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Response to the draft recommendations from the Primary Health Reform Steering Group on the Australian Government's Primary Health Care 10 Year Plan

The George Institute for Global Health is pleased to respond to the draft recommendations from the Primary Health Reform Steering Group on the Australian Government's Primary Health Care 10 Year Plan.

Our response is structured by the eight themes and the 20 recommendations. We have commented on each recommendation, outlining our reasons. We do not disagree with any recommendations.

As the report acknowledges, in Australia there is a growing burden on individuals in the health system with chronic conditions, with many conditions largely preventable. The current system is not "fit for purpose" and a business-as-usual approach to primary health care is not an option.

In 2018, The George Institute in partnership with the Consumers Health Forum Australia and the University of Queensland MRI Centre for Health System Reform and Integration released the report, *Snakes & Ladders: The Journey to Primary Care Integration*. The report outlined priorities to maximise opportunities to achieve better health and wellbeing outcomes for individuals, their families and communities. Many of the report recommendations are outlined in this submission.

The George Institute believes primary health care should be at the heart of the Australian health system. It needs to be of high value, integrated, equitable and patient-centred. It should be readily available and accessible for people across their life course, responding to acute needs at critical life stages and proactive in the intervening periods to promote health and well-being.

The COVID-19 pandemic has demonstrated the importance of primary health care, and its need to be innovative, agile and better prepared to ensure safe and secure connectivity between individuals, their families and the primary health care workforce. Although the pandemic has exposed many of our health system weaknesses, it has also highlighted extraordinary potential to rapidly address those weaknesses. What previously was thought to be a decades long process has been achieved in months. The momentum gained from such agility must not be lost and we strongly believe this mindset needs to be at the core of the proposed primary health care reforms.

In the recommendations, we note:

- No further details have been provided in relation to shifting away from fee-for-service funding models. We believe there needs to be a substantial shift away from fee-for-service payment systems toward a more flexible funding model based on needs and outcomes. Such models should be accompanied by service delivery reform to support value-based, whole person care.
- No mention of planetary health. Climate change is an existential threat to health. Primary health care is in a unique position where it has responsibilities to both mitigate

climate change (through development of low carbon health systems) and be at the forefront of health system adaptation to respond to the health impacts of climate change and promote planetary health.

- An opportunity to establish an Australian Primary Health Care Innovation and Translation Institute. This would be similar to the US Center for Medicare and Medicaid Innovation, which is a government-led innovation initiative that is continuously developing and testing new service delivery models and has a mandate to scale and spread the most promising innovations nationally.
- Under 'Primary care workforce development and innovation' (recommendations 10-14), Aboriginal and Torres Strait Islander health professionals play a critical role in provision of comprehensive primary health care and are missing from workforce development.

We look forward to you submitting your final report to the Minister for Health, followed by the Minister acting upon the report's final recommendations.

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

Recommendation 1 (One system focus): Reshape Australia's health care system to enable one integrated system, including reorientation of secondary and tertiary systems to support primary health care to keep people well and out of hospital.

Our recommendation: Agree.

Our comments: The George Institute believes primary health care should be at the heart of the Australian health system. It needs to be integrated, equitable and patient-centric, recognising the social and cultural determinants of health. It should be readily available and accessible for people across their life course, responding to acute needs at critical life stages and proactive in the intervening periods to promote health and well-being.

As outlined in the *Snakes & Ladders: The Journey to Primary Care Integration* report, integrated care was described by primary health care stakeholders as "joined-up care for everyone when they need it and where they need it".

The George Institute agrees with this recommendation and believe it will ensure there is a focus on:

- Prevention: Keeping people healthy for longer and preventing hospitalisations.
- Funding reform: Investing in primary health care and ensuring the overall system evolves from being siloed and fragmented to an integrated and coordinated approach; and
- Evidence: Whole of system data to support evidence-informed decision making, continuous monitoring of system performance with a particular focus on ensuring outcomes are equitably distributed.

Recommendation 2 (Single primary health care destination): Formalise and strengthen the relationship of individuals, families and carers with their chosen primary health care provider and practice.

Our recommendation: Agree.

Our comments: The George Institute supports voluntary patient registration (VPR) as it will assist in ensuring there is a formal and single health care destination and reference point for individuals, their families, and the primary health care workforce. Each person has a unique journey in the health system throughout their lives, and this recommendation recognises the importance of the relationship with primary health care providers and practice in continuity of care.

The George Institute recommends that government dedicate considerable time and resources to work with primary health care providers to ensure the formalisation and strengthening of this recommendation. Large-scale adoption will require substantial organisational change and has potential to impact the culture of primary health care in Australia in non-trivial ways.

Recommendation 3 (Funding reform): Deliver funding reform to support integration and a one system focus.

Our recommendation: Agree.

Our comments: The George Institute strongly supports funding reform. It is vital primary health care funding is sustainable with a focus on high quality services and outcomes for individuals, not quantity or volume of services. To ensure this, health care consumers and civil society organisation should central to the discussions around funding reform priorities and not just the primary health care workforce.

The George Institute recommends:

- Significant shift away from a fee-for-service payment systems toward flexible funding models based on needs and outcomes.
- Linking organisational funding, board and management performance contracts to the attainment of minimum standards related to patient engagement, experience and health outcomes.
- Introducing regional alliance funding models that promote health system governance reform and integrated health service delivery.
- Judicious introduction of financial and non-financial incentives for primary and hospital sectors to work collaboratively and robust evaluation of those incentives to ensure they achieve the intended outcomes.

Recommendation 4 (Aboriginal and Torres Strait Islander health): Implementation of the National Agreement on Closing the Gap for Aboriginal and Torres Strait Islander peoples through structural reform of the primary health care system.

Our recommendation: Agree.

Our comments: The George Institute believes primary health care plays a fundamental role in supporting the priority reforms of the National Agreement on Closing the Gap for Aboriginal and Torres Strait Islander peoples.

The Aboriginal and Torres Strait Islander health sector has consistently demonstrated models of excellence in the delivery of comprehensive primary health care. These models are underpinned by principles of community control, self-determination and represent examples of best practice that are applicable to the wider Australian community.

A patient centred, community-led, shared decision-making approach co-designed with Aboriginal and Torres Strait Islander peoples through meaningful partnerships with Aboriginal Community Controlled Health Organisations (ACCHOs) is essential, especially in relation to future reforms in the primary health care system.

Disappointingly, there remain large gaps in achieving a sufficiently representative workforce and an under-recognition of the diverse roles played by Aboriginal and Torres Strait Islander health professionals in the delivery of primary health care. This should have been outlined in 'Primary care workforce development and innovation' (recommendations 10-14).

The George Institute recommends that government needs to, in close collaboration with Aboriginal and Torres Strait Islander communities and organisations, identify strategies to strengthen Aboriginal and Torres Strait Islander workforce capacity; set clear targets; and implement plans to address gaps in healthcare workforce participation. In building the workforce of Aboriginal and Torres Strait Islander health professionals, primary health care systems must ensure workplaces are culturally safe. It is the responsibility of primary health care systems to develop and implement processes that foster ongoing reflexivity of staff, and a commitment to improving Aboriginal and Torres Strait Islander health care and health outcomes.

Recommendation 5 (Local approaches to deliver coordinated care): Prioritise structural reform in rural and remote communities.

Our recommendation: Agree.

Our comments: The George Institute believes primary health care should be equitable regardless of where individuals, their families and the primary health care workforce is located.

In rural and remote Australia, there should be a connected approach built around the strengths of these locations and communities.

The George Institute recommends:

- Removing funding barriers with the development of regional budgets combining Commonwealth and State/Territory funding. These budgets would be flexibly administered by Primary Health Networks (PHNs), ACCHOs and Local Health Networks (LHNs), prioritising prevention and integrated primary health care with other parts of the health sector and social services.
- Linking the system by establishing regional alliance organisations that are jointly governed by PHNs, ACCHOs and LHNs, and other community-based service providers where appropriate. Regional health alliances will play a core role enabling better coordination, communication, discharge planning and handover to and from hospital, harnessing the power of general practices, ACCHOs and other community services to better support population health.
- Upskilling and greater support to regional primary health care professionals to better identify and manage low risk specialist and ambulator care needs, particularly for chronic disease management and monitoring. This needs to be combined with innovative specialist support services (including but not limited to telehealth) that are not dependent on fee-for-service funding models and allow greater flexibility in service provision.

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

Recommendation 6 (Empowering individuals, families, carers and communities): Support people and communities with the agency and knowledge to better self-care and manage their wellness and health within a system that allows people to make the choices that matter to them.

Our recommendation: Greater specificity to the wording of this recommendation is required.

Our comments: The George Institute believes this recommendation is commendable and we do not disagree. However we recommend greater specificity to the wording of this recommendation. We believe self-care is a shared responsibility between individuals, government and society.

As outlined in the Self-Care for Health: A National Policy Blueprint by the Mitchell Institute for Education and Health Policy at Victoria University, we share their vision for "better health for all, through better self-care by all" and their understanding of self-care to be "the role of individuals in preventing disease, managing their health and actively participating in their health care" and that it "is influenced, enabled and informed by a range of external forces that sit beyond the individual".

Recommendation 7 (Comprehensive preventive care): Bolster expanded delivery of comprehensive preventive care through appropriate resourcing and support.

Our recommendation: Clearer wording is required that stipulates how "appropriate resourcing and support" are identified and tracked.

Our comments: The George Institute strongly supports this recommendation, as we believe preventative health should occur across the life course and should address the social and environmental determinants of ill health.

We believe, as recommended in the 2017 Productivity Commission's report, Shifting the Dial: 5-year productivity review, the creation of pooled funding mechanisms such as the Prevention and Chronic Condition Management Fund for PHNs, ACCHOs and LHNs, as well as reconfiguring the health care system around the principles of patient centred care.

As previously outlined, The George Institute recommends the removal of funding barriers, with the development of regional budgets combining Commonwealth and state/territory funding that prioritise prevention and integrated primary health care. Greater integration with private sector payers and providers is also considered essential to overcoming fragmentation and the achievement of 'one health system'.

The George Institute supports building on the lessons learnt from the Health Care Homes (HCHs) approach to provide a setting where individuals with complex and chronic conditions can receive enhanced access to holistic coordinated care and wrap around support for multiple health needs. HCHs have potential to promote interprofessional team-based approaches, as well as shifting to outcomes-based models of care. However, we note substantial shortcomings in how the federal model was implemented. We also note that an independent evaluation of HCHs will be conducted and recommend there be critical review of the recommendations arising from this evaluation to inform the development of future implementation models.

Recommendation 8 (Improved access for people with poor access or at risk of poorer health outcomes): Support people to access equitable, sustainable and coordinated care that meets their needs.

Our recommendation: Agree.

Our comments: Despite Australia having a high performing health system overall, it has consistently underperformed relative to comparable member nations of the Organisation for Economic Co-operation and Development (OECD) on equitable access to high quality health care.

The George Institute believes the primary health care system needs to be an equitable and patient centric system including self-determination for Aboriginal and Torres Strait Islander peoples. We believe it needs to be inclusive to all Australians and tailored to communities, including but not limited to lesbian, gay, bisexual, transgender, intersex, queer and other sexuality, gender and bodily diverse people (LGBTQI+) communities, people with disability, older people, people in residential or aged care, people with mental illness, and culturally and linguistically diverse (CALD) communities.

The George Institute recommends active recruitment to the workforce of people from different communities, regional and local settings, and diverse backgrounds to ensure the primary health care system has linkage and collaboration around the needs of individuals, families and communities with lived experience.

As previously outlined in the submission, The George Institute recommends a patient-centred, community-driven, shared decision-making approach to addressing access barriers; a strong commitment to reduction of out-of-pocket costs; and an explicit focus on measuring health system performance by a range of equity domains to ensure no one gets left behind.

Leadership and culture

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

Our recommendation: Agree.

Our comments: The George Institute supports leadership development at multiple levels in the primary health care system and the need to actively engage leaders from other parts of the health system. This includes policy leaders, organisational leaders, clinical champions, academics, community leaders including Aboriginal and Torres Strait Islander Elders, expert patients and their families or carers.

The George Institute believes exercising leadership in primary health care will be crucial to ensuring ongoing and seamless system reform, as well as managing cultural and change management. Exercising leadership will have a 'future proofing dimension' by making sure the primary health care system is both sustainable and innovative into the future.

Primary care workforce development and innovation

Recommendation 10 (Building workforce capability and sustainability): Address Australia's population health needs with a well-supported and expanding primary health care team that is coordinated locally and nationally for a sustainable future primary health care workforce.

Our recommendation: Agree.

Our comments: The George Institute believes that for the primary health care system to be successful, it needs to build workforce capability. Workforce design, development and deployment are major building blocks of any system. We believe a diverse workforce that is representative of the Australian population will produce better long-term health outcomes.

In particular, we support the need for ongoing education, training, building of cultural capabilities and development opportunities for the primary health care workforce. Given the diversity of this workforce, these opportunities must be tailored to the specific requirements of each health professional group. We also support the need for a greater emphasis on primary health care teams and the critical role that coordinated, connected and high functioning teams play in delivering care.

As previously outlined, The George Institute recommends the employment of people from diverse communities, regional and local settings, and diverse backgrounds to ensure the primary health care system has linkage and collaboration around the needs of individuals, families and communities.

The George Institute recommends that the Australian government strengthen its commitment to adhere to the WHO Global Code of Practice on International Recruitment of Health Personnel. We recommend safeguards are put in place to ensure that overseas recruitment policies do not impact adversely on the ability of countries with under-resourced health systems to achieve universal health coverage. We recommend that there be reciprocity to those countries from which the Australian health system has gained benefit through skilled health workforce migration.

Recommendation 11 (Allied health workforce): Support and expand the role of the allied health workforce in a well-integrated and coordinated primary health care system underpinned by continuity of care.

Our recommendation: Agree.

Our comments: The George Institute commends this recommendation to better support the allied health workforce and views this diverse workforce as a key part of the primary health care team.

In addition to the important and often neglected roles played by the major allied health professions, we believe there needs to be greater recognition of the vital roles played by Aboriginal and Torres Strait Islander health practitioners, social service providers and other self-regulated allied health professions. The primary health care workforce should be in an integrated, equitable and patient centric system that maximises the contribution of all allied health professionals and appropriate funding models need to be developed to incentivise collaboration.

Recommendation 12 (Nursing and midwifery workforce): Support the role of nursing and midwifery in an integrated Australian primary health care system.

Our recommendation: Agree.

Our comments: The George Institute strongly recognises the pivotal role of nursing and midwifery in the primary health care system.

As previously outlined, The George Institute recommends greater emphasis on team-based approaches to primary health care that allow all health professionals to practice at the top of their license, minimise waste and duplication of services, and recognises the unique contributions of each team member to support patient-centred care.

Recommendation 13 (Broader primary health care workforce): Support and develop all appropriate workforces in primary health care to better support people, the existing health care workforce and achieve an integrated, coordinated primary health care system.

Our recommendation: Agree.

Our comments: The George Institute believes it is important that all health professionals who contribute to primary health care are recognised. As previously outlined, we believe a diverse primary health care team that is representative of the Australian population is needed.

As previously outlined, The George Institute also recommends a strategy to integrate health and social service care providers with a particular focus on integration with aged care, disability, housing, employment and other community services.

Recommendation 14 (Medical primary care workforce): Support, streamline and bolster the role of GPs (which includes Rural Generalists) in leading and coordinating care for people, while building and ensuring a sustainable and well supported medical primary care workforce.

Our recommendation: Agree.

Our comments: As previously outlined, The George Institute supports the streamlining and bolstering the role of general practitioners as part of an overall strategy to foster and support team-based care for people.

We recommend greater support to international medical graduates who comprise around 30% of the health care workforce and over 60% of the general practitioner workforce in rural and remote areas. This includes:

- Greater support services to assist with preparation for living and working in rural and remote areas.
- Social support services to recognise the considerable financial and emotional hardship experienced, particularly during the early years of migration.

- Ongoing supervisory support services after passing the Australian Medical Council examinations and general medical registration has been granted.

Innovation and Technology

Recommendation 15 (Digital infrastructure): Develop digital infrastructure and clinical systems to better support providers to deliver safe and effective care.

Our recommendation: Agree.

Our comments: The George Institute believes the development of digital infrastructure and clinical systems will improve health system performance. The COVID-19 pandemic has demonstrated the importance of innovation in primary health care, the need to rapidly respond to changing circumstances, and a need to ensure safe and secure connectivity between individuals, their families and the primary health care workforce.

The George Institute recommends that greater funding be allocated via the Medical Research Future Fund (MRFF) to national digital health innovation trials. We recognise that in the future more primary health care services will be delivered remotely through digital technology and telehealth service delivery models. Greater funding to national digital health innovation trials will build a more robust evidence base on effective digital health intervention strategies in primary health care and a greater understanding of the specific health systems contexts that support or constrain implementation of those strategies.

Recommendation 16 (Care innovation): Enable a culture of innovation to improve care at the individual / population level, build 'systems' thinking and ensure application of cutting-edge knowledge and evidence.

Our recommendation: Agree.

Our comments: The George Institute believes in the role of government creating an environment to support innovation. As previously outlined, we believe in the development of digital infrastructure and clinical systems.

The George Institute recommends core funding for large-scale primary health care innovations which draw on a 'health systems thinking' approach. Such innovations would not be pilots, rather they are designed with scalability and sustainability in mind at the outset. They would also not be academic-led initiatives, rather they would reflect collaborations represented by a diverse set of stakeholders. The US Center for Medicare and Medicaid Innovation is one international example of a government-led innovation initiative that is continuously developing and testing new service delivery models and has a mandate to scale and spread the most promising innovations nationally. In alignment with this approach, we support the establishment of a government body, the Australian Primary Health Care Innovation and Translation Institute.

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

Recommendation 17 (Data): Support a culture of continuous quality improvement with primary health care data collection, use and linkage.

Our recommendation: Agree.

Our comments: The George Institute believes in the importance of data, as it enables evidence-informed decision making. However, quality improvement programs are variably implemented and often have low rates of adoption amongst primary health care providers.

Building on the Practice Incentives Quality Improvement Incentive, The George Institute recommends greater support is required to primary healthcare providers who are not engaging in quality improvement processes with increased focus on the constraints and enablers to wider scale participation. We also recommend large scale data linkage programs to support a whole of system understanding of quality so that providers and the community can review performance across the health system.

Recommendation 18 (Research): Empower and enable contextually relevant, translational and rapid research and evaluation in primary health care, addressing questions directly relevant to service delivery in localised context.

Our recommendation: Agree.

Our comments: Currently primary health care research is woefully under-funded and there are limited opportunities to support academic career development for primary health care providers.

The George Institute recommends increased and targeted primary health care research investments in order to address current imbalances in research funding. As mentioned earlier, we support the establishment of a body, the Australian Primary Health Care Innovation and Translation Institute which could in turn be supported by research funding agencies including the National Health and Medical Research Council (NHMRC) and MRFF. The Institute would be underpinned by the World Health Organization (WHO) concept of 'embedded implementation research' in which multiple stakeholders co-design research questions and apply state-of-the-art methods to answering those questions. A core part of this process is that research and policy be codesigned with consumers.

Emergency preparedness

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

Our recommendation: Agree.

Our comments: The George Institute supports integrated and coordinated emergency preparedness and response. The COVID-19 pandemic has demonstrated the importance of primary health care, and its need to be innovative, and better prepared to ensure safe and secure connectivity between individuals, their families and the primary health care workforce. However, greater attention also needs to be paid to the inter-pandemic period in which mid-and long-term strategies are implemented to foster greater health system resilience. Such an approach also extends to non-pandemic emergencies, including but not limited to those arising from climate change induced emergencies such as bushfires, flooding and drought.

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

Recommendation 20 (Implementation):

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

Our recommendation: Agree.

Our comments: The George Institute believes the Australian Government's Primary Health Care 10 Year Plan is just the start, and not the end, towards ongoing and long-term reform of the primary health care system. We believe strategic planning is essential to ensure its viability and success.

The George Institute is strongly supportive of an Implementation Action Plan with clear articulation of measurable short-, medium- and long-term goals to support the reforms proposed.

We look forward to supporting commitments from the Australian Government to strengthen primary health care now and well into the future.

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