A health policy report – September 2018

The George Institute for Global Health

CHF Consumers Health Forum OF Australia

The University Of Queensland
AUSTRALIA

Acknowledgements

We acknowledge the lands of the First Peoples upon which this report was written and pay our respects to Elders past, present and future.

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Snakes & Ladders
The Journey to Primary Care Integration

This report presents the arguments as to why all political and other leaders must act now to transform Australia's health system to ensure it is sustainable, effective, efficient, and leads to greater satisfaction for both consumers and service providers.

The report provides priorities for those leaders to maximise opportunities to achieve better health and wellbeing outcomes for individuals, their families and communities, and thereby unlock both social, capital and economic benefits for Australia.

The recommendations have been synthesised and derived from expert discussions and reflect established evidence that health systems with strong primary health care are more efficient, have lower rates of hospitalisation, fewer health inequalities and better health outcomes including reductions in rates of people dying.

While Australians generally enjoy some of the best health outcomes in the world, it is widely recognised the current health system is under increasing strain. Factors leading to this strain include the growing burden of chronic disease, an ageing population, an unsustainable funding system which includes adverse incentives to achieve volumes of services rather than better outcomes, workforce challenges, and digital innovation which is driving solutions but also comes at a cost.

Many OECD countries have recognised the importance of sustainable and effective integrated and comprehensive primary health care which is consumer (patient) centred and takes a whole-of-person approach to better meet the needs of individuals, families and communities.

Australia has made some significant moves to strengthen its primary health care system. Examples include the formation of Primary Health Networks (PHNs) and trials of Health Care Homes (HCHs), along with associated bilateral agreements between the Commonwealth and the states and territories on coordinated care reforms to improve patient health outcomes and reduce avoidable demand for health services. However, the system and funding remain heavily tipped towards hospital and other institutional care as the hub of most importance. Equally it is hospital and institutional care that attracts most of the public and media scrutiny and often is a political focus.

Re-orientation towards strong, integrated primary health care as the driver of better health and wellbeing outcomes, needs solutions that help to overcome some of the inherent challenges in Australia, with the aim of ensuring:

- ***A consumer centred approach***
- ***Continuity of care and integration of services around the needs of individuals, families and communities through clear care pathways***
- ***Equitable access to safe and high-quality care***
- ***A seamless passage through the system regardless of who funds, governs or provides services***
- ***Coordination of service planning and delivery within the sector and with other health, social, and economic sectors which impact on the health and wellbeing of individuals and communities***
- ***Enhanced sustainability of a system which is under ongoing pressure to meet the population's needs at the same time as containing costs and delivering high-value care.***

We hope you enjoy this report

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About this report

On 1 August 2018, the Consumers Health Forum of Australia (CHF), The George Institute for Global Health and the University of Queensland MRI Centre for Health System Reform and Integration convened a special policy roundtable with key stakeholders across the health sector. The roundtable – Snakes and Ladders: The Journey to Primary Care Integration – is part of a series of roundtables, co-hosted by The George Institute for Global Health and the Consumers Health Forum of Australia.

Participants were people who have been engaged in the conversation on primary health care reform so far and those who have a track record in implementing innovative reforms in integrated primary health care. It included consumer advocates, health care providers, clinicians, academics, industry, government and policy experts from across Australia.

The purpose of the roundtable was to formulate independent recommendations on pressing changes needed to transform the health system and ensure it is more responsive to consumer needs. This objective demands an increased emphasis on integrated primary health care and ensuring it has a stronger place in the health system.

The aim of the roundtable was not to debate whether primary health and integrated care reform is needed, but to focus on transformation and implementation. The objective was to shape near, medium and longer-term recommendations about how Australia can move towards a strengthened primary health care system at all levels.

Participants considered: what specific recommendations can be made to effect change? They thought about the system levers which need to move first in year one, year three and year five and came up with concrete, on-the-ground actions which form a logical pathway to advance change over time. This would progressively build a platform from which achievement of short and medium-term goals will lead to the achievement of longer term goals.

Integrated care happens when organisations work together to meet the needs of local populations. Some forms of integrated care involve local authorities to help achieve objectives, and the most ambitious forms of integrated care aim to improve population health by addressing the causes of illness and the social determinants of health.

In using the term 'consumer', we mean people who use health services, as well as their family and carers. This includes people who have used a health service in the past or who could potentially use a service in the future.

By primary care, we mean those services which usually are the first point of contact in the health system, such as general practice, pharmacy, allied health, nursing, dentistry, Aboriginal and Torres Strait Islander health services (including Aboriginal Community Controlled Health Organisations), health promotion and a broad range of community health services.

Primary care is a component of primary health care, which includes a broader range of those social, economic and environmental factors which influence health, social and emotional wellbeing, including social connectedness, childhood development, housing, education, employment, engagement with the justice system and the physical environment.

Integrated care was described at the workshop as "joined-up care for everyone when they need it and where they need it". The principles adopted by CHF to describe patient-centred care were also used to describe "integration":

- ***Appropriate care***
- ***Accessible and affordable care***
- ***Consumer involvement in planning and governance at all levels***
- ***Trust and respect***
- ***Coordinated and comprehensive care***
- ***Whole-of-person care***
- ***Informed decision making.***

Our approach

There have been many reports, strategies, policies and frameworks over time which have provided the evidence and established the case for primary health care renovation and transformation. They include:

- The Productivity Commission report, Shifting the Dial: 5-year productivity review (2017), which recommended the creation of a Prevention and Chronic Condition Management Fund for PHNs and LHNs, as well as reconfiguring the health care system around the principles of patient centred care
- The National Primary Health Care Strategic Framework (2013), which was agreed by all Australian, state and territory governments but which has had scant attention at an intergovernmental level ever since
- The Report of the Primary Health Care Advisory Group, Better Outcomes for People with Chronic and Complex Health Conditions (2015) which recommended consideration of bundled payment systems (a pool of funds to be used flexibly to best meet the needs of consumers, instead of the current siloed, disjointed and difficult to navigate funding system), Health Care Homes as a means of supporting team-based care and improved coordination of care
- The George Institute/CHF reports, Putting the Consumer First (2016), Patient-centred Health Care Homes in Australia – Towards Successful Implementation (2016), and Going Digital to Deliver a Healthier Australia (2018).

The Council of Australian Governments (COAG) National Health Reform Agreement (2011) and its revised schedules (2017) commit the Australian, state and territory governments to cooperate and coordinate on primary care, with the Australian Government having lead responsibility for managing primary care.

There has been no lack of policy direction, with the messages about what needs to change being highly consistent over a long period of time. What has been missing is not the knowledge but rather coordinated commitment from all levels of Government to a clear pathway forward and the systematic implementation over time of changes which can transform Australia's health system.

There is a need for commitment from all levels of government to a longer-term vision of a primary health care-led system which is pursued relentlessly and consistently over time, with staged investments and changes to build that system and reap the benefits for consumers, providers, taxpayers and society.

As a basis for framing this report, the '4S' framework – self, service, setting and system – was used to analyse where Australia is currently positioned on integrated primary health care and to identify areas for action. This framework is broadly based on work undertaken to analyse joint working across health and social care in the United Kingdom by the UK National Audit Office. It also follows the World Health Organization systems thinking model:

- "Self" considered key topics such as people's experience, consumer enablement, health literacy, and consumer attitudes
- "Service" covered topics such as access, service delivery, workforce, new service models and new funding models
- "Settings" looked at issues including regional and local settings, health and social service integration, joint planning, and consumer reported outcomes measurement
- "Systems" covered topics including governance models and structures, burden of disease, needs of diverse populations, and whole of person care and infrastructure essential to a high performing integrated primary health care system.

Recognising the inevitable (and desirable) overlap within this framework, this report utilises three domains – self, services and settings, and systems.

> "The challenge for governments is to meet community expectations across the spectrum of healthcare services against the backdrop of fiscal constraints, escalating costs and rising expectations."
>
> *- Community Pulse 2018: the Economic Disconnect. The Committee for Economic Development of Australia*

5 key themes and 10 priorities for implementation and transformation

Clear the way by removing funding barriers

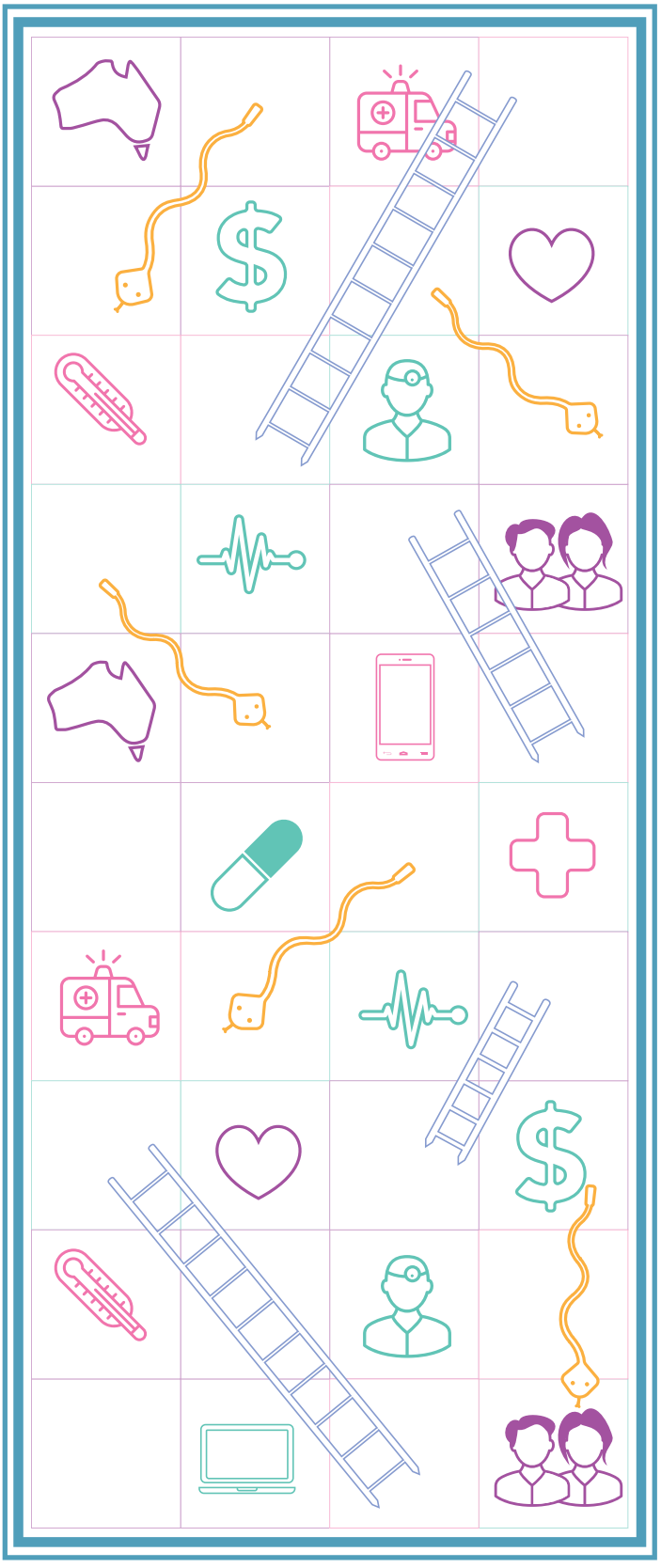
1. Fund equitable access to a revised model of Health Care Homes across Australia, based on the original Primary Health Care Advisory Group (PHCAG) recommendations, with participation remaining voluntary for both practices and consumers, and including a significant shift away from largely fee for service payment systems.
2. Strengthen Medicare through the development of regional budgets combining Commonwealth and State/Territory funding. These budgets would be flexibly administered by PHNs and LHNs, prioritise prevention and integrated primary health care and have strong governance arrangements that mandate consumer participation and decision-making.

Create regional solutions

3. Establish formal agreements between the Commonwealth, the states and territories, Primary Health Networks (PHNs) and Local Hospital Networks (LHNs) (or their equivalent) to improve local and regional system performance and deliver integrated, consumer centred services.
4. Progressively empower PHNs to take greater responsibility and accountability for creating primary health care systems in their local areas. This includes broadening the objectives of PHNs and devolving additional funds from the national level to PHNs, with greater flexibility, authority and accountability to commission services based on population health needs and with consumer codesign models supported to share decision-making.
5. Require PHNs and LHNs to work together as co-commissioners of services, to design and develop alliance contracting arrangements with service providers where desired outcomes are specified and service providers are incentivised to work as partners in achieving those outcomes.

Test and showcase innovation

6. Implement a major demonstration project to empower consumers with complex chronic diseases to plan and manage their health by providing them with flexible individual funding packages – personalised budgets – where they have choice of services and providers (similar to the NDIS and aged care reforms).



7. Fund a Consumer Enablement Portal to bring together and better promote access to a broad range of high quality consumer literacy, self-management, decision making tools and other information resources to empower consumers to better engage and participate in decisions about themselves, their families and other support people, the services they receive and the systems they connect with.

Link up the system

8. Recognising the importance of professional collaboration and team-based care within care settings as well as across primary, secondary and tertiary health care, introduce funding models which promote joined up models of health service delivery, including incentives which:
   - Appropriately support non-prescribing pharmacists in general practice
   - Establish GP Liaison Officers in all metropolitan and regional settings
   - Promote hospital-based specialists providing liaison, advice, support, education or clinics within general practice based on community need
   - Significantly expand access to care coordinators, health system and social service navigators and health coaches on a regional basis for those with complex chronic conditions
   - Increase the numbers of Aboriginal and Torres Strait Islander and Culturally and Linguistically Diverse (CALD) people at all levels of the health workforce
   - Promote development, professionalisation and employment of a peer workforce with lived experience, with priority for mental health and suicide prevention peer workers.
9. Recognise the important role of primary health care information – including patient experience measures – as fundamental to better patient management, service development and quality improvement, integration, and accountability. Scope and develop a primary health care information strategy that includes:
   - A national minimum data set and performance framework for primary health care to measure impact and outcome of services
   - Mandated measurement and reporting of consumer experience through Local Hospital Networks, Primary Health Networks and the services they fund as important measures of better health outcomes.
   - Link organisational funding, board and management performance contracts or agreements to the achievement of standards on consumer engagement and experience.

Lead into the future

10. Invest in the establishment of a government-led National Centre for Health Care Innovation and Improvement. The centre would support system stewardship by testing and scaling up new models of care and payment systems that work for patients, build capacity in the commissioning work of PHNs and their co-operation with LHNs, and spearhead national efforts to support the development of clinical and consumer skills in leadership, change management and improvement science. The centre should be a private-public partnership involving clinical, consumer, academic and industry leaders and philanthropic funding.

Further detail on these priorities is included in the next section on overarching priorities for action. A range of other priorities was identified, many of them linked to (and in some cases enabling) these ten overarching priorities. These priorities can be found in the Appendix, Table 1 – A Five Year Plan on page 18. Table 1 organises "next tier" recommendations into the steps needed over a 1-3-5 year outlook to achieve the 10 overarching recommendations.

The overarching priorities for action

Clear the way by removing funding barriers

1. ***Fund equitable access to a revised model of Health Care Homes across Australia, based on the original Primary Health Care Advisory Group (PHCAG) recommendations, with participation remaining voluntary for both practices and consumers, and including a significant shift away from fee for service payment systems.***

The Primary Health Care Advisory Group (2015) put forward the Health Care Homes (HCHs) model to provide a setting where consumers with complex and chronic conditions can receive enhanced access to holistic coordinated care and wrap around support for multiple health needs. This is currently being trialed in around 170 practices to date nationally.

Concerns have been raised about funding and implementation of the Australian model. However, the principles which underpin the model are well established, tested and implemented in other countries such as New Zealand, the United Kingdom, and the USA.

HCHs provide great opportunities for transformational reform in the Australian health system. They aim to promote consumer-centred care and move away from a focus on activity through fee for service medicine to a focus on outcomes. They provide additional time and flexibility for general practice to take a whole-of-person approach to health and wellbeing and promote interprofessional team-based approaches. They provide capacity for GPs and other members of the care team to reach out to their patients rather than patients coming to their doors – a more connected community.

There was a strongly held view at the roundtable that:

- Recognising the strength of the policy settings for HCHs (or Patient Centred Medical Homes – PCMH), there should be a review (in partnership with consumers) of the implementation and regulatory requirements for the current trial of HCHs to understand the challenges which have limited take-up and impact to date.
- Phase 2 roll-out of HCHs should be commenced, with greater flexibility in the funding and delivery model, including adoption of the principles from the report, ***Patient-centred Health Care Homes in Australia – Towards Successful Implementation.*** This phase should provide significantly enhanced access to HCHs, both across primary health care services and for all patients connected to participating practices – not just those with complex chronic illnesses.
- Equitable access should be provided to HCHs across Australia, with a general roll-out across the country. Participation in HCHs would remain voluntary for practices and patients, however support structures should be established to assist practices that are interesting in transitioning to HCH models.

This overarching priority builds on other recommendations in Appendix, Table 1:

- Transition from largely fee for service general practice to a flexible funding model based on needs and outcomes, rather than occasions of service. Over time, consider including these funds in regional budgets.

2. ***Strengthen Medicare through the development of regional budgets combining Commonwealth and State/Territory funding. These budgets would be flexibly administered by PHNs and LHNs, prioritise prevention and integrated primary health care and have strong governance arrangements that mandate consumer participation and decision-making.***

Recommendations 2–4 set the platform for establishing regional budgets where funding is pooled between the Commonwealth and states/territories to enable a joined-up approach to commissioning services which are consumer-centred and offer wrap around, whole of person care and access to services.

Regional budgets give the opportunity to plan, design, commission and deliver services which are responsive to local needs and priorities. However, this needs to be approached carefully, to ensure that the outcome is not simply a diversion of primary health care funds to the acute care sector to support hospital budgets which inevitably come under pressure.

Rather the aim should be to relieve that pressure and to support a focus on prevention and integrated primary health care where people are kept well and functioning within the community and their own homes as much as possible, with outreach support from hospitals and specialised sub-acute, and community health services.

The objectives are obvious. Such a model overcomes perverse incentives in funding arrangements and

promotes continuity and integration of care. While Medicare fee for service and PBS arrangements through community and hospital pharmacies would be preserved, it would begin to reduce fragmentation and competition between the Commonwealth and states and territories. It also promotes increased efficiency and effectiveness.

It creates the environment to develop an increased emphasis on prevention that integrates risk assessment across health and social care, with healthcare delivered in the most appropriate setting for the consumer. It enables the removal of barriers which prevent people from having choice about where and how their healthcare is delivered in the most appropriate setting for them.

It also enables what has been termed the "missing middle" to be straddled – the gap between what primary health care does now and the interface with the acute and emergency sectors. With joined up funding and clear pathways, and a clear focus on strengthened primary health care, providers can be supported to work at top of scope of practice, supported by specialised services, and that gap – which consumers often fall through – can be bridged.

Fundamental to the model is good governance arrangements, including a strong role for consumers and clinicians, with systems not only designed to include codesign with consumers and clinicians, but where Boards and management are contractually required to demonstrate that codesign.

This overarching priority builds on other recommendations in Appendix, Table 1:

- Transition from largely fee for service general practice to a more flexible funding model based on needs and outcomes, rather than occasions of service. Over time, consider including these funds in regional budgets.

Create regional solutions

3. ***Establish formal Agreements between the Commonwealth, the states and territories, Primary Health Networks (PHNs) and Local Hospital Networks (LHNs) (or their equivalent) to improve local and regional system performance and deliver integrated, consumer centred services.***

There have been previous calls for Tripartite Agreements between the Commonwealth, the states and territories, and PHNs as an enabler to assist achievement of the COAG National Health Reform Agreement to cooperate and coordinate on primary care reform. This cooperation and coordination are essential if Australia is to truly establish a consumer centred health system.

This move to formal, four-way sets of agreements recognises that LHNs (or their equivalents) should be a core partner in these arrangements, and not be at arm's length so that their association with the Commonwealth or with PHNs is via states and territories.

All integration is local – it cannot be easily imposed from either the national or state level. There are examples of promising local cooperation and coordination developing between PHNs and LHNs. But these are not consistent and the development of formalised agreements with the imprimatur of governments will lay the ground rules in relation to expectations of cooperation, coordination and integration.

These agreements need to recognise the special needs of those who are disadvantaged, at risk, or who are challenged to access the right services at the right time. This includes Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse communities (CALD), those living in rural and remote areas and those with low household incomes. They also need to address the vital role of carers and volunteers in the health and social care systems.

This overarching priority builds on other recommendations in Appendix, Table 1:

- Recognising the role of information as a fundamental integration tool, develop a national data set and performance framework for primary health care to measure impact and outcome of services. Data should be collected and used for clearly specified purposes, including to inform needs analysis and planning, enable measurement and analysis of performance, and enhance patient management.
- Invest in creating inter and intra professional teams, enabling the workforce that is needed to work best in this model of care and for every team member to work to full scope of practice.

4. ***Progressively empower PHNs to take greater responsibility and accountability for creating primary health care systems in their local areas. This includes broadening the objectives of PHNs and devolving additional funds from the national***

level to PHNs, with greater flexibility, authority and accountability to commission services based on population health needs and with consumer codesign models supported to share decision-making.

PHNs have been established as commissioners of services – the glue that aims to bind the various pieces of the primary health care system together and interfaces with the acute sector. They are funded by the Australian Government to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and to improve the coordination of care to ensure patients receive the right care in the right place at the right time.

The establishment of PHNs was an important initiative in aiming to rebalance the health system towards stronger prevention and primary health care. This recognised the imbalance between state and territory hospital and health services, and the thousands of what are generally small business owners – general practices, pharmacists, dentists and allied health professionals, for example – working in the primary care sector.

While there are significant expectations about what PHNs should do, PHNs have limited budgets and limited control to be able to meet these expectations. Unlike state-owned and run hospitals who manage their own budgets, for example, most primary care funding does not go directly to PHNs (e.g. Medicare Benefits, Pharmaceutical Benefits) but rather subsidises patients attending many thousands of independent private providers – general practices and pharmacies. They also have limited authority and are subject to significant restrictions and controls on their flexibility to act locally.

The roundtable strongly supported the role of PHNs and the vital importance of their role in working to rebalance the health system towards prevention and integrated primary health care. However, it was considered that PHNs needed to be given stronger levers to effectively influence and change the system.

This includes a mandate to broaden their scope to enable greater focus on health promotion and illness prevention, backed by adequate funding, devolution of all Commonwealth programs (and funding) so that they are run locally, and increased autonomy so that they are truly accountable to their local communities.

PHNs should be designated as the first choice for any increases in funding by the Commonwealth towards any local or regional services. Choosing an alternative approach weakens their capacity to leverage change and, where there is an exception, there should be a very strong and transparent case for that exception. Progressively, the devolution of appropriate family and children's, aged care and other social services to PHNs should be considered for integrated health and social care commissioning.

5. ***Require PHNs and LHNs to work together as co-commissioners of services, to design and develop alliance contracting arrangements where desired outcomes are specified and service providers are incentivised to work as partners in achieving those outcomes.***

A key requirement of the quadripartite agreements should be a commitment by PHNs and LHNs to work together – with governance arrangements ensuring partnership with consumers – to plan, design, and commission services which are whole of person focused and which make a consumer's pathway through the health and social care systems seamless. The consumer should not have to worry about who funds and owns the various services they need, and nor should they have to tell their story to a variety of different providers. The PHN commissioning processes and decisions, including any co-commissioning with other agencies, should involve consumers. This should include steps to ensure consumers insights and advice is captured in the needs assessment phase, service design and evaluation phases. It should also involve consumers in funding decisions about services to be funded. Systemic involvement of consumers in commissioning carries an obligation on PHNs to equip consumers with the skills and knowledge to be able to fulfill these roles well.

Alliance contracting has been a feature of regional funds pooling in NZ from 2013 . It facilitates the bringing together of clinical and executive leaders from DHBs, PHOs and other local services around 'whole of system' service delivery. It focuses on addressing the 'wicked problems' of service delivery at local level especially gaps in services, health inequity, and opportunities to better integrate services around community /primary care delivery and could serve as a model to consider in Australia.

This overarching priority builds on other recommendations in Appendix, Table 1:

- Provide additional funding to enable implementation

of the Productivity Commission recommendation to establish "Funding pools for Local Hospital Networks and Primary Health Networks to use for preventive care and management of chronic conditions at the regional level."

- Agreements should be underpinned by clear principles which build a consumer centred system and a whole of person approach – recognising and responding to the evidence of the strong links between physical, mental, social and emotional health and wellbeing.

Create regional solutions

6. ***Implement a major demonstration project to measure the impact of empowering consumers with complex chronic diseases to plan and manage their health by providing them with flexible individual funding packages – personalised budgets – where they have choice of services and providers (similar to the NDIS and aged care reforms).***

Personalised budgets can provide empowerment and choice for consumers who often feel they are being directed to a service or services with little choice. This is particularly the case for people with chronic and complex illnesses who may require a significant number of providers in both the primary and secondary service systems.

The NDIS and aged care reforms provide models of personalised budgets where the locus of control is being switched from the provider of services to the consumer of those services. In implementation, they have had their challenges, but the principles of those models have strong support across society.

Such an arrangement will not be for everyone and any such model needs to be consulted and communicated clearly. Feasibly it is a model which should be able to be codesigned with consumers and involving a substantial trial by 2023.

This overarching priority builds on other recommendations in Appendix, Table 1:

- Fund care coordinators or case navigators (via PHNs) in hubs within regional/local settings with responsibility for ensuring people at high risk can access health and social services.

7. ***Fund a Consumer Enablement Portal to bring together and better promote access to a broad range of high quality consumer health literacy, self-management, shared decision-making tools and other resources to empower consumers to better engage and participate in decisions about themselves, their families and other support people, the services they receive and the systems they connect with.***

Consumers continue to report a significant power imbalance with providers of services, including in communications with GPs and other primary health care providers. In many cases, this is not seen as deliberate – generally there has been an improvement in communication and in endeavours to ensure consumers are engaged as equals.

However, Australia currently has relatively low rates of health literacy and high rates of preventable chronic diseases. Patients seek help for their conditions later and are less likely to self-manage well and comply with their treatment and medications.

The recognition of the need for consumers to be regarded as partners in care, supported by shared decision-making practices is reasonable in Australia, bolstered by measures such as the National Safety and Quality Health Service Standards. There has been some leadership notably from the ACSQHC, some state-based agencies such as the Agency for Clinical Innovation, and NPS MedicineWise's stewardship of Choosing Wisely Australia, however efforts are patchy and poorly coordinated. The problem is not so much that resources don't exist, it is that consumers are not given clear 'sign posts' about how to find and use them. A single point of access is missing.

Specific programs need to be put in place and taken up to measure and build health literacy and enable consumers to engage and participate effectively – for themselves, their families and other support people (including carers), but also with services and systems. Health literacy funding should recognise varying need, for example costs are likely to be higher in disadvantaged communities and those with high numbers of CALD people in their populations. There are many such programs already in existence. These include Choosing Wisely Australia's Five Questions to Ask Your Doctor and the ACSQHC question builder tool.

Effective integrated care models also need the support of consumers with informed decision making if they are to contribute to planning and governance, with trust and respect from all parties.

When consumers move between services or care settings there should be a plan in place for what happens next and proactive follow up of the plan. The plan should include medical services and follow-up as well as referral to a range of other supports designed to help people function as a contributing member of the community.

This overarching priority builds on other recommendations in Appendix, Table 1:

- Enhance competency in consumer enablement strategies for health providers by embedding learning of these skills inside education, training and continuing professional development.
- Ensure consumers are engaged in codesign of policies and services and are equal partners in evaluation of services.
- Involve consumers in governance arrangements throughout all levels of health care.
- Mandate that funding and contractual arrangements from government to service providers must include performance reporting and indicators for evidence of effective engagement with consumers in codesign, monitoring and reporting.
- Fund scholarships, bursaries and programs which support people from diverse backgrounds to develop the skills and competencies they need to operate as equals in engagement and participation in services, settings and systems.
- Require health services to develop structures and processes which educate Boards, CEOs, managers and clinicians on the value of consumer experiences as essential skills to be built in and developed alongside other skills such as leadership, finance, human resource management, strategy development, governance and risk management.
- Require services to budget for and organise appropriate training and continuous development with consumers so that consumers can participate effectively and as equals in corporate and clinical governance, including training in health literacy. In turn, services should engage consumers to educate them on consumer service experience and opportunities for improvement.
- Require services and systems to utilise a broad range of digital opportunities to engage consumers and enable them to express views and provide advice and feedback "en masse" on issues and improvements needed, with a focus on their experience of service.
- Build in funding as standard features in tender and contracts to recognise and support the additional costs associated in undertaking effective consumer engagement and participation, as well as recognition of the extra time which proper codesign processes will take to achieve optimum results.

Link up the system

8. Recognising the importance of professional collaboration and team-based care within care settings and across primary, secondary and tertiary health care, introduce funding models which promote joined up models of health service delivery, including incentives which:

- Appropriately support engagement of non-prescribing pharmacists in general practice
- Establish GP Liaison Officers in all metropolitan and regional settings
- Promote hospital-based specialists providing liaison, advice, support and clinics within general practice based on community need
- Significantly expand access to care coordinators, health system navigators and health coaches on the basis of need and region for those with complex chronic conditions
- Increase the numbers of Aboriginal and Torres Strait Islander and CALD people at all levels of the health workforce,
- Promote development, professionalisation and employment of a peer workforce with lived experience, with priority for mental health and suicide prevention peer workers.

Workforce design, development and deployment are major building blocks in any health system change agenda. Strong, integrated primary care is only possible where that workforce collaborates around the needs of individuals, families and communities.

This recommendation identifies a series of vital steps in developing a team-based, interprofessional approach:

- **Pharmacists**

From 1 July 2019, a new Workforce Incentive Program will streamline existing GP, nursing and allied health incentive programs, replacing the General Practice Rural

Incentive Program and the Practice Nurse Incentive Program (PNIP). There will be two streams – a Practice Stream and a Doctor Stream – and for the first-time general practices will be able to access incentive payments of up to $125,000 a year (plus potentially a rural loading) to employ non-dispensing pharmacists.

However, employment of pharmacists will be in competition with existing incentives to employ practice nurses and allied health practitioners (already available under PNIP).

The inclusion of pharmacists within general practice brings benefits for patients in terms of better medicines management, and to the system through better use of medicines and reduced adverse events. To speed up the desirable inclusion of pharmacists within practices, the Australian Government should dedicate a component of the professional services program under future Community Pharmacy Agreements to support models of care that integrate general practice and pharmacy services, and fund general practices (through increased funding of the Workforce Incentive Program or through PHNs) as an incentive to employ non-dispensing pharmacists.

- **General Practice Liaison Officers**

GPLOs play an important role in enabling better coordination, communication, discharge planning and handover to and from hospital and general practice/community settings – an area of notorious challenge over decades within the Australian health system. They should be supported by LHNs and PHNs to operate in all metropolitan and regional hospitals.

- **Hospital based specialists providing community outreach**

If GPs, nurses and allied health professionals are to operate at the top of their scope of practice, and support people to remain active in the community instead of having to seek specialist hospital care, they need to be supported by specialists who can assist them with patients with higher acuity, severity or complexity. Funding mechanisms are required which support this approach.

- **Care coordinators, health system navigators and health coaches**

People with complex needs often face great difficulty in navigating the health system, fall through the gaps in the system, go without necessary services, can receive duplicated and therefore wasteful services, and can end up requiring what could have been avoidable hospitalisations. Care coordinators, navigators and coaches can all help overcome these problems and should be deployed in hubs throughout Australia (general practices, Aboriginal Community Controlled Health Services and rural hospitals) as needed.

- **Aboriginal and Torres Strait Islander health workforce**

Significant efforts have been made to increase the numbers of Aboriginal and Torres Strait Islander people in a range of health professional areas. However, there remains a large gap in achieving a sufficiently representative workforce and an under-recognition of the diverse roles played by Aboriginal and Torres Strait Islander health professionals in the delivery of comprehensive primary and integrated health care services.

Work should be undertaken by governments in close collaboration with Aboriginal and Torres Strait Islander organisations to identify the shortfall in Aboriginal and Torres Strait Islander workers needed across the health sector and clear policy targets and implementation plans should be set to address the gap in workforce participation.

- **Peer workers**

The importance of peer-workers engaging and supporting people in the health system is becoming increasingly well recognised. The number and breadth of role of peer workers continues to expand, albeit not consistently across Australia – the recognition of peer workers as vital professionals is still in its developmental stages.

The variation in the definition, accountabilities and roles of the peer workforce is a barrier to the inclusion of peer workers as formal members of the multidisciplinary team and therefore limits the valuable contribution they can make to improving health care delivery.

Supporting the growth and recognition of the peer workforce as an emerging profession is seen as a vital cog, particularly in mental health and suicide prevention, but also in other areas e.g. cancer services, diabetes management. Peer workers can add significant value to the multidisciplinary team, for example by including them in Emergency Departments to assist in de-escalation of trauma for people who attend with acute or manic episodes, and by "walking with" and following

up with people who are discharged from hospital after a suicide attempt.

These workforce enhancements will not occur quickly by simple policy decisions and recognition of the desirability of change. Rather they require commitment backed up by additional funding as incentives for desirable change.

9. ***Recognise the important role of primary health care information – including patient experience measures - as fundamental to better patient management, service development and quality improvement, integration, and accountability. Scope and develop a primary health care information strategy that includes:***

- A national minimum data set and performance framework for primary health care to measure impact and outcome of services
- Mandated measurement and reporting of consumer experience through Local Hospital Networks, Primary Health Networks and the services they fund as important measures of better health outcomes and better experience of care. Link organisational funding and Board Director and management performance contracts contracts/agreements to achievement of standards on consumer engagement and experience

Primary health care information should not sit in isolation of the broader health system, but rather it should be viewed as an essential component, which when linked with other data sets, can enable a whole of person/service/setting/systems approach.

The first priority in developing a minimum data set should be to clarify its purpose – its intended use. Consumers often feel that data are collected for purposes unknown and potentially not used – there is lack of transparency. Data collections should have clearly specified purposes, including to inform needs analysis and planning, enable measurement and analysis of performance, and enhance patient management.

Data collection should include use of tools which measure consumer experience and which already exist, such as patient- reported experience (PREMs), patient-reported outcomes (PROMs), and Your Experience of Service (YES).

Consumer experience of service is increasingly being shown to be fundamental to achieving good outcomes in the health system. What a provider views as a good patient outcome may not necessarily align with the views of a consumer – e.g. an exclusive focus on 'getting better' may come at the expense of poor experiences of care and treatment, potentially demeaning health care, and mean lower quality of life according to what the consumer values.

There is a growing awareness that clinical outcomes alone are not a sufficient measure of system performance as patient perceptions often differ from clinicians' assessments. Patient reported outcomes and experiences can be used to inform the interaction between patients and provider but are also a valuable component of population health surveillance at a broader level and can inform policy and service design decisions.

Mandating measurement and reporting of consumer experience will provide valuable information that will inform design, development and delivery of services, will lead to more efficient and effective services, and greater satisfaction for both consumers and services – the Quadruple Aim to achieve a high performing health system.

Lead into the future

10. ***Invest in the establishment of a government-led National Centre for Health Care Innovation and Improvement. The centre would support system stewardship by testing and scaling up new models of care and payment systems that work for patients, build capacity in the commissioning work of PHNs and their co-operation with LHNs, and spearhead national efforts to support the development of clinical and consumer skills in leadership, change management and improvement science. The centre should be a private-public partnership involving clinical, consumer, academic and industry leaders and philanthropic funding.***

Many of the policy settings and new directions needed to drive transformational reform for better integrated and coordinated primary health care have been identified and documented. However, gaps exist between policy commitment and the implementation and translation of policy intent into changed systems and services. There have been many attempts to reform the health system and numerous ideas have either failed or faltered during the implementation process.

The evidence is clear: investment in change and change management expertise and capability in the system is needed if implementation is to be effective and sustained, with broad support and adoption from stakeholders.

There is much we already know about the circumstances that can determine whether changes in the health system succeed or fail. Policy mandated change in a complex health system is unlikely to effect change, while clinically or evidence-based change might. Local innovation from within the system is far more likely to succeed than a decision coming from outside the system. Change is accepted when people are involved in the decisions and activities that affect them, but they resist when change is imposed by others (Braithwaite, 2018). In Scotland, for example, reports have found that national mandates for change, but implementation driven locally through shared funding, risk and accountability translated into better collaboration between sectors of the health and social systems who may not have worked together in the past (Bayliss and Trimble, 2018). This final recommendation will assist in building PHN capacity to research and economically evaluate local needs in their work identifying and commissioning services.

Our ten recommendations are based on evidence and where expert opinion of roundtable participants and other authoritative commentators, most recently the Productivity Commission, believe we have opportunity to innovate. They also are based on lessons and observations made about how Australia has gone about implementing precursor or current reforms such as the coordinated care trials, the trial of HCHs and introducing My Health Record.

However, as with any ambitious agenda, we are experimenting with change as much as any country and therefore there is strong need to nurture a culture of innovation and put in place sound frameworks to learn along the way.

As one group of US researchers put it: primary care practice transformation is hard work. They describe the complex nature of primary care practices, the challenges of introducing change and quality improvement and the scale and nature of the change required to move models of care to the idealised vision of the patient centred medical home.

In the US the National Academy of Medicine describes the concept of a learning health system as a means of ensuring innovation, quality, safety and value in health care. In the UK, various modernisation and quality agencies have been established to help drive transformation of health care.

In Australia no such national agencies to steward change, innovation and improvement exist. We have the Australian Commission for Safety and Quality in Healthcare, and state level agencies such as Safer Care Victoria and the NSW Centre for Clinical Excellence, all of which have a primary focus on promoting quality and safety in hospitals settings. They do not have a wider, whole-of-health system purview. Australia also has had forums focused on supporting leadership such as the National Lead Clinicians Group which have not been sustained, and there are current demonstration initiatives of innovative ways for consumers and clinicians to learn and lead together such as the Collaborative Pairs Australia demonstration project being coordinated by CHF, which test out this joint leadership program initiated by the UK Kings Fund in the Australian context. An overarching centre with the mandate to drive change could both house, support, further develop and sustain such forays.

Australia needs to develop a national model to support health system wide transformation which is fit-for-purpose for our unique circumstances and systems. Various options could be explored that could help build rapid implementation and translation capability including the feasibility of partnering with global organisations with the desired expertise such as the Institute for Healthcare Improvement (IHI). A centre such as the one proposed here would take a 'start up' approach to health care innovation heavily backed by its principal investor: the Australian public.

Consumer empowerment and clinician leadership is needed to support and enable political and other leaders to design and implement models which support transformational change and a stronger, integrated primary health care system. The invitation is open.

> Knowing is not enough;
> we must apply.
> Willing is not enough;
> we must do"
>
> ***- Goethe***

Where to next?

Australia requires accelerated action on primary care reform to reduce current strains on the health system. It is well established that the drivers of such change depends on a range of factors:

- Funding incentives
- Data and benchmarking, particularly where there are clear reporting and accountability arrangements
- The reward system
- Evidence
- Power and control
- Ownership of the change
- Workforce design and scope of practice
- History of the system in which change is being implemented and the associated willingness to do something differently
- The health system environment

A strong primary health care system is fundamental to increasing efficiency, reducing hospitalisations, lowering health inequalities and ultimately improving health outcomes for all Australians. The recommendations in this report outline the ***right settings for system change***, critical to transform our health system and strengthen consumer-centred and community-based primary health services for generations to come. *The report recommendations can be distilled into 14 key elements needed to create a model for transformation and implementation:*

Common objectives
Shared long-term vision among stakeholders

Clinician leadership
Clinicians using evidence to embrace and drive change

PHNs with authority and funding levers
Increased funding, accountability and autonomy

Prevention and primary health care led
Reorient the system for better access, effectiveness and efficiency

Regional budgets
Fund pooling with consumer informed outcomes and involvement

Funding models reward outcomes not activity
Broader funding models and reduced perverse incentives

Communicate, communicate, communicate
A clear and transparent engagement strategy

Consumer empowerment in their own care and system engagement
Consumer centred system

Joint planning and alliance contracting
Between Commonwealth, states, territories, PHNs and LHNs

Technologically enabled
Data and digitally driven

Integrated models of care
Health Care Homes V2, rewards for innovation and linkage with all relevant providers

Codesign with consumers and clinicians
To go further, go together

Funding certainty
Use a 3-5 year horizon

Investment in implementation and innovation
Sustained, persistent and properly funded

Thank you

The George Institute for Global Health, the Consumers Health Forum of Australia and The University of Queensland MRI Centre for Health System Reform and Integration are grateful for the participation of the following representatives in the roundtable discussion, and in subsequent consultation and feedback, that form the basis of the recommendations provided in this report. The views and recommendations in this report represent the outcomes of the roundtable discussion. The report does not necessarily reflect the specific views of roundtable participants or the organisations they represented (some of whom may have official positions that differ from that represented in the report).

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Appendix

Table 1: A Five-Year Plan

	Year 1	*Year 3*	*Year 5*
Self	Fund a Consumer Enablement Portal to house and better promote consumer literacy, self-management, decision support and other enablement programs to empower consumers to engage and participate in decisions about themselves, their families and other support people, the services they receive and the systems they connect with. Mandate measurement and reporting of consumer experience through Local Hospital Networks, Primary Health Networks and the services they fund as important measures of better health outcomes and better experiences of care. This includes use of tools such as patient-reported experience (PREMs), patient-reported outcomes (PROMs), and Your Experience of Service (YES). Enhance competency in consumer enablement strategies for health providers by embedding learning of these skills inside education, training and continuing professional development.	Ensure consumers are engaged in codesign of policies and services and are equal partners in evaluation of services. Fund care coordinators or service navigators (via PHNs) in hubs within regional/local settings with responsibility for ensuring people at high risk can access health and social services.	Implement a major demonstration project to measure the impact of empowering consumers with complex chronic diseases to plan and manage their health by providing them with flexible individual funding packages – personalised budgets – where they have choice of services and providers (similar under the NDIS and aged care reforms).
Services and settings	Recognising the strength of the policy settings for Health Care Homes (HCHs) (or Patient Centred Medical Homes – PCMH). The implementation needs to have an increased focus on implementation failures, blockages and lessons learnt. This information needs to be shared widely to build strategies for improving implementation and gearing up wholesale adoption of the model. Require health services to develop structures and processes which educate Boards, CEOs, managers and clinicians on the value of consumer experiences as essential skills to be built in and developed alongside other skills such as leadership, finance, human resource management, strategy development, governance and risk management. Require services to budget for and organise appropriate training and continuous development with consumers so that consumers can participate effectively and as equals in corporate and clinical governance, including training in health literacy. In turn, services should engage consumers to educate them on consumer service experience and opportunities for improvement.	Commence Phase 2 roll-out of HCHs, with greater flexibility in the funding and delivery model, including adoption of the principles from the report, Patient-centred Health Care Homes in Australia – Towards Successful Implementation. This phase should provide significantly enhanced access to HCHs, both across primary health care services and for all patients connected to participating practices – not just those with complex chronic illnesses. Require services and systems to utilise a broad range of digital opportunities to engage consumers and enable them to express views and provide advice and feedback "en masse" on issues and improvements needed, with a focus on their experience of service. Invest in creating inter and intra professional teams, enabling the workforce that is needed to work best in this model of care and for every team member to work to full scope of practice. Recognising that more and more services will be delivered remotely through digital technology, remove funding and structural barriers which restrict or prevent access to those services e.g. A move from fee for service to funds pooling and cashing out between the Commonwealth and the states and territories to develop new payment mechanisms and enable more equitable access to digital health services including telehealth.	Fund equitable access to a revised model of Health Care Homes across Australia, based on the original Primary Health Care Advisory Group (PHCAG) recommendations, with participation remaining voluntary for both practices and consumers, and including a significant shift away from fee for service payment systems. Build in funding as standard features in tenders and contracts to recognise and support the additional costs associated in undertaking effective consumer engagement and participation, as well as recognition of the extra time which proper codesign processes will take to achieve optimum results. Link organisational funding and Board Director and management performance contracts/ agreements to achievement of standards on consumer engagement and experience.

	Year 1	Year 3	Year 5
System	Recognising the importance of professional collaboration and team-based care across primary, secondary and tertiary health care, introduce funding models which promote joined up models of health service delivery, including incentives which: - Appropriately support engagement of non-prescribing pharmacists in general practice - Establish GP Liaison Officers in all metropolitan and regional settings Mandate that funding and contractual arrangements from government to service providers must include performance reporting and indicators for evidence of effective engagement with consumers in codesign, monitoring and reporting. Involve consumers in governance arrangements throughout all levels of health care. Establish formal Agreements between the Commonwealth, the states and territories, Primary Health Networks (PHNs) and Local Hospital Networks (LHNs) (or their equivalent) to improve local and regional system performance and deliver integrated, consumer centred services. These agreements should require PHNs and LHNs to work together as co-commissioners of services, to design and develop alliance contracting arrangements where desired outcomes are specified and service providers are incentivised to work as partners in achieving those outcomes. Agreements should be underpinned by clear principles which build a consumer centred system and a whole of person approach – recognising and responding to the evidence of the strong links between physical, mental, social and emotional health and wellbeing. Conduct a scoping exercise of different models of health care change translation and improvement agencies in relevant countries. Convene a consortium of interested parties to jointly design the scope and the purpose of a National Centre for Health Care Innovation and Improvement including options for governance, form and function.	Promote hospital-based specialists providing liaison, advice, support and clinics within general practice based on community need Significantly expand access to care coordinators, health system navigators and health coaches on a regional basis for those with complex chronic conditions Fund and evaluate different models of consumer/clinician engagement such as Collaborative Pairs. Progressively empower PHNs to take greater responsibility and accountability for creating primary health care systems in their local areas. This includes broadening the objectives of PHNs and devolving additional funds from the national level to PHNs, with greater flexibility, authority and accountability to commission services based on population health needs and with consumer codesign models supported to share decision-making. Provide additional funding to enable implementation of the Productivity Commission recommendation to establish "Funding pools for Local Hospital Networks and Primary Health Networks to use for preventive care and management of chronic conditions at the regional level." Recognising the role of information as a fundamental integration tool, develop a national data set and performance framework for primary health care to measure impact and outcome of services. Data should be collected and used for clearly specified purposes, including to inform needs analysis and planning, enable measurement and analysis of performance, and enhance patient management. Run a consultation strategy to elaborate on the purpose, governance, form and function of a proposed Australian a National Centre for Health Care Improvement and Innovation. Confirm founding organisations and refine the model based on stakeholder feedback Develop a business case for start-up funding.	Increase the numbers of Aboriginal and Torres Strait Islander people at all levels of the health workforce, so that parity is achieved with the non-Indigenous workforce when burden of disease measures are applied. Promote development, professionalisation and employment of a peer workforce with lived experience, with priority for mental health and suicide prevention peer workers. Fund scholarships, bursaries and programs which support people from diverse backgrounds to develop the skills and competencies they need to operate as equals in engagement and participation in services, settings and systems. Strengthen Medicare through the development of regional budgets combining Commonwealth and State/Territory funding. These budgets would be flexibly administered by PHNs and LHNs, prioritise prevention and integrated primary health care and have strong governance arrangements that mandate consumer participation and decision-making. Transition from largely fee for service general practice to a more flexible funding model based on needs and outcomes, rather than occasions of service. Over time, consider including these funds in regional budgets. Present the business case to prospective public and private funders.

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