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AMA Submission in response to Draft Recommendations from the Primary Health Reform Steering Group

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Introduction

The AMA broadly welcomes the Primary Health Reform Steering Group's (PHRSG) Draft Recommendations and acknowledges the extensive consultation that has been undertaken to inform the draft recommendations.

Government investment in general practice has not matched the increased demand for care nor the costs of providing that care. The Australian population is growing, ageing, and patients have more complex health needs – both physical and mental.

General practice is underfunded with the Medicare Benefits Scheme systematically devaluing GP services through inadequate indexation and a consultation item structure that fails to keep up with the growing complexity of care and the need for GPs to spend more time with their patients.

The viability of general practices is under threat and this undermines attractiveness of general practice as a career. Urgent reform and greater support for general practice and primary care is needed, which makes the finalisation and implementation of a 10-Year Primary Care Plan critical to both the future of general practice and the sustainability of our health care system.

The high level recommendations made by the Steering Group, if implemented well, have the potential to support better care for patients and improve population health outcomes and the future sustainability of the health care system.

The AMA looks forward to working further with the Steering Group on finalising its recommendations and guiding the Government's Primary Health Care 10 Year Plan.

General Comments

The AMA welcomes the focus on the reform of funding arrangements for general practice as part of efforts to improve and strengthen primary care. Change is difficult and building on the current systems as the discussion paper outlines, and as the AMA has advocated in its Delivering Better Care for Patients: The AMA 10-Year Framework for Primary Care Reform, will support and encourage GPs, general practices, specialist services, and providers of allied health, to embark on the journey that will enable our health system to evolve so it can continue to meet current and future needs.

The recommendations articulate the changes needed to ensure the centrality of general practice to patient care and that general practices are appropriately resourced and supported to deliver high quality care and improved health outcomes for their patients. Only through strengthening general practice and the primary care system with improved funding arrangements will the value of our GPs and multi-disciplinary health care teams working as one for the patient be fully realised and the objectives of the Quadruple Aim met.

If these recommendations are effectively implemented, we can refocus the nature of our health system to foster good health, while optimising care for all Australians experiencing physical or psychological ill-health. Shifting the current funding paradigm to one that remunerates and rewards preventive health care and better supports value-based care rather than one that preferentially rewards volume-based care will be key to the sustainability and ongoing ability of our health care providers to deliver quality care.

The AMA in its abovementioned 10-Year Framework articulated the increases to funding for general practice and general practice research that is required. To that end the AMA supports the intention and direction of the PHRSG recommendations provided there is a commitment from Government that general practice funding is increased to 16% of total health expenditure and that a GP-led governance structure is put in place for implementation.

The AMA firmly believes that, provided GPs are appropriately resourced, formalising the doctor patient relationship through Voluntary Patient Enrolment (VPE) will strengthen the continuity and longitudinal nature of care provided. It will require greater accountability from other parts of the health care sector to collaborate with a patient's GP/general practice and improve care by enhancing coordination, fillings gaps in access to care and reducing duplication.

It will give general practices the ability to define their patient population, better understand and address patient needs and gaps in care as well as measure care outcomes. Improved funding for general practice will generate savings through better care, greater efficiency and lowering the burden on other more expensive parts of the health system that can be reinvested to support much needed initiatives in areas such as improved wound care in general practice.

The AMA notes the actions proposed under each recommendation and advises that Implementation Working Groups will be needed to inform and guide their implementation.

Responses to Survey Questions

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

1.1 Do you agree with this recommendation?

Yes.

This recommendation acknowledges the need for primary health care to be better funded. Currently, total government spending on hospitals is six times more than is spent on general practice and Productivity Commission and Australian Institute of Health and Welfare data shows that disparity is only increasing. This recommendation highlights that Commonwealth and State governments need to work together and share in the responsibility of funding general practice and primary care to support it in caring for the community and preventing avoidable hospital admissions. The recommendation acknowledges the need for flexibility so that regionalised solutions that best work for a community can be supported.

1.2 What do you see as the challenges in implementing this recommendation?

The challenge with this recommendation will be in creating a shared vision with agreed outcome measures to which each of the key stakeholders will commit to. This commitment must be bi-partisan to ensure longevity beyond political terms.

The AMA has already specified that the Government must commit to general practice funding being increased to 16% of total health expenditure and that a GP-led governance structure is put in place for implementation.

Another challenge will be accounting for differing localised solutions. Agreed objectives and performance indicators will be vital in enabling each solution to be fairly evaluated against those objectives. Importantly, if a solution has not met its objectives understanding what factors influenced the result will be vital as learnings are shared and solutions are modified within a continuous improvement framework to deliver on objectives.

Collectively, Local Health Networks, Primary Health Networks, General Practices, allied health providers and community services are going to need to work together to ensure improved access and health outcomes for their populations. This will likely require bilateral funding and performance agreements to provide pool funding arrangements, data transparency to inform wait times and referral pathways, and IT solutions that support shared care.

Eliminating cost shifting behaviours and blame game mentality across levels of government should be an outcome of a one system focus. As we have seen National Cabinet working together in response to COVID-19 so too do we need to see all governments working together to best support the health care of Australians now and into the future.

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

2.1 Do you agree with this recommendation?

Yes.

While almost 80% of Australians have a preferred GP, formalising this relationship will give practices greater vision of their patient cohort to better support preventive and proactive care, and maximise continuity of care reducing wastage across the system when care is duplicated or repeat diagnostics could have been avoided.

VPE will help support improved communication between health providers and across health sectors. It will also provide the basis on which supplementary funding can be provided to support and reward best practice primary care and improved patient outcomes.

2.2 What do you see as the challenges in implementing this recommendation?

Educating patients about the benefits of patient enrolment is going to be paramount as the power is with the patient and enrolment, based on the Budget commitment for MyGP, patient driven. The benefits of enrolment need to meaningful, including assess to clinically appropriate telehealth services and other relevant services.

General practices clinical software will need modification to accommodate patient enrolment and to track patient interactions across the multidisciplinary team. General practices must be supported with software that delivers the required functionality to support this and the usage of other digital health solutions in providing comprehensive patient care. Introducing licencing provisions to ensure interoperability across digital platforms may be one way to ensure practices can readily adapt.

Demonstrating to GPs and practice owners the benefits of patient enrolment, the supplementary funding it will enable, and how that will facilitate a better experience for them in caring for their patients will be essential for their engagement. Part of the challenge in this regard will be facilitating an equitable distribution of funding to support both the practice and the work of the individuals within it. Certainly, the peak representative bodies will have a role to play in this but the Government must provide funding to support both the cultural change and administrative modifications practices will need to make.

2.3 Please provide any examples of best practice for implementation of this recommendation (from Australia or overseas).

A number of other countries have implemented systems of patient enrolment. However, it is important that the system adopted here is suited to the Australian context and aligns with the concept of the patient centred medical home. The Australian community is accustomed to choice and a fee for service system that is supported by access to a patient rebate. The Australian model of enrolment must build on this approach that has a track record of delivering good outcomes for patients.

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

3.1 Do you agree with this recommendation?

Yes.

The AMA supports a blended funding model and where appropriate the use of pooled funding arrangements to support value based care. A blended model must have fee for service at its core but may include additional payments such as practice and service incentives, funding for preventative health care or enhanced care for chronic disease patients, infrastructure grants, and quality improvement measures.

3.2 What do you see as the challenges in implementing this recommendation?

Funding reform must deliver a significant boost in resources for general practice to support the systems and cultural changes required for practices wanting to enhance the use of their care teams and provide wrap-around care. Pooled funding can support a range of functions, which includes:

- multidisciplinary health care staff to provide patient services;
- support staff including medical assistants, social prescribers, care coordinators and system navigators and peer support workers;
- support for training, systems development and leadership;
- data and analytics;
- reflection and quality improvements;
- interface, pathway and systems development; and
- professional development.

Effective data will be key to informing funding requirements and care initiatives and GPs will need to be supported to implement greater use of clinical coding in their daily practice to enhance the quality of available data. Coding takes additional practitioner time and Service Incentive Payments (SIPs) will be required to support this work.

It is vital that funding reforms are co-designed to ensure care can be maximised and efficiently delivered. Funding arrangements must be transparent and matched to community need with outcome measures that are comparable across different communities.

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

4.1 Do you agree with this recommendation?

Yes. Addressing the health inequities experienced by Aboriginal and Torres Strait Islander Australians, that stem from social and cultural determinants of health need to be prioritised and supported with sustainable and guaranteed funding for programs and services.

4.2 What do you see as the challenges in implementing this recommendation?

The AMA is pleased to see high level commitment to successfully implement the health objectives identified under the National Agreement on Closing the Gap. It is positive to see the investment in the ACCHO model of primary care, as well as Aboriginal and Torres Strait Islander leadership in health, and growing the health workforce.

For this recommendation to be successful – it requires sustainable and ongoing resourcing along with the relevant reforms to be reflected within the budget as well as relevant policies and programs.

We would also encourage broader government investment to redress disparity across all determinants of health to fully realise the objectives of Closing the Gap, as these are intricately connected to health and wellbeing for Aboriginal and Torres Strait Islander peoples.

4.3 Please provide any examples of best practice for implementation of this recommendation (from Australia or overseas).

The AMA suggests the Department look to the leadership of the Aboriginal and Torres Strait Islander health peak sector for guidance in this regard.

Recommendation 5 (Regionalised approaches to deliver unified care): Prioritise structural reform in rural and remote communities

5.1 Do you agree with this recommendation?

Yes. This recommendation reflects recognition that more innovative approaches to funding are needed to support rural primary health care.

5.2 What do you see as the challenges in implementing this recommendation?

The AMA would like more information about the Rural Area Community Controlled Health Organisations (RACCHOs) proposal. Aboriginal Community Controlled Health Organisations (ACCHOs) report difficulties in obtaining continuous funding, with short term grants from dozens of sources undermining the ability to ensure continuity of employment for healthcare providers and services to the community. It is unclear how RACCHOs would interact with Primary Health Networks (PHNs) and we do not want them to undermine existing private general practices. The AMA would support a model that builds on existing general practices with funding for allied health services coordinated through the general practice. The AMA would welcome an opportunity to contribute to the further development of this action either through a working group or through a formal submission to the Steering Group.

The AMA remains concerned about credentialing. Inconsistent rules between states, regions and hospitals are undermining the push for more rural generalists. This will require cooperation between Commonwealth and the jurisdictions. There should be consistent signals sent by all hospitals and facilities regarding what is an acceptable standard to work in a location.

5.3 Please provide any examples of best practice for implementation of this recommendation (from Australia or overseas).

The AMA's Easy Entry, Gracious Exit model has been successfully adapted in parts of Australia. The AMA supports Commonwealth funding to be available for communities that use this model.

The AMA would encourage the piloting of virtual practice networks that share a practice manager and administrative services. For example, bookkeeping, accounting, chasing of debtors, recalls, health promotions etc. This could all be done remotely through the use of cloud and other technology to allow access to practice software.

Some rural and remote general practices have successfully incorporated home monitoring to improve their patients' outcomes, but there are no rebates for this. Technology exists for monitoring of blood pressure, PR, SpO2, weight, BSL at home with devices that can wirelessly transmit data to software within the practice. Even without wireless connectivity patients can enter the data themselves via a portal.

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

6.1 Do you agree with this recommendation?

Yes. Supporting health literacy is important because it impacts a patient's health care decision making, their engagement in their health care and with the health system, and their adherence and compliance to their treatment plan[1]. The lower health literacy the more likely a patient will experience an adverse health outcome and require more health resources. In addition, patient activation plays an important role in disease prevention and management. The more activated patients are the more the costs associated with the burden of disease are reduced for both the individual and society.

6.2 What do you see as the challenges in implementing this recommendation?

Primarily, efforts to improve health literacy must respond appropriately to the varying needs of diverse population groups. This should include the provision of accessible health

[1] Australian Commission on Safety and Quality in Health Care (ACSQHC). Health literacy: Taking action to improve safety and quality. Sydney: ACSQHC, 2014, p 12-13 at https://www.safetyandquality.gov.au/sites/default/files/migrated/Health-Literacy-Taking-action-to-improve-safety-and-quality.pdf

information, easily navigable design of public health facilities, and dissemination of education and health promotion campaigns.

Determining a patients' ability and capacity to engage in their health care, understand their condition and its implications, make prescribed lifestyle changes, and adhere to medication regimens and to treatment or management plans are already fundamental aspects of the general practitioner – patient relationship. However, this work needs to be better resourced so GPs can more fully support their patients improve their health outcomes. The remuneration structure for attendances needs modification so the additional time required with patients on activities such as this is not progressively devalued.

General practices also need ready access to validated tools, integrated into their clinical software, for assessment, behaviour guidance, and improvement monitoring and this must be resourced. PHNs for example could be resourced to work with practices and software providers to make patient activation measures available to all willing general practices. Their use could then be reinforced via incentive payments to reward practices who can demonstrate increased patient activation levels.

6.3 Please provide any examples of best practice for implementation of this recommendation (from Australia or overseas).

6.4 Please provide any examples of successful digital solutions and devices.

The AMA while not wishing to endorse solutions specifically is aware of a number of digital solutions that collectively:

- Enable remote monitoring of a patient's clinical indicators;
- Support patients with information on managing their care;
- Engage patients in reporting on their clinical indicators;
- Provide a measure of a patient's activation levels, health literacy, experiences and outcomes;
- Enable shared care planning and management;
- Stratify patients according to their risk factors;
- Support clinical decision making; and
- Identify and access appropriate pathways of care.

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

7.1 Do you agree with this recommendation?

Yes. This recommendation supports building a more resilient health system that is not just equipped to treat and manage disease but also to prevent it or reduce its occurrence. It also acknowledges that quality preventive and health care is required and provided across a lifetime.

7.2 What do you see as the challenges in implementing this recommendation?

The challenge for health funders will be in funding activity for which there is no immediate benefit. As much preventive health care delivers improved health comes over the longer term funding measures could be threatened and undermined by short term political cycles.

Preventive health funding needs to support a prevention activity rather than disease specific prevention items, such as the Medicare Benefit Schedule Item for Heart Health Assessments. Resourcing activities such as preventive screening, health assessments, and counselling on health related issues such as nutrition, physical activity, smoking cessation and alcohol consumption will support this work while enabling the collection of longitudinal data on preventive activities.

It will be vital to co-design appropriate measures on which to report as agreed preventive actions are taken and the benefits unfold.

Clinical software that is adaptable to the changing needs of GPs, particularly in tracking and reviewing preventive actions and care provided across the health team will be essential not only in compiling data that informs further preventive care activities but also its outcomes.

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

8.1 Do you agree with this recommendation?

Yes.

8.2 What do you see as the challenges in implementing this recommendation?

Concerns around patient privacy are likely to be issue in collecting data on this group of patients. Patients must be supported with easy to understand information about the privacy protections that are in place to protect their personal information.

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

9.1 Do you agree with this recommendation?

Yes. The Health Care Homes project has highlighted the difficulties of achieving cultural change without strong leadership.

9.2 What do you see as the challenges in implementing this recommendation?

The AMA notes the action that reform thinking be included in the education and training of medical professionals including undergraduate curricula and early career professional transition programs. However, established health professionals would also benefit from support with reform thinking. The AMA suggests that reform thinking also needs to be supported as a CPD activity across primary care disciplines to foster innovative models of care and adaptability to support high value patient centred care.

9.3 What do you see as the areas of opportunity for leadership and cultural change?

The greatest opportunities for leadership are in:

- funding reform and moving away from entrenched practices related to volume-based care;
- removing regulatory barriers, such as limited access to MBS funding for telehealth services conducted by telephone, participant requirements for multi-disciplinary case conferences, and point of care testing, to support GPs in providing innovative and coodinated care solutions; and
- workforce upskilling and utilisation in a collaborative model of care.

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

10.1 Do you agree with this recommendation?

Provided GPs, and in particular the patient's nominated GP, are always central to the health care team the AMA supports this recommendation.

10.2 What do you see as the challenges in implementing this recommendation?

One of the first challenges will be in ensuring a sustainable GP workforce into the future. Recent research shows that medical graduates are increasingly choosing specialty training pathways other than general practice. This trend coupled with a falling rates of GP job satisfaction [2] highlights the problem.

The AMA Vision Statement for General Practice Training outlines how this can be addressed. This includes providing a a clear training pipeline from medical student exposure, though pre-vocational experience to a well-structured and supportive vocational training program. GP trainees need a sustainable employment model to ensure equitable employment conditions with their counterparts in other specialist training programs so that general practice training is an attractive and viable option for doctors.

When it comes to fostering rural generalism within the medical practitioner workforce will require:

- clearly defined training programs and pathways;
- establishing a general set of competencies for all doctors in training;
- enhanced training opportunities for generalist medical practitioners to enable the acquisition of speciality procedural skills and/or expertise;

[2] Scott.A. 2021. General Practice Trends. ANZ-Melbourn Institute Health Sector Report. Sourced online at:: https://www.anz.com.au/content/dam/anzcomau/pdf/ANZ%20Health%20Economics%20Report_ts%20(spread).final2%20no%20trims.pdf

- greater recognition and support for generalist medical practitioners;
- more comparable remuneration and employment conditions for generalists; and
- ongoing modelling to quantify and predict generalist workforce requirements and distribution

The primary health care sector is dominated by services provided by private operators operating as private businesses. The costs of additional training for private operators involve the direct costs of training and the opportunity cost of taking time away from business operations. The support for undertaking education and training and the benefits for having done so must be attractive enough to overcome such hurdles.

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

11.1 Do you agree with this recommendation?

The AMA supports expanding the role of the allied health workforce and enhancing patient access to their services as part of care arrangements managed and coordinated by the patient's medical home (ie their usual GP and/or practice they have enrolled with). Uncapping the Workforce Incentive Program would be an important step forward in supporting practices to build and fully utilise their multi-disciplinary teams in meeting the comprehensive care needs of their patients.

Access to funded allied health services must remain contingent on GP referral or part of a model of service that is delivered through a general practice. The continuity and coordination of appropriate care cannot be assured if the patient's GP has no involvement or oversight of services accessed. While the AMA was supportive of many of the recommendations of the MBS Review Taskforce on Allied Health it did not support inter-disciplinary referral for allied health providers. The AMA strongly believes best care is provided where the GP is working collaboratively and in consultation with other members of the multi-disciplinary team.

11.2 What do you see as the challenges in implementing this recommendation?

Working to top of scope should not be utilised as a mechanism for task substitution. GPs provide cradle to grave care and build a trusted relationship with patients over many encounters. An appointment for a minor health issue is not only important in building that trusted relationship but can sometimes reveal underlying issues impacting the health of the patient and can thus be just as important as a complex disease consultation. It is vital that the multi-disciplinary team can support the GP in caring for their patient but not circumvent them.

Developing alternative funding models to support the delivery of allied health care as part of a coordinated plan of care may require the restructure of current business models for allied health providers.

The AMA supports the proposal to undertake research into alternate funding models to fee-for-service to determine how allied health services could be better integrated in primary health care. While fee-for-service is an effective funding model for more acute services the AMA believes there is scope for blended funding arrangements for chronic and complex conditions, requiring comprehensive, integrated and well-coordinated care. This could include funding to support enhanced care for those patients anticipated to need a suite of allied health services, incentives for integrating allied health services into medical practices, or practice grants for innovative integrated models of care.

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

12.1 Do you agree with this recommendation?

The AMA supports collaborative models of care where nurses and midwives work closely with a patient's doctor in delivering high quality and well coordinated care.

12.2 What do you see as the challenges in implementing this recommendation?

Closures of comprehensive rural maternity services reduce patients access to safe and effective maternity care and undermines the skills of GP obstetricians, rural generalists, nurses and midwives. The trend in such closures must be reversed.

The trend of excluding medical practitioners (GPs, GP obstetricians, and obstetricians) from models of maternity care and of reducing comprehensive maternity services in parts of rural Australia must also be immediately reversed.

There must be meaningful and ongoing input from general practice, in the development and implementation of maternity service models of care and care must be led by a doctor with obstetric training.

Collaborative arrangements between nurse practitioners and midwives with GPs or obstetricians must be maintained to provide the assurance of medical oversight and to ensure patient care is not fragmented.

Any national primary care nursing strategy must be underpinned by principals of collaborative care, of working as part of the medical team not independent of it.

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

13.1 Do you agree with this recommendation?

Yes. It is important that the public has reassurance that there are minimum standards in place across all providers of primary health care services.

13.2 What do you see as the challenges in implementing this recommendation?

The broader primary health care workforce is disparate in nature and the challenge will be in enhancing each of the professions understanding of their role from a holistic perspective and of the need for collaborative models of care.

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

14.1 Do you agree with this recommendation?

Yes.

14.2 What do you see as the challenges in implementing this recommendation?

A challenge will be in ensuring access to advanced skills posts to provide rural generalists training and experience in speciality areas that will see rural communities better supported in accessing timely care within their regional community. There needs to be a nationally consistent approach for negotiating advanced skills posts, with adaptive practices to suit local needs and contexts. A key element for any rural generalist post must be that the generalist practitioner work within the community as a GP as well. Generalist posts cannot be solely hospital-based positions.

Streamlining credentialling requirements for GPs working as Visiting Medical Officer's would enhance the attractiveness of this work and provide greater workforce flexibility for practitioners to also work as locums or as part of a fly-in-fly out workforce.

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

151 Do you agree with this recommendation?

Yes. This supports improved connectivity and integration across health care teams and the health system which will enhance the delivery of seamless best practice care.

15.2 What do you see as the challenges in implementing this recommendation?

There must be some regulation and licencing arrangements implemented around clinical software requiring it to be interoperable and easily integrated with existing software before it is market ready. Licencing provisions regulated by the Australian Digital Health Agency is an option for consideration in implementing this. Having a set of minimum standards for the developers of clinical and practice software to adhere to is another. Whether a licensing or minimum standards pathway is undertaken consultation with key stakeholders will be essential.

15.3 Please provide any examples of best practice for implementation of this recommendation (from Australia or overseas).

Examples of innovative solutions relevant to this recommendation include patient partnership platforms that remotely collect metrics from patients, whether via wearables, connected devices, or patient entered measures, be they biometric or experiential. We understand these have been used across the Western Sydney Integrated Care Program.

These platforms are based around a patient centred shared care plan where data collected by patients and providers across the system is able to be shared equally amongst providers of care. This allows data to be extracted from multiple systems such as clinical software in a general practice as well as hospital based systems and made accessible to all providers at point of care regardless of their location. This also enables the patient and their carers to be involved as active members of their own care team.

Solutions such as this during the COVID-19 pandemic have allowed care team members to provide care in a coordinated fashion regardless of where they may be geographically located.

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

16.1 Do you agree with this recommendation?

Yes. Creating an Australian National Institute for Primary Health Care Research Translation and Innovation is inline with the AMA's call in its Delivering Better Care for Patients: The AMA 10-Year Framework for Primary Care Reform for the reinstatement of the Australian Primary Healthcare Institute.

16.2 What do you see as the challenges in implementing this recommendation?

Implementing this recommendation is going to require Government to commit funding to projects that may not deliver results in the short term. Evaluation periods of two years, for example, often do not allow enough time for the benefits of innovation to fully emerge, particularly by the time, training and recruitment are taken into account. Withdrawal of project funding too early ensures benefits are never realised and can lead to the learnings being lost. Having an overarching body such as an Australian National Institute for Primary Health Care Research Translation and Innovation would help ensure that learnings are not lost but translated into project modifications for ongoing evaluation.

A further challenge will be the need for cultural reform across the whole health system if inter-disciplinary collaboration is to be fully embraced.

Practices must be supported in pursuing models of excellence in care.

16.3 Please provide any examples of best practice for implementation of this recommendation (from Australia or overseas).

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

17.1 Do you agree with this recommendation?

Yes. This recommendation outlines what is needed to ensure quality comparable data for use in driving ongoing quality improvement.

17.2 What do you see as the challenges in implementing this recommendation?

Equipping GPs and others within the primary care workforce to make effective use of data for quality improvement purposes will certainly need to be embedded in training programs as an inherent part of providing evidence based care and continuous quality improvement.

Funding quality improvement activity must be multi-pronged, ie funded at the input level as well as the output level. For practitioners their time on quality improvement activities needs to be remunerated and quality improvement outcomes rewarded.

Regarding the proposed redirection of funding based on collected, nationally consistent and comparable data – it will be important to ensure that appropriate measures are in place that will support the accuracy of data and discourage activities such as "cherry picking" and "upcoding".

17.3 Please provide any examples of best practice for implementation of this recommendation (from Australia or overseas).

The Australian Primary Care Collaboratives Program demonstrated that the Quality Improvement Collaborative methodology could be applied within an Australian context and deliver improvements in most of the topic areas[3]. For example, diabetic patients participating in the program over a period of 18 months HbA1c levels improved by 50%[4].

What the collaboratives also demonstrate is that if funding is removed before quality improvement initiatives are embedded, they are not sustained. The AMA Delivering Better Care for Patients: The AMA 10-Year Framework for Primary Care Reform provides advice on utilising tranches to build cultural change to embed the culture of continuous quality improvement.

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[3] Knight AW, Caesar C, Ford D*, et al* Improving primary care in Australia through the Australian Primary Care Collaboratives Program: a quality improvement report *BMJ Quality & Safety* 2012;**21:**948-955.

[4] Knight AW, Ford D, Audehm R*, et al* The Australian Primary Care Collaboratives Program: improving diabetes care *BMJ Quality & Safety* 2012;**21:**956-963.

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

18.1 Do you agree with this recommendation?

Yes. It is important that GPs and other primary care providers can learn from the research and innovations of their peers and look to how this information could be used to enhance care for their patients.

18.2 What do you see as the challenges in implementing this recommendation?

The provision of persistent and dedicated streams of funding over the long term is essential. Research into primary care needs to be funded beyond the 10 Year Plan.

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

19.1 Do you agree with this recommendation?

Yes. The AMA has long advocated for measures to ensure communities have immediate access to GP care, and other primary care services such as medication replacement in emergency situations.

19.2 What do you see as the challenges in implementing this recommendation?

If ever there was a time for a one system focus it is during an emergency response or in the aftermath of a disaster. All levels of Government need to work together and develop response plans that involve GPs and the primary care sector to ensure communities have immediate access to and receive quality primary health care.

The Commonwealth Government needs to retain standard protocols to use in an emergency or disaster situation including:

- Flexible use of Medicare Provider Numbers;
- Access to Medicare Benefits while practising in a temporary premises;
- Access to services for people who have Medicare/DVA cards;
- Flexibility in claiming some of the MBS mental health items; and
- Providing essential medicines and filling scripts outside the standard PBS rules.

Such protocols or provisions need to be implemented immediately upon the declaration of an emergency or disaster situation.

Relaxation of restrictions around for example telehealth, chronic disease and mental health items if linked to VPE might also be required where a practice needs to temporarily hand over the care of the patients to another due to experience a disaster situation.

19.3 What has worked best for you during disasters such as the COVID-19 pandemic, bushfires and other disasters?

Recommendation 20 (Implementation): Ensure consumers, communities, service providers and peak organisations are engaged throughout implementation, evaluation and refinement of the 10 Year Plan

20.1 Do you agree with this Implementation Action Plan approach?

Yes.

20.2 Do you see any challenges in implementing primary health care reform?

It will be essential that each implementation advisory or steering group is led by people who have an in depth understanding of the aims of these recommendations and who are committed to achieving the realisation of the vision outlined for primary health care moving forward. The AMA suggests that each implementation should include a member of the Primary Health Reform Steering Group to ensure there is continuity between the vision, as outlined in the Recommendations and the implementation.

The key challenge with any implementation will be ensuring sufficient funding is allocated to support it. Funding modelling must be part of the discussion and process for implementation groups and not something that is done as a separate exercise at departmental levels. A viable solution can be rendered useless if it is not properly funded.

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