
# AHHA response to the Draft recommendations from the Primary Health Reform Steering Group

August 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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# TABLE OF CONTENTS

# EXECUTIVE SUMMARY

The Australian Healthcare and Hospitals Association (AHHA) welcomes the opportunity to provide feedback on the *Draft recommendations from the Primary Health Reform Steering Group*, in informing the Australian Government's Primary Health Care 10 Year Plan.

## 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 recommendations of the Steering Group for the Australian Government's Primary Health Care 10 Year Plan is a **significant missed opportunity for health sector reform**.

## RESPONSE TO THE DRAFT RECOMMENDATIONS

The plan must present a vision for what primary health care will look like in 10 years, with the coordinated actions that clearly demonstrate how the system will shift over time. This is critical in successfully reforming Australia's health system for future long-term sustainability, and must be properly resourced and act as a catalyst to change how health is perceived, provided and experienced.

As presented, the recommendations and associated actions are presented simplistically as a 'shopping list' of ad hoc actions in primary health care. For some of these, the evidence already confirms they are ineffective or they have been presented without the associated levers for them to be effective. Others reflect specific 'wish lists' of vested interest groups. Many reflect approaches that conflict with each other and/or the expressed overall objectives of primary health reform. **Overall, the recommendations and actions fail to come together to create an integrated system of care addressing community need, and this will undermine the ability of the plan to have any real sustainable impact.**

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

We have not responded to the recommendations and associated actions in the order they were presented by the Steering Group. Given their inter-related and inter-dependent nature, it was felt that considering them outside a coherent plan for reform places them at risk of being 'cherry-picked'. AHHA strongly suggests that the 10-year Primary Health Care Plan be re-drafted so that it assures:

- **person-centredness**, built around life stages and events that enable earlier interventions focused on maintaining wellbeing, building greater community health literacy and place-based interventions in health. It should not continue to be driven by condition, service or profession-specific approaches, but support integrated interdisciplinary team-based care coordinated around the needs of people accessing care;
- a strong **focus on outcomes and their measurement** to shift attention from volume to value. This will enable improvements at the point of care, as well as supporting proactive investment and alignment of funding mechanisms for prevention, wellness, equity and effective and accessible service provision at the regional and jurisdictional level;
- improvements in individual health literacy for **consumer agency** and improved self-care and **self-management**, in an environment that supports and promotes health and wellbeing;
- the **complete range of service providers and models of delivery** are recognised, including those provided remotely and/or based centrally, enabling them to be effectively developed and integrated to form local care pathways for population segments and communities;
- effective **local primary care leadership**, including in contributing to the reorientation of secondary and tertiary systems, with cross-sector accountability;
- mechanisms are introduced for **transparent, proactive and evidence-based investment** in workforce models and technology that focus on outcomes, including datasets and knowledge sharing platforms (clearinghouses).

More detailed feedback about specific recommendations and actions is provided in the following sections. This feedback has been framed according to some of the elements identified by the Steering Group as being objectives of reform (identified on page 7 of the Discussion Paper):

1. A primary health care system that delivers
2. A system that delivers care and is organised around consumers and the community
3. An equitable system
4. Proactive investment
5. Opportunities for innovation

# 1. A PRIMARY HEALTH CARE SYSTEM THAT DELIVERS

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:

- A clear definition of primary health care must be provided.
- The Primary Health Care 10-Year Plan needs to recognise the broad range of service providers and models of delivery, enabling them to be effectively developed and integrated to form local care pathways that achieve the best outcomes for individuals and communities.
- Reform in the delivery of primary healthcare services should be framed around life stages and events that focus on resilience and wellbeing. It must not be conceptualised as GP-centric.
- The Plan should provide direction to all agencies and stakeholders that support and impact on primary health care.

## DO RECOMMENDATIONS ADEQUATELY DEFINE THE PRIMARY HEALTH CARE SYSTEM?

Primary health care has been described by the Australian Government Department of Health as 'the first contact a person has with Australia's health system'. The Department acknowledge that many people associate primary health care with their local GP, but that primary care also includes 'care provided through nurses, allied health professionals, midwives, pharmacists, dentists and Aboriginal health workers', and that it can be provided in the home or in a range of community-based settings (Australian Government Department of Health 2018).

The Discussion Paper does not provide a definition of primary health care, but given longstanding discussions about the difference between primary care and primary health care, a clear definition should be provided. The definition should highlight the extension of 'the scope of the health task - from a focus on care for the already sick to the creation of the conditions for health' (Sweet 2010) in accordance with the WHO Alma Ata Declaration. Primary medical care is an essential part of primary health care, but different approaches and different tasks must also be present to create the conditions for health. Such recognition is important for providing some certainty in an environment where there is significant dependency on a diverse range of small businesses to shift their business models.

The health professionals and services that contribute to primary health care must be recognised as integral members of the primary health care team centred around people and their communities, not just 'add-ons' to general practice. While current recommendations by the Steering Group identify a health workforce and services more broadly than general practice, the health tasks beyond primary medical care could more appropriately be led by other members of the team. Reform needs to enable this.

Inclusion of primary health care services provided remotely must also form part of the 10-year plan. Health contact centres provide an important primary health care service, having the potential to provide access to advice and health care equitably and with efficiency.

Healthdirect demonstrated a crucial role in primary care during the COVID-19 pandemic, providing nationally consistent advice through various channels, including a national call centre, symptom checker and online information (Desborough et al. 2020; Healthdirect 2021). Healthdirect, with funding by the Australian Government Department of Health, also rapidly scaled a pilot of a Video Call program for primary health care services in response to COVID-19 to support continuity of care. There are numerous other health contact centres that serve a role for specific populations. Examples include the Breastfeeding Helpline, a range of mental health helplines (e.g. BeyondBlue, Blue Knot, Butterfly Foundation, eheadspace, Lifeline, Kids Helpline, PANDA, Suicide Call Back Service, just to name a few) and these are important to embed in primary care pathways.

The integration of centrally-based health contact centres with local health service pathways is a crucial issue. Cloud technology is being used to facilitate improvements, enabling more-tailored guidance for employees and improve caller interactions. Efforts to better integrate with local health service pathways have also been demonstrated, such as with integration of the healthdirect nurse triage helpline and local PHN commissioned after hours services (healthdirect 2019). Adoption and integration must be underpinned by best practice modalities, assure consumer wellbeing is paramount and involve outcome monitoring that drives continuous quality improvement.

The Plan should also provide direction to the agencies that support primary health care, including the Australian Institute of Health and Welfare, the Australian Digital Health Agency, the Australian Commission on Safety and Quality in Health Care, the Australian Government Departments of Health and Social Services and the Therapeutic Goods Administration, as well as those involved in workforce development and regulation (at the national, state, territory and service level). The Plan should also serve as a reference point for contracts and agreements entered into by governments that impact on primary health care (e.g. Community Pharmacy Agreement and NPS MedicineWise).

# 2. A SYSTEM THAT DELIVERS CARE AND IS ORGANISED AROUND PEOPLE AND THE COMMUNITY

AHHA strongly supports that the Australian Government's Primary Health Care 10 Year Plan achieves 'the development of a primary health care system that delivers care and is organised around consumers and the community' (Discussion Paper, p.7). To enable effective primary health care reform, it is AHHA's position that:

- Primary health care must be person-centred and enable holistic, multidisciplinary support with a focus on wellbeing and prevention.
- The term patient, as used in 'voluntary patient registration', should not be continued in the context of primary health care, as there is an important need to focus on the whole person, not just their medical conditions.
- Any requirement for people to register with a provider should be linked to improving outcomes for a person or their community. Reforms that incentivise coordination and integration of care are important, but must not restrict consumer choice. Registration should not restrict access to models of care that achieve the outcomes that matter to people. Any introduction of registration must be accompanied by clear mechanisms (including funding mechanisms) that support team-based care, whether team members are within a general practice or independent of a general practice.
- Consumer agency, self-care and self-management must be supported, both through improvements in health literacy and person-centred models of care.
- Primary Health Networks are well-placed to provide stewardship in the development of localised models, co-designing with people and communities, with models that provide clear pathways of care and a focus on the outcomes to be achieved.
- Local primary care and clinical leadership must be supported in the co-design of new models of care.

## DO RECOMMENDATIONS FOR VOLUNTARY PATIENT REGISTRATION SUPPORT THIS OBJECTIVE?

The recommendations of the Steering Group appear to centre achieving person-centred care around patients formalising their relationship with a single primary health care destination (Recommendation 2), established through voluntary patient registration (VPR). Being 'consumer-led' is assured by consumers being able to choose and nominate their GP.

While the preliminary context in the Discussion Paper identifies that the primary health care destination could take many forms, the action of patient registration is immediately limited to general practices and ACCHOs (action 2.1.1). MBS funding of services such as for chronic disease management, health assessments and telehealth are also then restricted for patients to a single service with whom they are registered (actions 2.1.3 and 2.1.4). Support to access health care, such as in the after-hours and through care coordination or system navigation, is similarly restricted (action 2.1.6).

VPR appears foundational in further recommendations, including funding reform that supports greater longitudinal multidisciplinary and intersectoral team care (action 3.2.1), access to primary health care data for understanding individual and community needs (action 7.9) and tailoring services for disadvantaged individuals (action 8.1).

## WHAT IS THE RELATIONSHIP WITH THE EVIDENCE?

VPR is a concept that appears to have been drawn from one of Bodenheimer's 10 Building Blocks of High-Performing Primary Care, referred to as 'Empanelment' (Bodenheimer, et al. 2014). AHHA supports the 10 building blocks as providing a practical conceptual model for helping practices towards becoming high-performing in providing person-centred primary care, and recognises them as elements largely within the control of a practice. However, limitations of the research and experience, as acknowledged by the authors, must be taken into consideration with adoption in Australia, in particular that:

- Pathways of building block implementation have not been empirically tested, although engaged leadership and data-driven improvement are well-established as foundational, with some evidence that these attributes are associated with better performance;
- Small, independent private practices are underrepresented in the research; and
- Practices included in the research were initially selected on the basis of them being known as innovators and having a reputation for high performance, therefore introducing sample bias.

Further, empanelment as described by Bodenheimer, et al. (2014), links patients to a care team and primary care clinician. The formation of the team is fundamental, with the team assuming responsibility for their patient 'panel' and working together to balance patient demand for care and capacity to provide that care. Recognising that large teams can be unmanageable, 'teamlets' or stable pairings of a clinician and a clinician assistant(s) who routinely work together are established, with other multidisciplinary team members supporting several 'teamlets'.

## WHAT IS NEEDED FOR VPR TO BE EFFECTIVELY IMPLEMENTED IN AUSTRALIA?

1. **Reform to primary health care must be centred around improving outcomes for a person or community**

   Introduction of VPR without implementation of the other building blocks of reform becomes just another provider-centric, fee-for-service funding mechanism that rewards a provider's activity without being linked to achieving improved outcomes for the person or their community.

   The Discussion Paper identifies that 'implementation of primary health care reform needs to be staged', and this is supported by AHHA. However, implementation of VPR, particularly given it is being proposed as a prerequisite for accessing funding towards other services (e.g. telehealth, care coordination/navigation), must be dependent on data-demonstrated improvements in care and the outcomes that matter to people. It should not be an isolated first step in the reform process.

It is anticipated that much can be learned from the evaluation of the Health Care Homes program. Unfortunately, while the most recent report has not been publicly released, it should be released to enable stakeholders to consider the findings in contributing to this consultation.

The interim evaluation report (through to June 2020) identified that for benefits to be realised with registration, practices need to achieve an adequate level of scale in the number of patients registered (HPA 2020, p. 10). While the proposed VPR extends eligibility for registration from the criteria used for Health Care Homes (i.e. having multiple chronic conditions according to three tiers of complexity) to all patients, the focus of practices should be those patients who will benefit from VPR, recognising that for many patients it may not be a preferred approach to primary health care. For these patients, there must still be appropriate access to health care services. Access to appropriate care should not be restricted for those choosing not to participate. This emphasises the need to be patient-centred and outcomes-focused rather than general practice centric.

**2. Reform must not create additional barriers to accessing appropriate health services**

There are many legitimate reasons why people may choose not to register with a single primary health care destination. People should not be restricted from having access to models of care that are appropriate to achieving the outcomes that matter to them as a result of choosing not to participate in VPR. Examples include:

- Young people. Service availability, opening hours, out-of-pocket costs; assurance of confidentiality and the logistics of transport have been identified by young people as barriers to accessing health services, and particularly for those who are marginalised and experiencing poor health, higher psychological distress and/or chronic physical and mental health conditions and those in rural areas (Robards, et al. 2019; Walker &Reibel 2013).
- People accessing certain types of services, e.g. sexual and reproductive health, drug and alcohol counselling.
- People with higher self-management capability. The ability to manage one's own health and healthcare is inversely related to primary and secondary care utilisation and inefficient utilisation (Barker, et al. 2018).

Reforms that incentivise coordination and integration of care are important, but must not restrict consumer choice. Policies must also be supportive of providing access and opportunities for self-m anagement and self-care. While policies to address the health needs of high utilisation patients tend to focus on improving the coordination and integration of care, recognising self-management capability and ensuring access to models of care (e.g. telehealth) that support patients to manage their own care more must also be available.

**3. Reform must be supported by improvements in individual health literacy for consumer agency and improved self-care and self-management**

Reforms to health, aged care and disability sectors are seeing a shift to establishing greater consumer empowerment and individual choice. Research in relation to aged care showed high consumer support for consumer-directed care, with Australians desiring choice and flexibility,

but also having low confidence in being able to exercise that choice for various reasons including literacy (McCallum & Rees 2017).

The introduction of VPR will also require people to exercise choice, and so should be accompanied by a commitment to improving health literacy and enabling self-care across the system. The Discussion Paper identifies a limited number of actions (actions 6.1-6.5), however for the benefits of self-care to be realised, it needs to be an integral part of the healthcare system, understood and operationalised as a collaboration between individuals and health care providers.

*Self-care for health: a national policy blueprint* (Nichols, et al. 2020) provides a framework for action to achieve integration of self-care across Australia's health system. Priorities include addressing structural health system issues to better enable self-care, embedding self-care support for individuals across health services, and promoting and supporting informed self-care and behaviours for all individuals. These, and the associated actions, should be included in the Australian Government's Primary Health Care 10-year Plan.

4. **Reform must enable team-based care as a fundamental building block**

The need for integrated, team-based models of care has been promoted for decades (Farre & Rapley 2017), yet the health system is still facing challenges in operationalising such models. The barriers are substantial, but not insurmountable (AHHA 2020) and the Australian Government's Primary Health Care 10-year Plan must ensure that team-based models of care are enabled in primary care.

Findings from the Health Care Homes interim evaluation (through to June 2020) showed that general practices found working as a team with external providers as challenging. Given the majority of primary health care is provided by independent, private, and typically small, businesses, the introduction of VPR must also be accompanied by clear mechanisms (including funding mechanisms) that support all members of the team, whether they be within a general practice or independent of a general practice.

The adequacy of five MBS services per client per calendar year, as currently available to allied health providers on referral by a GP, has been challenged over time. Limitations on numbers of services should be tied to evidence-based best practice and achieving outcomes, not a mandated number based on controlling expenditure. However, simply increasing further fee-for-service funding for allied health services will exacerbate the ongoing focus on volume of services over value. Rather, value-based approaches to health care should be pursued at the local level, and Primary Health Networks are well-placed to provide stewardship in the development of localised approaches, co-designing with people and communities, with models that provide clear pathways of care and a focus on the outcomes to be achieved.

Recognising the socioeconomic and sociocultural aspects of people's lives that can affect their health and wellbeing, non-clinical services and supports must also be included in team-based care arrangements (RACGP & CHF 2019). Social prescribing has been a mechanism for enabling primary health providers to address the wider social determinants of health, and so a systematic,

nationally scaled and locally implemented approach to social prescribing should also be supported in the Primary Health Care 10-Year Plan.

Further to the actions identified by the Steering Group (action 1.4), reform must be enabled by (AHHA 2020):

- Practices and services engaged in population health planning and data-driven models of care
- Clinical governance frameworks that span and link jurisdictional and professional boundaries, and provide local ownership and shared agreement of the care to be provided
- Person-centred data and interoperable technology, with the use of indicators and measures embedded in clinical workflows, enabling real-time, shared goal-setting and decision-making with the person and across sectors
- An investment in physical infrastructure, creating environments where teams can share and collaborate
- Workforce development, fostering capabilities such as in co-design, data analysis and quality improvement, and technology that supports team-based care
- Funding models which incentivise the use of indicators and measures in routine clinical practice, supporting participation in population health planning and providing greater flexibility in how teams achieve the desired outcomes.

## DO RECOMMENDATIONS FOR A ONE SYSTEM FOCUS AND LOCALISED APPROACHES SUPPORT THIS OBJECTIVE?

The Steering Group recognises that a person-centred health and care journey requires the health system to be re-shaped to enable one integrated system, including reorientation of secondary and tertiary systems to support primary care (recommendations 1 and 3).

It is acknowledged that the *2020-2025 Addendum to the National Health Reform Agreement* has created a funding mechanism by which joint planning and funding at the local level can be enabled. Local solutions and partnerships are important for meeting community needs and the Steering Group has identified a range of actions that will facilitate this.

Critically important in these local solutions is the need for **local primary care leadership**. Primary Health Networks must continue to be supported to foster the development and performance of the primary care sector, with the flexibility and accountability to achieve improvements.

However, it must also be recognised that the majority of primary health care is provided by independent, private, and typically small, businesses. This contrasts to the large structures of state hospital services, which may provide support in relation to such enablers as data analysis, skill development and infrastructure (although noting this also varies between states). This can create an imbalance in the way in which contributions to population health planning and co-design of models of care can be developed and provided.

The desired shift to primary and community based care requires clinical leadership from those with an in-depth understanding of primary health care. While the Steering Group has recognised the need

for supporting ongoing leadership (recommendation 9), challenges can be much broader, particularly, for example, in rural and remote areas, where workforce shortages can result in clinicians needing to make a choice between participation in co-design or meeting the care needs of their community. Investment is needed to ensure there is appropriate primary care leadership in data-driven reform.

The Steering Group proposes to prioritise structural reform in rural and remote communities (recommendation 5), with a range of actions (5.1-5.6) identified. Importantly though, these cannot be considered in isolation of the 'one system focus' proposed (recommendation 1), where local solutions, partnerships and empowered teams are enabled, nor in isolation of their proposals for care innovations (recommendation 16) with evidence-based innovation addressing problems.

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 (Wakerman, et al. 2009) and these continue to hold true today. It is unclear from the Discussion Paper the local context in which, for example, Rural Community Controlled Organisations should be created in contrast to the diversity of models already in operation (e.g. the Rural Flying Doctor Service). Instead of specifying models, national support should be directed to facilitating shared learning and innovation around shared areas of focus (recommendation 9.2.7) with guidance on how to effectively apply the evidence in the local context. A common evaluation framework, for example building on the research of Wakerman, et al. (2009), could be used to present the evidence and experience with different models together with the critical factors for success. This would support evidence-based co-design of models within the local context.

Building on recommendation16.1 for a research translation and innovation body, consideration should be given to developing a knowledge sharing platform or **web-based clearing house**, where sharing of quality assessed evidence, for example, case studies, academic and grey literature—specific to and supporting the Australian context—would bring information together in a usable way to support a value-based approach to primary health care reform. There is significant activity that can inform reform in primary health care in Australia, but this is not consistently captured in the academic literature (nor published in a timely manner). Building a repository of evidence, including quality-assessed grey literature, would assist in scaling up small scale trials and projects, removing duplication and supporting collaboration. The model used by the National Institute for Health and Care Excellence (NICE) in the UK may inform such a repository.

# 3. AN EQUITABLE SYSTEM

AHHA strongly supports that the Australian Government's Primary Health Care 10 Year Plan achieves 'a move to an equitable system' (Discussion Paper, p.7). To enable effective primary health care reform, it is AHHA's position that:

- Indicators of equity from an individual and family perspective, including in relation to out-of-pocket costs, must be developed to inform improvements in cost as a barrier to access to primary health care.
- Any increased role for private health insurers in primary care must neither reduce access nor increase costs for non-insured consumers. Open and transparent evaluation of initiatives is essential and must be publicly released to inform debate.

## DO RECOMMENDATIONS ADDRESS OUT OF POCKET EXPENSES?

In the introductory information in the Discussion Paper, the reliance on patient out-of-pocket expenses is noted, particularly in comparison to international peers (p.2), which AHHA identifies as needing to be addressed.

Bulk billing rates are often reported in Australia as an indicator of out-of-pocket costs and equity of access. However, this is frequently challenged as bulk billing represents the number of services that are bulk billed, not the number of patients who have incurred no out-of-pocket costs. People delaying or not seeking care is also not reported.

Research suggests that while average household out-of-pocket expenditure on health care has remained relatively constant, those with lower incomes were more likely to have catastrophic expenditure (spending more than 10% of household income on health care) compared with those with higher incomes (Callander, et al. 2019).

In addressing improved equity and access more broadly, the Steering Group has identified services could be tailored through VPR (action 8.1) or through co-designed solutions assumed to be through services commissioned locally (action 8.2). However, out-of-pocket costs are still reported without consideration of a patient's entire care pathway, instead looking at each provider and touch point of health service delivery in isolation. This masks the true out-of-pocket costs barrier faced by many consumers and challenges the ability to identify those most at risk of experiencing poorer care outcomes. An episodic approach to the provision of care also does not enable a value-based approach to health care being adopted where the entire pathway of care needs to be considered.

Once identified, there is still a substantial reliance on independent, private, and typically small, businesses from taking the required action (i.e. offering bulk billing) to address inequities. There is no data as to whether these are targeting the people most in need.

The Australian Government's Primary Health Care 10 Year Plan needs to ensure indicators are developed that provide a genuine reflection of equity from an individual/family perspective, including in relation to out-of-pocket costs, to inform improvements in cost as a barrier to primary health care. An essential element to developing these indicators is to also capture the longitudinal nature of out-of-pocket costs faced by individuals.

# 4. PROACTIVE INVESTMENT

AHHA strongly supports that the Australian Government's Primary Health Care 10 Year Plan moves to a system 'that proactively invests in the health and wellbeing of all Australians', with a 'focus on prevention and wellness' (Discussion Paper, p.7). To enable effective primary health care reform, it is AHHA's position that:

- The Primary Health Care 10-Year Plan cannot continue to ignore development of a primary healthcare national minimum dataset with common data standards and reporting frameworks.
- Specific disaster response and planning mechanisms must be initiated through a bottom up approach, driven by existing structures at the local level to ensure resource distribution reflects local need.

## DO RECOMMENDATIONS ACHIEVE A DATA-DRIVEN APPROACH TO SUPPORT PROACTIVE INVESTMENT IN PRIMARY CARE?

Proactive investment in primary health care will be best supported by good data. The Steering Group has proposed an action (action 6.1) relating to patient reported measures to both align the system and enable providers to focus care on what matters to patient, but little else to make clear the expectations for a data-driven approach to reform.

Consolidated primary healthcare data in Australia is poor. However, individual providers of primary healthcare often hold significant information on the services provided to patients, the conditions for which they are being treated and the progression of a patient's recovery or further deterioration of their condition. Consolidating this data could be facilitated ideally through the development of a primary healthcare national minimum dataset that provides common data standards and reporting frameworks.

The work of AIHW to develop a National Primary Health Care Data Asset (NPHCDA) provides the opportunity to move our health system in a direction that can better inform our understanding of population health, patient journeys through the healthcare system and to focus on the outcomes that patients value most. These outcomes should be viewed comprehensively to include clinical, service, and patient reported outcomes and experience measures.

AHHA supports the development of a comprehensive NPHCDA, and in the medium to longer term, a national minimum dataset for primary healthcare. However, we also recognise that the environment in which primary healthcare is delivered requires an initially pragmatic approach to the scope of primary healthcare services from which data can be collected.

It is not clear the current status of AIHW's work to develop the data asset. However, AHHA supports the initial collection of primary healthcare data only from general practices, but AHHA also believes that the Australian Government's Primary Health Care 10-Year Plan should have an explicit medium-term goal for the AIHW to expand coverage of the primary healthcare sector to include specialists,

pharmacy, allied health, dental, palliative care, community nursing, mental health, alcohol and other drugs, maternal and child health.

As the scope of primary healthcare services reported is broadened, the value of the NPHCDA will be enhanced. AIHW has the opportunity to articulate a plan to progressively move towards a more comprehensive dataset on primary healthcare through the collection of all data on care provided to patients outside of the hospital. Together with a more expansive understanding of individual's experience of healthcare through the collection of patient reported outcomes and experience measures, deeper insights will be available to inform how the healthcare system needs to be adapted to meet patient's needs and expectations.

## DO RECOMMENDATIONS SUPPORT PRIMARY HEALTH CARE EMERGENCY PREPAREDNESS?

The Steering Group's recommendations for emergency preparedness appear to reflect the findings and recommendations of the Royal Commission into National Natural Disaster Arrangements. AHHA's submission to the Royal Commission is available here, which in particular supports Primary Health Networks (PHNs) and Local Hospital Networks (LHNs) or equivalent, being empowered to work in partnership to develop resilient local health systems though the targeted strengthening of person-centred, locally driven, collaborative, and integrated healthcare services and pathways, whilst also ensuring integration with other social support services to fulfil priorities of the COAG National Health Reform Agreement.

# 5. OPPORTUNITIES FOR INNOVATION

AHHA strongly supports that the Australian Government's Primary Health Care 10 Year Plan moves to a system that improves 'the uptake of innovation opportunities' (Discussion Paper, p.7). To enable effective primary health care reform, it is AHHA's position that:

- The Primary Health Care 10-Year Plan must proactively incorporate the opportunities that technology and data provide in mobilising a prevention and self-management system.
- Workforce redesign must be proactively pursued to meet the needs of people and communities. Analysis of opportunities must be transparently and objectively analysed with models being based on evidence and focused on outcomes.

## DO RECOMMENDATIONS SUPPORT TECHNOLOGICAL INNOVATION AND THE ADOPTION OF VIRTUAL CARE MODELS?

The Steering Group recommendations appear more reactive, than proactive, in approaching developments occurring in technology and data (recommendations 15 and 16). Within the 10 years of this plan, rapid developments in technology will likely revolutionise, not just mobilise, opportunities for innovation in primary care and preventive health.

The COVID-19 pandemic has revealed many ways technology and data can be used to protect health, including contact tracing apps, temperature sensing drones, apps to monitor social distancing and facial recognition surveillance. Primary health care was relatively slow to pivot to optimal virtual models of care. MBS data showed the shift was primarily a substitution of face-to-face consultations with telephone consultations. This is despite healthdirect immediately scaling a Video Call service and providing free access for primary health care services. In contrast, some hospital services demonstrated a rapid pivot to provide quality virtual models of care. These models, for example, rpavirtual, involved video consults, remote monitoring technologies, escalation pathways and patient access to a 24/7 virtual care service (Shaw, et al. 2020). These models have been reported to have been possible as result of prior planning and proactive investments in digital infrastructure and workforce. Primary health care reform requires similar planning and proactive investment.

The Steering Group has made a recommendation to develop digital infrastructure (recommendation 15), and while the actions are all important, they appear to lack recognition of the advancements that are possible and that are being leveraged in other industries, but also in the tertiary system in Australia. Further, alongside the actions recommended, virtual models of care and technological innovation need to be introduced through co-design with patients, but also proactive efforts to ensure affordability and equitable access to new technologies and clinical treatments. Clinical governance and funding models will need to be developed to facilitate adoption. The cross-sector leadership and governance mechanisms for a one-system focus (recommendation 1) would appropriately facilitate the introduction of such innovation in the local context.

Artificial intelligence (AI) also offers promising opportunities to improve health through preventive rather than reactionary measures. It has the ability to collect, compile, analyse and learn from big data, augmented by real-time data from patients, and create personalised and predictive feedback

for individuals. It can improve diagnostics, catalyse patient adherence through engagement, and integrate with remote monitoring devices, all directly influencing the behaviour of patients and improving preventive and self-management health action. There are ever-increasing data sources that can support preventive strategies, including electronic health records, personal digital devices, pervasive sensor technologies and access to social network data. While data and devices are often siloed, the feasibility of health-data-sharing platforms to obtain and aggregate health data is being explored (Dhruva et al. 2020) and integration being achieved.

The Australian Government's Primary Health Care 10 Year Plan needs to proactively include the opportunities that technology and data provide in mobilising a prevention and self-management system, address the data privacy concerns and actively advancing ethical practices and social responsibility.

## DO RECOMMENDATIONS MAKE OPTIMAL USE OF THE WORKFORCE?

The Steering Group presents a number of recommendations to build workforce capability and sustainability for primary health care (recommendation 10), and by professional groups (11-14). Actions range from very specific targets to broad-ranging statements, and capturing national strategies to local analysis, planning and coordination – both ends of the spectrum being important. AHHA supports multidisciplinary service models being promoted with professionals working to the top of their scope.

Achieving this will require models of workforce redesign being considered holistically, based on evidence, to understand how they meet the needs of communities. Action 10.6 proposes a review of policy changes for equity. Transparent and objective analysis will be critical for assessing workforce redesign proposals. Much could be learned from the health technology assessment processes of PBAC and MSAC, including the recent review of assessing software as a medical device according to the potential for benefit and risk of harm, in order to develop a process for pursuing workforce design that is not influenced by vested interests.

# REFERENCES

Australian Government Department of Health 2018, Fact sheet: Primary health care, viewed 16 July 2021, https://www1.health.gov.au/internet/main/publishing.nsf/Content/Fact-Sheet-Primary-Health-Care

Australian Healthcare and Hospitals Association (AHHA) 2020, 'Enabling person-centred, team-based care', viewed 15 July 2021, https://ahha.asn.au/sites/default/files/docs/policy-issue/enabling_person-centred_team-based_care_-_refreshing_the_blueprint.pdf

Barker, I, Steventon, A, Williamson, R, Deeny, S 2018, 'Self-management capability in patients with long-term conditions is associated with reduced healthcare utilisation across a whole health economy: cross-sectional analysis of electronic health records', *BMJ Quality & Safety*, vol. 27, pp. 989-999, http://dx.doi.org/10.1136/bmjqs-2017-007635

Bodenheimer, T, Ghorob, a, Willard-Grace, R & Grumbach, K 2014, 'The 10 building blocks of high-performing primary care', *Annals of Family Medicine*, vol. 12, no. 2, pp. 166-71, https://www.annfammed.org/content/annalsfm/12/2/166.full.pdf

Callander, E, Fox, H & Lindsay, D 2019, 'Out-of-pocket healthcare expenditure in Australia: trends, inequalities and the impact on household living standards in a high-income country with a universal health care system', *Health Economics Review*, vol. 9, art. 10, https://doi.org/10.1186/s13561-019-0227-9

Desborough, J, Dykgraaf, S, Toca, L, et al. 2020, Australia's national COVID-19 primary care response, Med J Aust, vol. 213, iss. 3, pp. 104-106, doi: 10.5694/mja2.50693

*Healthdirect* 2019, after hours Primary Care Linkages Service, viewed 19 July 2021, https://about.*healthdirect*.gov.au/after-hours-primary-care-linkages-service

*Healthdirect* 2021, *Healthdirect*, viewed 16 July 2021, www.*healthdirect*.gov.au

Health Policy Analysis (HPA) 2020, 'Evaluation of the Health Care Homes program – Interim evaluation report 2020, Volue 1: Summary report', Canberra: Department of Health, https://www1.health.gov.au/internet/main/publishing.nsf/Content/AD51EBE397452EF5CA2580F700164BAD/$File/HCH%20Interim%20eval%20report%202020%20Vol%201%20Summary%20report%20(Final.pdf

McCallum, J & Rees, K 2017, 'Consumer directed care in Australia: early stage analysis and future directions', National Seniors Australia, Brisbane, https://agedcare.royalcommission.gov.au/system/files/2020-06/NSA.9999.0006.0001.pdf

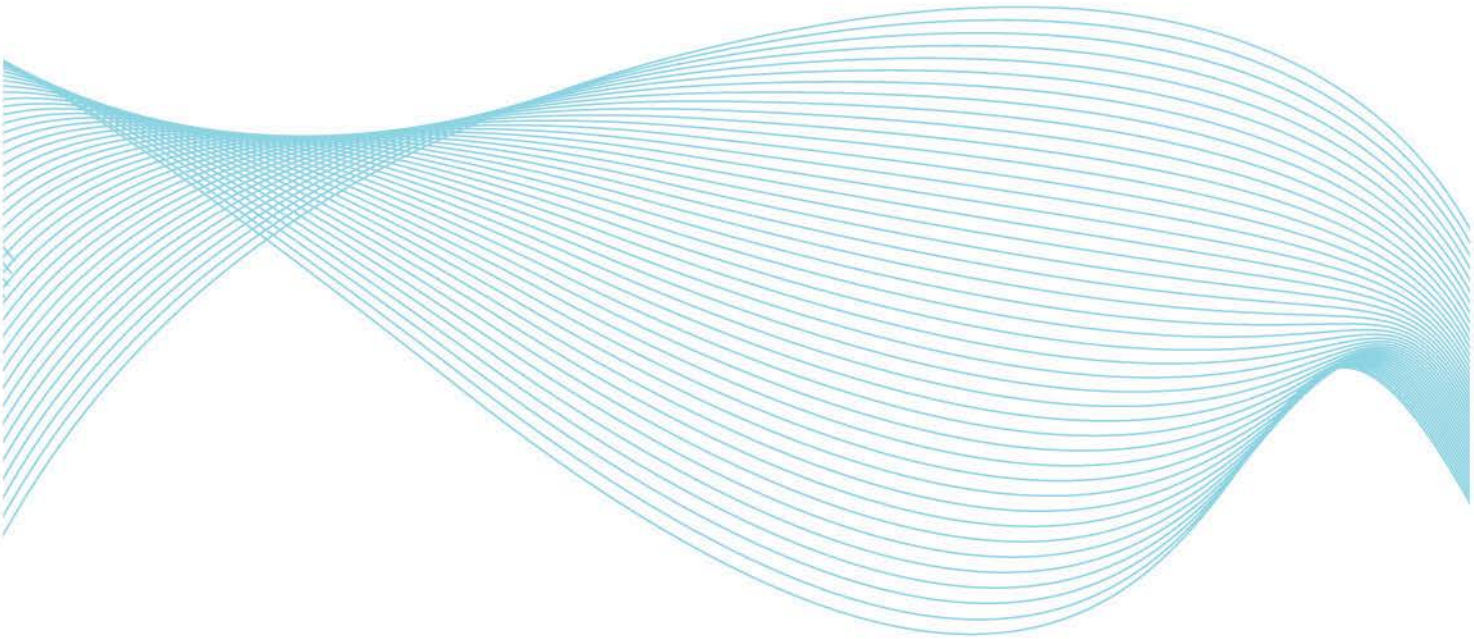
Nichols, T, Calder, R, Morgan, M, et al. 2020, 'Self-care for health: a national policy blueprint'. Policy paper 2020-01, Mitchel Institute, Victoria University, Melbourne, https://www.vu.edu.au/sites/default/files/mitchell-institute-self-care-for-health-a-national-policy-blueprint.pdf

Robards, F, Kang, M, Luscombe, G, et al. 2019, 'Predictors of young people's healthcare access in the digital age', *Australian and New Zealand Journal of Public Health*, vol. 43, iss. 6, pp. 582-588, https://doi.org/10.1111/1753-6405.12936

Shaw, M, et al. 2020, 'rpavirtual: a new way of caring', Deeble Institute for Health Policy Research, viewed 26 July 2021, https://ahha.asn.au/sites/default/files/docs/policy-issue/deeble_perspectives_brief_no._13_-_rpavirtual_-_a_new_way_of_caring_0.pdf

Sweet, M (ed.) 2010, Primary care vs primary health care: who cares? (part 3), viewed 16 July 2021, https://www.croakey.org/primary-care-vs-primary-health-care-who-cares-part-3/

Walker, R & Reibel, T 2013, 'Young people's experiences with health services: a literature review', Telethon Institute for Child Health Research, viewed 4 August 2021, https://www.telethonkids.org.au/globalassets/media/documents/news-and-events/youth-health-research-young-people-s-experiences.pdf



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