Care That Puts People First:

Responding to the health challenges of today, preparing for those of tomorrow

THE AUSTRALIAN GENERAL PRACTICE NETWORK

Primary Health Care Position Statement

Delivering local health solutions through general practice

Responding to the health challenges of today, preparing for those of tomorrow

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Primary Health Care Position Statement

The Australian General Practice Network (AGPN) represents a network of 111 local organisations (Divisions of general practice), as well as eight state and territory based entities. More than 90 per cent of general practitioners and an increasing number of allied health professionals and practice nurses are members of their local division. The Network is involved in a wide range of activities, including health promotion, early intervention and prevention strategies, chronic disease management, medical education and workforce support.

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Foreword

We are facing an unprecedented opportunity for potential transformational change in Australian health policy. Government commitments to a national primary health care strategy and prevention agenda provide an opportunity to put forward our ideas for primary health care and general practice, as well as a unique opportunity to position the Divisions of General Practice Network (the Network) as an integral building block for the future.

Investing in and building the capacity of primary health care is fundamental to improving health system performance as measured by better population health outcomes, enhanced patient care, quality, community and individual satisfaction, value for money and reductions in health inequalities.

This *Primary Health Care Position Statement* updates the Network's original 2005 *Statement*. It outlines our vision for Australia's primary health care system and general practice and the Network's place in that system. The *Statement* provides principles that should underpin a primary health oriented system – with *care that puts people first* as the core principle.

The *Statement* sets out a preferred future for primary health care, general practice and the Network. It does not describe where we are now, nor is it a work plan. It is aspirational in its vision, but recognises the need for a systematic, coordinated and inclusive approach if we are to realise the full potential of our health system as a fundamental building block of a modern, caring society.

Achieving this vision will require new investment and clear leadership from Australian governments – working in partnership with others in the health sector as well as with other sectors which impact on the health of the community – to shift the focus from an over-reliance on hospitals to primary health care. This is work which must begin now to overcome the unacceptable and avoidable failings of the current health system.

I am confident this *Statement* will continue to inspire and lead debate, and ultimately influence better health policy in Australia. I commend this *Statement* to you.

Dr Emil Djakic
Chair
March 2009

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Executive Summary: The *Position Statement* at a glance

Executive Summary: The *Position Statement* at a glance

A paradigm shift towards an enhanced primary health care system is required to improve the way health care is delivered, funded, organised and governed, and to best meet the current and future needs of Australians.

Health budgets are under increasing pressure, chronic disease is on the rise and there are major health inequalities within society. Most existing payment systems reimburse inputs rather than outcomes and there are few incentives to avoid or slow the rate of expensive hospitalisation, to invest in prevention and to allocate funding based on need. Divided responsibilities for health funding and delivery mean that patients experience fragmented and poorly connected services.

Primary health care represents the platform for the development of a health system which is more equitable, inclusive and fair, and which meets growing expectations for better system performance.

This *Statement* is AGPN's position on primary health care policy. It reflects the evidence about primary health care and outlines the aspirations for transformation of the Australian health system into what is recognised as world's best practice: one which is led by comprehensive, integrated patient-centred primary health care.

> "Moving towards health for all requires that health systems respond to the challenges of a changing world and growing expectations for better performance. This involves substantial reorientation and reform of the ways health systems operate in society today: those reforms constitute the agenda of the renewal of Primary Health Care."[1]

Key Principles

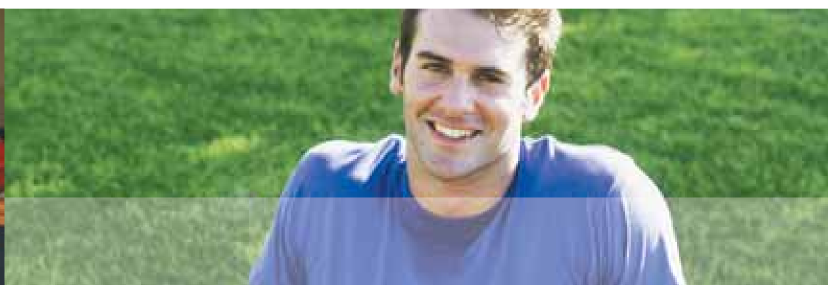
- Primary health care delivers better care and outcomes for individuals and communities.
- There must be equitable access to comprehensive primary health care for all Australians.
- An effective primary health care system is patient-centred – patients have the right to expect comprehensive, integrated and coordinated care.
- The relationship between a patient and their general practitioner (GP) is the cornerstone of an effective primary health care system.
- Access to comprehensive general practice is an essential component of an effective health system and includes acute and chronic disease management, health maintenance and preventative care.
- Australia's future health system must be built around general practice working with others to deliver integrated primary health care to the community.
- The primary health care system must be reoriented to include incentives to reward quality practice, supplementing fee-for-service, and to encourage and reward preventative health care and self management.
- Multidisciplinary team based care, with a GP as the clinical lead, improves outcomes in primary care.

1 World Health Organization. *World Health Report 2008: Primary health care – now more than ever.* Geneva: WHO Press; 2008.

- Continuity of care improves health outcomes.
- Primary health care needs will be better met if there are new regional enterprises to integrate and coordinate the allocation of federal and state resources based on community need.
- General practice and divisions should have a greater role in regional primary health care resource allocation and delivery.
- An individual electronic health record, enabling consistent information to be shared between all health providers, will improve patient safety and care delivery as well as enabling a strengthened focus on the health of the population.
- Health policy must pay particular attention to groups within the population who have particular health needs or inequitable access to care: Aboriginal and Torres Strait Islander peoples, children and young people, older Australians and people with chronic disease.
- Priority must also be given to models of care in rural and remote Australia where small populations and distance pose difficulties in attracting and retaining health providers.

Primary health care service delivery

- A GP as the clinical lead is essential to team based care. Team based care will usually include practice nurses and will often include other allied health professionals. In remote communities, nurses and Aboriginal Health Workers typically play a lead role.
- Where clinically appropriate, non-GP providers will access Medicare rebates for a limited number of services.
- Incentives and programs should exist to promote general practice as an attractive career pathway for medical and nursing graduates and to support, retain and develop the primary care workforce.



- Team based care will often designate a clinician like a nurse to assist in care coordination, and will ideally also include a service coordinator to assist those with complex needs access the full range of services they need.
- Timely communication and common goals between providers ensures that care is integrated.
- A system of voluntary patient registration for patients with chronic disease will enable practices to better identify patient populations and maintain accurate disease registers. Patients will still have access to providers of choice for their health needs.
- Voluntary registration makes it possible to identify those patients for whom practices are responsible, facilitate proactive and systematic care and improve continuity of care. Patients benefit by having access to a regular and trusted provider as their entry point into comprehensive, person-centred primary health care.

Primary health care financing

- A blended payment system including fee-for-service, pay-for-performance and capitation payments will best support the general practice setting to deliver optimum care.
- Capitation payments will not replace GP fee-for-service arrangements, fee-for-service will remain the basis for remunerating GPs.
- A blended payment system with voluntary patient registration can be used to identify and reward practices that have adopted a quality improvement approach to chronic disease management and prevention and can demonstrate improvements in patient outcomes.
- A blended payment system can be used to supplement the resources of practices that are managing patients with chronic disease, so as to provide the GP with the tools and the teams needed to improve that patient's outcome.
- A blended payment system can be a tool to provide more equity in primary care expenditure to ensure that resources are allocated where the need is greatest, supplementing fee-for-service arrangements.
- A blended payment system that includes fee-for-service and practice payments should better support:
  - the role played by nursing and allied health care providers of patient care within a general practice team
  - non face-to-face contact by GPs and other members of the practice team acting on behalf of the GP
  - infrastructure (physical space and eHealth) to accommodate multidisciplinary teams and encourage general practice involvement in undergraduate and post-graduate training
- Payments to practices on a per capita basis (capitation) will give practices the flexibility to deliver care solutions for preventative health and chronic disease management best suited to particular practice populations– this could include home visits, telephone counselling and lifestyle modification groups.

- Payment-for-performance will supplement fee-for-service and will focus on rewarding improved outcomes for a practice population rather than activity. Outcomes will be set against realistic health improvement measures agreed in consultation with the profession, supplementing fee-for-service arrangements. The systematic collection and analysis of clinical data will be used to set benchmarks, plan interventions and monitor improvement.
- Expansion of programs such as the *Access to Allied Psychological Services (ATAPS)* and *More Allied Health Service (MAHS)* Programs will overcome service gaps and promote improved access to care for services not covered by Medicare.

Primary health care organisation

- Divisions of general practice aim to improve the health of their communities by supporting general practice and delivering primary health care programs and services. They also have an important role in supporting the entire practice team.
- GPs provide the vast majority of primary health care — comprehensive general practice must always be an essential component of an effective health system. The divisions that represent GPs should have a far greater role in allocating primary health care resources on a regional level than they do currently.
- A regionalised approach to health care funding and delivery with primary health care and general practice at its centre is essential if we are to improve health and achieve a sustainable system in Australia. This is the solution to desirable health system goals such as:
  - access and equity
  - cost savings and efficiency
  - enhanced community participation in health care
  - primary care-led care
  - emphasis on prevention and heath promotion
  - increased accountability of decision makers.
- Australia's health system should have regional enterprises with responsibilities such as population health planning, purchasing, facilitating community engagement, a role in linking patient, primary health care and acute care systems and comprehensive primary health care delivery.
- Key functions of regional enterprises must be to promote cooperation at a regional level to ensure that resources in primary care are allocated according to the needs of the local community. This can be best achieved through a coordinated approach to the allocation and administration of federal and state resources regionally through a single organisation.
- The Divisions of General Practice Network is a unique and well established infrastructure that is already delivering comprehensive primary health care solutions in many parts of Australia.
- The Network values excellence, has embraced continuous quality improvement principles and is developing a framework to set standards and drive improvement, performance and growth into the future.
- Building on the fifteen year investment already made in the Network to introduce regional primary health care enterprises is sound and prudent public policy: reform should use what works and what already exists as the platform for the future. The Network fits that description.
- While retaining its unique and vital capacity to engage and support general practice, the Network is the natural and best placed nation-wide system to build on in developing new regional primary health care enterprises.

Background

Background

Since the release of the original *Primary Health Care Position Statement* of the Australian Divisions of General Practice in 2005, the health policy debate in Australia has shifted extensively. Awareness of the pressures facing Australia's health system and of the merits of a more primary health care oriented system has grown. We know more about effective primary health care: through the work of the World Health Organization (WHO) globally and the Australian Primary Health Care Research Institute (APHCRI) and others nationally, there is a growing evidence base and groundswell for change. The monograph accompanying this *Statement* provides a meta-analysis of recent literature and more detailed overview of our current policy environment.

Calls for a national primary health care strategy and to renew the focus on preventative health care have been heeded.

Primary health care: the national policy drivers

By global standards, Australia's health system rates well and overall we enjoy good health. We have high life expectancy and declining mortality rates. Despite this, we still face significant health challenges, and our health system is complicated and fragmented.

Australia has among the highest hospitalisation rates in the world and prevalence of chronic diseases is rising at alarming rates. Health inequalities continue to be a serious issue, especially for Aboriginal and Torres Strait Islander peoples and those living in rural and remote Australia.

Yet each year some 700,000 people undergo potentially preventable hospitalisations, while the Australian and international evidence is clear that many chronic diseases which result in serious illness and premature deaths – diabetes, heart disease, and cancer, for example – can be either prevented or better managed through primary health care.[2]

Over-reliance on public hospitals at the expense of preventative and rehabilitative services results in substantially higher costs. Our system is rapidly becoming too expensive to sustain. Yet annual spending on prevention is less than two per cent of total health spending, compared to almost 40 per cent spent on hospitals.[3]

Responsibility for funding and planning health care is shared between different government levels and accountability is often unclear. Consumers experience fragmented and disconnected care; not one system, but many. They also experience a system that, as a result of late intervention, focuses more on illness than wellness. Lack of continuity leads to poor health outcomes, frustrates patients and care providers alike, and increases costs. Effective local population care planning and funding is obstructed because of split responsibilities at a local level.

There are workforce challenges and Medicare alone does not offer equity of access to care, with per capita spending decreasing as rurality increases. Payment systems largely reimburse inputs rather than outcomes and there are few incentives to avoid or slow the rate of hospitalisation and to invest in prevention. There is urgent need to change the way health care is funded, organised and governed.

Governments across the country are now looking for new ways of managing health and achieving value for money in health: the orientation of our health system needs to shift to focus more on primary health care and on a whole, unified "joined up" system that puts the patient at the centre.

Policy reform is underway: the Council of Australia Governments' (COAG) National Reform Agenda has put increased emphasis on primary health care delivery. Key areas of focus are Indigenous health, chronic disease prevention and management, self management, early childhood development and health workforce. At the federal level, the government has embarked on a health care reform agenda that better acknowledges the role of general practice and primary health care teams. Commitments include a National Primary Health Care Strategy, a National Preventative Health Strategy and the work of the National Health and Hospitals Reform Commission, responsible for developing a National Health Reform Plan.

WHO: Key aspects of primary health care

Based on the *World Health Report 2008 – Primary Health Care: Now More Than Ever*[4], from the World Health Organization, the following key aspects can be ascribed to people-centred primary health care:

> **Focus on health needs:** primary care provides a place to which people can bring a wide range of health problems – it is not simply a focus on illness and cure, nor a focus on priority diseases.

2 Australian Institute of Health and Welfare. *Australian hospital statistics 2006–07*. Health services series no. 31. Cat. no. HSE 55. Canberra: AIHW; 2008.

3 World Health Organization. op cit.

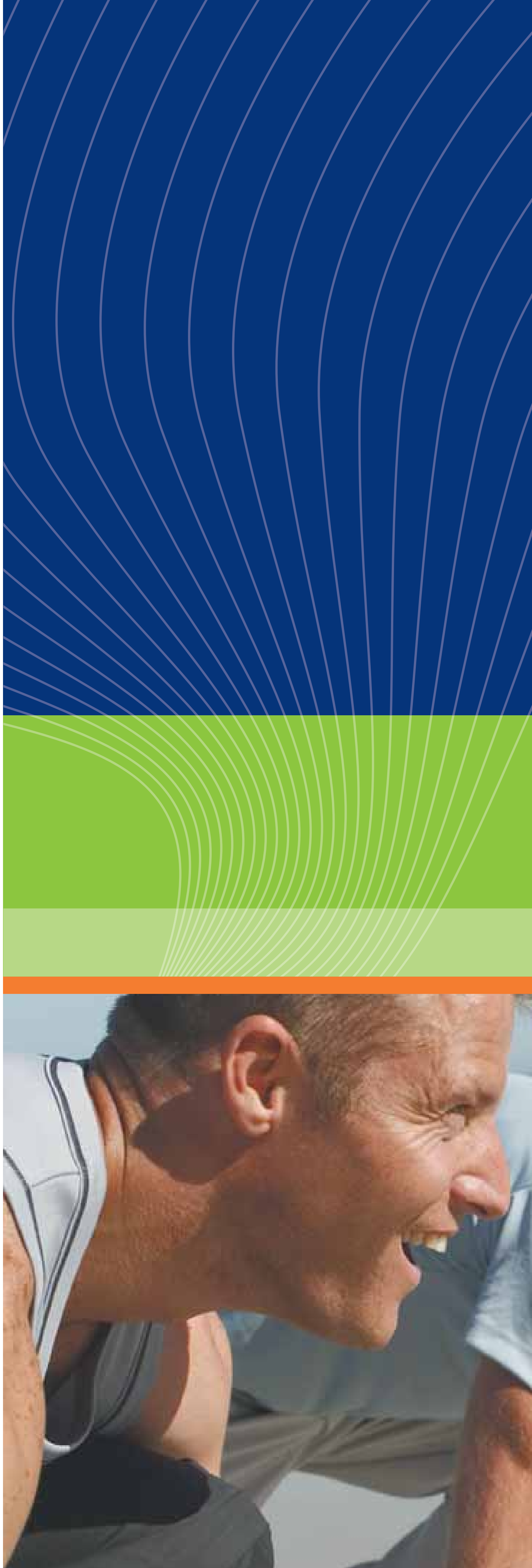
4 Ibid

- **Enduring personal relationships:** primary care is a hub from which patients are guided through the health system – relationships are not limited to the moment of consultation, nor to program implementation.
- **Comprehensive, continuous and person-centred care:** primary care facilitates ongoing relationships between patients and clinicians, within which patients participate in decision-making about their health and health care; it builds bridges between personal health care and patients' families and communities – it is not simply about episodic curative care or program-defined disease control interventions.
- **Responsibility for the health of all in the community along the life cycle, including responsibility for tackling determinants of ill-health:** primary care opens opportunities for disease prevention and health promotion as well as early detection of disease – responsibility is not limited to effective and safe advice to the patient at the moment of consultation, nor to disease control targets among the target population.
- **Primary care requires teams of health professionals:** GPs, nurses, and others with specific and sophisticated biomedical and social skills.
- **People are partners in managing their own health and that of their community** – consumers are not simply users of the care they purchase, nor are population groups simply targets of disease-control interventions.
- **Primary care requires adequate resources and investment, and can then provide much better value for money than its alternatives** – it should not be treated as the poor end of the health spectrum.

"There is a substantial body of evidence on the comparative advantages, in terms of effectiveness and efficiency, of health care organised as people-centred primary care. Despite variations in the specific terminology, its characteristic features (person-centredness, comprehensiveness and integration, continuity of care, and participation of patients, families and communities) are well identified."[5]

WHO also notes that programs that target priority health problems through primary care need to be complemented by public health interventions, including reforms that secure healthier communities by integrating public health actions with primary care and by pursuing healthy public policies across sectors.

5 Ibid



Section One:
What health system will best meet Australia's future needs?

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1.1 Creating a primary health care oriented system

Key principles:

> *Primary health care delivers better care and outcomes for individuals and communities.*
>
> *There must be equitable access to comprehensive primary health care for all Australians.*
>
> *An effective primary health care system is patient-centred – patients have the right to expect comprehensive, integrated and coordinated care.*

Modern societies demand more from their health systems – for themselves and their families and communities. Support for better health equity and an end to exclusion; for health services that are centred on people's needs and expectations; for health security for the communities in which they live; and for a say in what affects their health and that of their communities is increasing. These expectations explain the current demand for a better alignment of health systems and provide today's primary health care movement with reinvigorated social and political backing.[6]

Primary health care stands at the centre of care systems. It is the key entry point for consumers, delivering core medical and preventative care, and helping consumers coordinate and integrate care.[7] An essential component of an effective primary health care system is comprehensive general practice which includes health maintenance, preventative care, and acute and chronic disease management.

Strong primary health – its financing, organisation and delivery – is important to population health.[8]

Globally, the WHO has advocated for renewal of primary health care.[9] Most OECD countries have undergone reform that has included strengthening their primary care systems.[10]

An integrated health system which relies more on primary health care and general practice than on specialist and hospital care will deliver improved population health outcomes, equity, access and continuity of care while lowering long term costs.[11, 12] Government must invest more in health promotion, patient self management, early intervention and team-based chronic disease management.

1.2 The importance of general practice

Key principles:

> *The relationship between a patient and their general practitioner (GP) is the cornerstone of an effective primary health care system.*

General practice is at the coalface of primary health care – GPs are often the first point of clinical contact for individuals and families. A primary health care workforce underpinned by generalism will be well equipped to deliver cost-effective, equitable and accessible health care.[13] Vocational registration in 1989 consolidated general practice as a distinct discipline. Contemporary general practice is increasingly delivered in a team environment, with each member contributing to service delivery. General practice is at the frontline of health care with a twin focus on individuals and the community: it will remain as the cornerstone of our health system. Career pathway development, remuneration for generalists recognising the increasing complexity of their work, financing supporting generalist led primary health care teams and improved education and infrastructure are required to strengthen generalism in the primary health care team.[14]

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6 Ibid.

7 Starfield B. *Primary Care.* New York: Oxford University Press; 1998.

8 Macinko J, Starfield B & Shi L. The Contribution of Primary Health Care Systems to Health Outcomes within Organisation for Economic Cooperation and Development (OECD) Countries 1970-1998. *Health Services Research*; 38:3; June 2003.

9 World Health Organization, op cit.

10 Ibid.

11 Starfield B. *Balancing health needs, services and technology.* New York: Oxford University Press; Revised edition; 1998.

12 Health Evidence Network. *What are the advantages and disadvantages of restructuring a health care system to be more focused on primary care services?* Europe: World Heath Organization; 2004.

13 Gunn J, Naccarella L, Palmer V, Kokanovic R, Pope C & Lathlean J. *What is the place of generalism in the 2020 primary health care team?* University of Melbourne & University of Southhampton; systematic review; November 2007.

14 Ibid.

1.3 Promoting the principle of equity of access

Key principles:

> *Access to comprehensive general practice is an essential component of an effective health system and includes acute and chronic disease management, health maintenance and preventative care.*

> *Australia's future health system must be built around general practice working with others to deliver integrated primary health care to the community.*

The principles underpinning primary health care support the right of all Australians to have equity of access to the right primary care professional, at the right time in the right place at the right price. Care must be timely, affordable, appropriate, safe and comprehensive and continuous.

The challenge is to make these principles a reality.

GPs and comprehensive general practice are central to primary health care delivery in Australia. Consumers will have improved access to other members of the team such as practice nurses, nurse practitioners and allied health professionals working under the clinical leadership of the GP. Where clinically appropriate, non-GP providers will access Medicare rebates for a limited number of services. Models of care will take into account the challenges faced by rural and remote Australia, particularly where it is not possible to attract and retain GPs and other members of the multidisciplinary team.

As the focus on wellness grows, consumers' access to care and support will be increased through new models of care delivery and self-help support, including phone coaching, on-line services, and community-based group education and programs that maintain health.

To contain expensive hospital care where this can be avoided, consumers with complex and enduring conditions will access clinical and non-clinical service coordination services. Service coordinators, working with practices, will assist consumers to navigate the health and social support systems.

Services like **headspace**, MAHS and ATAPS will expand to overcome service shortfalls. This will better serve those communities poorly served by private providers with after hours, preventative health, chronic disease management and residential aged care facility (RACF) based services. Utilising practice nurses and various other nurse roles such as nurse practitioners and mental health nurses, the Network will coordinate outreach services for rural / remote areas and facilitate access to evidence-based eHealth solutions such as video conferencing, tele-medicine, and online consumer self management and health education.

1.4 Reorienting towards health promotion and illness prevention

Key principles:

> *The primary health care system must be reoriented to include incentives to reward quality practice, supplementing fee-for-service, and to encourage and reward preventative health care and self management.*

Primary health care is a setting for health promotion and illness prevention activity. Australians regularly attend their general practice. It is well placed to play an expanded role in a national prevention agenda by enhancing practice capacity to engage in prevention and linking with broader community prevention initiatives. Practitioner and practice level incentives for prevention are required, as is voluntary patient registration. Regional partnerships between local government, divisions of general practice, business and community organisations will reduce barriers for prevention and increase enablers to healthy lifestyle choices.

1.5 Integrated service delivery

Key principles:

> *Multidisciplinary team based care, with a GP as the clinical lead, improves outcomes in primary care.*
>
> *Continuity of care improves health outcomes.*
>
> *An individual electronic health record, enabling consistent information to be shared between all health providers, will improve patient safety and care delivery as well as enabling a strengthened focus on the health of the population.*

Improving coordination and continuity of care must be key goals of the health system. Care across care settings will be coordinated and episodes of care captured in patients' medical histories to avoid medical errors, maintain optimal quality and outcomes, and avoid duplication and other inefficiencies that lead to frustrated and overwhelmed patients.[15]

Consumers will experience a single system, whatever their entry point or stage of care. Consumers will access primary health care providers who are linked with the different parts of the health system, be they other general practices, allied health providers, residential aged care, community pharmacy, pathology services, community and home based health, specialists, or hospitals and other institutional services. EHealth systems will be a fundamental enabler of integration.

Each member of the team will be aware of the care provided by others. Health records will be complete, up-to-date, accurate and shared. Consumers will not be required to 'tell their story' to multiple providers. Transition between team members and services will be seamless and supported.

Team-based clinical systems will provide consumers with holistic care. Providers will understand and make effective use of peers' skills. Solo practitioners or small practices will be able to form 'virtual' multidisciplinary clinics through use of technology and strong local referral pathways. Technological supports such as individual electronic health records (IEHRs), secure messaging, practice software with automated notifications and clinical decision support systems will enable integration. Agreed standards and investment in eHealth infrastructure throughout the health system will make this possible. Referral systems for effective and safe transitions of patient care will include coordinated discharge processes between primary and acute services.

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15 Schoen C et al. Primary Care and Health System Performance: Adults' Experiences in Five Countries. *Health Affairs*; 2004.

1.6 A single, joined-up health system

Key principles:

> *Primary health care needs will be better met if there are new regional enterprises to integrate and coordinate the allocation of federal, state and territory resources based on community need.*
>
> *General practice and divisions should have a greater role in regional primary health care resource allocation and delivery.*

Too often wastage, duplication and gaps arise in the current system through the separation and cost shifting between Commonwealth and State/Territory funded health services. To overcome the problems associated with the shared responsibility for health it is essential that we move towards a 'single health system'. Aligning and stabilising organisational boundaries to areas of common interest – particularly where partnerships are important to health outcomes – such as area health service boundaries, divisions of general practice and local government, will help build a genuinely patient-centred system.

Integrated information systems, data management and eHealth solutions, including IEHRs, are key building blocks to enable such bodies to operate effectively. This issue is dealt with in greater detail in *Section 2.4: eHealth, Data and Information Management*.

1.7 Tackling the challenge of health inequalities

Key principles:

> *There must be equitable access to comprehensive primary health care for all Australians.*
>
> *Health policy must pay particular attention to groups within the population who have particular health needs or inequitable access to care: Aboriginal and Torres Strait Islander peoples, children and young people, older Australians and people with chronic disease.*
>
> *Priority must also be given to models of care in rural and remote Australia where small populations and distance pose difficulties in attracting and retaining health providers.*

While there has been substantial progress in improving the health of the Australian population over recent decades, there remain substantial inequalities within society. The response to the needs of these populations has often been fragmented and disjointed, rather than involving a comprehensive, integrated approach to overall health and wellbeing. *Section Three: Priority Groups* deals with this issue in greater detail.

Section Two: What this vision means for health

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Our vision for the primary health care system requires action in four key areas:

> Delivery (particularly multidisciplinary teams)
> Financing
> Organising (particularly the development of regional enterprises)
> eHealth, data and information management.

2.1 Primary heath care delivery

"The support for a renewal of primary health care stems from the growing realisation among health policy-makers that it can provide a stronger sense of direction and unity in the current context of fragmentation of health systems and an alternative to the assorted quick fixes currently touted as cures for the health sector's ills."[16]

Key principles:

> *A GP as the clinical lead is essential to team-based care. Team-based care will usually include practice nurses and will often include other allied health professionals. In remote communities, nurses and Aboriginal Health Workers typically play a lead role.*
> *Incentives and programs should exist to promote general practice as an attractive career pathway for medical and nursing graduates and to support, retain and develop the primary care workforce.*
> *Team-based care will often designate a clinician like a nurse to assist in care coordination, and will ideally also include a service coordinator to assist those with complex needs access the full range of services they need.*
> *Timely communication and common goals between providers ensures that care is integrated.*
> *A system of voluntary patient registration for patients with chronic disease will enable practices to better identify patient populations and maintain accurate disease registers. Patients will still have access to providers of choice for their health needs.*
> *Voluntary registration makes it possible to identify those patients for whom practices are responsible, facilitate proactive and systematic care and improve continuity of care. Patients benefit by having access to a regular and trusted provider as their entry point into comprehensive, person-centred primary health care.*

2.1.1 Multidisciplinary teams

While not all clinical presentations require a team approach, growing chronic disease levels and complex morbidity demand a multidisciplinary response. Australians will be best served by strong relationships between individual consumers and their primary care team. The team will provide patient-centred, holistic, comprehensive, proactive, integrated, and systematic care.

The size and configuration of general practices and clinics will be varied. General practice will remain predominantly privately owned and encompass large multidisciplinary clinics, large GP-centric practices, nurse-led clinics, medium sized general practices, small and solo practices. Multidisciplinary care will be supported through eHealth solutions, infrastructure funding, funding / incentives for collaborative care, programs to improve the range of practice nursing and allied health professionals services to practices, local referral pathways, inter-professional learning, and education and training to embed team-based care.

2.1.2 Defining the team

GPs will provide continuing, comprehensive, whole-patient primary medical care to individuals and families. The practice team will include the clinical team (in particular, a GP and practice nurse) and the administrative team (the practice manager, reception and administrative staff).

The practice nurse workforce will expand. Ideally, every Australian practice will have at least one practice nurse who will fulfil key roles: clinician, quality controller, educator, organiser, connector, and problem solver. Nurse practitioners and nurses with advanced or specialised skills will be more common in the general practice setting.

Allied health professionals, as members of the primary care team, will improve access and patient outcomes by delivering specialised care, and help relieve pressure on the core general practice team. Team-based care will be delivered according to an agreed care plan developed for that individual consumer.

16 World Health Organization. op cit.

2.1.3 Team leadership

Within the primary health care system, GPs are expert generalists – the health care providers with the knowledge and skills to meet holistic health needs. Nurses are also expert generalists, with advanced knowledge and a nursing care skill set.

GPs will be the clinical leaders with responsibility for providing continuity of care and coordinating the team's delivery of the consumer's holistic care. Roles within the general practice team will be clearly delineated, with each team determining the roles and responsibilities that deliver patient-centred care and match members' skills, experience and training.

At times, other members of the team will deliver particular aspects of care relevant to their expertise. In a number of limited clinically appropriate circumstances for which there is an evidence base, consumers will be able to access Medicare funded services directly from allied health providers.

Consumers will have the option of appointments with the practice-based nurse for monitoring and coordination of care; or with a nurse practitioner for assessment and management of health and illness presentations within their scope of practice. These clinicians will also triage patients and provide patient education, consulting with the GP to prioritise and commence development of a care plan. This care will not happen in isolation of their usual care GP and general practice team, who will remain the hub for their patients' care. Referral from the GP will remain the entryway to specialist care.

2.1.4 New roles

The health system will fund new clinical and non-clinical roles where there is an evidence base, demonstrating improved patient outcomes, workforce pressure relief, an eased burden on the acute care setting and value for money.

Advanced clinical roles such as GP consultants[17] offer opportunity for career progression and recognise advanced clinical roles that some clinicians already fulfil. Senior clinicians will be remunerated for more complex care and delegate less complex and more routine care to other team members. GP supervisors and mentors will also be adequately funded to fulfil this role.

Advanced clinical roles for general practice nurses, like nurse practitioners, will also evolve. Nurse practitioners will work collaboratively with the GP and the general practice team, providing clinical assessment and therapeutic management of health and illness presentations within their scope of practice. The role and duties of nurse practitioners in the general practice setting will be clearly defined, and teams will determine models to meet local population primary health care needs. Funding models will support the engagement and remuneration for nurse practitioners where community need is identified.

Practices will also be supported by new, non-clinical roles. Service coordinators and community and home care workers will assist high need patients to navigate the system and link with social care services to support recovery and rehabilitation, avoid hospital readmission and maintain good health.

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17 Similar to the 'advanced generalist' concept currently under consideration by the RACGP.

2.1.5 Network support for multidisciplinary teams

The Network will develop and promote multidisciplinary team-based care models, and support teams through interdisciplinary and multidisciplinary learning at all stages of the professional lifespan. Learning will focus on leadership, communication and team working skills. The Network will advocate for undergraduate training programs for doctors, nurses and allied health professionals to have greater emphasis / content on primary care and for team working modules in GP registrar training programs and allied health training courses.

Nursing and other allied health undergraduate courses will include placements in general practice and primary care, and workforce programs will support the transition and retention of newly graduated nurses and allied health professionals into general practice and primary care. Education and support will be provided to practices on coordinating of reminder and recall systems, supporting and educating patients in chronic disease self management, reinforcing preventative messages provided by other members of the team, and conducting health checks and health assessments. Training and professional support programs will prepare practice nurses to deliver disease specific nursing care and health promotion.

2.1.6 Workforce development

Access to primary health care will be enhanced as the 'skills escalator' concept is embraced so that all primary health care clinicians will be working to the full extent of their clinical training.

Re-orientation of care around multidisciplinary teams will help relieve current workforce pressures. GPs will be able to focus on more complex tasks such as diagnosis, managing co-morbidity, treating patients with complex problems and preventing avoidable hospitalisation. Tasks will be delegated to others such as practice nurses who will work in advanced clinical roles, offer specialised care in certain areas such as chronic disease management and also provide outreach services. Practice nurses will also routinely provide prevention and education services.

A comprehensive primary health care workforce strategy will exist to address workforce supply, fund the appropriate number of training places, expose students and post-graduates to the general practice setting, ensure workforce programs are aligned and coordinated, and ensure a mix of training for profession-specific and inter-professional learning needs.

New agreed national criteria will be developed to identify areas of workforce need, including up-to-date indices of rurality. The strategy will also support workforce development in Indigenous health. The time and expertise practices and individual providers contribute to workforce training will be supported through infrastructure grants (to provide consultation rooms, medical equipment and necessary resources for trainees) and remuneration. Rural practice incentive payments will support equitable health workforce distribution across the country.

The Network will work with workforce agencies to recruit and retain providers in workforce shortage areas through service models such as 'easy access, gracious exit', short-term placements and locum relief. Practitioners new to communities will be supported through peer support networks.

The Network will facilitate and deliver education and training programs on national priority areas including orientation and re-entry programs for nurses to work in general practice and initiatives to attract doctors and allied health professionals to general practice and / or rural areas.

A nationwide international medical graduates integration, orientation and support scheme focusing on clinical skills and local cultural knowledge will also be available.

Data collection and monitoring that informs improved workforce planning at local and regional levels will be facilitated through the Network.

2.1.7 Voluntary registration

Under voluntary registration arrangements, Australians will have the choice of registering with a specific general practice for prevention or management of chronic disease care. Building a relationship with a single doctor or practice over time provides a critical foundation for primary health care[18] and supports GPs and patients to take a long-term approach to health care.[19] It assures Australians that a specific general practice will be responsible for coordinating their chronic health needs, undertaking proactive preventative health care including monitoring their health, administrating registers, recalls and reminder systems, and coordinating their access to additional health services.

Through better patient knowledge, voluntary registration promotes continuity of care, saves consultation time, ensures better quality of care, more accurate prescribing, and reduced testing and duplication in delivery of specific interventions or services. Voluntary registration will also improve a practice's knowledge of their practice population, allowing better planning at the practice. It provides scope to remunerate practices for a commitment to a community and enables 'value add' services like phone coaching and self management training.[20]

Voluntary registration offers consumers more proactive and systematic care for chronic disease. It will not prevent Australians from choosing their GP and general practice, including choosing a new GP, nor stop access to an alternative GP should circumstances require this.[21] Voluntary registration also benefits patients by providing them with a regular and trusted provider as their entry point into comprehensive, person-centred primary health care and fosters a stable, long-term, personal relationship.

2.1.8 Community and consumer participation

Consumers, their carers and communities are the principal stakeholders in health care. As front line health care, the primary health care system has a responsibility to support consumers and communities to maximise their health outcomes.

Optimal health is achieved through healthy lifestyle, seeking help when necessary and working in a partnership model of health care. Individual consumers and communities will be empowered participants in health. Those who are vulnerable and disadvantaged will also be recognised and supported.

Consumers will choose their primary health care providers and have access to their individual electronic health record. During consultations, as far as practical, consumers will be recognised as having a unique understanding of their health, treated as a partner, involved in decision making and actively supported to self manage.

Consumers and community will be involved in decision making and governance at all levels, including health service accreditation and health system planning.

The Network will ensure consumer and community participation in divisional governance through representation on divisional boards, advisory committees and / or as associate members. Divisions will train divisional staff and health providers to work with consumers, carers and community groups and involve consumers and carers in multidisciplinary training programs (during development, delivery and evaluation) for health professionals.

18 Schoen C et al. op cit.

19 *Towards A National Primary Health Care Strategy - Key themes from the 3rd National Health Reform Conference 2008*. 17th November 2008.

20 Ibid.

21 For example, seeking a second opinion or accessing care when on holiday.

2.1.9 Quality, safety, evidence and accountability

Consumers need confidence that primary health care operates within a safe, outcomes-focused, quality improvement framework. All Australians have a right to health care that is patient-centred, evidence based and provided by practitioners who are accountable to their patients, communities and their profession's standards.

In the future, national quality standards of competency and training for all members of the primary health care team and throughout the health care system will be in place. Accreditation processes will set standards and ensure safe practices, and contribute to continuous improvement and continuing professional development for the workforce.

Mechanisms for reporting and learning from adverse incidents will be available for general practice and primary health care professionals.

As part of the new primary health care system, the Network will ensure quality, safety, evidence and accountability by measuring and being accountable for its own performance and supporting information management systems that assist in the measurement of health outcomes and system performance.

Divisions will engage in the Network's accreditation and quality performance framework that focuses on patient outcomes and includes systems for continuous quality improvement.

All Network members will support the development and use of realistic, evidence-based national health system performance indicators and accreditation standards that maintain quality, are achievable, and inclusive of non-mainstream primary health care services.

At the practice level, divisions will implement quality use of medicines programs and support the establishment of adverse and sentinel events reporting. Ongoing support will be provided to promote the uptake of best-practice quality payment incentives such as those currently available under systems such as the Practice Incentive Payment (PIPs) Program.

2.2 Primary health care financing

"In high expenditure health economies, which is the case of most high-income countries, there is ample financial room to accelerate the shift from tertiary to primary care, create a healthier policy environment and complement a well-established universal coverage system with targeted measures to reduce exclusion."[22]

Key principles:

> *A blended payment system including fee-for-service, pay-for-performance and capitation payments will best support the general practice setting to deliver optimum care.*

> *Capitation payments will not replace GP fee-for-service arrangements, fee-for-service will remain the basis for remunerating GPs.*

> *A blended payment system with voluntary patient registration can be used to identify and reward practices that have adopted a quality improvement approach to chronic disease management and prevention and can demonstrate improvements in patient outcomes.*

> *A blended payment system can be used to supplement the resources of practices that are managing patients with chronic disease, so as to provide the general practitioner with the tools and the teams needed to improve that patient's outcome.*

> *A blended payment system can be a tool to provide more equity in primary care expenditure to ensure that resources are allocated where the need is greatest, supplementing fee-for-service arrangements.*

> *A blended payment system that includes fee-for-service and practice payments should better support:*

> > *the role played by nursing and allied health care providers of patient care within a general practice team*

> > *non face-to-face contact by GPs and other members of the practice team acting on behalf of the GP*

> > *infrastructure (physical space and eHealth) to accommodate multidisciplinary teams and encourage general practice involvement in undergraduate and post-graduate training*

> *Payments to practices on a per capita basis (capitation) will give practices the flexibility to deliver care solutions for preventative health and chronic disease management best suited to particular practice populations—this could include home visits, telephone counselling and lifestyle modification groups.*

22 World Health Organization. op cit.

- *Payment-for-performance will supplement fee-for-service and will focus on rewarding improved outcomes for a practice population.*
- *Expansion of programs such as the ATAPS and MAHS Programs will overcome service gaps and promote improved access to care for services not covered by Medicare.*

Funding and payment systems in primary care will encourage and reward the right kind of care for Australian health consumers. They will focus on outcomes rather than just activity and will be set against realistic health improvement measures that have been agreed in consultation with general practice, consumers and other primary health care professions.

2.2.1 Practice-level payments

Payment systems within general practice will be blended, recognising the important role of fee-for-service in straightforward, one-off episodic care. A blended system will recognise and remunerate best practice care and improved outcomes in different settings (e.g. Aboriginal Medical Services, rural, RACFs, home visits) and at different times (e.g. after hours) as well as provide flexible payment options for appropriate remuneration of nurses, other primary health care professionals and practice management staff.

The payment system will recognise non-patient contact time (including education and training and quality assurance activities such as accreditation), and appropriately remunerate the range of presentations that occur within general practice. New payment arrangements will recognise and allow for a career structure for those employed within the practice (like better pay for GP or nurse leaders).

Blended payment systems will include:

- Fee-for-service payments for acute, episodic and chronic disease related care provided by GPs. Fee-for-service payments will also include allied health services provided on referral from general practice and an expanded set of payments for practice nurses.
- Supplementary capitation payments made for consumers who voluntarily register, giving the practice scope to provide flexible prevention and chronic disease management services like home visits, lifestyle modification groups and telephone counselling.
- Payments for improvement such as PIPs, that recognise quality improvement activities (e.g. information management, data collection and cleansing, teaching) and support employment of practice nurses. The payment formula will address socioeconomic and geographical disadvantage.
- Pay-for-performance that rewards improved outcomes set against realistic health improvement measures agreed in consultation with the profession. Systematic collection and analysis of clinical data will be used to set benchmarks, plan interventions and monitor improvement.

Fee-for-service will remain the main method of remuneration in the primary care system. Capitation and improvement payments will supplement this, rewarding practices that adopt quality improvement measures, demonstrate improved patient outcomes and provide additional prevention and chronic disease services. Options will be available under fee-for-service for those consumers who choose not to voluntarily register with a practice for chronic disease related care.

Infrastructure funding will ensure the community is not denied access to necessary services. Practices and divisions will be able to apply for infrastructure grants to address needs such as housing the multidisciplinary team and IM/IT systems, as well as providing support for what would otherwise be non-viable / unsustainable practices; e.g. capital investments required to deliver services in rural / remote areas where there will never be an economic return on the capital required.

Red tape will be minimised and the Medicare Benefits Schedule (MBS) will be streamlined and simplified. The number of items will be reduced, ambiguities cleaned up and preventative work enabled. New MBS items will not be needed as alternative payment mechanisms will be available. Investment in practice systems (e.g. data extraction tools, reporting, invoicing and payments) will ease administrative burden. New payment systems will be simplified and easier for all to use.

2.2.2 Multidisciplinary team care payments

Payments to support multidisciplinary team care will be broadened to improve access. Allied health professionals working as members of the multidisciplinary team will receive fee-for-service payments under Medicare for services provided on referral from the general practitioner.

In defined and clinically appropriate circumstances, direct access to Medicare funded allied health services will be possible for a limited number of services. If a cycle of care is required, the consumer's usual GP will be engaged under Team Care Arrangement-type payments to ensure the consumer is treated holistically.

Allied health professionals will also be employed by practices (using capitation funding) or division programs (see below).

2.2.3 Division level payments: fundholding, divisions and regional enterprises

Fundholding will allow divisions and regional enterprises to identify local needs and address service gaps. New payment systems will not require GPs to fundhold. The primary purpose of fundholding is to overcome service gaps, address access blocks and provide consumers with clear referral pathways from general practice to allied health care. The Network will hold funds to:

- Administer expanded allied health service models such as MAHS and ATAPS to help with workforce distribution and provide consumers with more equitable access to multidisciplinary teams, regardless of their geographical location.
- Employ service coordinators to assist defined patient populations with, or at high risk of, chronic disease who voluntarily choose to register with a practice for their multidisciplinary care provision.[23] These service coordinators will facilitate consumer access to services recommended by their general practice.
- Administer expanded lifestyle modifications programs that provide subsidised pathways to preventive health services.

2.3 Primary health care organisation

"...another set of arrangements is critical for the transformation of conventional care – ambulatory and institution-based, generalist and specialist – into local networks of primary-care:

- *bringing care closer to people, in settings in close proximity and direct relationship with the community, relocating the entry point to the health system from hospitals and specialists to close-to-client generalist primary-care centres*
- *giving primary-care providers the responsibility for the health of a defined population, in its entirety: the sick and the healthy, those who choose to consult the services and those who choose to not do so*
- *strengthening primary-care providers' role as coordinators of the inputs of other levels of care by giving them administrative authority and purchasing power."* [24]

Key principles:

- *Currently, divisions of general practice aim to improve the health of their communities by supporting general practice and delivering primary health care programs and services. They also have an important role in supporting the entire practice team.*
- *General practitioners provide the vast majority of primary health care – comprehensive general practice must always be an essential component of an effective health system. The divisions that represent GPs should have a far greater role in allocating primary care resources on a regional level than they do currently.*
- *A regionalised approach to health care funding and delivery with primary health care and general practice at its centre is essential if we are to improve health and achieve a sustainable system in Australia. This is the solution to desirable health system goals such as:*
  - *access and equity*
  - *cost savings and efficiency*
  - *enhanced community participation in health care*
  - *primary care-led care*
  - *emphasis on prevention and health promotion*
  - *increased accountability of decision makers.*

[23] Consumers will continue to receive fee-for-service care through the MBS system for episodic care and for those with chronic disease who do not choose a coordinated care package.

[24] World Health Organization. op cit.

> *Australia's health system should have regional enterprises with responsibilities such as population health planning, purchasing, facilitating community engagement, a role in linking patients, primary health care and acute care systems, and comprehensive primary health care delivery.*
>
> *Key functions of regional enterprises must be to promote cooperation at a regional level to ensure that resources in primary care are allocated according to the needs of the local community. This can best be achieved through a coordinated approach to the allocation and administration of federal and state resources regionally through a single organisation.*
>
> *The Divisions of General Practice Network is a unique and well established infrastructure that is already delivering comprehensive primary health care solutions in many parts of Australia.*
>
> *The Network values excellence, has embraced continuous quality improvement principles and is developing a framework to set standards and drive improvement, performance and growth into the future.*
>
> *Building on the fifteen-year investment already made in the Network to introduce regional primary health care enterprises is sound and prudent public policy: reform should use what works and what already exists as the platform for the future. The Network fits that description.*
>
> *While retaining its unique and vital capacity to engage and support general practice, the Network is the natural and best placed nation-wide system to build on in developing new regional primary health care enterprises.*

Organised primary health care has international support. It is associated with improved health outcomes and greater cost effectiveness. Structurally, this has taken a number of forms, including primary care organisations (PCOs). In Australia, PCOs have emerged as divisions of general practice.

Core roles of PCOs vary, but broadly they are to improve health outcomes, manage demand and control costs, engage primary care physicians, enable greater integration of health services, develop more accessible services in community and primary care settings, and enable greater scrutiny and assurance of service quality.[25]

There is growing evidence that PCO style organisations, with appropriate capacity, improve the health of their population once initial attention to organisational development and practice-based primary care services has been embedded. For example, where PCOs contract with practices and other providers against specified performance and outcome frameworks, there is evidence providers achieve specified health outcomes.[26] Similarly, there are many organisational interventions through PCO-type organisations to increase primary health care access like ATAPS and MAHS.

25 Smith J & Sibthorpe B. Divisions of general practice in Australia: how do they measure up in the international context? *Australia and New Zealand Health Policy*; 4:15; 2007.

26 Ibid.

2.3.1 Australia's solution: regional enterprises

In the future, new regional enterprises will help overcome fragmentation of care, blame shifting and red tape. They will pool funds and be the single funds manager for primary health care coordination within a region.

Functions of the enterprise would include:

- Funds pooling and allocation of regional budgets
- Local / regional decision making and planning of population health activities
- Community engagement and intersectoral linkages; e.g. general practice, aged care, housing, local government
- Workforce planning, recruitment and support
- Primary health care program delivery, particularly planned health services targeting three key areas:
  - prevention and early intervention strategies
  - improved chronic disease management
  - reduced hospital admissions and improved after hours service provision
- Contracting providers for delivery of health services and brokering access to services, data management, evaluation and quality monitoring.

The size of regional enterprises will be determined by their function. Issues to be taken into account include:

- Community and provider engagement
- Local provider relationships
- User and provider empowerment
- Local planning
- Population and public health planning
- Inter-agency cooperation
- Geographic relationships, distance and communities of interest
- Administrative efficiency and economies of scale
- Ability to manage risk.

Services will be tailored to the needs of local populations and address local service gaps. This approach will end cost shifting and duplication between governments and the private sector, as well as enable better integration of private practice and community based services, along with an enhanced interface with hospital based services. These local arrangements will support the existing private practice (i.e. MBS fee-for-service) and hospital systems.

A more efficient and effective health system, featuring regional enterprises, will be supported by a COAG-endorsed strategic framework that includes clearly defined roles and responsibilities, agreed performance indicators, clear guidelines for funds administration and an equitable allocation of health resources. Governance structures will be transparent and address potential conflict of interest issues arising from any dual purchaser / provider roles by enterprise members. International models demonstrate a range of systems to separate planning and purchasing roles from service delivery roles.

The Network will be the fundamental national infrastructure supporting primary health care delivery in Australia: the ideal vehicle for creating regionally based enterprises as the foundation for population health planning, purchasing and patient engagement with the system. There are already exemplars within the Network—particularly in rural and remote areas—of locally planned and delivered solutions that have overcome the commonwealth / state divide through pooled funds to deliver integrated services aligned to community needs.[27] Divisions will build on these successes and play a fundamental and proactive part in regionalisation.

Divisions will be funded to expand their roles developing a wider membership base and taking on greater responsibilities for the health and wellbeing of the population over time. The Network will build on its existing scope, agility and position within the community to respond quickly and effectively in the roll-out of national and local primary health care programs. Support for general practice and governance involving GPs will remain a key function– this is one of the unique functions of the Network and must not be lost.

[27] For example, the Integrated Primary Mental Health Service, a service delivery partnership between the North East Victorian Division of General Practice and Northeast Health Wangaratta; also the delivery of primary care services by North and West Queensland Primary Health Care in 37 communities.

Divisions, in a new and strengthened role, will continue to be the means by which GPs are supported and connected with the rest of the system at the same time as empowering general practice, in partnership with other community stakeholders, to have an even greater role in allocating primary care resources on a regional level.

All divisions will 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.

Irrespective of which level individual divisions choose to participate, they will:

> Engage the sector and the community so as to reflect their primary health care environment. Locally determined governance models will engage those working with general practice - Australia's GPs, practice nurses, nurses with advanced or specialised skills, practice managers, allied health professionals and Aboriginal health workers. Options for this engagement include full or associate membership, governance, reference groups and / or other feedback mechanisms.

> Be accountable, high-performing and accredited organisations using evidence and data to inform their activities, operating under national performance indicators that emphasise quality and are consistent with other parts of the health sector.

- Excel in a contestable environment by having the capacity to demonstrate their achievements and to engage general practice and serve communities.
- Promote and support comprehensive primary health care delivery.
- Link with other relevant sectors such as local government, education, community services and the business community to address local health need.
- Lead the development of information management systems that meet clinical, business and population health planning and delivery needs.

2.4 eHealth, data and information management

One of the most powerful health care policy tools is investment in information management, improved data management and cleansing and information technology (IT). EHealth solutions will be fundamental to the future capability of the primary health care sector. Integration of all parts of the health sector will depend on robust eHealth, data collection and information management systems. Care at the individual and health service levels will be informed by the collection of data, its transformation into 'information', and connectivity between health care providers for communication of that information. IEHRs will underpin the system.

Health data including biometrics, treatment, scheduling, medications, test results and key health outcomes will be routinely collected at all stages of care in accordance with appropriate privacy principles. Particular attention will be given to data that assists with the prevention, detection and management of chronic disease.

At the primary care level, data will be used to create knowledge and evidence which enables primary care providers to better identify, understand and plan for practice populations. Effective patient-management systems will include recall and reminder systems, preventive and screening practices and clinical decision support tools.

Practices will routinely use technology for billing and claiming and confirming Medicare eligibility. Prescribing, referral, ordering of pathology tests and on-site processing of MBS reimbursement claims will be electronic.

On-line consultations and ePrescribing will provide more accessibility and convenience for patients, including in remote areas, and will attract government reimbursement in the same manner as face-to-face consults and services.

Connectivity between health care providers will facilitate timely sharing and transfer of data and information. A connected and interoperable health system will enable consumers' data to be accessed and shared by authorised health providers wherever the consumer is. Consumers will also be able to access their IEHR.

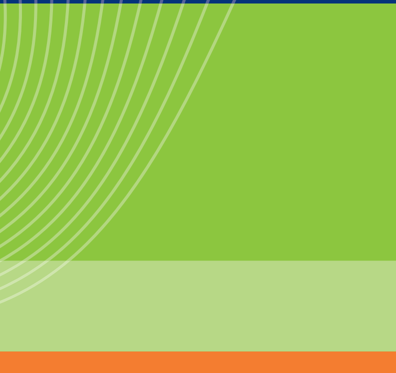
The Network will improve eHealth, data and information management and cleansing systems by informing policies and regulations to ensure the security of information, development of interoperable tools and systems, and development of commonly agreed and understood standards for data management.[28] The Network will work with software and IT providers as representatives of the primary care sector and collaborate in the development of eHealth tools.

At the practice level, the Network will support practices to collect quality data, including provision of education and training in recording, searching and extracting clinical records. The Network will support practices to collate and interpret data, returning it to practices as population level health information used for benchmarking, peer review, clinical outcomes assessment and to offer tailored packages of care. This, in turn, will enable the Network to support quality improvement initiatives such as the Australian Primary Care Collaboratives.

At the regional level, divisions will aggregate de-identified patient data to inform regional decision making and health services planning, as well as to monitor performance and contribute to policy development. The Network will play a central role in building communication, agreement and common understanding between sector stakeholders, especially between primary health and the hospital sectors.

28 For example, covering privacy, consent, governance, storage and access.

Section Three: Priority groups



Section Three: Priority groups

3.1 Aboriginal and Torres Strait Islander peoples

Aboriginal and Torres Strait Islander peoples have historically been among the most disadvantaged Australians. These Australians continue to experience disadvantage in health, education, employment, income and housing.

In the future Aboriginal and Torres Strait Islander peoples, the Aboriginal community controlled health sector and the broader health system share responsibility for their health. Indigenous Australians will have improved access to both Aboriginal Community Controlled Health Services (ACCHSs) and culturally secure mainstream health services.

In responding to the gap in health outcomes between Indigenous and other Australians, the broader primary health care sector will work in partnership with the Aboriginal community controlled health sector. Mainstream health services are also an important resource for Indigenous Australians. The provision of culturally appropriate care and the delivery of chronic disease prevention and management will be key areas of focus.

The Network will work with the Aboriginal Community Controlled Health Sector, mainstream primary health care services and other organisations active in Indigenous health to formalise relationships between divisions and ACCHSs, provide support to obtain and / or maintain general practice accreditation, establish effective outreach programs that improve access to screening and early detection, and offer joint chronic disease prevention and management initiatives.

The ACCHS model will be strengthened through access to division training and education events, development of career pathways to advanced clinical roles for Aboriginal Health Workers, direct access by registered Aboriginal Health Workers to appropriate MBS item numbers and improved funding for salaries, infrastructure and equipment.

The Network will improve the delivery of culturally sensitive and secure care through promoting improved identification and recording of Indigenous consumers [29], provision of cultural safety training, and use of Indigenous specific MBS item numbers. The Network will take a strong public health and intersectoral approach to help address the social determinants of health.

3.2 Children and young people

A good start in life is one of the best ways to prevent illness and maintain health throughout life. Primary heath care is the ideal setting in which to work proactively to promote physical, mental and emotional health and reduce the likelihood of illness from an early age.

Combining health promotion campaigns in schools, workplaces and communities with proactive preventative approaches provide the information and interventions required to ensure children and young people receive the best possible start.

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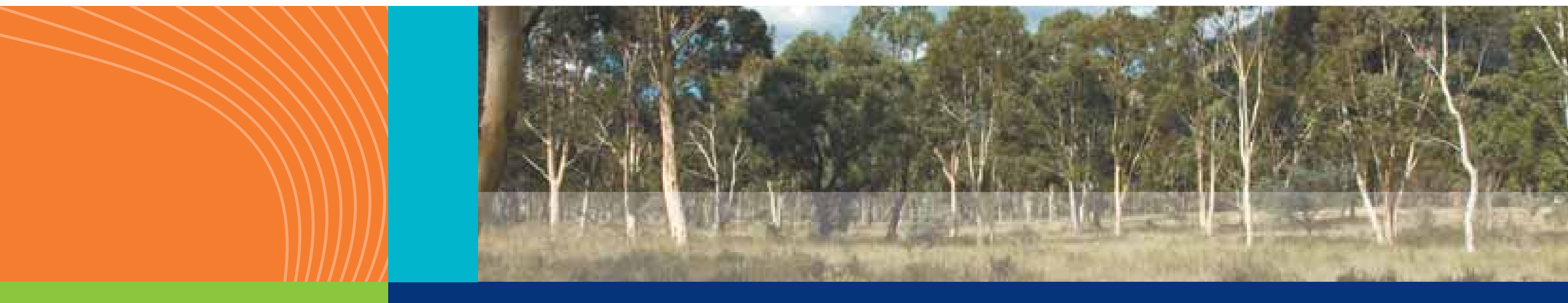
29 Improved Indigenous identification will start with first contact and be reflected in practice tools such as clinical software tools and recall / reminder systems.



Early identification and treatment by multidisciplinary teams for developmental problems can help prevent lifelong problems. By working with families and understanding the holistic needs of the consumer, general practice is well placed to provide advice and care to positively affect health outcomes, even before a child is born.

The Network will support children and young people by providing healthy lifestyle advice to pregnant women and preventative health services through immunisation programs, and by promoting child health checks. The Network will also facilitate and implement positive parenting programs like *Every Family* to reduce risk factors in children in relation to mental illness, behavioural problems and poor social and vocational outcomes in later life. The Network will work with communities to provide networks for social and mental health support for young people such as **headspace**, and work with schools to promote healthy lifestyles around key risk factors such as nutrition, exercise, smoking and alcohol.

3.3 Older Australians

A real challenge for Australia is the ageing population. The proportion of the population aged over 65 years is predicted to double to 25 per cent in the next forty years.[30] For Australians aged 85 years and over the growth will be even more rapid. Primary care can ensure that, as Australians age, they maintain as healthy a life as possible, remain in the home of choice for as long as possible (with support as required), are integrated and socially connected within the community, and are supported with dignity and care at the end of their lives.

Older Australians will experience structured, timely and well coordinated multidisciplinary primary care, including evidence-based cycles of care to prevent or reduce avoidable hospital admission or readmissions. Carers will also be recognised and supported by the system.

Residential Aged Care Facilities (RACFs) will experience quality service delivery and improved outcomes through more effective team-based arrangements. RACF residents will access greater continuity of care through improved integration between general practice, hospitals and community health.

The Network will advocate for funding models and incentives that encourage GPs to provide primary care services to older Australians within RACFs, including blended fee-for-service and capitation payments.

The Network will hold and allocate funds to establish MAHS-type programs to contract allied health professionals and service coordinators to increase access to well coordinated multidisciplinary primary care for older Australians, especially those in RACFs. The Network will also coordinate integrated service provision across palliative care, mental health and nursing services and deliver community based preventative health programs for older Australians like seniors' exercise sessions and other health promotion activities. Divisions will provide education and training to promote greater understanding of aged care, including end of life decision making.

30 Australian Government Attorney-General's Department. *Inter Generational Report 2007.* Canberra: Commonwealth of Australia; April 2007.

3.4 People with chronic disease

The changing demographics and disease profile in Australia mean that people with chronic disease will be one of the most important groups for primary health care and the Network to support.

People with chronic disease will receive support in a variety of ways, beginning when disease is first recognised. Primary health care will recognise co- and multi-morbidity, and treat the whole of consumer's health needs. Intervention will commence early and will work to prevent disease progression and the development of complications. For people with serious and complex disease, the system will provide quality care including rehabilitative and hospitalisation prevention services.

As part of the new primary health care system, the Network will support people with chronic disease by delivering or purchasing programs that address promotion and prevention, chronic disease management and hospitalisation prevention.

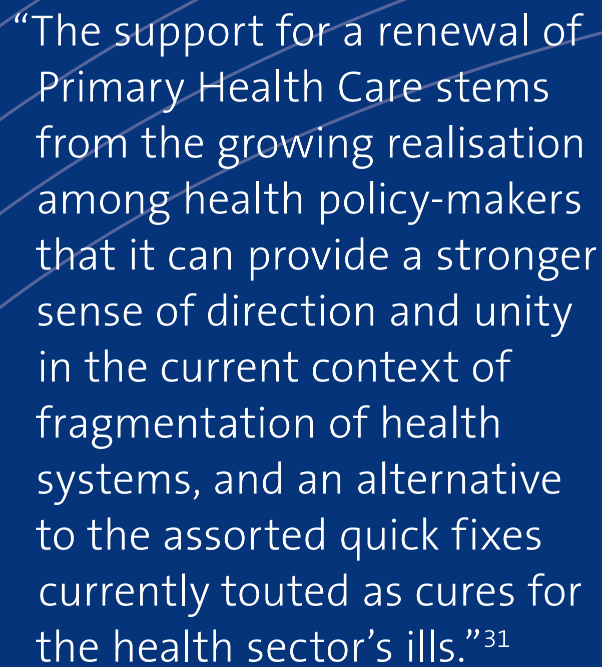
3.5 People in rural and remote Australia

Rural and remote communities face particular challenges in accessing primary health care. Access to services is limited, and higher mortality rates across most major disease areas for people in rural and remote Australia reflect this. Workforce shortages limit scope for multidisciplinary care, referral and consumer choice, and the closure of many rural health services such as maternity care is a cause of concern.

Divisions will support initiatives targeting workforce shortages in rural and remote communities. These will include MAHS and ATAPS style programs that allow employment of health care providers, 'easy access, gracious exit' models and locum support services. Some divisions will operate multidisciplinary clinics that offer the community collocated services and providers greater support.

Divisions will coordinate outreach services delivered by practice nurses and nurse practitioners, facilitate access to evidence based eHealth solutions such as video conferencing and tele-medicine, deliver education and training that supports GP procedural skills, and offer support networks for health professionals and students to encourage younger health professionals to remain in country areas. Divisions will have a role in coordinating local on-call rosters and emergency responses. Consumers will be offered online self management and health education, and phone coaching services.

Regional enterprises will allow for further targeting of programs and initiatives specific to rural and remote areas. Divisions' innovation and community knowledge will be crucial to continued delivery of flexible, local solutions.



"The support for a renewal of Primary Health Care stems from the growing realisation among health policy-makers that it can provide a stronger sense of direction and unity in the current context of fragmentation of health systems, and an alternative to the assorted quick fixes currently touted as cures for the health sector's ills."[31]

[31] World Health Organization. op cit.

"Business as usual for health systems is not a viable option. If these shortfalls in performance are to be redressed, the health problems of today and tomorrow will require stronger collective management and accountability guided by a clearer sense of overall direction and purpose."[32]

[32] Ibid.

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