinated manner to this change. This is most obvious at the points of intersection, for example people who are treated both in the hospital sector and primary health care, and in the management of conditions that were once undertaken in hospital, but can now effectively be managed out-of-hospital.

There are many points of failure in the primary health care sector, for both patients and health care professionals:

- Access to the full range of primary health care professionals can be a major issue, either because the health professional required is not located in the region, or because an individual has physical, cultural or affordability barriers in getting to the health professional.
- Even where services are on the ground, both patients and providers can find it difficult to navigate the range of services and providers to obtain the best care possible.
- Funding models are relatively inflexible, and sometimes mitigate against the right care being provided by the right person appropriate to their health care needs at the time.

These problems apply across the board for patients and providers. For those patients with higher care needs, and who need to see a variety of health care providers, there are additional issues in relation to:

- quality and safety, especially at the point of information transfer;
- affordability of services; and
- referral pathways.

The options for the Australian Government, as the major funder in this sector, in responding to the changing needs of both patients and providers has been a choice between whole of system responses, such as through the MBS, or specific targeted programs. In some cases, the MBS has been used to try and address specific, targeted problems, but with limited success and some unwanted outcomes. The MBS works well as a public health insurance system for episodic care or ill-health for whole-of-population, and has been effective in underwriting the costs of running small business for GPs.

There are several key enablers for change identified throughout the Report. These are:

- regional integration;
- information and technology, including eHealth;
- skilled workforce;
- infrastructure; and
- financing and system performance.
These are whole-of-system issues that, in the absence of change, will continue to cause problems for both patients and providers. Addressing these issues is integral to implementing targeted change to increase the focus on prevention or better manage chronic and complex conditions.

From the 10 Elements identified in the Discussion Paper and analysed in this Report, four Key Priority Areas for change have been distilled:

1. improving access and reducing inequity;
2. better management of chronic conditions;
3. increasing the focus on prevention; and
4. improving quality, safety, performance and accountability.

To implement many of these changes requires some sort of regional governance structure to drive integration, facilitate change management and ensure that the reforms deliver real outcomes for patients at the local level, in particular to manage the program funding around chronic disease management and prevention activities.

Changes to primary health care arrangements would also benefit from acknowledging the changing interface between the acute and primary health care sectors, by promoting a more integrated role for specialists in the management of patients out-of-hospital.
Attachments

Attachment A – Stakeholder consultation

External Reference Group (ERG)

On 11 June 2008 the Hon Nicola Roxon MP, Minister for Health and Ageing, announced the appointment of an External Reference Group (ERG) to assist in the development of the Draft National Primary Health Care Strategy.

Membership

The ERG, chaired by Dr Tony Hobbs, is non-representational, with members of the group contributing on the basis of their personal experience and expertise. The ERG includes a range of primary health care experts from around Australia, including a pharmacist, a midwife/birth reform advocate, a physiotherapist, a psychologist, a general practice nurse, a consumer representative, primary health care academics and strong representation from general practice including those with Indigenous, rural and remote experience. A list of ERG members is included in Table 12.

Terms of Reference

The ERG was asked to work closely with the Australian Government to develop the Draft Strategy, including:

• providing expert input on primary health care issues being considered as part of the development of the Strategy;
• reviewing and commenting on information relating to the Strategy prior to release for broader consultation; and
• assisting the Department in the analysis of, and responses to, the range of comments which may be received from broader consultation processes.

Modus Operandi

The Department of Health and Ageing provided secretariat support to the ERG, including high level administrative support for the Chair, Dr Tony Hobbs.

The ERG met 10 times between July 2008 and June 2009 with eight face-to-face meetings. At the earlier meetings, the Group spent considerable time canvassing the key issues that needed to be considered in the development of the Draft Strategy. Subsequent ERG meetings allowed discussion on the development of the Discussion Paper and the Draft Strategy.

To further inform the ERG’s consideration, a number of guest speakers were invited to attend ERG meetings, including representatives from the Australian Indigenous Doctors’ Association, Congress of Aboriginal and Torres Strait Islander Nurses, National Aboriginal Community Controlled Health Organisation, National E-Health Transition Authority, National Health and Hospitals Reform Commission, National Health & Medical Research Council and the National Preventative Health Taskforce.

The ERG Chair, Dr Tony Hobbs, represented the ERG in many forums, including conferences and seminars. In addition to providing updates on the progress of the Draft Strategy development, Dr Hobbs also used these occasions to seek stakeholder views and input.
### Table 12: ERG Members

<table>
<thead>
<tr>
<th>Chair</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Dr Tony Hobbs</strong></td>
<td>Dr Hobbs is a GP Obstetrician at Cootamundra in the NSW Riverina district, where he has promoted an innovative model for integrated primary care. He is also the Immediate Past Chair of the Australian General Practice Network.</td>
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<th>Members:</th>
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<tbody>
<tr>
<td><strong>Mr Peter Fazey</strong></td>
<td>Mr Fazey is a specialist musculoskeletal physiotherapist. He has worked primarily in private practice for 25 years and is currently a lecturer in manual therapy and the clinical programs coordinator at the University of Western Australia, Centre for Musculoskeletal Studies. Mr Fazey is also the Immediate Past President of the Australian Physiotherapy Association and a Fellow of the Australian College of Physiotherapists.</td>
</tr>
<tr>
<td><strong>Professor Mark Harris</strong></td>
<td>Professor Harris is a leader of primary health care research in Australia with a broad range of interests, including health system development, especially integration of health services (within primary health care and between primary and secondary care), and the prevention and management of chronic diseases especially diabetes and cardiovascular disease. He is also a Professor of General Practice at the University of NSW.</td>
</tr>
<tr>
<td><strong>Associate Professor Noel Hayman</strong></td>
<td>Associate Professor Hayman is the Clinical Director of the Inala Indigenous Health Service in Brisbane. His interests include primary health care access and service delivery in Indigenous communities, especially improving the access of Indigenous people to mainstream health services and medical education. He is also the Secretary of the Australian Indigenous Doctors Association.</td>
</tr>
<tr>
<td><strong>Professor Claire Jackson</strong></td>
<td>Professor Jackson’s interests include health service integration, models of primary care and governance. She practises in Inala Queensland and has had general practice experience in urban and rural Australia and overseas. Prof Jackson is also a Professor in General Practice and Primary Health Care at the University of Queensland.</td>
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<tr>
<td><strong>Ms Judy Liauw</strong></td>
<td>Ms Liauw is a community pharmacist. She has been the Director and Manager of Westside Pharmacy, Ulverstone, Tasmania since 1985. Ms Liauw is a National Councillor on the Pharmacy Guild of Australia and holds other positions including the Chair of the Guild’s Women and Young Pharmacists Committee. She is also a Member of the Pharmacy Board of Tasmania and the Chair of the Australian Association of Consultant Pharmacy from July 2008.</td>
</tr>
<tr>
<td><strong>Professor Lyn Littlefield OAM</strong></td>
<td>Professor Littlefield is a clinical psychologist with over 20 years of experience as a clinical academic and in mental health in hospital and community settings. She has devoted much time in working towards improving health, and particularly mental health and services in these areas. Prof Littlefield is the Executive Director of the Australian Psychological Society and the Honorary Executive Officer of Allied Health Professions of Australia. She was previously the Head of the School of Psychological Science at La Trobe University and the inaugural Director of the Victorian Parenting Centre.</td>
</tr>
<tr>
<td><strong>Ms Anne Matyear</strong></td>
<td>Ms Matyear is a general practice nurse. Her interests include optimising the role of nurses in general practice and increasing the contribution of general practice nursing in the formulation of public health policy. Ms Matyear is the current President of the Australian Practice Nurses Association and a Member of the Board of Directors at the Ipswich and West Moreton Division of General Practice.</td>
</tr>
<tr>
<td><strong>Mr Mitch Messer</strong></td>
<td>Mr Messer has made a strong contribution to Australian health care over many years as a consumer representative. He is a consumer member of the Pharmaceutical Benefits Advisory Committee and a former member of the Governing Committee of the Consumers’ Health Forum of Australia. He is also a founding member and current Chairperson of the Genetic Support Council of WA (Inc.), President of Cystic Fibrosis Australia and Worldwide, and a Trustee of the Australian Cystic Fibrosis Research Trust.</td>
</tr>
<tr>
<td><strong>Dr Rod Pearce</strong></td>
<td>Dr Pearce is a general practitioner who has been an advisor for the last 20 years to local, state and federal governments on general practice issues. Dr Pearce continues his involvement with many local and national committees including Australian General Practice Accreditation Limited, and Australian Technical Advisory Group on Immunisation. He is also the current Federal Chairman of the Australian Medical Association Council of General Practice.</td>
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</table>
Dr Vasantha Preetham

Dr Preetham is a practising GP in Perth, Western Australia. She was invited to contribute to the discussion around developing a long term national health strategy at the Prime Minister’s Australia 2020 Summit in Canberra in April 2008. Dr Preetham is also the Immediate Past President of the Royal Australian College of General Practitioners.

Professor Hal Swerissen

Professor Swerissen is an expert on health policy with an extensive research record in the design and development of primary health and community services. Prof Swerissen is currently the Dean of the Faculty of Health Sciences and Professor of Public Health at La Trobe University and is also the Australian Institute for Primary Care’s Director of Research and Development.

Dr Barbara Vernon

Dr Vernon is an Australian birth reform advocate with a strong interest in improved provision of maternity services, particularly enhancing women’s access to primary care by midwives. She is also the Executive Officer of the Australian College of Midwives.

The Consultation Process

Consultations comprised a call for written submissions and meetings (both formal and informal) with stakeholders, including with senior state and territory government officials.

Discussion Paper


The Discussion Paper was structured around 10 proposed key Elements of an enhanced primary health care system and canvassed a wide range of important issues. For each Element, the Discussion Paper described the current situation and what this means for consumers and health care practitioners, with a focus on identifying major issues that would need to be addressed in the development of the Draft Strategy. The Paper also set out a series of questions to assist individuals and groups to structure their input and invited comment through written submissions, by the end of February 2009.

265 written submissions were received from a wide range of interested individuals and organisations, including professional associations, academic institutions, non-government organisations and consumers of primary health care, as well as state and territory governments. A list of submissions is provided in Table 13.
Stakeholder submissions were published on the Department of Health and Ageing website at: http://www.health.gov.au/internet/main/publishing.nsf/Content/primaryhealthstrategy-submissions. To ensure that the privacy of third parties, private contact details (eg, addresses, phone numbers and email addresses) contained in submissions were removed.

**Other Consultation**

A National Primary Health Care Strategy Cross Jurisdictional Group (NPHCS CJG) comprising senior health department officials from each state and territory, with experience in primary health care, was convened as a mechanism for consultation with the jurisdictions during the development of the Draft Strategy. The NPHCS CJG met on two occasions, providing a forum for high level consideration of issues being considered as part of the Draft Strategy development.

The Department also drew upon the submissions provided to the National Health and Hospitals Reform Commission (NHHRC) and the National Preventative Health Taskforce. The views of stakeholders are reflected throughout the Report.

**Table 13: List of Submitters**

A list of stakeholders who made written submissions on the Discussion Paper: *Towards a National Primary Health Care Strategy* is included below. Note that submissions numbers 6, 11, 102 and 114 were classified by the authors as confidential and as such, were not published on the Department of Health and Ageing website or made available to the public.

<table>
<thead>
<tr>
<th>Number</th>
<th>Submitter Name</th>
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<tr>
<td>001</td>
<td>S. Downs</td>
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<tr>
<td>002</td>
<td>Health Workforce Queensland</td>
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<tr>
<td>003</td>
<td>Healthlink Family Medical Centres</td>
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<td>004</td>
<td>I. Linwood</td>
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<td>005</td>
<td>R. Currie</td>
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<td>007</td>
<td>I. Esslemont</td>
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<td>008</td>
<td>Hastings Macleay General Practice Network</td>
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<td>009</td>
<td>B. Vanrenen</td>
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<td>010</td>
<td>Silver Chain</td>
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<td>012</td>
<td>C. Boyle</td>
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<td>013</td>
<td>L. Kelly</td>
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<td>P. Lake</td>
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<td>E. Pica</td>
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<td>016</td>
<td>M. Light</td>
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<td>017</td>
<td>GP Partners Adelaide</td>
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<td>Number</td>
<td>Submitter Name</td>
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<tr>
<td>018</td>
<td>G. Birch</td>
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<td>258</td>
<td>Optometrists Association of Australia</td>
</tr>
<tr>
<td>259</td>
<td>Australian College of Rural and Remote Medicine, General Practice Education and Training, General Practice Registrars Australia and Royal Australian College of General Practitioners</td>
</tr>
<tr>
<td>260</td>
<td>Cerebral Palsy League of Queensland</td>
</tr>
<tr>
<td>Number</td>
<td>Submitter Name</td>
</tr>
<tr>
<td>--------</td>
<td>--------------------------------------------------------------------</td>
</tr>
<tr>
<td>261</td>
<td>North Coast Area Health Advisory Council</td>
</tr>
<tr>
<td>262</td>
<td>Rural Doctors Association of Australia</td>
</tr>
<tr>
<td>263</td>
<td>Australian Osteopathic Association</td>
</tr>
<tr>
<td>264</td>
<td>Queensland Health</td>
</tr>
<tr>
<td>265</td>
<td>Sunshine Coast Division of General Practice – Consumer Panel</td>
</tr>
</tbody>
</table>
## Attachment B – Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Name / Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
</tr>
<tr>
<td>ACCHO(s)</td>
<td>Aboriginal Community Controlled Health Organisation(s)</td>
</tr>
<tr>
<td>ACCHS(s)</td>
<td>Aboriginal Community Controlled Health Service(s)</td>
</tr>
<tr>
<td>ACSQHC</td>
<td>Australian Commission on Safety and Quality in Health Care</td>
</tr>
<tr>
<td>AGPAL</td>
<td>Australian General Practice Accreditation Ltd</td>
</tr>
<tr>
<td>AGPN</td>
<td>Australian General Practice Network</td>
</tr>
<tr>
<td>AHP</td>
<td>Allied Health Professional</td>
</tr>
<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
</tr>
<tr>
<td>AMS</td>
<td>Aboriginal Medical Service(s)</td>
</tr>
<tr>
<td>APHCRI</td>
<td>Australian Primary Health Care Research Institute</td>
</tr>
<tr>
<td>ATAPS</td>
<td>Access to Allied Psychological Services (Program)</td>
</tr>
<tr>
<td>BEACH</td>
<td>Bettering the Evaluation and Care of Health (Program)</td>
</tr>
<tr>
<td>CALD</td>
<td>Culturally and Linguistically Diverse (populations)</td>
</tr>
<tr>
<td>CDM</td>
<td>Chronic Disease Management</td>
</tr>
<tr>
<td>CHETRE</td>
<td>Centre for Health Equity, Training, Research and Evaluation</td>
</tr>
<tr>
<td>CHIC</td>
<td>Connecting Healthcare in Communities</td>
</tr>
<tr>
<td>CJG</td>
<td>Cross Jurisdictional Group</td>
</tr>
<tr>
<td>COACH</td>
<td>Coaching patients on Achieving Cardiovascular Health</td>
</tr>
<tr>
<td>COAG</td>
<td>Council of Australian Governments</td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
</tr>
<tr>
<td>CPD</td>
<td>Continuing Professional Development</td>
</tr>
<tr>
<td>CRC</td>
<td>Cooperative Research Centre</td>
</tr>
<tr>
<td>CVD</td>
<td>Cardiovascular Disease</td>
</tr>
<tr>
<td>DoHA</td>
<td>Department of Health and Ageing</td>
</tr>
<tr>
<td>DVA</td>
<td>Department of Veterans Affairs</td>
</tr>
<tr>
<td>EPC</td>
<td>Enhanced Primary Care</td>
</tr>
<tr>
<td>ERG</td>
<td>External Reference Group</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GP</td>
<td>General practitioner</td>
</tr>
<tr>
<td>HACC</td>
<td>Home and Community Care</td>
</tr>
<tr>
<td>HARP</td>
<td>Hospital Admissions Risk Program</td>
</tr>
<tr>
<td>HWA</td>
<td>Health Workforce Agency</td>
</tr>
<tr>
<td>ICT</td>
<td>Information and Communications Technology</td>
</tr>
<tr>
<td>IEHR</td>
<td>Individual Electronic Health Record</td>
</tr>
<tr>
<td>Acronym</td>
<td>Name / Title</td>
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<td>---------</td>
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</tr>
<tr>
<td>IHP</td>
<td>Integrated Health Promotion</td>
</tr>
<tr>
<td>IGR2</td>
<td>Second Intergenerational Report (published by Australian Treasury)</td>
</tr>
<tr>
<td>IMGs</td>
<td>International Medical Graduates</td>
</tr>
<tr>
<td>MAHS</td>
<td>More Allied Health Services (Program)</td>
</tr>
<tr>
<td>MBS</td>
<td>Medicare Benefits Schedule</td>
</tr>
<tr>
<td>NACCHO</td>
<td>National Aboriginal Community Controlled Health Organisation</td>
</tr>
<tr>
<td>NCDS</td>
<td>National Chronic Disease Strategy</td>
</tr>
<tr>
<td>NEHTA</td>
<td>National E-Health Transition Authority</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Government Organisation</td>
</tr>
<tr>
<td>NHA</td>
<td>National Healthcare Agreement</td>
</tr>
<tr>
<td>NHHRC</td>
<td>National Health and Hospitals Reform Commission</td>
</tr>
<tr>
<td>NHMRC</td>
<td>National Health and Medical Research Council</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Survey</td>
</tr>
<tr>
<td>NPHCP</td>
<td>National Primary Health Care Partnership</td>
</tr>
<tr>
<td>NPHCS</td>
<td>National Primary Health Care Strategy</td>
</tr>
<tr>
<td>NPS</td>
<td>National Prescribing Service</td>
</tr>
<tr>
<td>NQPS</td>
<td>National Quality Performance System</td>
</tr>
<tr>
<td>NRRHIP</td>
<td>National Rural and Remote Health Infrastructure Program</td>
</tr>
<tr>
<td>OD</td>
<td>Organisational Development</td>
</tr>
<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
</tr>
<tr>
<td>PBS</td>
<td>Pharmaceutical Benefits Scheme</td>
</tr>
<tr>
<td>PCP(s)</td>
<td>Primary Care Partnership(s)</td>
</tr>
<tr>
<td>PCT(s)</td>
<td>Primary Care Trust(s)</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary health care</td>
</tr>
<tr>
<td>PHCRED</td>
<td>Primary Health Care Research, Evaluation and Development</td>
</tr>
<tr>
<td>PHCRIS</td>
<td>Primary Health Care Research and Information Service</td>
</tr>
<tr>
<td>PHO(s)</td>
<td>Primary Health Organisation(s)</td>
</tr>
<tr>
<td>PIP</td>
<td>Practice Incentives Program</td>
</tr>
<tr>
<td>PSR</td>
<td>Professional Services Review</td>
</tr>
<tr>
<td>QIP</td>
<td>Quality in Practice</td>
</tr>
<tr>
<td>RACGP</td>
<td>Royal Australian College of General Practitioners</td>
</tr>
<tr>
<td>RFDS</td>
<td>Royal Flying Doctor Service</td>
</tr>
<tr>
<td>Acronym</td>
<td>Name / Title</td>
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<tr>
<td>---------</td>
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</tr>
<tr>
<td>RHS</td>
<td>Regional Health Services</td>
</tr>
<tr>
<td>RoGS</td>
<td>Report on Government Services</td>
</tr>
<tr>
<td>RPHS</td>
<td>Rural Primary Health Services (Program)</td>
</tr>
<tr>
<td>SLE</td>
<td>Simulated Learning Environment</td>
</tr>
<tr>
<td>TIS</td>
<td>Translating and Interpreting Services</td>
</tr>
<tr>
<td>VET</td>
<td>Vocational Education and Training</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
References


2. ibid.


Australian Institute of Health and Welfare, 2009. Health and community services labour force, National health labour force series number 42. cat. no. HWL 43, AIHW, Canberra. Census data is collected from all persons aged 15 years and over about their main job held during the week before census night and the results are classified using the Australian and New Zealand Standard Classification of Occupations.

This report focussed on a person's occupation rather than their industry of employment. The report stated that an additional 293,580 people worked in the health care and social assistance industry but were not employed in a health or social service occupation. These were primarily managers, accountants, tradespersons and labourers.


ibid, p. 80.

ibid.


ibid.


38. This report defines primary health care services as those provided to whole populations (public health and community health services) plus those rendered in, or flowing from, a patient-initiated contact (GP consultations, hospital emergency attendances, GP-ordered investigations and prescriptions, over-the-counter medicines and so on). Secondary/tertiary services can be defined within the system by referral or hospital admission.
42. Definition developed by the Australian Primary Health Care Research Institute for ADGP Primary Health Care Position Statement 2005, also included in the Australian Medical Association Primary Health Care position paper, 2006.
45. Pan American Health Organisation, 1999. *Methodological Summaries: Measuring Inequity in Health*, Epidemiological Bulletin, vol. 20, no.1. The concept of inequity has been considered synonymous with the concept of inequality; however, it is fundamental to differentiate between the two. While inequality implies differences between individuals or population groups, inequity refers to differences which are unnecessary and avoidable but, in addition, are also considered unfair and unjust.


51. Family Medicine Research Centre, 2009. *To what extent is equity of access now established in those areas defined under Government policies as ‘Outer metropolitan areas of need’?,* produced for the Australian Government Department of Health and Ageing.


75. Australian Government Department of Health and Ageing, unpublished data.


77. The Medicare Safety Net covers the difference between the Medicare fee and the Medicare benefit, which averages around $11 for a non-GP service. When a person or family accumulates $383.90 in gaps in a calendar year the Medicare benefit increases to 100%, removing that gap.

78. The Extended Medicare Safety Net was introduced in 2004 to meet out-of-pocket medical costs. Once an individual or family reaches a threshold of Medicare-related out-of-pocket costs in a calendar year Medicare reimburses 80% of the out-of-pocket costs for the remainder of the year. The current thresholds are $555.70 for Commonwealth concession card holders and families eligible for Family Tax Benefit Part A and $1,111.60 for the general population. In 2007, this safety net distributed $324 million in benefits to 422,000 families and individuals.

79. The net medical expenses tax offset allows taxpayers to claim a tax offset of 20% of net medical expenses over $1,500 for a broad range of health care services provided by doctors, dentists, opticians and chemists. The Australian Taxation Office reported 667,160 claims for the offset in 2006-07 (7.2% of all taxpayers), totalling $420.7 million in foregone tax revenue.

80. A household is defined as a group of related or unrelated people who usually live in the same dwelling and make common provision for food and other essentials of living; or a lone person who makes provision for his or her own food and other essentials of living without combining with any other person.
The ABS report’s explanatory notes makes it clear that it is not possible to draw conclusions on the proportion of income spent on different expenditure groups because the lowest quintile’s average is distorted by some households reporting low income by underreporting their incomes; having access to economic resources, such as wealth; income could be temporarily low reflecting business start up; and many low income households are single pensioner households which may use their assets to maintain a higher standard of living than implied by their incomes alone.


The disadvantaged categories reflect ABS population data relating to income, education, unemployment and skilled employment.


Based on Medicare Australia data from July 2006 to June 2007.

The unpublished Western Australian study, *A multifacet intervention to reduce demand for ED services of aged care facility residents through improved primary care services*, was funded through a State Health Research Advisory Council grant.


98. Submission from North East Victorian Division of General Practice (Sub #126)
99. Submission from Congress of Aboriginal and Torres Strait Islander Nurses (Sub #59)
100. Submission from Western Region Health Centre (Sub #125)
101. Submission from Country Women's Association of NSW (Sub #41)
102. Submission from Pfizer Australia (Sub #131)
103. Submission from The Pharmacy Guild of Australia (Sub #178)
104. Submission from Royal College of Nursing, Australia (Sub #127)


110. ibid.
111. ibid.

112. Australian Bureau of Statistics, 2006. Adult Literacy and Life Skills Survey: Summary results, ABS cat. no. 4228.0, available from: http://www.abs.gov.au/ausstats/ subscriber.nsf/0/822A471C221C7BA4CA2573CA00207F10/$File/42280_2006%20(reissue).pdf (accessed June 2009). The mean weekly income of those Australians with a level of literacy below the minimum requirement to meet the demands of everyday life was $504 while the mean weekly income of Australians achieving the minimum requirement was $695. Australians with the highest levels of literacy earned an average weekly income of $890. Similarly, for Australians for whom English is a second language, only 36% (prose scale) and 38% (document scale) achieved above the minimum requirement compared to 54% and 53% respectively of the general population.


128. Submission from NT Department of Health and Families (Sub #204)
129. Submission from Consumers Health Forum of Australia (Sub #169)
130. Submission from South Australian Refugee Health Network (Sub #27)
131. Submission from The School of Nursing and Midwifery, The University of QLD (Sub #25)
132. Submission from Brooke Street Medical Centre (Sub #63)
133. Submission from Cancer Council Australia and Clinical Oncological Society of Australia (Sub #170)
134. Submission from Greater Green Triangle GP Education and Training (Sub #120)
135. Personal submission (Sub #56)
136. Submission from Dementia Advisory Group (Sub #151)
137. Personal submission (Sub #56)
144. Noting that community pharmacists already have some role in preventive care through programs introduced as part of the third and fourth Community Pharmacy Agreements.


153. Cited in Harris M, 2008. *The role of primary health care in preventing the onset of chronic disease, with a particular focus on the lifestyle risk factors of obesity, tobacco and alcohol*. Centre for Primary Health Care and Equity, University of NSW, paper produced for the National Preventative Health Taskforce.


160. Cited in Harris M, 2008. *The role of primary health care in preventing the onset of chronic disease, with a particular focus on the lifestyle risk factors of obesity, tobacco and alcohol*. Centre for Primary Health Care and Equity, University of NSW, paper produced for the National Preventative Health Taskforce.

161. ibid.

162. ibid.


164. Submission from NSW Government (Sub #187)

165. Personal submission (Sub #14)

166. Submission from Australian Practice Nurses Association (Sub #203)
Noting that community pharmacists already have some role in preventive care through programs introduced as part of the third and fourth Community Pharmacy Agreements.


193. ibid, pp. 104–107.

194. ibid, pp. 57-61.


198. ibid.

199. ibid.


201. Submission from South Australian Government (Sub #43)

202. Submission from The Royal Australian College of General Practitioners (Sub #173)

203. Submission from Australian General Practice Network (Sub #141)

204. Submission from Rural Doctors Association of Australia (Sub# 262)

205. Submission from Australian Practice Nurses Association (Sub # 203)

206. Submission from Australian College of Nurse Practitioners (Sub #104)

207. Submission from National Prescribing Service (Sub #103)

208. ibid.

209. Submission from Australian Psychological Society (Sub #231)

210. Submission from National Aboriginal Community Controlled Health Organisation (Sub #140)

211. Submission from Australian Chronic Disease Prevention Alliance (Sub #196)

212. Submission from Centre for Primary Health Care and Equity, University of NSW (Sub #168)

213. Submission from Australian Chronic Disease Prevention Alliance (Sub #196)

214. Submission from Southern General Practice Network (Sub #233)

215. Submission from Optometrists Association of Australia (Sub #258)

216. Submission from Consumers Health Forum (Sub #169)


222. ibid.


224. ibid.


235. ibid.


238. Submission from Consumers Health Forum (Sub #169)
239. Submission from the Greater Green Triangle University, Department of Rural Health (Sub #225)
240. Submission from The Victorian Healthcare Association (Sub #172)
241. Submission from General Practice Network South (Sub #62)
242. Submission from Darebin Community Health (Sub #60)
243. Submission from headspace – Australia’s National Youth Mental Health Foundation (Sub #250)
244. Submission from Australian General Practice Accreditation Limited/Quality in Practice (Sub #114)
245. Submission from Central Coast Division of General Practice (Sub #55)
246. Submission from Australian Health Care Reform Alliance (Sub #212)
247. Submission from Health Issues Centre (Sub #144)
248. Submission from Brisbane South Division of General Practice (Sub #182)
249. Submission from Australian Association of Academic General Practice (Sub #38)
250. Submission from National Primary Health Care Partnership (Sub #149)
251. Submission from Board of Hastings Macleay General Practice Network (Sub #34)
252. Submission from Australian Medical Association (Sub #51)
253. Submission from NSW Government (Sub #187)
254. Submission from Australian Association for Academic General Practice (Sub #38)
255. Personal submission (Sub #143)
256. Submission from Australian Physiotherapy Association (Sub #123)
257. Submission from National Primary Health Care Partnership (Sub #149)


267. ibid.

268. ibid.


270. Submission from Consumers’ Health Forum of Australia (Sub #169)

271. Submission from Ipswich and Moreton Bay Division of General Practice (Sub #84)

272. Submission from Australian Medical Association (Sub #51)

273. Submission from Australian Nursing Federation (Sub #200)

274. Submission from Royal District Nursing Service (Sub #134)

275. Submission from the Australian Nursing Federation (Sub #200)

276. Submission from Allied Health Professions of Australia (Sub #232)

277. Submission from Australian General Practice Network (Sub #141)

278. ibid.

279. Submission from ACT Health (Sub #180)

280. Submission from National Prescribing Service (Sub #103)

281. ibid.

282. ibid.

283. Submission from Allied Health Professions Australia (Sub #232)

284. Submission from Australian Institute of Health and Welfare (Sub #223)

285. Submission from National Rural Health Alliance (Sub #81)

286. Submission from Speech Pathology Australia (Sub #130)

287. Submission from Royal Flying Doctors Service of Australia, National Office (Sub #97)

288. Submission from Health Care Consumers’ of the ACT (Sub #64)

289. Submission from Aboriginal Health Council of South Australia (Sub #50)

290. Submission from Australian Practice Nurses Association (Sub #203)

291. Submission from The Royal Australian College of General Practitioners (Sub #173)

292. Submission from The Pharmacy Guild of Australia (Sub #178)

293. Submission from Private Mental Health Consumer Carer Network (Australia) (Sub #153)

294. Submission from Health Care Consumers Association of the ACT (Sub #64)

295. Submission from Consumers Health Forum of Australia (Sub #169)
296. Submission from The Royal Australasian College of Physicians (Sub #253)
297. Submission from Australian Nursing Federation (Sub #200)
298. Submission from National Prescribing Service (Sub #103)
299. Submission from NSW Government (Sub #187)
300. Submission from G21 Geelong Region Alliance (#Sub 29)
301. Submission from Greater Green Triangle University, Department of Rural Health (Sub #225)
302. Submission from the Health Inequalities Research Collaboration Primary Health Care Network (Sub #57)
303. Submission from GP Links Wide Bay (Sub #211)
304. Submission from Australian Association of Practice Managers (Sub #202)
305. Submission from The Royal Australian College of General Practitioners (Sub #173)
306. Submission from Australian General Practice Network (Sub #141)
307. Submission from GP Connections (Sub #23)
308. Submission from National Primary Health Care Partnership (Sub #149)
309. Submission from Australian General Practice Network (Sub #141)
310. Submission from Australian Health Care Reform Alliance (Sub #212)
311. Submission from Rural Doctors Association of Australia (Sub #262)
314. ibid.
315. ibid.
316. ibid.
323. ibid.
324. ibid.


The growth in less segmented, multi-disciplinary practice is progressing alongside enhancements in the roles and number of health professions, such as practice nurses and nurse practitioners. 


From 1 July 2010, the following health professions will be regulated under the new National Registration and Accreditation Scheme: chiropractic, dental (including dentists, dental hygienists, dental prosthetists, dental therapists and oral health therapists), medicine, nursing and midwifery, optometry, osteopathy, pharmacy, physiotherapy, podiatry, and psychology. From 1 July 2012 the following health professions will be regulated under the scheme: Aboriginal and Torres Strait Islander health practice; Chinese medicine; and medical radiation practice.


Submission from Rural Health Workforce Australia (Sub #247)
Submission from Australian Medical Association (Sub #51)
Submission from Australian Primary Health Care Research Institute (Sub #226)
Submission from Royal College of Nursing, Australia (Sub #127)
Submission from Australian Association for Academic General Practice (Sub #38)
Submission from Australian Primary Health Care Research Institute (Sub #226)
Submission from Victorian Association of Maternal and Child Health Nurses (Sub #66)
Submission from Australian Nursing Federation (Sub #200)
Examples of jurisdictional inbound/outbound call centre activities include:

- a trial of outbound call coaching service for the Western Australian Department of Health for low risk participants with diabetes and other chronic diseases who have never been hospitalised.
- Medibank Private’s ‘Better Health’ service for members with heart disease, heart failure, COPD and diabetes which includes telephone coaching to assist patients better manage their condition.
- the Department of Veterans’ Affairs congestive heart failure program for veterans in NSW (under the study Care coordination in the delivery of health services to veterans).
- HCF’s Healthy Heart program for members with congestive heart failure or coronary artery disease which includes telephone coaching to help people better understand their care plan and their condition; and to better monitor and manage their health.


386. Submission from Australian General Practice Network (Sub #141)
387. Submission from Australian Health Professions Association (Sub #232)
388. Submission from Royal District Nursing Service (Sub #134)
389. Submission from Australian Health Care Reform Alliance (Sub #212)
390. Submission from Australian General Practice Network (Sub #141)
391. Submission from The Royal Australian College of General Practitioners (Sub #173)
392. Submission from NSW Government (Sub #187)
393. Submission from The Royal Australian College of General Practitioners (Sub #173)


