DELIVERING BETTER CARE FOR PATIENTS:

THE AMA 10-YEAR FRAMEWORK FOR PRIMARY CARE REFORM

AMA

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Contents

01 EXECUTIVE SUMMARY

General practice is the cornerstone of successful primary health care, which underpins population health outcomes and is key to ensuring we have a high-quality, equitable, and sustainable health system into the future.

GPs have a profound influence on both health outcomes and health expenditures. It is estimated that primary healthcare professionals control or influence approximately 80 per cent of healthcare costs, which means that they have an important role to play in ensuring that health expenditure remains sustainable.

The AMA has a vision for the future of primary health care in Australia.

Patient care should be integrated and well-coordinated by supporting general practices to build multidisciplinary healthcare teams to meet their patients' needs. These GP-led teams will be better placed to manage and reduce the risk of patient comorbidities and reduce adverse medication events through increased access to a broad range of health expertise.

Data-driven quality care initiatives will improve patient outcomes through evidence-based health care.

General practice will be seen as a rewarding and inspiring career by new medical graduates to generate a sustainable GP workforce.

A well-distributed medical workforce will ensure all Australians have equitable access to care regardless of their location. Data-driven quality incentives will also inform where specialised health care providers are needed to support area-specific patient needs.

Achieving the AMA's vision will lead to a reduction in preventable hospitalisations that will ultimately result in efficient delivery and cost of primary care in Australia.

Here, the AMA outlines the importance of, and growing demands on general practice in Australia, some immediate funding goals that will ease the financial pressures on general practice, and long-term reforms for general practice that should be implemented as part of the Federal Government's 10-year Primary Health Care Plan. The AMA's long-term reforms will ensure the economic sustainability of general practice in the face of an ageing population that is burdened by chronic and complex disease.

02 PRESIDENT'S MESSAGE

Federal AMA President, Dr Tony Bartone

Ensuring the future of general practice in Australia

The AMA 10-Year Framework for Primary Care Reform

General practice is the absolute foundation of Australia's world class health system. Indeed, our primary care community outcomes are extremely impressive over many decades.

Research in Australia and internationally shows that a well-funded and resourced general practice sector not only improves the health outcomes of individuals and communities, it creates significant savings in overall healthcare expenditure and improved utilisation of other healthcare facilities, as well as avoiding duplication and wasting of precious scarce healthcare funding.

Despite unprecedented and unrelenting pressure and uncertainty during the COVID-19 pandemic, the medical profession has responded with incredible resilience - especially GPs, who are on the front line of Australia's healthcare system and the COVID-19 response.

However, Government investment in general practice has not matched the increase in the cost and demand for providing high-quality patient care.

The Australian population is growing, ageing, and developing more complex health needs as the incidence of chronic disease and mental ill-health continues to increase. General practice funding models need to change to meet the needs of the community.

COVID-19 highlighted the significant extent that general practice has been detrimentally underfunded for years, even decades, as large financial incentives were needed to keep many practices viable.

Against this backdrop, the Government has committed to supporting general practice into the future with the announcement of its 10-Year Primary Care Plan.

In response, this document outlines the AMA's vision for the future of general practice in Australia over the next 10 years and beyond. This is the AMA's 10-Year Plan.

In the AMA's vision for general practice:

- general practice is resourced to support integrated and well-coordinated patient care through GP-led multidisciplinary teams;
- data-driven quality care initiatives will improve patient outcomes through evidence-based, targeted interventions;
- general practice will be seen as an inspiring and rewarding career to ensure a sustainable GP workforce into the future; and
- the general practice workforce will be well-distributed and will utilise technology to ensure that every Australian has access to high-quality health care.

Importantly, this document provides a framework that can be implemented over three tranches to support the transformation of general practice into high-performing, patient-centred medical homes.

Several measures within *The AMA 10-Year Framework for Primary Care Reform*, most notably telehealth, have already been introduced to support general practice and to reduce risks of infection within the community during the COVID-19 pandemic.

These measures have been effective in keeping general practice sustainable in a time of crisis.

Telehealth services have been embraced enthusiastically by the health profession and patients. The effectiveness and benefits of telehealth services are clear, and should remain in the long term to strengthen general practice and enhance patient access to care.

The successful implementation of telehealth is not the end of the conversation, however. It represents only a fraction of the innovation and transformation required in the rest of the general practice framework. It does, however, show that general practice in Australia is ready and able to embrace the changes outlined in this document.

If governments and the profession embrace these recommendations, the future for general practice will be positive and enduring – to benefit doctors, their patients, and the broader community.

Dr Tony Bartone

President

03 STRONG PRIMARY HEALTH CARE IS IMPORTANT FOR HEALTHY COMMUNITIES

Primary health care is the front line of the healthcare system and usually the first level of contact of individuals, the family and community with the national health system. It is scientifically sound, universally accessible and constitutes the basis for a continuing healthcare process. It provides comprehensive, coordinated and ongoing care by a suitably trained workforce comprised of multi-disciplinary teams supported by integrated referral systems. Primary health care includes community development, health promotion, patient advocacy, illness prevention, and treatment and care of the sick (including supportive management of chronic disease, palliative and end of life care, and rehabilitation)[1,2].

The primary health care system is designed to provide the right care at the right time, at the right place, ensuring a healthier population. Community-based primary care is cost-effective and acts as both an enabler and gateway to other services to ensure they are provided in a timely way when needed. This is achieved through coordination of care between different health providers and different parts of the healthcare system to ensure a seamless, integrated, effective experience for the patient and minimise costly fragmentation, duplication or gaps in care.

04 GENERAL PRACTICE IS THE KEY FOR AN EFFICIENT AND COST-EFFECTIVE PRIMARY CARE SYSTEM

A well-funded and resourced general practice sector is pivotal for success of primary health care in Australia[3,4]. The World Health Organisation and others have found that the populations in countries (including Australia) with strong general practice have[5]:

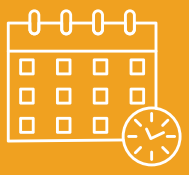
- Lower all cause morbidity (lower rates of ill-health) and mortality;
- Better access to care by all members of the community;
- Reduced preventable hospital admissions[6–8];
- Lower rates of people being readmitted to hospital after treatment;
- Less use of emergency services[9];
- Fewer consultations with consultant specialists;
- Better detection of adverse effects of medication interventions;
- Better health outcomes for Aboriginal and Torres Strait Islander communities[10]; and
- Significant savings in the healthcare system[3].

The significant impact of general practice on health outcomes and expenditure is a consequence of the crucial role GPs play as the first medical contact for most patients, and in their provision of ongoing health management. For GPs, this involves managing undifferentiated presentations, knowing when to avoid unnecessary intervention and expenditure, and providing continuing management spanning prevention, diagnosis; and acute and chronic care.

General practice is the most accessed form of health care in Australia, with almost 85 per cent of patients seeing a GP each year[11], and over 95 per cent of patients attending the same practice[12]. Despite being so heavily accessed, general practice services represent approximately 7.7 per cent of total government expenditure on health[13], receiving $9.8 billion in spending in 2018-2019. This is equivalent to only $391 per person annually.

Inadequate support for general practice results in the fragmentation of care between general practice and other arms of the health system, and causes significant cost increases to the health system. In 2016-2017, 6 per cent of all hospitalisations were due to 22 preventable conditions that could be managed by general practice. This accounted for over 2.8 million bed days[14].

Increased support for general practice and preventative primary health care will have far reaching economic and social effects. Poor health is associated with absenteeism, presenteeism and lower productivity[15], and people with poor health or multiple health conditions have lower workforce participation[16]. More investment into general practice would assist in the early diagnosis and treatment of acute and chronic diseases, and improve workforce participation and economic productivity due to a healthier community.



05 EMERGING PRESSURES

Increasing demand on the Australian health care system

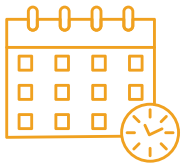
There are a range of factors putting pressure on the Australian health system related to changing population needs and demographics, and increased costs associated with providing high-quality health care.

Our population is growing and ageing. By 2057, it is projected that over 22 per cent of the population will be 65 years and over[17]. This, combined with changing lifestyle factors (like obesity), has resulted in chronic and complex diseases becoming commonplace. In 2014-15, 50 per cent of Australians reported having at least one of eight chronic diseases, with 25 per cent estimated to have two or more[18].

The increased prevalence of chronic health conditions has greatly increased the demand for, and cost of, treatments[19]. In addition, patients with chronic diseases account for 47 per cent of costly preventable hospitalisations[14]. Non-demographic factors, including wage growth, have increased the cost of medical workforce labour and the delivery of health services[19].

There are still widespread difficulties for physically and socially isolated communities in accessing health care. This includes Aboriginal and Torres Strait Islander peoples, rural and remote communities, older people, and culturally and linguistically diverse people. Health inequalities have manifested as a gap in life expectancy between Indigenous and non-Indigenous Australians of around 10.6 years for males and 9.5 years for females[18]. Despite having similar rates of chronic disease compared with other parts of the country, rural and remote Australians have a higher burden of disease, mortality rate and more potentially avoidable deaths[18].

Fragmentation of care is becoming more common as health system pressures grow. Poorly coordinated patient care within the health system and inadequate links between health and social services results in poorer health outcomes and increased health care cost[20]. Ill-considered cost reduction strategies, like task substitution of non-medical health professionals for GP-led patient care, are increasingly proposed as a solution to these pressures. However, this further fragments patient care and results in poorer health outcomes and increased costs long-term.



Pressure on the sustainability of general practice

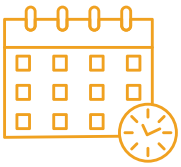
General practice is the cornerstone of primary care, linking patients with all other health services. However, the capacity of general practice to meet the needs of the community is limited by current funding models.

The Government's indexation of Medicare rebates has never kept pace with the rising cost of medical practice. The chronic underfunding of Medicare rebates has seen the permanent closure of some practices in areas where mixed billing is not possible. On average, Average Weekly Earnings and Consumer Price Index increase by 3 per cent per year, and practice costs rise by the same amount. Medicare rebates increased by just 1.2 to 2.5 per cent between 1995 to 2012, before the recent Medicare freeze prevented indexation completely[21]. The recommencement of Medicare rebate indexation has done little to abate the ongoing deficiency in funding.

Medicare funded services are often inflexible or inadequate, and do not cater to the changing needs of patient care. There is still limited access to modern methods of care (i.e. telehealth—notwithstanding the introduction of temporary COVID-19 MBS telehealth items), and limited resources to support GPs in providing a comprehensive range of services, including preventative medicine. Red tape burdens, including the non-face-to-face time involved in chronic disease management and the completion of medical forms is not remunerated adequately by Medicare items. GP visits to residential aged care facilities (RACF) are also poorly remunerated, with recent changes to Medicare items leaving some GPs worse off[22].

There is also limited support for rural and remote practices or practices in socially disadvantaged areas. Critical medical workforce shortages in rural Australia and infrastructure limitations require significant long-term planning and investment from the Government. This would ease the pressure on rural and remote doctors, enable better access for patients in these areas, and allow for the expansion of health services in a GP-led team[22].

The impact and benefits of general practice interventions are often not realised due to limited investment into general practice research. Research improves patient care, and is important for teachers of general practice and future innovation. Around 2 per cent of National Health and Medical Research Council funding is directed to support primary care research, including general practice. This funding is woefully inadequate and is well below the contribution of general practice and primary care in the context of the broader health system[23].



Despite efforts to increase the general practice medical workforce, especially in rural and remote Australia, there is a continued shortage of GPs in some areas. Interest in general practice as a profession has declined, with growth in the number of GP registrars slowing since 2016[24]. There are several reasons why prevocational doctors choose another specialty over general practice. A crucially important one is the prospect of a significant cut in pay, along with the inferior conditions involved in moving from a hospital-based role to a GP registrar position. This includes non-transferrable leave entitlements and a lack of work-life balance[22]. Prospective GP supervisors for GP registrars also need more support for training and education, and appropriate remuneration to ensure supervisors are rewarded and paid for their time.

The role of GPs continues to be undermined by non-medical health professionals. There is an increasing push for task substitution because it is perceived to be cheaper and more convenient. Task substitution would likely lead to negative and expensive long-term consequences to health outcomes and the health system[22]. This includes the ongoing push for pharmacist prescribing and the provision of health assessments and vaccinations, nurse practitioners accessing Medicare outside of a collaborative arrangement, and midwife-led maternity care excluding GPs and GP obstetricians. Importantly, the AMA supports the formation of multidisciplinary teams, but not when they exclude general practice. Every interaction between the patient and a GP is an opportunity for ongoing holistic care. This degree of ongoing and preventative health care is only possible within general practice.

06 RECENT GOVERNMENT INVESTMENT INTO GENERAL PRACTICE AND PRIMARY HEALTH CARE

The Australian Government has started to invest in the future of primary health care, with the announcement of several 10-year strategies, including the 10-year Primary Health Care Plan. Immediate funding measures have also been introduced, with the 2019 Federal Budget delivering almost $1 billion for primary care over five years from 2018-19.

This is a much-needed and significant investment to general practice – the driving force of quality primary health care in Australia. Funding for general practice includes:

- $448.5 million to provide more flexible access to care for patients over 70;
- $201.5 million for the revised *Practice Incentive Program Quality Incentive (PIPQI)* and maintaining the current aged care incentive;
- $187.2 million for lifting the freeze on the indexation of all remaining general practitioner services on the Medicare Benefits Schedule; and
- $62.2 million for the National Rural Generalist Pathway and the provision of additional training places for GPs in rural, remote and regional communities

07 IMPLEMENTING BUDGET MEASURES IN PRIMARY CARE: SHORT-TERM MEASURES AND BOLT-ONS

Chronic disease management funding

A key reform of the Government's 10-year Primary Health Care Plan was support for GPs to provide more flexible care for patients over 70, and for Indigenous Australians aged over 50. This was intended to be through a new voluntary patient enrolment payment model that would supplement usual services funded through the MBS.

Voluntary enrolment is designed to formalise and strengthen the relationship between patients and their GP to improve continuity of care and patient experience through the provision of non-face-to-face services.

However, due to the COVID-19 pandemic, the Government's Voluntary Patient Enrolment initiative has been delayed. The Government is reviewing implementation details and considering options for refinement of this program, given the overwhelming success and widespread use of telehealth during the pandemic.

The AMA has long supported reforms for chronic disease management items, as they are well utilised, but have too much red tape. The AMA supports a blended funding model that links access to Chronic Disease Management (CDM) and Team Care Arrangement (TCA) items with voluntary patient nomination. Simplifying the process for GPs to refer patients to allied health services would enable a multidisciplinary team-based approach to patient care. There is scope to encourage the participation of non-GP allied health professionals to these GP-led teams through the addition of MBS items for multidisciplinary case conferences. Likewise, linking Medication Management Reviews to CDM and TCA plans would support proactive care and better medication management.

This type of approach to chronic disease management would support patients by: helping them to self-manage their condition; utilise locally based care; assist in the sustainability of general practice; and reduce potentially avoidable admissions by supporting integrated and well-coordinated care for complex patients.

The success of chronic disease management relies on reviewing the patient's progress during treatment, and updating the management plan accordingly. The redistribution of funding from the current CDM and TCA MBS items towards Review items would facilitate and reward longitudinal care. The AMA is prepared to adopt this approach, provided GPs using the existing CDM items appropriately are not disadvantaged by the proposed funding structure. The AMA's proposed reforms for CDM items are supported by, and reflective of, the General Practice and Primary Care Clinical Committee Report as part of the MBS Review Taskforce[25].

Practice Incentive Program Quality Improvement Incentives

The Practice Incentive Program Quality Improvement Incentive (PIPQII) commenced on 1 August 2019, and is designed to support and reward general practice for continuous quality improvement in both the delivery of best practice care and patient outcomes.

The AMA has been working over the better part of the last decade with the Department of Health through the PIP Advisory Group (PIPAG) to bring the PIPQII to fruition, without losing other valuable incentives, like the GP Aged Care Access Incentive, the Procedural GP payment and the Indigenous Health Incentive.

Central to any quality improvement activity is the collection of data. Data provides information about where general practices are now, and how they are improving during and after the implementation of their quality improvement measures. It was important to the AMA to ensure that eligible practices could undertake their own quality improvement, and establish their own baseline data on which to assess their progress.

Due care was given to ensuring the privacy of patient, practitioner and practice, and minimising any unintended consequences, particularly those that work against the quality of patient care. The AMA supports the aggregation of de-identified data from practices to support population health planning, while maintaining data privacy.

The introduction of PIPQII is a significant opportunity to promote general practice quality improvement, obtain robust data, and allow for better target population health planning. In the future, the AMA is optimistic that the National Primary Health Care Data Asset will extend on the benefits of PIPQII, and contain high-quality data about primary health care to assist in the understanding of the health system, and a patient's experiences within it. This kind of data is critical for better population health planning, and will help identify gaps in primary health services to improve patient outcomes.

08 ADDITIONAL SHORT-TERM MEASURES TO EASE THE PRESSURE ON GENERAL PRACTICE

The AMA supports several measures that are yet to receive financial incentives from the Government, but would provide some assistance to general practices to improve the quality and continuity of patient care, and financially support practices.

Funding

Commonwealth Government funding for general practice services currently stands at around 12.7 per cent of total health expenditure[13,26]. This represents a modest investment that has delivered excellent health outcomes for most patients. While the Commonwealth is the dominant funder of general practice services, patients also contribute around 6.5 per cent of total general practice costs. The AMA supports the concept that those patients that can afford to do so should make some contribution to the costs of the GP care that they receive, provided appropriate safety nets exist to protect vulnerable groups from out-of-pocket costs to ensure that these do not become a barrier to care.

Funding for general practice services in Australia is based on a blended model of funding, although the predominant funding model is fee-for-service. Fee-for-service has proven to be an effective funding model over many years and should remain the primary source of funding for general practice services. It works well for most patients, providing autonomy and choice, as well as access to care based on clinical need.

There is significant scope to build on the blended funding arrangements, particularly in tackling chronic and complex disease and the increasing prevalence of mental health issues and illness, which requires comprehensive, integrated and well-coordinated care. A blended model may include practice and service incentives, funding for preventative health care or enhanced care for chronic disease patients, infrastructure grants, and quality improvement measures (discussed separately below).

Funding goal

GPs are managing more problems in each consultation than they did a decade ago, as patients, particularly older patients, present with multiple reasons for the encounter. GPs are also spending more time with patients and manage the vast majority of the problems presented to them[12]. With Australia's growing and ageing population, this trend is set to continue. Yet funding for general practice is not growing in keeping with this trend. The combined forces of rising demand and diminishing funding will have a significant impact on the quality of care practices are able to provide.

To ensure that general practice is equipped to meet these challenges, the Commonwealth needs to deliver real resources to frontline GP services. Government health spending on general practice services has not kept pace with a growing workload. The AMA wants to see an increase in Commonwealth Government funding for general practice so that it represents at least 16 per cent of total health spending, and mandate this figure to ensure continued support for general practice. This should be part of an effort to re-orientate the health system to focus more on general practice, with long-term savings to the health system anticipated in return.

Importantly, a similar increase in primary care investment by the Oregon Health Authority, USA, resulted in significant savings in their overall health expenditure. During the implementation of the Oregon Patient-Centred Medical Home Program, for every US$1 invested in primary care, US$13 in savings were reported in other services, such as specialty, hospital and emergency care[27]. Over three years, the program saved an estimated US$240 million, highlighting the significant impact of investment in primary care on overall health system spending.

Quality and continuity

Voluntary nomination

The medical home should encourage the development of a long-term stable relationship between the patient, the GP and the practice.

In this respect, the AMA has supported the implementation of an administratively simple system of voluntary nomination with a general practice for patients with chronic disease. This would not have an impact on a patient's access to their MBS rebate, however, voluntary enrolment would be a prerequisite in order to access reformed chronic disease management funding.

The AMA has previously recommended a PIP/SIP style funding model to support voluntary nomination for chronic disease, with this funding to cover administration, Shared Health Summary uploads to the MyHealth record, and the significant non face-to-face work associated with the care of patients with complex and chronic disease.

Moving forward, voluntary nomination should be introduced for other patient groups until it is widely adopted by the entire Australian population. Nomination funding should unlock access to a broader range of services for patients, which can be delivered through more innovative methods such as telehealth, as well as support preventative care.

Extended MBS consultation items

Using the present MBS consultation items, the more time a GP spends with a patient, as per Level A to D attendance items, the less that time is valued.

Since fee-for-service is primary source of funding for general practice, this must be corrected. As a critical starting point, the AMA is calling for an extended level B item, as the current model disincentivises doctors from spending more time with patients, leading to missed opportunities for preventative and holistic care. An extended level B item will promote, support and reward quality practice. This is particularly important for supporting complex patient care, which is becoming more common in general practice due to the ageing population, and increasing prevalence of chronic conditions.

Patient engagement in their own care planning

The AMA supports the development of advice and support mechanisms to activate and engage patients in their own care planning. This would include the assessment and support of a patient's health literacy of their own ongoing health issues.

This will empower patients to understand their condition, treatment and management options. Such knowledge will help to objectively inform patients' outcome expectations and encourage patients to take action that results in the best health outcomes for them.

Wound care

The AMA has called for the provision of a stock of Government-funded dressings directly to practices or, alternatively, the development of a schedule that GPs could bill against to cover the costs of dressing provided to patients, targeted at:

- Patients with diabetes who have a diabetic foot ulcer or diabetic leg ulcer;
- Patients with a venous or arterial leg ulcer; and
- Patients 65 years of age and over or at high risk of a chronic wound.

This would provide patients with access to higher quality dressings and, combined with appropriate educational resources and best practice guidelines, improve the overall quality of wound care for patients.

The AMA welcomes recommendations from the Draft Report of the Wound Management Working Group (part of the Medicare Benefits Schedule Review Taskforce) that also highlight several options to reform wound care funding within general practice[28].

The AMA's Submission in response to the Draft Report is broadly supportive of the recommendations from the Wound Management Working Group, as they aim to improve support for high-quality wound care within a GP-led team-based approach to care[29].

Prevented unplanned hospitalisations

Improved care coordination and discharge planning

Specifically targeted at voluntary nominated patients with chronic disease who are most at risk of unplanned hospitalisation (including readmission), this would provide additional funding support with a quarterly 'care coordination' payment to GPs to reward a more proactive and team-based approach to care. This would include, where appropriate, improved discharge planning.

This would be in addition to the usual fee-for-service items, including CDM funding, and would operate in a similar way to the Department of Veterans' Affairs Coordinated Veterans' Care program.

Improving patient access to care

After-hours GP services

The AMA has called for bringing forward the Medicare definition of after-hours in-rooms consultation items to commence at 6.00pm on weeknights and 12 noon on a Saturday. This would effectively align arrangements between GP clinics and Approved Medical Deputising Services and encourage access to care through a patient's usual GP or general practice.

Aged care

There have been some recent changes to MBS items, and to the derived fee calculations for GP visits to RACFs that are intended to improve access to GP care.

Since March 2019, GPs can claim a flag-fall item number (90001 $55) for the initial attendance at an RACF in addition to the item number (90035 $37.60) for the service if they bulk bill. However, this structure leaves GPs who see many patients in one RACF visit financially worse off[30].

The AMA is calling for a 50 per cent increase to Medicare rebates to adequately compensate family doctors for the additional time and complexity involved in an RACF visit, compared to a consultation within general practice. This recommendation is based on the outcomes of a recent AMA survey (2017 AMA Aged Care Survey) that indicated that RACF attendance items need to be increased to compensate for the currently unpaid non-contact time in coordinating patient care.

Rebates for home visits should also be increased so they are equal to MBS rebates for RACF visits. While GPs often see just one patient during a home visit, it is more time consuming than attendance at RACFs, due to the absence of nursing staff in patients' homes.

Telehealth

The AMA has been a strong telehealth advocate for many years, and has previously supported carefully targeted telehealth interventions for specific patient groups (e.g. those with chronic disease, mobility problems, residential aged care facilities, Aboriginal and Torres Strait Islander people), and the expansion of telehealth services in rural and remote Australia.

However, since the introduction of temporary telehealth MBS items during the COVID-19 pandemic, Australian patients have overwhelmingly embraced telehealth as an important part of their health care management, with over 17 million Medicare-funded telehealth services provided — mostly by GPs and other specialists — since the Medicare telehealth items were introduced in March.

This has made a very strong case for the effectiveness and benefits of telehealth services, and for the Government to make the COVID-19 telehealth reforms a permanent feature of our health system.

The AMA has worked with the Government on how to integrate telehealth seamlessly and fully into day-to-day general practice and other relevant medical specialties, to ensure continuity of care for patients. The AMA has recommended that GPs or general practices allow patients to voluntarily nominate a GP and/or a practice in order to be able to access telehealth services from their GP once the current interim telehealth arrangements are due to end. This will ensure that 'pop up' or purely 'virtual' opportunistic models of telehealth that fragment care and, in some cases, blur the important distinction between the prescribing and dispensing of medicines, cannot take advantage of permanent MBS telehealth items.

Mental health

GPs play a key role in the prevention and amelioration of issues causing mental illness. Patients now see their GP for mental health conditions more than any other health issue, yet little funding has been directed to general practice to allow GPs to provide adequate mental health services in a primary care setting.

The AMA calls on the major parties to commit to fund a dedicated general practice-based mental health program that allows GPs to provide coordinated care and case management within local communities (rather than by referral to tertiary centres) and deliver improved health outcomes in patients. Funding should also be provided to allow general practices to employ dedicated mental health staff, such as mental health nurses or case coordinators, to ensure that more mental health care is provided in the primary care setting.

The 2030 mental health vision announced by Health Minister Greg Hunt needs to incorporate a strong GP focus to ensure continuity of patient care. Rural and remote areas need to be carefully considered in this plan as current services are inadequate compared with metropolitan areas.

Adult catch-up vaccinations

The AMA continues to support the provision of vaccinations within general practice. We encourage the Government to strengthen their support for vaccination in general practice, as this is the most appropriate setting for ensuring continuity of care. GPs are expertly trained to determine what vaccination strategy is best clinically indicated for their patients in conjunction with advice from the Australian Technical Advisory Group on Immunisation.

All Australian adults should be eligible for free catch-up vaccinations, under the National Immunisation Program (NIP), to protect as many people as possible from preventable diseases.

Practice support

Modernisation of non-fee-for-service funding

The AMA supports the introduction of indexation of payments under the Workforce Incentive Program (WIP). These have not been indexed for many years. This undermines the longevity of these programs, and practices suffer as they face rising administration and medical workforce costs.

In addition, lifting the caps of subsidies available through the WIP would better support the employment of nurses, pharmacists, and other allied health professionals within general practice to support enhanced access to GP-led team-based patient care.

It would also improve the equitability of services for patients whose usual GP works in a large general practice. Lifting the cap on WIP subsidies would enable larger practices to employ the same ratio of nursing and allied health staff as smaller practices. Patients attending larger practices have the right to the same level of nursing and allied health services as those attending smaller practices.

It is important that staffing models offer general practices the flexibility to employ clinical and/or administrative staff that best support GPs to care for their local communities.

09 LONG-TERM REFORM TO ENSURE SUSTAINABLE, HIGH-QUALITY GENERAL PRACTICE

Health systems around the world are attempting to achieve the Quadruple Aim for health care improvement. Figure 1 illustrates this approach to optimising health system performance, which consists of[31]:

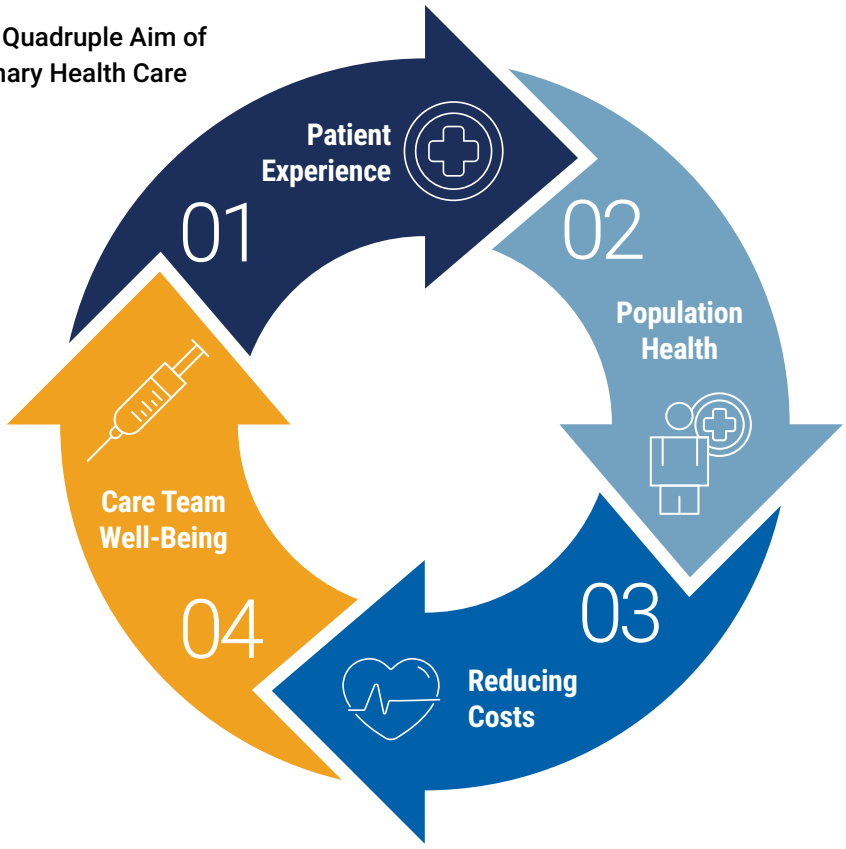
- Enhancing the patient experience of care
- Improving patient outcomes
- Reducing costs per capita
- Improving provider experience

Strong primary care is crucial for achieving the Quadruple Aim, as it is the foundation for a high-quality and cost-effective health care system. Countries with a strong primary care system experience better population health and lower rates of unnecessary hospital admissions.

Comprehensive primary care is associated with slower growth in health care spending[3].

Figure 1

The Quadruple Aim of Primary Health Care



This is critical, as our health system will need to rely on primary care to cope with the growing and ageing population with complex health issues while still being affordable within Government health budget spending.

Evidence suggests that there are several key identifiable features associated with high-quality primary care. These features are encompassed by the concept of a patient-centred medical home (PCMH).

Building a primary care system that has a widespread adoption of PCMHs requires a large amount of investment and planning. Internationally, this has been achieved by using the *10 building blocks of high-performing primary care* as a foundation for broad primary care reform.

The patient-centred medical home

The patient-centred medical home is a model of care emerging internationally that aims to deliver services that meet most patients' physical and mental health care needs[3]. It is GP-led, patient-centred, comprehensive, team-based, coordinated, accessible, equitable, and focused on quality and safety. The success of PCMHs requires practice payment reform that recognises the added value provided to patients using this model of care[32].

This definition of PCMH is reflected by the AMA's Position Statements *General Practice in Primary Health Care 2016* and *The Medical Home 2015*, as well as the RACGP's statement, *A quality general practice of the future*, endorsed by all general practice organisations nationally in 2012[33,34].

There is strong evidence to support the positive benefits of the PCMH model of primary care. This includes:

- Improved access to care[35–38];
- Improved clinical parameters and outcomes[39–41];
- Improved chronic and complex disease management[35–37,39–43];
- Improved preventative care services (e.g. vaccination, health checks)[37,38,42,44];
- Improved condition-specific quality of care[40–43,45];
- Improved palliative care[36];
- Decreased use of inappropriate medications[36,43,44]; and
- Reduced avoidable hospital admissions and readmissions, emergency department use and overall care cost[36,40,43,46,47].

The Federal Government is already aware of the positive impact of the PCMH on primary health care outcomes as reflected by its establishment of the Health Care Homes pilot. This pilot was recently extended until 30 June 2021, and attempts to provide comprehensive care to patients with chronic and complex conditions using the PCMH-like framework. While the intent of the Health Care Homes pilot is worthy, it has so far failed to achieve its stated goals due to poor funding arrangements and issues with its design and implementation[48].

However, there are challenges involved with the systemic transformation of general practice care to a PCMH model, as it often involves significant changes to routine operations of practices. Challenges include difficulties with electronic health records, issues with funding and payment models, insufficient practice resources and infrastructure, inadequate measures of performance, and inconsistent accreditation standards[33].

The 10 building blocks of high-performing primary care

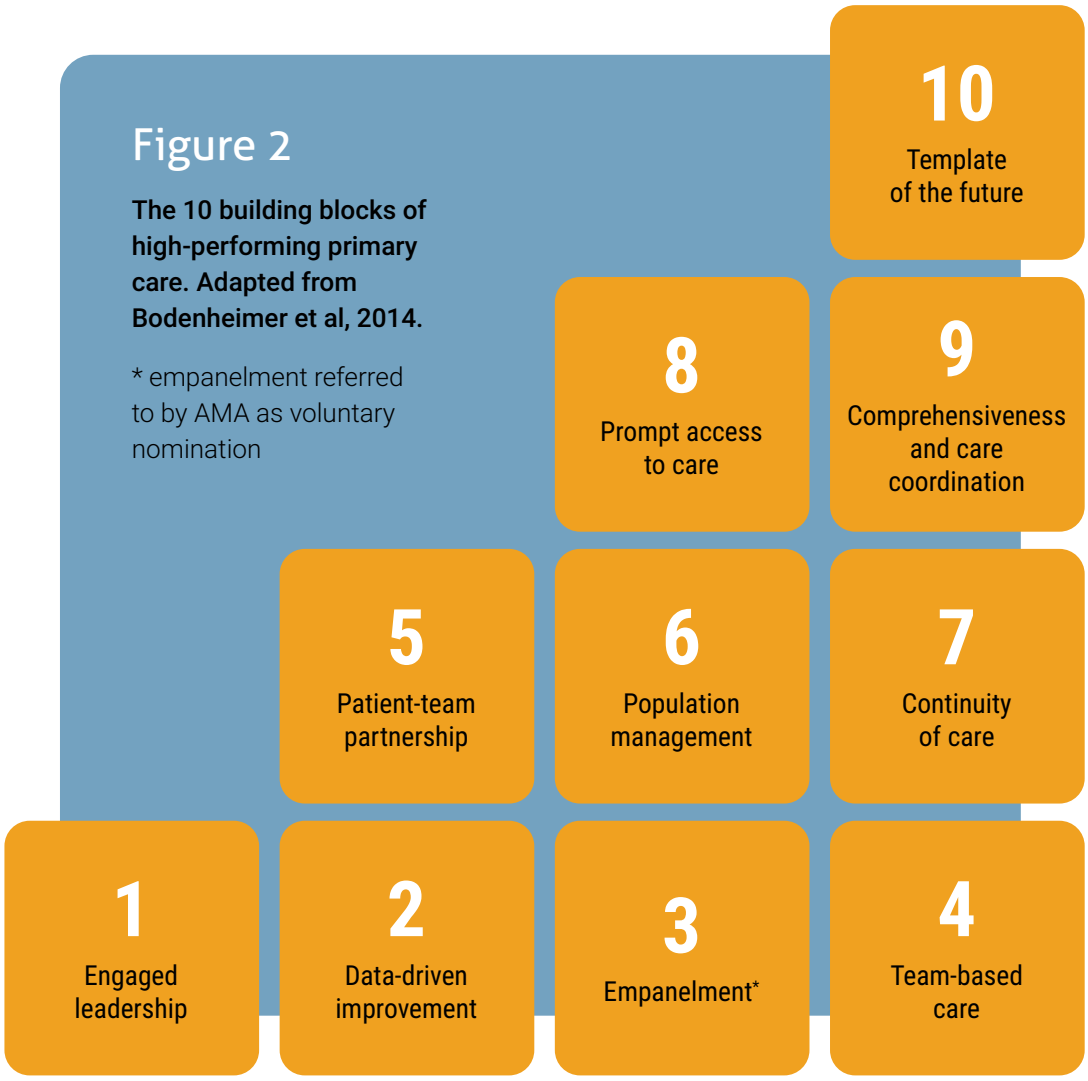


Figure 2

The 10 building blocks of high-performing primary care. Adapted from Bodenheimer et al, 2014.

* empanelment referred to by AMA as voluntary nomination

Achieving the Quadruple Aim using the PCMH model is a complex process that requires a significant investment of time and resources. As such, a "roadmap" to help guide the transformation of primary care towards the PCMH has been developed[49].

This is known as the *10-building blocks of high-performing primary care*.

These building blocks are designed to provide the framework to facilitate change in primary care. Figure 2 outlines the relationship between the building blocks and highlights that the first four building blocks (engaged leadership, data-driven improvement, empanelment (voluntary nomination), and team-based care) are foundational, and need to be achieved before reaching success in the higher order blocks. Success of the building blocks relies on engaged leadership. This element is primarily education, to equip leaders with the skillset they need to set the positive example for change within the profession.

Data-driven quality requires the meaningful use of data (such as PIPQII) to measure improvements over time and determine the success of general practice transformation.

Empanelment (voluntary nomination) means patients being engaged with their care team to promote the success of their own health care.

Team-based care is the hardest of the building blocks to achieve and requires a lot of time and structure. Overarching payments to practices to support non-face-to-face time with patients, like practice staff training or funding for meetings, are required. Quality Improvement strategy meetings involving practice staff are a key and unpaid part of team-based care.

Many of the AMA's recommended *additional short-term measures to ease the pressure on general practice* are the early indicators of building blocks 2 (in the form of PIPQII), 3 and 4 (chronic disease management reform).

10 BUILDING A SUSTAINABLE PRIMARY CARE WORKFORCE

Long-term sustainable changes in primary care need to be supported by long-term strategies to ensure there is a sustainable medical workforce.

Government initiatives need to make pursuing a career in general practice more appealing for new graduates – especially in rural areas where workforce shortages are widespread.

The Prevocational General Practice Placements Program (PGPPP) was a training program that enhanced junior doctors' understanding of primary health care and encouraged them to take up general practice as a career. The PGPPP had the additional benefit of exposing general practice and its critical role in the broader health system to doctors who chose to practice in other non-GP specialties. However, this program ceased in 2014, as it was deemed that the general practice workforce was adequate.

Since then, the demand for GPs has increased — especially in rural and remote communities — but the number of applications for general practice training pathways have decreased.

New Government programs aimed at addressing the GP workforce shortages in rural and remote communities have recently commenced, including the Stronger Rural Health Strategy — Junior Doctor Training and the More Doctors for Rural Australia (MDRAP) program.

These programs are in their infancy and will need sustained investment and evaluation to ensure that they produce GPs for rural Australia. This has recently been addressed by the National Medical Workforce Strategy Scoping Framework.

The AMA is also working closely with the Government to develop a single employer model that would provide more equity in renumeration, training support and leave entitlements for GP registrars compared with hospital-based registrars to better support a career in general practice.

The AMA will be working to ensure that general practice receives the support to provide a high-quality general practice workforce for the future and that supervisors are rewarded for their crucial role in training the new generation of doctors.

11 SUCCESSFUL EXAMPLES OF PRIMARY CARE REFORM

Case study 1: The Western Sydney Initiative

The Western Sydney initiative, run by the Western Sydney Primary Health Network (WentWest), is an example of a widespread system change that can start to make a real difference to the health of their community and their patient population, and to reduce health care costs and expenditure, while improving access to care.

Western Sydney is one of Australia's diabetes hot spots. 47 per cent of the general population have blood glucose levels in the diabetic or prediabetic range and the prevalence of diabetes in patients admitted to the local hospital is rising by 1 per cent year on year.

40 per cent of the population have presented to emergency departments at least once in a four-year period with 30 per cent higher total cost of admission in diabetes compared to non-diabetics. This is likely due to the 30 per cent longer bed stays in diabetics admitted to hospital compared with non-diabetics.

Through a combination of practice level improvements supported by intensive PHN education, and integration with hospital-based diabetes outreach services supporting care at a practice level, there has been a significant improvement in diabetes care. Some practices now have 85 per cent of their patients with diabetes well controlled, and the public diabetes clinic at the hospital has a waiting time of zero days.

Specific health and economic outcomes of the Western Sydney Initiative have been assessed for the program's final evaluation report[50]. Indications of better managed and improved health outcomes for patients include:

- 23 per cent reduction in ambulance arrivals;
- 27 per cent reduction in the length of ED stays;
- 32 per cent reduction in ED presentations;
- 34 per cent reduction in unplanned hospitalisations;
- 25 per cent reduced length of stay for unplanned hospitalisations; and
- 37 per cent reduction in potentially preventable hospitalisations.

Together, these outcomes had significant impacts on health care costs, with a 33 per cent reduction in the cost of emergency departments (NWAU), and a 38 per cent reduction in the cost of hospitalisation (NWAU).

Notably, the Western Sydney Initiative has achieved significant health cost savings, improved health system efficiency and better patient outcomes through their adoption of the PCMH model and the 10 building blocks of high-performing primary care. WentWest started their PCMH journey in March 2015 by partnering with 25 local general practices and applying the principles of the PCMH model in the Australian context. WentWest continues to facilitate the successful implementation of the PCMH model with the involved practices by providing ongoing education around the model's 10 critical building blocks, which is delivered by a dedicated support team.

Case study 2: The Canterbury Initiative, New Zealand

Christchurch's emergency department was often in gridlock, but now has one of the lowest rates of acute admissions and readmissions in the country, and the shortest hospital stays. This was possible due to comprehensive changes to general practice, which keeps patients out of hospital, and consequently quickens hospital treatment times. Patients are discharged as soon as possible into community support[51].

Less strain on hospitals meant elective surgery rose by 23 per cent in five years, and with shorter wait times.

GPs have direct access to a broader range of diagnostic tests, meaning patients are 'worked up' before they arrive at outpatient or specialist appointments. Streamlining this process means that no valuable time is wasted for the patients, GPs and specialists. GPs also treat patients in general practice for conditions that were once hospital-based, including the removal of skin lesions.

Combined, this has saved patients more than 1 million waiting days for treatment.

Improvements in community care infrastructure to support older people in their homes for longer has reduced the number of people entering RACFs.

Overall, better, faster care, with more of it available outside hospitals, was delivered.

The reduction in health care costs were indisputable. In 2007, the health system was NZ$17 million in deficit on a turnover of $1.2 billion. In 2010-2011, it was on track to make $8 million surplus.

The ongoing progress of the health system overhaul was severely hampered by 2011 Christchurch earthquake, with a large amount of infrastructure damaged or destroyed completely, including five general practices and 14 per cent of RACF beds. Despite the loss of infrastructure, the changes in the health system already achieved sustained continued growth and optimisation of primary care.

Not all improvements to hospital performance required an expansion of hospital services. Changes within primary care reduced hospital demand without changing capacity.

Canterbury's financial control (management control, financial information systems, and service performance) was rated one of the best, if not the best in the country in a 2011-2012 audit.

Canterbury achieved this success through the implementation of several key initiatives, the most notable being HealthPathways. Their success heavily relied on the widespread utilisation of information technology.

12 THE AMA'S VISION FOR THE FUTURE OF PRIMARY CARE IN AUSTRALIA

1. Well-coordinated and integrated patient care by supporting general practices to build multidisciplinary health care teams to meet their patients' needs. These GP-led teams will be better placed to manage and reduce the risk of patient comorbidities and reduce adverse medication events through increased access to a broad range of health expertise. This should be funded using non-fee-for-service payments;
2. Improved patient outcomes by using data-driven quality care initiatives, supported by the recently funded *Practice Incentive Program Quality Improvement Incentive*;
3. Highlighting general practice as a rewarding and inspiring career to generate a sustainable GP workforce;
4. A well-distributed medical workforce to ensure all Australians have equitable access to care regardless of their location. Data-driven quality incentives will also inform where specialised health care providers are needed to support area-specific patient needs; and
5. A reduction in preventable hospitalisations that will ultimately result in efficient delivery and cost of primary care in Australia.

For the patient, this means that seeing their GP is affordable, and thus more accessible. They can also access a GP close to home regardless of where they live in Australia. Patients are encouraged to see their trusted GP/practice for treatments when they are sick, and for advice about how to stay healthy and productive. Patients will receive seamless and integrated care as they have an established relationship with their GP/practice, and their needs are understood.

The general practice becomes a hub for the patient to access a range of services, reducing the need for the patient to visit multiple places, and streamlining their care. Patients are encouraged to access preventative care and early treatment in this hub from their GP to keep them healthy and active within their homes and the community. When a patient is unable to attend a practice in person, they can access these services from their GP using video conferencing, phone or email.

GPs and their teams can educate patients on all facets of their health and social systems. The patient has everything they need in one place.

13 METHODS FOR ACHIEVING REFORM IN GENERAL PRACTICE

The proposals described in this document represent measures that will support general practice in the short-term and start the process of cultural change within the profession. This provides the basis to look at funding reforms based on the *10 building blocks of high-performing primary care*, to create patient-centred medical homes that deliver on the objectives of the Quadruple Aim.

Long-term, the AMA envisages a move towards a mixed funding model (fee-for-service and non-fee-for-service funding) with the potential for significant funding for general practice to be delivered through non-fee-for-service funding arrangements.

The move towards reform based on the 10 building blocks is reflected by AMA initial general practice funding package proposals that include voluntary nomination, funding for PIPQII, after-hours care, improvements to aged care access, telehealth and CDM reforms.

The AMA's model for general practice reform

The AMA proposes that the funding to support the transformation of general practices to practices that are high performing patient-centred medical homes be implemented over three tranches. This transformation is necessary to ensure general practice can rise to the challenge of delivering quality care to patients, particularly to those at risk of, or with chronic disease, that is patient-centred and cost effective, and which will reduce patients' need for more complex, high-cost health care.

Each tranche within the transformation process represents a gained maturity within the practice and its practitioners as they move to becoming high performing patient-centred medical homes. The deliverables under each tranche map to the objectives of Quadruple Aim.

Each tranche lays the foundation for the next tranche. The investment for each tranche provides the incentive and reward for undertaking the transformation that will ensure patient-centred, pro-active, comprehensive, cost-effective care and deliver long-term savings to the health system with better management of patient risk factors and chronic disease, reducing the cost burden of chronic disease, avoidable hospital admissions, and providing patients with more years of productivity and greater quality of life.

The AMA supports flexibility in the adoption of the PCMH model in the local, Australian context while ensuring there are clearly defined core elements and standards that make a PCMH. While implementing the model, an adaptive approach that reflects local population needs and community characteristics, and builds on existing good practice should be followed.

Tranche 1—Foundational Improvements for Practice Transformation

Tranche 1 is foundational, building and establishing capabilities for more sophisticated reporting and accountability which will enable more targeted and efficient delivery of health services where they are needed, to whom they are needed, and in the way they are needed.

The foundational elements include data quality, empanelment, culture of measurement, and Clinical Governance structure and improvement culture.

This foundation will upgrade the capacity of general practice to deliver care in a truly patient-centred environment at an efficient cost (compared with hospitals). This is an essential component of an integrated health system.

Starting to embed the collection of these metrics, including patient experience measures, is a ground-breaking step in the primary care space, leading to greater efficiency, accountability, and outcomes.

Undertaking this transformation requires time spent on training and upskilling, and putting in place processes and mechanisms for team-based care.

This tranche aligns with Building Blocks 1, 2 and 3 (engaged leadership, data-driven improvement and empanelment).

Participation in this process will be voluntary, but necessary for further levels of improvement[52].

Participating practices and practitioners will be funded for the time required to lay down the foundations of change. This will include undertaking Primary Health Network-supported training, implementing learnings and installing the process that will enhance practices' knowledge of their patients' risk and disease profiles, so they can deliver more patient-focused, team-based care as the practice matures through the tranches of change.

Access to payment for overarching non face-to-face services will be for practices who undertake the Primary Health Network-supported training, with nomination payments being an add-on. PIPQII participation is a requirement to satisfactorily meet the requirements of Tranche 1.

To support the cultural change and leadership needed by the profession to facilitate general practice reform, the AMA calls for investment by State/Territory and Federal Governments to provide clinical and business leadership training to general practice owners and teams. Similar training was made available to health care leaders in The Canterbury Initiative in New Zealand (case study 2), and was credited as critical for the overall success of their health system transformation. This can complement ongoing support and training for general practices by Primary Health Networks, akin to the program offered by WentWest in Western Sydney (case study 1).

Practices that complete the building blocks under this Tranche will:

Deliverable	Quadruple Aim
Have the majority of their clinical and administrative staff under the prescribed training modules and participate in subsequent practice-based building block implementation workshops	Improved total cost of care Improved patient experience Improved population outcomes Improved provider experience
Have a data quality framework – with the following in place • Basic Clinical governance framework • Basic implementation framework to improve data collection & quality	Improved population outcomes
Have quality data (i.e. cleansed data) – improving capacity to deliver population health	Improved population outcomes
Collect patient experience data	Improved patient experience
Demonstrated improvements in the collection of clinical data	Improved population outcomes
Hold regular data quality meetings (discussing findings, gaps & measures to address, actions to be taken, assignment of duties)	Improved population outcomes Improved total cost of care
Have undertaken an evaluation of improvements	Improved total cost of care Improved population outcomes

The objectives of Tranche 1 are reminiscent of previous work done by the Australian Primary Care Collaboratives Program to support general practice in improving clinical outcomes for patients with chronic and complex conditions. The elements underlying this Program — education, small cycles of incremental change, and data reporting and feedback — are reflected in the foundational building blocks needed to support long term reform in primary care.

Tranche 2—Implementation and Establishing the Use of Primary Care Teams

Tranche 2 is the consolidation and action phase and aligns with building blocks 4, 5, 7, and 9 along with elements of 6. Funding in this phase enables the practice team to analyse and use the data they have collected to deliver patient care in a targeted and seamless way. It is expected the activities of this tranche would align with a properly funded Quality Improvement Incentive.

This involves time in the working day, outside of direct face-to-face consultation but important for the delivery of quality patient care. In this phase, funding needs to support the time spent in daily meetings to plan patient care with the practice team for the day, in weekly practice team meetings to identify, discuss, plan and report on quality improvement activities, in the targeted monitoring of patients' conditions, and in providing patient and carer education regarding the patient's condition and best management.

Practices that have completed the requirements of Tranche 1 would be able to access Tranche 2 funding to further build the healthcare team, deliver an expanded range of services to patients with specific conditions in line with their specific pathway of care, and provide enhanced access options to patients for receiving care.

This phase of transformation involves undertaking quality improvement activities, building the health care team, distributing aspects of patient care within the health care team and coordinating patient care across the team.

A practice participating in this tranche is still building its systems to deliver and remunerate team-based care, to connect the patient with their health care providers, and to facilitate feed-back loops to ensure continuity and coordination of care. It will be identifying the common conditions of its patient population and considering approaches to proactively reduce their occurrence or to offer an expanded range of services (i.e. group sessions, telemonitoring, telehealth etc.) to engage and assist patients to better manage their health and conditions.

Incentives to complete Tranche 2 may include having some of the deliverables of Tranche 2 in place to continue accessing WIP beyond a certain amount of time.

Practices that complete the building blocks under this tranche will:

Deliverable	Quadruple Aim
Conduct brief daily meetings (huddles) to plan patient care for that day	Improved patient experience Improved population outcomes Improved provider experience
Conduct weekly clinical case conferencing	Improved population outcomes
Conduct monthly meetings analysing patient population data for the purposes of identifying and addressing care needs	Improved population outcomes Improved total cost of care
Have quality improvement initiatives in place	Improved population outcomes Improved total cost of care Improved patient experience
Report on process and patient outcomes	Improved patient experience Improved population outcomes Improved total cost of care
Demonstrate improvement in at least 4 out 10 PIP Quality Improvement measures	Improved population outcomes Improved total cost of care
Deliver enhanced access options and proactive care to patients	Improved patient experience Improved population outcomes Improved total cost of care
Prepare individualised care plans shared with members of the healthcare team as appropriate	Improved population outcomes Improved patient experience
Utilise the healthcare team in delivering the right care, by the right provider, at the right time	Improved total cost of care Improved patient experience Improved population outcomes Improved provider experience

Tranche 3—Moving Towards Population Health Management and Enhanced Care Systems

Tranche 3 is the maturation of the transformation process. The investment in this phase provides for increased infrastructure costs to deliver enhanced care. This might include a training room for running patient education sessions, exercise classes or shared appointments, use of a virtual waiting room technology for planned telehealth consultations for empanelled patients, etc.

Funding during this phase would also support population health initiatives focused on keeping people healthier for longer. It enables the ongoing analysis of patient and population health data, and for the development and testing of innovative solutions to target problem areas, provide greater access or address unmet needs. Funding also provides for the coordination of the patient's care across the healthcare continuum.

This tranche aligns with building blocks 6, 8, and 10.

This tranche will aim to achieve outcomes like The Western Sydney initiative, which is an example of system change which can start to make a real difference to the health of their community and their patient population, and to reducing the healthcare costs and expenditure, and improving access to care.

Tranche 3 is where practices are rewarded for improved outcomes.

Practices that complete the building blocks under this tranche will:

Deliverable	Quadruple Aim
Enhanced access to care through email/phone and virtual services	Improved patient experience Sustainable costs
Linked data sets (coordinated through the Primary Health Network)	Improved population outcomes
Extensive use of multidisciplinary practice teams	Improved patient experience Improved population outcomes Improved total cost of care Improved provider experience
Improved coordination of care	Improved patient experience Improved total cost of care
Have measurable quality improvement initiatives in place	Improved population outcomes Improved total cost of care

14 EXPECTED OUTCOMES OF THE AMA'S SUGGESTED REFORM IN GENERAL PRACTICE

The PCMH model has been shown both nationally and internationally to achieve the Quadruple Aim: improvements in patient experience, population outcomes, total cost of care and provider experience. Recent local evidence from the Western Sydney Initiative (case study 1)—a region of great diversity, with high levels of chronic disease, unemployment and social disadvantage—clearly demonstrates that the strides made towards the Quadruple Aim were significant. The AMA expects that when adopted nationally, similar outcomes can and will be achieved on a broader scale. Flexibility in the implementation of the model will ensure that the needs of each community are met to achieve the same positive health and economic outcomes.

15 PROGRAM EVALUATION

To ensure the success of our model for the future of primary care, there needs to be appropriate and thorough evaluation of the program's outcomes. This is difficult at present due to the lack of funded primary care research in Australia since the Australian Primary Healthcare Institute ceased operation in 2015.

This is a significant issue as general practice is a distinct medical specialty that requires its own specific research. This will provide GPs with an opportunity to explore their field of practice and produce cutting-edge findings and innovative models of care that will assist the profession to improve the services they provide.

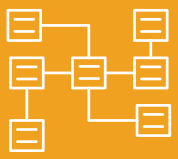
PIPQII represents a measured step towards collecting data that will help drive improvements in patient care and identify regions where there is poor public health, eg diabetes hotspots.

The AMA is calling for the expedition of the National Primary Health Care Data Asset that will extend on PIPQII and contain high-quality data about primary health care to assist in the understanding of the health system, and a patient's journey and experiences within it. This kind of data is critical for better population health planning, and will help identify gaps in primary health services to improve patient outcomes. The Data Asset will play a critical role for nationwide evaluation of new primary care models.

The recent investment of $45 million over nine years by the Federal Government for the Primary Health Care Research Initiative is also a promising step in the revitalisation of primary care research in Australia. The first round of funding for projects that align with the priorities of the Government's 10-year Primary Health Care Plan are due to commence in 2020. The Medical Research Future Fund funds the initiative, and grants are administered by the National Health and Medical Research Council (NHMRC).

Building on this, the AMA is also calling for the reinstatement of the Australian Primary Healthcare Institute to ensure that there is ongoing, high-quality research in Australian primary care. Long-term primary care reform needs to be supported by evidence that the reform is having a positive effect on public health, health expenditure, and the experiences of patients and the medial workforce i.e. achieving the Quadruple Aim for healthcare improvement.

At present, the amount of funding for general practice research is woefully inadequate to achieve these research and program evaluation goals, and is well below the contribution of general practice and primary care in the context of the broader health system. The AMA believes a fairer distribution of NHMRC funding should be allocated to general practice and primary care research, and calls for a dedicated stream of funding for general practice research in the order of 8 per cent of its grants budget.



16 ROLE FOR PRIMARY HEALTH NETWORKS IN GENERAL PRACTICE REFORM

Primary Health Networks could play an increasingly important role in supporting general practice during the move towards the PCMH.

In order to succeed, Primary Health Networks must form and maintain strong relationships with GPs and general practices. These relationships are fundamental if Primary Health Networks are to effectively support and collaborate with general practices so that GPs are better placed to provide holistic patient-centred care. If Primary Health Networks understand the needs of the general practices within their community, they could provide significant practice support during the implementation of the tranches to ensure a smooth transition into the new model of care.

Importantly, not all general practices will be equipped to have a complete multidisciplinary team in-house. There needs to be flexibility in the model for team-based care to occur using online, telehealth and/or videoconferencing. Primary Health Networks, through collaboration with general practices, will play a critical role in the formation of these teams by commissioning services for general practices as they expand into PCMHs. Primary Health Networks will soon have a wealth of public health data about their communities with the successful implementation of PIPQII. Working together with practices, Primary Health Networks can help identify where more work is needed to improve patient outcomes, and assist practices to implement improvements where necessary.

Finally, building more collaborative relationships between Primary Health Networks, Local Hospital Networks and general practice is critical to improve the transition of patients between primary and tertiary care. This will move beyond the PHMC towards the patient-centred medical neighbourhood, where the patient can seamlessly access care across all services in our health system through well-coordinated and cooperative relationships and funding arrangements. These collaborative relationships between primary care, tertiary care and Primary Health Networks are important factors for the success of the Western Sydney Initiative.

17 RECOMMENDATIONS

Strong and well-supported general practice is crucial for the future of sustainable, affordable and high-quality primary health care in Australia. The AMA calls for immediate action from the Government to relieve the growing financial and workforce pressures on general practice, that will support general practitioners to provide the right care, at the right time, in the right place. The AMA has provided a framework to support this immediate action, as well as a plan for long-term reform in general practice that will transform practices into patient-centred medical homes. In summary, this framework recommends that:

1. Primary care reforms build on the existing GP-led model of primary health care, which delivers high-quality, cost-effective outcomes for patients.
2. The Government work closely with the AMA and the medical profession to develop and implement a suitable funding model that will encourage and enable the transformation of general practice into a medical home. This includes these three core components:
    - Funding that supports the provision and undertaking of training to facilitate cultural and structural changes within general practice and across the primary care sector. This will promote effective and viable care provision through GP-led multidisciplinary teams within a patient-centred medical home model;
    - Fee-for-service funding supplemented through overarching payments to support the non-face-to-face time required for comprehensive, proactive and coordinated patient care; and
    - Implementation of the three Tranches outlined in this framework using a stepped funding model to support the transformational process.
3. General practice is adequately funded to reach its full potential and meet the increasingly complex healthcare needs of the community. This would entail:
    - Federal Government spending on general practice services be increased to at least a mandated 16 per cent of total health spending, recognising that as general practice transformation matures and more patients are treated in primary care, funding may need to increase further in order to proportionately match this growth in demand.
    - Ensure high-quality research in Australian primary care by increasing Government investment in general practice research to at least 8 per cent of the NHMRC funding pool, expediting the National Primary Health Care Data Asset, and reinstating the Australian Primary Healthcare Institute.

- The Government immediately increase efforts to support general practice in providing preventative and high-quality health care to patients with increasingly complex needs by:
    + Introducing an extended Level B MBS Consultation Item;
    + Redistributing current funding for chronic disease management to facilitate and reward longitudinal care;
    + Better support for wound care provided in general practice;
    + Yearly indexation of incentive payments and lifting the caps on subsidies.

4. The Government continue to invest in long-term strategies to ensure there is a sustainable medical workforce. This includes initiatives to make pursuing a career in general practice more appealing for new graduates—especially in rural areas where workforce shortages are widespread. New programs should be properly evaluated to determine whether they have had a positive impact on current workforce shortages.

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