



Standing Council on Health

NATIONAL PRIMARY HEALTH CARE STRATEGIC FRAMEWORK

APRIL 2013



National Primary Health Care Strategic Framework

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NATIONAL PRIMARY HEALTH CARE STRATEGIC FRAMEWORK

APRIL 2013

The National Primary Health Care Strategic Framework is a nationally agreed policy document developed by the Commonwealth, State and Territory Health Departments.

The Framework was approved by Health Ministers, through the Standing Council on Health, in April 2013.



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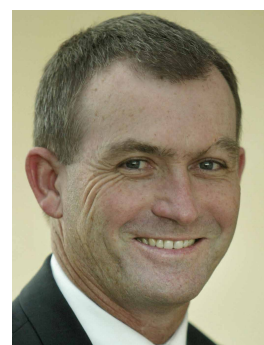
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FOREWORD

The National Primary Health Care Strategic Framework is the first national statement, endorsed by the Standing Council on Health, which presents an agreed approach for creating a stronger, more robust primary health care system in Australia.

Evidence demonstrates that those health systems with strong primary health care are more efficient, have lower rates of hospitalisation, fewer health inequalities and better health outcomes including lower mortality.

While Australians generally enjoy some of the best health outcomes in the world, it is widely recognised the current health system is under increasing strain from the growing burden of chronic illness and an ageing population.

This Framework builds on major health reforms already underway and will contribute towards our goal of achieving a safe, equitable, effective and sustainable health system.

Our vision for primary health care in Australia is clear. We aim to:

- improve health care for all Australians, particularly those who currently experience inequitable health outcomes;
- keep people healthy;
- prevent illness;
- reduce the need for unnecessary hospital presentations; and
- improve the management of complex and chronic conditions.

The Framework focuses on four strategic outcomes:

- building a consumer focused and integrated primary health care system;
- improving access and reducing inequity;
- increasing the focus on health promotion and prevention, screening and early intervention; and
- improving quality, safety, performance and accountability.

The Commonwealth in partnership with each state and territory will develop state-specific bilateral plans to implement the Framework. These plans will specify the actions to be undertaken to address the issues of most importance within each jurisdiction and where collaborative action can make the greatest gains.

Primary health care providers are critical to leading new approaches in how we deliver health care in our communities, such as patient-centred care, interdisciplinary approaches, and the optimal use of information and communication technologies.

Consumers also have an essential role. We need to support individuals and families to make informed choices about their health care needs and to be actively engaged as partners with their health care team.

This Framework is an important step in an ongoing process of improvement, reform and cultural change in our health system. It will help ensure that our primary health care system not only meets the challenges of today, but that it's ready for the needs of the future.



The Hon Tanya Plibersek MP

Minister for Health and
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Purpose, Scope and Context of the Framework

Purpose of the Framework

The National Primary Health Care Strategic Framework (the Framework) promotes a new approach for the Commonwealth, states and territories to work in partnership to better integrate health care across care settings and to improve health outcomes for all Australians.

For the first time, it provides a mechanism for coordinated action at the Commonwealth, state and local levels to enable a more harmonised approach in primary health care planning and service delivery.

The Framework specifically builds on the *National Primary Health Care Strategy*, which was released in May 2010 following a comprehensive national consultation process. This Strategy and its suite of supporting papers (available at www.yourhealth.gov.au) discusses in more detail many of the issues raised within this document.

The aim of the Framework is not to duplicate the work of the Strategy, but to bring into focus key priority areas identified in the Strategy as national challenges most in need of action that we can address over the upcoming years.

Scope of the Framework

The National Primary Health Care Strategic Framework takes a broad and comprehensive view of primary health care.

The Framework recognises the central role of General Practitioners (GPs) and evolving models of general practice in the primary health care system of the future. It also recognises that the concept of primary health care is wide and extends beyond the traditional 'general practice' focus of care. Recognising that GPs will continue to build on their pivotal role in primary health care, the Framework acknowledges there is also a whole suite of other skilled health care professionals and organisations providing primary health care services to the Australian community.

The Framework also recognises the role of the consumer and carers. The absence of a patient centred focus from health care services can lead to fragmented care, consumers who are poorly informed about their care needs and options, and gaps and or duplication of services received. Through being engaged and having access to reliable and appropriate information and support, consumers are better placed to adhere to treatment regimes and manage lifestyle related risk factors, which will lead to better clinical outcomes and better quality of life.

The Framework acknowledges the need to improve equity of access to health services and is designed to encompass the full range of health care services that are provided in the home and community setting. This includes: health promotion, prevention and screening, early intervention, treatment, support for independent living, management of chronic health conditions, such as diabetes, mental illness, and cancer, and lifestyle factors including obesity, smoking, and diet.

It also recognises the needs of specific population groups, including: parents and children, young people, older people, people living in rural and remote areas, Aboriginal and Torres Strait Islander people, people of lower social or economic circumstances, refugees and people from culturally and linguistically diverse backgrounds. Specific needs of Aboriginal and Torres Strait Islander people will be targeted through the new National Aboriginal and Torres Strait Islander Health Plan. This Plan will assist governments to develop policy and design programs to improve the health and social determinants of health for Aboriginal and Torres Strait Islander people.

The Framework acknowledges the interactions between primary health and other parts of the health care continuum, including specialist care, acute, sub-acute and non-acute care sectors, aged care, disability, early childhood, population health and Indigenous health services, and that some models of care seek to deliver sub-acute and acute services in the home and community settings. The Framework also acknowledges the interactions between primary health and other social and welfare services and notes effective pathways between these services are an important part of addressing the social determinants of health and assisting disadvantaged people.

The role of Australia's new primary health care organisations, Medicare Locals, and the opportunities they bring for future primary health care are also clearly acknowledged.

National Health Care Reform – Where does the Framework fit?

The National Primary Health Care Strategic Framework has been developed within the broader context of the National Health Reforms agreed by the Commonwealth and the state and territory governments (referred to as the 'States').

The *National Health Reform Agreement 2011* (NHR Agreement) sets out the intention of governments to work in partnership towards improving health outcomes for all Australians, and to ensure the sustainability of the Australian health system.

The Agreement outlines major structural reforms needed to build the foundations of Australia's future health system, including national initiatives such as the introduction of activity based funding, and the establishment of the Independent Hospital Pricing Authority, the National Health Performance Authority, and the Australian Commission on Safety and Quality in Health Care.

It also supported the establishment of local governance mechanisms, such as the Local Hospital Networks and Medicare Local primary health care organisations, to improve responsiveness and accountability of health services to the community at a local level.

The NHR Agreement identified the need for the Commonwealth and States to work in partnership to develop this Framework in order to guide policy directions across priority areas in primary health care.

Primary health care is a vital component of the comprehensive health care system in Australia. While significant reform has occurred across the health and aged care system, a nationally agreed approach on primary health care has, so far, been missing.

A high quality, high performing health system needs a strong, integrated primary health care system at its centre. Health systems with strong and effective primary health care can achieve better health outcomes at a lower cost, than health systems that are more focused on acute and specialist care.

Building a strong, responsive and cost-effective primary health care system is essential if we are to maintain a healthier population and ease the burden on hospitals. By supporting health promotion

and education, early diagnosis and treatment and chronic condition management, primary health care contributes to reducing the risk of conditions progressing to the point where more intensive and expensive interventions may be required.

Australia's health system is characterised by a complex interaction of public, private and non-government organisations providing services that may be funded by the Commonwealth, the States, and through private payments by individuals. This complexity can lead to health service planning and delivery occurring in an uncoordinated and poorly integrated fashion, creating service fragmentation and gaps, and potentially less than optimal outcomes for consumers. It is this context that makes it imperative that we turn our efforts towards improving primary health care.

Responsibilities in Primary Health Care

Today, all levels of government continue to make significant contributions to primary health care services.

In accordance with the NHR Agreement 2011, the Commonwealth has lead responsibility for:

- system management, policy and funding for primary health care;
- establishing Medicare Locals to promote coordinated primary health care service delivery at a regional and local level;
- working with each State on system-wide policy and state-wide planning for primary health care services; and
- promoting equitable and timely access to primary health care services.

The Commonwealth does this through the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme, through funding of Medicare Local primary health care organisations, through specific program funding to non-government organisations and private providers of health services, as well as through payments to the States.

The Commonwealth also provides funding for hospital services and public health activities managed by States, including new growth funding arrangements¹.

State and territory governments are responsible for system management of public hospitals, including managing Local Hospital Network performance². The States are also responsible for funding and providing a range of community health services including prevention and health promotion services and services that help maintain community health and wellbeing³. Traditionally, some of these community health services have also included primary health care-type services.

The Commonwealth and States have a shared responsibility to ensure that all parts of the system operate in a coordinated and integrated way for the benefit of all Australians.

Details from the *National Health Reform Agreement 2011* that outline responsibilities relating to primary health care (*Schedule D – Local Governance* (clauses D29 to D43 on Medicare Locals) and *Schedule E – GP and Primary Health Care*) are at **Attachment A**.

1 Commonwealth of Australian Governments (2011), *National Health Reform Agreement*, Clauses 10; A1- A4

2 Commonwealth of Australian Governments (2011), *National Health Reform Agreement*, Clause 8

3 Commonwealth of Australian Governments (2012), *National Healthcare Agreement*, Clauses 24 - 27

Medicare Locals – primary health care organisations

A key primary health care initiative under the national health reforms is the establishment of a network of primary health care organisations, known as Medicare Locals.

This network was created in response to an identified significant need in the Australian health system. This need was for a body that could operate at a regional level and had the authority and accountability to plan, integrate and coordinate primary health care services on a local basis.

Medicare Locals, as the primary health care partners of Local Hospital Networks, will assist in supporting and enabling better integrated and responsive local primary health care services. As independent bodies, they will be working across boundaries in primary health care and creating interfaces with the acute and aged care sectors.

Medicare Locals also have responsibility for: population health planning and needs assessment for their regions, identifying gaps in primary health care services, and developing and implementing strategies, in collaboration with communities, population groups and service providers that address these service gaps.

For consumers and population groups, this will mean more equitable access to a safer, high quality health system that is better organised and integrated around their needs.

More detail on the Medicare Local primary health care organisations is available through the www.medicarelocals.gov.au website.

Implementing the Framework

Under the Framework, the Commonwealth, state and territory governments will maintain existing roles and responsibilities as described in the *National Healthcare Agreement (2012)* and the *National Health Reform Agreement (2011)*.

With significant levels of funding already being invested into the health system by both levels of government, the intent of the Framework is to target activity that can be undertaken within existing resources from across the entire system.

Considerable improvements can be achieved through concerted effort towards minimising gaps in the primary health care system, improving planning and coordination, focusing on keeping people healthy and out of hospital. Funding for new initiatives is very limited and can only be justified when underpinned by evidence of cost effectiveness.

Recognising the different roles and responsibilities of governments and the need to take account of the particular challenges and opportunities relevant to each individual state, the Framework will be delivered through a range of mechanisms.

These include:

- state-specific bilateral plans;
- direct action by the Commonwealth or States, as appropriate; and
- national action in accordance with Commonwealth-state agreed approaches.

The bilateral plans, to be agreed between the Commonwealth and each state and territory, will be the primary vehicle for implementing the Framework. Each bilateral plan will focus on identifying specific actions to address the issues of most importance to the individual jurisdiction and where the greatest gains can be made through collaborative action. The Council of Australian Governments (COAG) has agreed to the development of the state-specific plans by July 2013.

While the Framework primarily focuses on directing improvements for implementation by governments, it is important to acknowledge the essential role of consumers, carers, health care professionals and service providers from the public, private and non-government sectors, and to foster their support in the implementation of the Framework.

The Commonwealth and states will also work together to ensure the Framework is used to guide the development of regional level plans by Medicare Locals and Local Hospital Networks.

Primary Health Care in Australia

Primary health care encompasses a large range of providers and services across the public, private and non-government sectors.

At a clinical level, it usually involves the first (primary) layer of services encountered in health care and requires teams of health professionals working together to provide comprehensive, continuous and person-centred care.

While most Australians will receive primary health care through their GP, primary health care providers also include nurses (including general practice nurses, community nurses and nurse practitioners), allied health professionals, midwives, pharmacists, dentists, and Aboriginal health workers.

Primary health care is the frontline of Australia's health care system. It can be provided in the home or in community-based settings such as in general practices, other private practices, community health, local government, and non-government service settings for example, Aboriginal Community Controlled Health Services.

The types of services delivered under primary health care are broad ranging and include: health promotion, prevention and screening, early intervention, treatment and management.

Services may be targeted to specific population groups such as: older persons, maternity and child health, youth health, people living in rural and remote areas, Aboriginal and Torres Strait Islander people, refugees, and people from culturally and linguistically diverse or low socio-economic backgrounds.

Primary health care services may also target specific health and lifestyle conditions, for example: sexual health, drug and alcohol services, oral health, cardiovascular disease, asthma, diabetes, mental health, obesity and cancer.

Primary health care services will also look and operate differently as one moves from metropolitan areas to rural and remote settings. Significant variations may relate to geography, community and population characteristics, socio-economic circumstances, infrastructure, health status, and workforce mix and availability. Health services in rural and remote areas are particularly dependent on primary health care services, particularly those provided by GPs.

Social determinants of health strongly influence the health of individuals and communities, and affect the sustainability and accessibility of health services. It is therefore important that primary health service planning and delivery recognises the influence that factors such as housing, education, employment, infrastructure and transport can have on the health of those who live in the community, and build partnerships across sectors when there is a need to address specific issues affecting a community.

From the Consumer Perspective

Primary health care is important to all of us. While our needs for services will vary from person to person and are likely to change over time, every individual will need to access some form of primary health care services over the course of their lifetime. The majority of the population will use primary health care services every year.

The primary health care system needs to be better designed towards supporting the patient, their family and carer(s) to be in control and actively supported in decision making regarding their care. It is also about creating a system that is easy for consumers to access and use, and helps them to manage their health care needs and stay as healthy as possible.

Referred to as patient- or person-centred care, this approach requires health professionals to consider the patient as an individual within a social network – where his/her experiences, preferences, values and needs are taken into account in the planning and delivery of their health care.

In addition to recognising and valuing an individual's role in decision making about their health care, patient-centred care actively supports and empowers the individual in their own self-care and monitoring.

Systemic National Challenges in Health Care

One of the best ways to ensure a strong, effective health system is to have a strong, integrated primary health care system at its centre.

Re-orienting the health system towards primary health care will need solutions that help to overcome some of the inherent challenges in the Australian health care system, particularly:

- fragmentation arising from the divide between Commonwealth and state funded services;
- complexities in funding, governance and reporting arrangements;
- poor coordination of service planning and delivery within the sector and with other health care, social and welfare sectors; and
- system inadequacies, including workforce shortages and maldistribution.

In addition, the primary health care sector needs to look towards:

- supporting continuous improvement in performance, safety and quality;
- making the best use of the workforce, infrastructure and technologies;
- using the best available evidence-base; and
- providing appropriate services that meet the needs of the local community.

The Case for Change

Australians generally enjoy some of the best health outcomes in the world. In 2008-10, Australians' average life expectancy at birth was 79.5 years for males and 84.0 years for females⁴ – with the fifth highest life expectancy in OECD countries in 2009.⁵ The most recent National Health Survey (2007-08) indicates that 85 per cent of Australian citizens aged 15 years and over perceive their health status as good or better.⁶ We achieve these outcomes at a comparatively low cost, spending 9.4 per cent of gross domestic product on health in 2009-10.⁷ This expenditure is slightly under the OECD median of 9.6 per cent, less than similar OECD countries such as the United Kingdom (9.8 %), Canada (11.4 %) and New Zealand (10.3%), and significantly less than the United States (17.4%).⁸

At the same time, Australia faces some significant challenges to improving health outcomes and ensuring health system sustainability.

The National Primary Health Care Strategy identified that Australia's health system faces significant challenges due to the growing burden of chronic disease, an ageing population, workforce pressures, and unacceptable inequities in health outcomes and access to services. It noted that, for many individuals, the primary health care services they access and the quality of care that results, has

4 Australian Institute of Health and Welfare (2012), *Australia's Health 2012*, p120

5 OECD (2012), *Health at a Glance*, p7

6 Australian Institute of Health and Welfare (2012), *Australia's Health 2012*, p107

7 Australian Institute of Health and Welfare (2012), *Australia's Health 2012*, p468

8 OECD (2012), *Health at a Glance*, p197

depended on where they live, their specific condition, and the service providers involved, as much as their clinical needs and circumstances.

From a patient perspective there is evidence that people prefer to be cared for within their own homes and communities and this requires an emphasis upon high quality integrated care that will allow primary health care practitioners and hospital based specialists to more easily collaborate in the treatment of patients in the community.

It has been well documented that specific Australian population groups such as Aboriginal and Torres Strait Islander people, people living in rural and remote areas, people who are less well off, and those with additional or specialised health needs, experience significantly poorer health outcomes. Recent statistics clearly illustrate this:

- The life expectancy of Aboriginal and Torres Strait Islander peoples is 11.5 years lower for males and 9.7 years lower for females than non-Indigenous Australians.⁹
- People living in outer regional and remote areas are 4.5 times more likely to travel more than an hour to see a GP than those living in major cities.¹⁰
- The average person with disability has 3.1 long-term health conditions that may not be directly associated with their disability.¹¹
- Among older Australians living in the community, almost half aged 65-74 years have five or more long-term conditions, increasing to 80 per cent of those aged 85 years or over.¹²

In addition to these poorer health outcomes for some specific groups, there is a growing burden of chronic disease in Australia. Our obesity rates are among the highest in the world, with about 1 in 4 Australian adults classified as obese, which contributes to the increase in chronic conditions such as heart disease and diabetes. The changes in the burden of disease across Australia, when combined with the demographics of a rapidly ageing population, are increasing the overall pressure on Australia's health care system. This pressure is evident in demands for increased funding for resources including workforce and infrastructure. One of the key ways to address the financial sustainability of the health sector is to ensure that we use current resources in the most effective manner possible.

For many individuals, the primary health care services they access and the quality of care they receive is influenced as much by where they live, their cultural background, and social and economic circumstances, as their specific health needs. People also need to feel engaged in their own care, and have the option to be cared for within their own homes and communities whenever possible.

This requires some major changes in how we plan and deliver primary health care in Australia. Our health care professionals also need to look at new ways of working with consumers and with other providers so they can better meet the needs of the people in their care. Governments also need to find ways to bridge the system divides and better support a strong and effective primary health care sector.

To do so will achieve better health outcomes for all Australians.

9 ABS (2009) Experimental Life tables for Aboriginal and Torres Strait Islander Australians 3302.55.003

10 Commonwealth of Australia (2012), *National Strategic Framework for Rural and Remote Health*, p9

11 Australian Institute of Health and Welfare (2012), *Australia's Health 2012*, p6

12 Australian Institute of Health and Welfare (2012), *Australia's Health 2012*, p6



National Vision for Primary Health Care

The Commonwealth, states and territories have agreed to the following vision for primary health care:

National vision for primary health care:

A strong, responsive and sustainable primary health care system that improves health care for all Australians, especially those who currently experience inequitable health outcomes, by keeping people healthy, preventing illness, reducing the need for hospital services and improving management of chronic conditions.

Priorities and Objectives

The Commonwealth, state and territory governments agree to work together to ensure the ongoing improvement and sustainability of the primary health care system with the goal of ensuring effective, safe services for consumers aimed at providing care in the most appropriate and efficient setting, and improving health outcomes.

The Framework will prioritise action toward the following four strategic outcomes, which have been identified as requiring concerted focus:

- Build a consumer-focused integrated primary health care system;
- Improve access and reduce inequity;
- Increase the focus on health promotion and prevention, screening and early intervention; and
- Improve quality, safety, performance and accountability.

These strategic outcomes are considered to have the greatest potential to make a difference to consumers and will benefit from improved coordination of effort by governments.

Strategic Outcome 1

Build a consumer-focused integrated primary health care system

Primary health care services are integrated and coordinated within the primary health care sector and across the wider health system. The services are tailored to meet consumer needs and preferences and are appropriate to the needs of specific population subgroups.

Potential Actions

1.1 *Establish formal planning and engagement protocols between Medicare Locals and Local Hospital Networks, in partnership with consumers and other providers, to develop joint service plans and work together to ensure the delivery of services that achieve the best outcomes for individuals and the wider community.*

Medicare Locals and Local Hospital Networks will work with local consumers and providers to develop joint plans for the design and delivery of integrated, coordinated and responsive services at the local level. This will bring together vital data, information and knowledge from the primary and acute health sectors, consumers, providers and the broader social service system on the needs and priorities for local communities.

Joint planning and decision-making will provide a foundation that supports consumers in navigating the health system more effectively, and directs resources to the services which achieve the best possible outcomes - regardless of where those services are delivered or who funds them. Joint planning will also engage consumers and providers at the local level.

This engagement of key players in joint planning will also assist in the development of local health solutions to achieve shared performance indicators as agreed under the COAG Performance and Accountability Framework.

1.2 *Identify the health needs of individuals within different population groups and develop evidence based health care support and interventions, with a focus on prevention, health promotion, self-care and intervention.*

Individuals within different population groups will require different types of support from the health system. Risk varies among population groups according to a range of factors including age, sex, cultural background, geographical location, socio-economic status, past experience and family history, in addition to lifestyle factors, such as smoking, alcohol use, exercise and diet.

A relatively simple and tested model to stratifying risks within the population is to identify known experience of the health system, as well as modifiable group behaviours:

- a. people who are relatively high users of the hospital system (a small percentage of the population use a high proportion of hospitalisations);
- b. those who are at risk of becoming high users of the hospital system (those with complex chronic co-morbidities e.g. diabetes, coronary artery disease, chronic obstructive pulmonary disease, other respiratory disease, and hypertension);
- c. those with multiple modifiable risk factors (overweight or obese, smoking, excessive alcohol, risky sexual behaviours, etc.); and
- d. those with no or limited modifiable risk factors.

Interventions for these various groups should then be designed to match need, based on evidence of what works. This could rank, for example, from high level interventions such as case management and care coordination, to secondary prevention for those with chronic conditions, lifestyle modification, primary prevention, self-help and screening, and targeted as well as population-wide health promotion activities.

Population health planning and evidence based needs assessments to be undertaken through Medicare Locals and Local Hospital Networks will help identify important population within their local communities. The Commonwealth and States will work together to identify ways to better target assistance to individuals within these different groups.

This will support selection by clinicians – general practices, community health, hospitals, etc. – of those who would benefit from these different levels of intervention and support, as well as self-selection by consumers experiencing difficulty in managing their condition or conditions.

1.3 *Improve access for people who experience difficulty accessing primary health care, including Aboriginal and Torres Strait Islander people, people living in rural and remote areas, people with additional or specialised health care needs such as the elderly, people with disability, migrants or refugees and people with lower socio-economic status.*

It is recognised that certain population groups in Australia will experience poorer health outcomes than the majority of the population.

A range of existing initiatives are in place that aim to reduce service gaps and improve health outcomes for these groups. Key examples include the Closing the Gap initiatives, a range of targeted mental health early intervention and suicide prevention programs, and the National Strategic Framework for Rural and Remote Health. However, it is important to recognise that there is still more to be done.

This action will require further collaborative effort between the Commonwealth and States, both in the health sector and across portfolios, and including Local Hospital Networks and Medicare Locals, primary health care providers, and consumers and higher risk population groups.

1.4 *Recognising the importance of a child's formative years – including the health and wellbeing of their parents, care during pregnancy, and early childhood development – develop integrated packages of services and support that maximise the opportunity for lifelong health and wellbeing.*

Primary health care plays a crucial role in establishing the foundation for good health in the early childhood years.

While key aspects of ante and post natal care and preventative health care are provided through general practices, including health checks and immunisations, a range of other early childhood services contribute to improved early childhood health, for example, home visiting, parent education and breast feeding support. Schools also have a valuable role in teaching young children about their health and establishing healthier lifestyle habits.

Emerging issues, such as Foetal Alcohol Spectrum Disorder, highlight the need for coordinated action across a number of sectors. This action seeks to promote better integration of education, housing and social services in order to support healthier children and address gaps at the community level, including services for disadvantaged populations.

1.5 *Medicare Locals will work with consumers, communities, health service providers and others to examine innovative care coordination and/or case management arrangements for people with complex chronic conditions, which focus on secondary and tertiary prevention, improving health outcomes and literacy, and reducing avoidable hospitalisations.*

The National Primary Health Care Strategy identified that many patients, particularly those with complex needs, have been left to navigate the complex health system on their own. Even when supported by their GP or community health service, they have been affected by gaps in information flows and a limited ability to influence care decisions in other services. This has resulted in a small percentage of the population, who suffer from chronic complex conditions, accounting for a large percentage of avoidable hospitalisations.

The Commonwealth and States will identify possible models of multidisciplinary team care coordination and/or case management that will keep people healthy and reduce avoidable hospitalisations. Caring for people with chronic complex conditions at home or in the community will not only result in better health outcomes for individuals, but also reduce the pressure on the acute hospital system and on the community more broadly.

Examples of successful coordinated care include the Coordinated Veterans Care Program, as well as the Closing the Gap initiatives that deliver care coordination and support services through Aboriginal Medical Services. Other successful examples of coordinated care are also in place in some Medicare Locals.

This action will also support meeting the performance targets identified under the National Healthcare Agreement to improve the provision of primary health care services and reduce the proportion of potentially preventable hospital admissions by 7.6 per cent over the 2006-07 baseline to 8.5 per cent of total hospital admissions.¹³

13 SCRGSP (Steering Committee for the Review of Government Service Provision) 2009, *National Agreement performance information 2008-09: National Healthcare Agreement*, Productivity Commission, Canberra

1.6 *Promote the role of consumers as partners in the health care team and empower them to make decisions about their own health and social needs.*

Consumers have a right to make decisions about their own health care. When consumers are involved in decision-making, it results in better health outcomes, improved satisfaction, and greater ability in providing self-care.

Where practical, health system planning and design should evolve from a consumer perspective, with services being wrapped around the needs of the consumer, rather than consumers being required to adapt to the desires of policy makers, planners and providers.

Consumers need to be supported and encouraged to be partners in the health care team and be enabled to participate in decision-making about their assessment and treatment. This includes enhancing knowledge, improving decision-making, particularly in relation to consumer preferences and social or other lifestyle factors, and increasing consumer confidence in undertaking self-care.

This will require a change in the attitude and culture for many providers across the health system. However, it is an important shift that should be supported by all stakeholders.

1.7 *Develop and promote innovative ‘pathways through care’ models which support more integrated and seamless care for consumers.*

To improve health care for consumers it is important that consumers can, as much as possible, seamlessly move through the health system without being impeded by unintended barriers such as siloed delivery and funding structures. Commonwealth and State governments will support and build on demonstrated models that can provide ‘pathways through care’ that cut through these barriers to deliver a more seamless consumer experience.

Governments also aim to encourage ‘bottom up’ models of care. These models realise value for the consumer and can provide opportunities to be replicated and scaled accordingly. This will require clinical leadership and engagement to ensure collaboration and build partnerships across the care continuum. The increased use of the Personally Controlled Electronic Health Record (PCEHR) will also feed into this area.

This action can naturally extend in scope to include increased collaborations across allied health and other sectors through improved data collection and information sharing.

1.8 *Manage more complex, urgent cases within the community by facilitating the development of integrated and ambulatory urgent care services in areas of need.*

Throughout Australia, a range of general practices and other primary health care services (e.g. Aboriginal Community Controlled Health Services) have developed the competence and capacity to manage complex, urgent cases. However, in many areas a gap remains between the level of care currently available within the community and what care could be provided

in the community; for example, hospitalisations could be avoided where there is capacity for more acute and urgent care to be provided in the home or in walk-in or ambulatory centres, or coordinated through care coordination and case management. Reorientation of service provision to the community setting can be increased with the support of Telehealth and Telemedicine.

Governments will build on existing services and identify best-practice approaches to improve access to integrated care services within the community. This will also facilitate better linkages between the primary health care sector and specialists to build additional capacity in non-hospital settings.

Strategic Outcome 2

Improve access and reduce inequity

Primary health care is delivered through an integrated service system which provides high quality care across the country and actively addresses service gaps.

Potential Actions

2.1 Promote health system models that facilitate long term relationships between consumers and general practices to enhance the health and wellbeing of individuals and their families throughout their lives.

When people are sick, a GP is generally the first clinical point of call in the health system. While many consumers have established relationships with a GP, those who have not can fall through the cracks and may not access timely and necessary care.

Encouraging long term relationships – a longitudinal link – between consumers and a general practice will provide a means of avoiding these issues and, in turn, place greater accountability on the practice to manage the care of that consumer. It also acknowledges the role of the GP, or in regional or remote areas a nurse practitioner, as a gateway into the broader health system for most people.

There is increasingly compelling international evidence that multidisciplinary team-based health care delivery models, such as patient centered medical homes (PCMH), contribute to improved health outcomes, enhance the consumer experience of care, and reduce the need for expensive and avoidable hospital and emergency care.¹⁴

Australian adults with complex care needs who reported as having a PCMH reported having better coordinated care, fewer medical errors and test duplications, better relationships with their doctors, and greater satisfaction with care.

2.2 Work together with primary health care providers and professional organisations to promote the development of multidisciplinary teams in which all team members are supported to fully develop their clinical skills and potential.

The Commonwealth is working with the States to plan for and develop the workforce needed to meet the challenges of the future, including significantly increasing the supply of GPs and other primary health care professionals across Australia.

14 Deloitte (2008) The Medical Home: *Distributive Innovation for a New Primary Care Model*

It is important to recognise that there will be increasing pressures on the health workforce due to the range of issues driving demand for care and a desire to reorient towards a stronger primary health care approach as well as systematic approaches to training and recognition of other roles such as personal carers and attendants.

A growing demand for service provision will not be readily met, particularly in rural, regional and remote areas. In this environment the skills of health professionals should be maximised to enable all team members to work to their full scope of practice.

Health Workforce Australia, a Commonwealth statutory body, is also undertaking work on identifying new and expanded roles within the clinical workforce to fill gaps in current service delivery. For example, other countries have additional roles such as medical assistants and nurse anaesthetists.

By focusing GPs at the top of their scope of practice, this enables others within the care team, such as practice and community nurses, allied health and Aboriginal Health Workers, to work at the top of their scope of practice and better contribute to patient care. This will assist in promoting multidisciplinary teams in which all team members are fully supported to develop their clinical skills and potential. Further work also will be done to support the continued development of GPs with advanced or special skills that can help fill the gap between generalist and specialist care.

2.3 Explore funding models that include incentives for a focus on the health of the population, promote safety and quality and reduce preventable hospitalisations through primary and secondary prevention.

Australia currently has a mixed funding model, with a strong fee for service focus in the private sector and large-scale use of salaried arrangements in the public sector. Medicare, with its underpinning principle of universal access to a patient rebate for certain health services, remains a fundamental tenant of Australia's health financing arrangements.

However, there are a range of international models that may be appropriate for certain services and/or localities. For example, there is increasing international evidence about the benefits of a blended payment system – mixing fee for service, pre-payment and pay for performance with salaried arrangements – where those payments are designed to work together to achieve both quality and coordination of care. There are examples of such mechanisms in Australia, for instance the Diabetes Care Pilot, which is looking at innovative funding models that provide payments to providers for improved care of their patients with diabetes.

These options should be further investigated for their applicability to primary health care in Australia. In particular, there may be a need to examine models to maximise the emerging value of new and evolving technologies, and the potential for rapid expansion of remote or virtual consultations.

In looking at emerging models, it is important that funding remains flexible to ensure the needs and circumstances of different localities are accommodated. This means a more effective and flexible use of existing funding as a priority for all stakeholders.

2.4 *Translate both new and existing health system intelligence, including research, economic modelling and needs assessments, into evidence based planning and service delivery.*

This action ensures that national health service planning takes account of the available data, evidence, workforce availability and infrastructure needs in order to provide the most appropriate models of care for each community, including innovative and multidisciplinary models. These three elements are critical for improving access to appropriate care.

The Commonwealth and States will use existing and emerging health system intelligence to inform service planning and design, to ensure that needs identified through these processes drive improvements in access to care for those most in need. Governments will also look to develop and expand this resource and draw on relevant expertise for advice. They will also look to improve the quality and accessibility of data to inform planning and service delivery particularly with a “whole-of-system” viewpoint.

2.5 *Maximise the opportunities of eHealth, including the Personally Controlled Electronic Health Record (PCEHR) and Secure Messaging initiatives.*

The Commonwealth and States will work together to promote the use of eHealth to enable the secure exchange of information between Commonwealth and State services, and with private providers and non-government organisations in accordance with national privacy laws.

This will be achieved by expanding opportunities provided through telehealth, the National Health Call Centre Network, National Health Service Directory and the roll-out of the National Broadband Network. It also utilises advanced clinical software systems to support incorporation of best evidence, delivery of quality care, and continuing quality improvement.

Patient information management systems will support continuity of care by supporting better information exchange between health professionals over time and across different clinical settings. This will include the appropriate use of shared access to up-to-date patient information in the form of health summaries, referral documents, diagnostic results, notification of hospital admissions, inpatient care and discharge summaries, as agreed by the patient.

Strategic Outcome 3

Take action to tackle the social determinants of health and wellbeing with emphasis on health promotion, prevention, screening and early intervention

Individual and community wellbeing is promoted through a systematic approach at national, state and local levels to factors impacting on health status and better health outcomes.

Potential Actions

3.1 Identify ways to address the social determinants of health - such as social status, geographic location, health literacy, housing, education, employment and access to health services - which contribute to poor health outcomes.

There is a range of factors that contribute to a person's health and wellbeing. Many of these factors lie outside the health system. For example:

- education and employment are major determinants of the opportunity for families and individuals to maximise their health and wellbeing;
- transport and road infrastructure can be a significant factor on the ability to access essential health care services;
- suitable housing, access to clean water and fresh food are essential to maintaining good health; and
- a person's literacy levels as well as their socio-economic position impacts on how well they can interact with the health system.

There are programs in place that address these issues. The *Aboriginal and Torres Strait Islander Education Action Plan 2010-14* focuses on inter-sectoral collaboration around hearing health, young parents and integrated early childhood services. Other examples include: *Community Engagement Officers* who provide support to the homeless and those at risk of homelessness (Commonwealth Department of Human Services); and refugee health support programs such as the *Refugee Health Nurse Program* (Department of Health, Victoria), *Refugee Health Program* (Northern Territory Medicare Local), *Bi-Cultural Community Health Program* (Department of Health and Human Services, Tasmania).

Raising awareness of health impacts from other policy domains and taking a multi-sectoral approach to tackle those issues can improve population health and reduce the growing economic burden of the health care system. Consideration of the social determinants of health will also bridge the gap in health inequalities, as outlined in Strategic Outcome 2.

A whole of government approach at all levels is required in addressing the social determinants of health to achieve better health outcomes and to ensure policy and planning decisions appropriately consider potential implications on health. This necessarily requires governments to promote the engagement and involvement of organisations and service providers beyond the health sector and development of appropriate care pathways to address clients' social and welfare needs.

3.2 Target known lifestyle-related health risk factors, such as alcohol consumption, sun exposure, smoking, physical inactivity, poor diet and nutrition, and unsafe sexual practices.

This action leverages existing Commonwealth-State collaboration in preventive health through the *National Partnership Agreement on Preventive Health*. It will enhance the capacity of Medicare Locals to support population level approaches in primary health care, including preventive health, along with other organisations that have a major role in population level approaches and local planning.

It will also include working with the Australian National Preventive Health Agency (ANPHA) and supporting its role in identifying and developing best-practice interventions for health promotion and prevention. Activity will need to be implemented locally as part of integrated primary health care services. This will ultimately support the development and promotion of prevention-focused referral pathways and the implementation of locally relevant models of care.

In targeting risk factors and addressing health prevention, the role of allied health professionals should not be overlooked. For example, pharmacists and community services are well placed to participate in prevention, screening, early intervention and can assist in health self-management.

3.3 Undertake research and evaluation to identify the best use of new technologies and enable increasing use of home based monitoring, treatment and support.

In the context of technological advances, policy makers, funders and providers need to examine the best options available for providing home based monitoring, care and support that are based on research and evaluation.

Governments will make use of improved technology, including the National Broadband Network, eHealth and telehealth, to promote early intervention and monitoring to address health risks identified by Medicare Local and state needs assessments. This includes encouraging the use of technologies such as home monitoring applications which enable primary health care services to undertake remote monitoring of lifestyle and risk factors of consumers, and allow them to focus on those with chronic illnesses or those at risk of emergency care.

Social media, which has become increasingly integrated into everyday life, will also play an important role in patient treatment and support. For example, social media could be better used for messaging, management of self-care, patient recall and check-up services. To maximise opportunities presented by these new technologies it will be important to support communications and information technology literacy among target populations.

This action will enable service providers to analyse the seriousness of risks and determine appropriate interventions to ensure individuals at risk of deteriorating health to receive early and targeted care.

Strategic Outcome 4

Improve quality, safety, performance and accountability

Consumers and providers are engaged and collaborate on a continuous improvement cycle to enhance the safety and quality of primary health care services.

Potential Actions

4.1 *Ensure performance indicators are in place to determine whether primary health care services are being used as, when and how they should be.*

When undertaking major system change it is important to ensure that new or emerging practices are shown to be providing best-practice consumer care. This can be achieved through alignment of performance frameworks and establishment of shared performance indicators. However, it is equally important to ensure that reporting arrangements do not unnecessarily add to the administrative burden of service providers and health care organisations.

Under the National Health Reforms, the National Health Performance Authority (NHPA) is responsible for reporting on the performance of the health system across Medicare Local catchment areas through the Healthy Communities Reports.

4.2 *Support the Australian Commission on Safety and Quality in Health Care to develop safety and quality standards for primary health care, with the expectation that they will support integration by developing standards that are, where appropriate, consistent with those of the acute sector.*

The Australian Commission on Safety and Quality in Health Care (the Commission) has been established to lead and coordinate improvements in safety and quality in health care in Australia. A key role of the Commission includes the development of national safety and quality standards that can be applied to primary health care.

This includes the development of national clinical standards and guidelines with the National Lead Clinicians Group and the National Health and Medical Research Council. The development of clinical standards and guidelines, and strategies for their implementation, is identified as a priority to maximise health outcomes for patients.

To support better integration across health sectors, it is expected that primary health care standards, where appropriate, will be consistent with acute care standards. Options may include developing a single set of standards applying across both sectors, or developing a separate set of standards for primary health care that builds on the Commission's work in the acute care sector.

Into the future, Governments will work with the Commission, the National Lead Clinicians Group, and with primary health care providers and consumers to promote the uptake of these primary health care standards.

4.3 Collaborate to ensure the effective and appropriate collection and exchange of information and data to support performance improvement in primary health care.

Data collection and analysis is an essential activity to support improvement in performance, quality and safety within the primary health care sector. It is also important in ensuring transparency and accountability.

The Commonwealth and States are committed to improve the sharing of information to enable greater performance monitoring and accountability. This will be facilitated through a greater focus on information and data sharing to be pursued through bilateral negotiations.

Attachment A

Extracts from the National Health Reform Agreement

Schedule D – Local Governance – Clauses D29-D43

D29. Medicare Locals will be established by the Commonwealth by 1 July 2012.

D30. The Commonwealth will work with States, primary health care providers and other relevant groups to establish Medicare Locals as primary health care organisations across Australia.

D31. Medicare Locals will be the GP and primary health care partners of Local Hospital Networks, responsible for supporting and enabling better integrated and responsive local GP and primary health care services to meet the needs and priorities of patients and communities.

D32. Medicare Locals and State-funded health and community services will cooperate to achieve these objectives.

D33. The strategic objectives for Medicare Locals are:

- a. improving the patient journey through developing integrated and coordinated services;
- b. providing support to clinicians and service providers to improve patient care;
- c. identifying the health needs of their local areas and development of locally focused and responsive services;
- d. facilitating the implementation of primary health care initiatives and programs; and
- e. being efficient and accountable with strong governance and effective management.

D34. Medicare Locals will, among other functions, have responsibility for assessing the health needs of the population in their region, for identifying gaps in GP and primary health care services and putting in place strategies to address these gaps.

D35. Medicare Locals will be independent legal entities (not government bodies) with strong links to local communities, health professionals and service providers, including GPs, allied health professionals and Aboriginal Medical Services. Medicare Locals will reflect their local communities and health care services in their governance arrangements.

D36. As set out in Schedule E, the Commonwealth and States will work together on system-wide policy and state-wide planning for GP and primary health care. The Commonwealth will consult with States to ensure that:

- a. Medicare Locals are taken into account in system-wide policy and state-wide planning for primary health care; and
- b. plans required to be developed by Medicare Locals take account of state-wide plans.

D37. Medicare Locals and Local Hospital Networks will be expected to share some common membership of governance bodies where possible. Medicare Locals will be expected to work closely, and establish a formal engagement protocol, with Local Hospital Networks.

D38. Medicare Locals will be subject to the performance monitoring and reporting requirements of the Performance and Accountability Framework outlined in Schedule C. The Commonwealth will be responsible for ensuring Medicare Local performance in accordance with this framework, where it applies.

D39. The Commonwealth will establish performance management arrangements for Medicare Locals, and will ensure that the States have opportunities to access performance information as part of these arrangements. The NHPA will develop and produce reports on the performance of Medicare Locals and will provide confidential advice to the Commonwealth on poor performing Medicare Locals where ongoing poor performance has been identified. The Commonwealth will decide on the nature and timing of actions to remediate ongoing poor performance. Where the NHPA finds poor performance by a Medicare Local that plans and coordinates primary care services provided by a State, the relevant State will be consulted before the NHPA issues its final performance report.

D40. States will not establish duplicate GP or primary health care planning and integration organisations. To the extent that such organisations already exist, the Commonwealth and the relevant State will work together to agree a transition plan, including timing, for the organisation then to become part of Medicare Local arrangements.

D41. The Commonwealth and States will work together to create linkages and coordination mechanisms, where appropriate, between Medicare Locals and other State services that interact with the health system, for example services for children at risk, people with serious mental illness and homeless Australians.

D42. In establishing Medicare Locals, the Commonwealth will work co-operatively with States to ensure, wherever possible, common geographic boundaries with Local Hospital Networks. These boundaries may be reviewed over time by the Commonwealth in consultation with States.

D43. Medicare Locals will engage with the following stakeholders to enable their views to be considered when making decisions on service delivery at the local level, or service and capital planning at the State level:

- a. other Medicare Locals to collaborate on matters of mutual interest;
- b. Local Hospital Networks; and
- c. the local community and local clinicians, particularly in the area of safety and quality of patient care.

Schedule E – GP and Primary Health Care

E1. GP and primary health care services are integral to an effective and efficient Australian health system. The Commonwealth will renew its efforts to improve GP and primary health care services in the community in order to improve care for patients. The Commonwealth will take lead responsibility for the system management, funding and policy development of GP and primary health care with the objective of delivering a GP and primary health care system that meets the health care needs of Australians, keeps people healthy, prevents disease and reduces demand for hospital services.

E2. The Commonwealth and the States will work together on system-wide policy and state-wide planning for GP and primary health care given their impact on the efficient use of hospitals and other State funded services, and because of the need for effective integration across Commonwealth and State-funded health care services.

E3. The Commonwealth will develop by December 2012 a national strategic framework to set out agreed future policy directions and priority areas for GP and primary health care, informed by bilateral work on state-specific plans for GP and primary health care, with state-specific plans to be completed by July 2013.

E4. As part of its lead role in the delivery of GP and primary health care reform, the Commonwealth has a range of initiatives and reforms to Australia's GP and primary health care system under way or in the process of implementation, including Medicare Locals, GP Super Clinics and infrastructure grants, the practice nurse incentive, after hours arrangements, and additional GP and allied health professional training. These programs are currently being implemented and the Commonwealth will release implementation details for these programs, and consult the States in their development, as appropriate.

E5. States will work cooperatively with the Commonwealth in the implementation and ongoing operation of the Commonwealth's primary health care initiatives.

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All information in this publication is correct as at June 2013