AHHA response to the Consultation Draft – Future focused primary health care: Australia's Primary Health Care 10 Year Plan 2022-2032

November 2021

ahha
australian healthcare & hospitals association
the voice of public healthcare

OUR VISION

A healthy Australia, supported by the best possible healthcare system.

OUR MISSION

To conduct research, educate and influence the healthcare system to achieve better health outcomes, improved patient and provider experience, greater equity and sustainability.

OUR GUIDING PRINCIPLES

Healthcare in Australia should be:

Effective

Accessible

Equitable

Sustainable

Outcomes-focused.

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EXECUTIVE SUMMARY

The Australian Healthcare and Hospitals Association (AHHA) welcomes the opportunity to provide feedback on the *Consultation Draft – Future focused primary health care: Australia's Primary Health Care 10 Year Plan 2022-2032*.

WHO WE ARE

AHHA is Australia's national peak body for public hospitals and healthcare providers. Our membership includes state and territory health departments, Local Hospital Networks (LHNs) and public hospitals, community health services, Primary Health Networks (PHNs) and primary healthcare providers, aged care providers, universities, individual health professionals and academics. As such, we are uniquely placed to be an independent, national voice for universal high-quality healthcare to benefit the whole community.

ACHIEVING HEALTH REFORM

To achieve a healthy Australia supported by the best possible healthcare system, and as outlined in AHHA's blueprint for health reform[1], AHHA recommends Australia reform the healthcare system over the next 10 years by enabling person-centred, outcomes-focused and value-based health care. This requires:

1. A nationally unified and regionally controlled health system that puts people at the centre.
2. Performance information and reporting that is fit for purpose.
3. A health workforce that exists to serve and meet population health needs.
4. Funding that is sustainable and appropriate to support a high-quality health system.

Within this context, AHHA submits that the draft Primary Health Care 10 Year Plan brings together the recommendations of the Steering Group to provide a more coherent and coordinated approach to primary health care.

However, there are clear opportunities to support stewardship for primary health care reform, and better integrate the actions in the draft Plan with directions and activities already agreed by Health Ministers for the broader healthcare system.

[1] Australian Healthcare and Hospitals Association. 2021. Healthy people, healthy systems. Available at https://ahha.asn.au/Blueprint

RESPONSE TO THE CONSULTATION DRAFT

AHHA provides recommendations to:

- Address the **governance and accountability** for primary health care reform, through clear stewardship responsibilities for Primary Health Networks (PHNs) and an integrated clinical governance framework.
- Meet the **needs of people and communities**, through:
    - enabling the real-time use of data and information to inform shared decision-making in care;
    - more rapidly facilitating the adoption of person-centred telehealth and virtual models of care;
    - a sustained commitment to rural health services (not more trials) that leverages existing evidence and experience;
    - embedding innovative commissioning and funding models within primary health care; and
    - integrated workforce strategies for outcomes-focused, value-based health care.
- Promote and enable the crucial contribution of primary health care in addressing the health care sector's contribution to **climate change**.

1. GOVERNANCE AND ACCOUNTABILITY FOR REFORM

AHHA recognises the value of the primary health care system in improving the health and wellbeing of Australians. To enable effective primary health care reform, it is AHHA's position that:

- PHNs be empowered as stewards of health reform. This role must be recognised in the Plan, with the Australian Government Department of Health adopting frameworks that shift away from the focus of the PHN role as grant administrators and better reflect their broader role in leading health reform.
- An integrated system of clinical governance is needed, with explicit expectations of training for members of Boards and governing bodies, as well as clinicians.

CLEAR STEWARDSHIP RESPONSIBILITIES FOR PHNS ARE FOUNDATIONAL

The concept of stewardship in health governance was introduced over 20 years ago in the World Health Organization's World Health Report 2000. It brings the managerial principles of efficiency and effectiveness in decision-making together with ethical behaviours and social responsibility (Saltman & Ferroussier-Davis 2000). For stewardship to provide a successful model in health care reform, a clear and consistent strategic direction is required.

The Australian Government established Primary Health Networks in 2015 with the key objectives of 'increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time'. This requires understanding the health needs of communities, providing practice support to GPs and primary care providers, and strategic planning for the commissioning of services, with monitoring and evaluation.

The capacity of PHNs to act as regional stewards of primary health care reform, coordinating localised engagement with a range of key stakeholders, is critical for driving national change agendas for person-centred care. Without clear and consistent strategic direction in the Plan, this is a missed opportunity.

The need for broader healthcare reforms involving regional commissioning processes was strongly recommended in the 2017 Productivity Commission *Shifting the Dial* report (PC 2017). However, the draft Primary Health Care 10-Year Plan fails to embed the PHNs and make the identified reforms in commissioning a reality. Failure of the Plan to enable broader changes in how investments are managed will only reinforce the continued grant management relationship with providers, and the delivery of poorly defined and measured primary health care services.

This has again been identified most recently with the Productivity Commission *Inquiry Report on Mental Health* that proposed the creation of Regional Commissioning Authorities (PC 2020). This recommendation adds an unnecessary costly layer of bureaucracy to existing structures and conflicts with the commitments outlined in the *2020-25 Addendum to National Health Reform Agreement* for

the Australian Government, states and territories to 'work in partnership to implement arrangements for a nationally unified and locally controlled health system which will … improve local accountability and responsiveness to the needs of communities, through continued cooperation and collaboration between Local Hospital Networks (LHNs) and Primary Health Networks (PHNs) (Schedule E)' (CFFR 2020).

Agendas inconsistent with the desired strategic direction of primary healthcare reform have also been observed in the processes applied by the Australian Government Department of Health in administering the PHN grant program and funding arrangements. While there have been improvements in the timings of planning and reporting since PHNs were first established, processes still limit PHNs in being capable and high performing organisations, for example:

- the triennial activity work plans still requires separate plans for each schedule, compounding siloed investments
- lodgement dates and delays in approval of (or variations to) activity work plans impact on commissioning timeframes, limiting the time for codesign with communities and service providers and impacting continuity and security for commissioned service providers (including in terms of attracting and retaining staff or securing leases)
- processes and criteria for approval to carry over funding into the next financial year lacks transparency, and fluctuates over each year and schedule, even when funding amounts are only provided midway through a financial year.

Further, over time, stakeholders have reflected varied understanding of the PHN role, resourcing, shared goals and priorities. This impacts on trust, perceived credibility and willingness to engage, all factors crucial to effective healthcare reform.

Australia's Primary Health Care 10-Year Plan provides an opportunity to ensure there is a clear and shared understanding of the role of PHNs as stewards in healthcare reform.

INTEGRATED CLINICAL GOVERNANCE EXPECTATIONS ESTABLISHED

An integrated system of clinical governance, with explicit expectations of training for members of Boards and governing bodies, as well as clinicians, must be achieved within the Primary Health Care 10 Year Plan.

Clinical governance has been defined as 'the set of relationships and responsibilities established by a health service organisation between its state or territory department of health, governing body, executive, workforce, patients, consumers and other stakeholders to ensure good clinical outcomes' (ACSQHC 2017). It is recognised as an integrated component of corporate governance of health services.

A National Model Clinical Governance Framework was published in 2017, supporting a shared understanding of clinical governance in health services organisations, including clinicians, managers and members of the governing body (ACSQHC 2017). Elements of the Framework are mandatory for public and private health services in the acute sector to meet the requirement of accreditation against the National Safety and Quality Health Service Standards.

When the Framework was published, it was recognised that the delivery of health care requires people to move between different types of services across acute and primary sectors, and with safety and quality risks existing at these transition points, there is need for an integrated system of clinical governance for the whole health system (ACQHSC 2017).

The importance of clinical governance frameworks can also be observed through recommendations to the Royal Commission into Aged Care Quality and Safety (Royal Commission into Aged Care Quality and Safety 2021), the Productivity Commission Inquiry into Mental Health (PC 2020), the Royal Commission into National Natural Disaster Arrangements (Royal Commission into National Natural Disaster Arrangements 2020) and is anticipated in the recommendations to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability as well (Disability Royal Commission 2021).

The Aged Care Quality Standards now require services that provide clinical care to demonstrate the use of a clinical governance framework (Aged Care Quality and Safety Commission 2019), and there are various guidelines and resources for providers and Primary Health Networks in primary health care (e.g., RACGP 2014; PSA 2018; Jones & Killion 2017). However, an integrated system is needed, with explicit expectations for training for Boards and governing bodies articulated, as well as for clinicians.

2. MEETING PEOPLE'S NEEDS

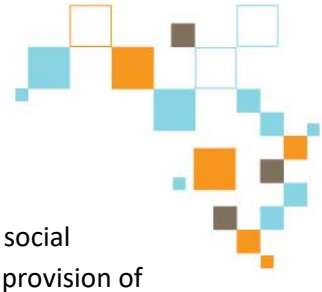
AHHA acknowledges the series of measures which lay important foundations for primary health care reform. To enable effective primary health care reform, it is AHHA's position that:

- Actions to support improved use of data be expanded from uses identified in the Plan (e.g., benchmarking, population health monitoring, investment decisions and incentive payments), to also include uses to inform shared decision-making in real-time care. Investment in primary care data, infrastructure, interoperability and linkages must be established to realise this purpose.
- Voluntary patient registration (VPR) must not restrict access to models of care that achieve the outcomes that matter to people. Any requirement for people to register with a provider should be directly linked to demonstrated health outcomes for that person or their community. Reforms that incentivise coordination and integration of care are important, but must not restrict consumer choice. The principles by which VPR is to be used must be clear upfront to empower informed decision-making and consumer engagement in their health journey.
- High quality telehealth and virtual care models have already demonstrated benefits beyond a model of care that requires people to register with a practice to achieve continuity of care. The Plan must demonstrate a commitment to enable the adoption of digital technologies that meet the needs of population segments other than those requiring continuity of care, across all life stages and events, and in a way that is outcomes-focused and value-based.
- Establishing health organisations to support comprehensive primary health care teams in rural areas should be a long-term endeavour, not a trial. It should be underpinned by strong governance, accountability for achieving defined goals and outcomes, and clear expectations for social stewardship. It should involve a continuous co-design process between stakeholders, with innovative models of care iteratively adjusted throughout implementation to address localised health needs.
- Innovative commissioning approaches and funding models within primary health care that are outcomes-focused and value-based be explored.
- Workforce strategies are developed that are integrated and achieve flexible, multidisciplinary practice in outcomes-focused, value-based models of care.

DATA AND REPORTING IS NEEDED IN PRACTICE TO INFORM CARE

Data linkage and the use of data for benchmarking, population health monitoring and investment decisions is identified in the Plan, with activities that support development of infrastructure, software, tools and the use of data for PIP and SIP indicators. AHHA supports this focus. However, the Plan must also support use of data to inform individual care in real-time.

PREMs and PROMs as outcome indicators, for example, are identified for PIP and SIP indicators (page28). However, for more personalised, proactive and value-driven health care, PREMs and



PROMs should be used in (near-)real time, together with systematic use of clinical and social indicators and measures of self-care capability and activity. These can then inform the provision of more holistic, team-based care. Investment in primary care data and infrastructure and linkage across the hospital, social and other sectors will be required to enable shared decision making in team-based care. This is discussed further in the AHHA Blueprint supplement*: Enabling person-centred, team-based care*.[2]

CONTINUITY OF CARE OR RESTRICTING ACCESS?

VPR is identified in the Plan as a foundation for primary health care reform. Patient choice is defended by nature of it being 'open on a voluntary basis' (page 11). However, it is clear from both the qualifying criteria and expectations that several services be limited to those who are registered (e.g., telehealth, health assessments, chronic disease management plans and medication reviews), that consumers will not have a genuine choice. AHHA has significant concerns that VPR is being developed without the necessary safeguards for assuring access to health care.

Further, there are concerns that the benefits of telehealth are being restricted to only where continuity of care supported through VPR is important, based on unqualified assumptions. On page 7, for example, it is stated that 'the safety and quality of telehealth can best be assured in the context of an ongoing relationship between practice, provider and patient'. However, there are now extensive examples of effective care models being established with telehealth and virtual models of care, in Australia and internationally. Reliance on inaccurate statements to inform the Primary Health Care 10-Year Plan (i.e., that safety and quality is best assured by an ongoing relationship, rather than through the design of the care model to achieve identified outcomes) is a critical concern.

AHHAs concern that 'future focused health care' is being pursued with the objective of restricting expenditure, rather than to achieve the best outcomes for the resources available, is further reinforced by the passive actions and delayed timeframes by which telehealth and virtual health care models are to be considered for implementation. Delaying evaluation of the 'emerging technologies for virtual care' for 4-6 years into the Plan (page 21-22) represents a missed opportunity to leverage the rapid advancements in technologies and adoption seen during the Covid-19 pandemic.

The Wellbeing Health & Youth Commissioners (Nguyen, et al 2021) provide one example of a population segment that have recently identified digital technologies as an integral aspect to young peoples' everyday lives, and they want them used to enhance how they 'receive and access credible and accountable health information and health care in ways that respect their identities, practices and rights'. With evidence that young people experience inadequate access to essential health services as a result of intersecting identities, they call for 'greater cultural sensitivity and diversity amongst health professionals, health services and health information to reflect the complexities of young people's lived experiences'. The Plan fails to demonstrate it has engaged the true concerns and opinions of youth.

Using the young population as an example, introducing VPR as the only mechanism for accessing telehealth for primary health care (for at least the first 4-6 years of the Plan's activities) ignores a

[2] https://ahha.asn.au/supplement-enabling-person-centred-team-based-care

person-centred approach to primary health care. The proposed approach to VPR and telehealth provides a mechanism to support continuity of care to address the needs of some population segments. However, AHHA strongly recommends that the Plan demonstrate a commitment to person-centredness by recognising life stages and events that enable earlier interventions focused on maintaining wellbeing, building greater community health literacy and place-based interventions in health. Policy and funding levers must support integrated interdisciplinary team-based care, codesigned and coordinated around the needs of the people accessing care.

RURAL ACCESS

AHHA acknowledges the investments that have been made to address the inequities of access to health services and poorer health outcomes among people in rural and remote Australia (pages 12-13), and supports an action area in the Plan dedicated to improving access to primary health care in rural areas (page 31).

However, AHHA has serious concerns with continued reliance on trials and pilot projects as a means of informing policy and service innovation in rural areas. For decades, research has reinforced that there is no one solution. In 2009, the Australian Primary Health Care Research Institute identified the essential service requirements and environmental enablers for the development of primary health care models in rural and remote Australia (Table 1) (Wakerman, et al. 2009) and these continue to hold true today. There have already been numerous analyses of rural services against this model that can inform the way forward.

Table 1. Essential service requirements and environmental enablers for the development of primary health care models in rural and remote Australia *(Wakerman, et al. 2009)*

Service requirements	Environmental enablers
▪ Governance, management and leadership ▪ Funding ▪ Linkages ▪ Infrastructure ▪ Workforce supply	▪ Supportive policy ▪ Federal and state/territory relations ▪ Community readiness

Actions that continue to advocate for trials in rural areas ignores those service requirements and environmental enablers necessary for these models to be successful and sustainable. The Plan should ensure a sustained commitment to investment in identified rural areas of need so that there is security and certainty:

- To attract and retain the required workforce
- For other service providers to have the trust to invest in the co-design process and incorporate these services in their pathways of care
- For the community to trust in their investment of time and effort in the codesign of services.

Investment for establishing health organisations to support comprehensive primary health care teams for rural Australia must not be a trial. It should be a long-term endeavour, underpinned by strong governance, accountability for achieving defined goals and outcomes, and clear expectations

for social stewardship. It must receive guaranteed sustainable investments, not short-term three-year trial project funding, with centrally identified service elements that are then withdrawn.

Research has shown that, in reshaping health care governance using pilot projects, success should not be analysed as a simple tool or work method, but through a continuous co-construction process between stakeholders (De Winter 2020). Building trust will be fundamental, not just at the local level, but vertically between stakeholders at the macro and meso levels. Opportunities to relay difficulties, fears, disagreements and clarification must be openly supported, with a willingness for iterative and incremental adjustments throughout implementation.

The trials proposed in the Plan should, instead, be directed towards innovative, commissioning approaches to locally-identified models of care implemented by the health care organisations that are established. The trials should involve an interactive model of policy, research and practice. This shifts the trials away from traditional forms of pilot projects where this is a fixed protocol that is not assessed until the end, and speeds the movement to effective practice (Hussey, et al. 2013).

SHIFTS FROM VOLUME TO VALUE

Funding reform identified in the Plan for primary health care is predominantly linked to VPR (page 28), with innovative funding models such as bundled payments limited to integrated care models with LHNs (page 36). However primary health care extends beyond general practice, and multidisciplinary team-based models of care may not always involve models integrated with LHNs.

As such, there must also be explicit actions to understand innovative commissioning approaches and funding models within primary health care that are outcomes-focused and value-based. These actions should be consistent with those agreed in the *Long-term health reforms roadmap* (Health Ministers 2021), including 'to identify and support removal of legislative, regulatory and technical barriers to implementing innovative funding and payment approaches'.

AHHA recommends that such work be included in the Primary Health Care 10 Year Plan.

WORKFORCE STRATEGIES

The Plan continues to support the siloed development of profession-based workforce strategies. Without an overarching strategy to achieve an integrated, multidisciplinary health workforce that works to their top of scope, there will continue to be barriers in the redesign of models of care. With evidence that the current organisation of health professionals and their associated scope of practice is not suited to meeting the needs of the Australian health system, AHHA have long called for a coherent national policy for the health workforce (Leggat 2014).

Opportunities to develop new models of care with flexible use of the health workforce and innovative funding models should be leveraged, such as with the development of a wound care consumables scheme (page 28), mental health stepped care pathways, hospital avoidance programs, after-hours care pathways, and chronic complex condition pathways (page 36).

AHHA recommends that such workforce objectives be included in the Primary Health Care 10 Year Plan.

3. ENVIRONMENTAL SUSTAINABILITY

It is AHHA's position that:

- The Primary Health Care 10 Year Plan promote and enable the crucial role of primary health care in addressing the health care sector's contribution to climate change.

PRIMARY HEALTH CARE AND CLIMATE CHANGE

The primary health care sector must demonstrate leadership in transforming the health system for sustainability, and this must be promoted through the Primary Health Care 10 Year Plan.

The health care sector contributes to 7.2% of Australia's total carbon emissions (Malik, et al. 2018), and is among the top health care carbon emitters per capita globally (Karliner, et al. 2019). Hospitals are the most resource intensive element of the system, highlighting the important role of primary care in reducing avoidable hospitalisations. Keeping people out of hospitals will be critical to reducing the sector's carbon footprint.

There is also a range of actions the primary health care sector can take to reduce their direct impact on the planet. AHHA explores these in a recently published Issues Brief, *Transforming the health system for sustainability: environmental leadership through a value-based health care strategy*.[3] For example, the carbon footprint can be reduced by identifying and eliminating low value care, resulting in a reduction in unnecessary use of resources and generation of waste. By considering the environmental impact across a full care pathway, opportunities to use models of care that utilise digital innovations (e.g., telehealth and virtual care models) can not only improve the outcomes that matter to people, but may also reduce emissions associated with travel.

[3] https://ahha.asn.au/publication/health-policy-issue-briefs/deeble-issues-brief-no-41-transforming-health-system

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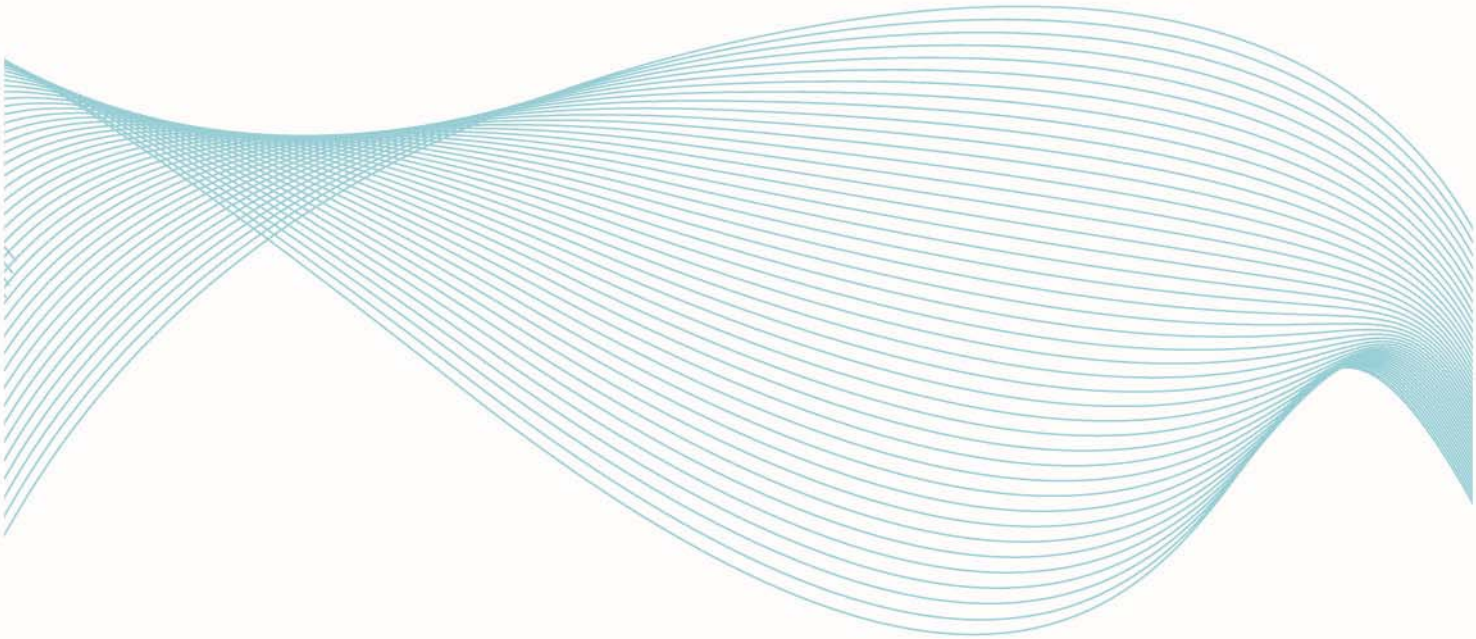

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