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**RACP feedback on Draft recommendations
from the Primary Health Reform Steering
Group: discussion paper**

July 2021

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 18,863 physicians and 8,830 trainee physicians, across Australia and New Zealand. The RACP represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, infectious diseases medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

Executive Summary

The RACP welcomes this opportunity to provide feedback on the Primary Health Reform Steering Group's (the Steering Group) Discussion Paper.

The RACP agrees that system-wide health reform is needed and that there are some fundamental service reforms that would benefit our community. The RACP has been a strong and consistent voice for national-level policy drivers to overcome fragmented and episodic care which disadvantages patients and providers, wastes resources and stymies evaluation of health outcomes, and for increasing communication and collaboration between and within healthcare providers and organisations.¹ The Steering Group has acknowledged the growing burden of chronic disease, the need to focus on population health, system integration and prevention, and that our healthcare organisational model is no longer fit for purpose. We share this view and agree with the overall direction of the recommendations.

Given that the Steering Group's recommendations are to assist in developing the Australian Government's Primary Care 10 Year Plan, our feedback suggests where the recommendations could be more nuanced, comprehensive, and better support integration where we might see significant impact on long-standing gaps in healthcare. We have provided key direction on these issues, particularly in relation to addressing the healthcare siloes that act as restraints to more effective, efficient and equitable health care provision where it concerns complex care.

Central to our feedback are these important points:

- 1) **Specialist and consultant physicians and paediatricians (referred to after this as "physicians and paediatricians") also practice in community-based ambulatory care and this should be considered when defining a 10 Year Plan for primary health care.** The purpose is to support continuity of care for both patients and health care providers and direct reform to improving health care connectivity. Healthcare for children, older persons, persons with dementia, occupational and environmental medicine are just some examples of community medicine in which there are strong links between general practitioners (GPs) – or GP specialists – and physicians and paediatricians, which we believe need to be strengthened throughout the health care system. Physicians and paediatricians are vital to the care of many health conditions involving primary care (obesity and diabetes and drug and alcohol addiction are just some of the examples). Excluding specialists from these recommendations disadvantages patients, fails to address the problem of high out-of-pocket costs and risks continuing a state of disconnected health care.

Three factors underline why any health care reform including comprehensive primary health care must include consideration of the timely and effective provision of services of physicians and paediatricians:

- The growing burden of chronic disease recognised by the Steering Group (including the burden among older persons, among children, the burden of dementia and the need to maintain the health of the many carers in the community).
- The need to better connect physicians and paediatricians with GPs to support coordinated care.
- The need to reduce hospital admissions and localise hospital service delivery where appropriate.

- 2) **The report should be oriented to reflect a genuinely comprehensive primary healthcare approach.** The report title suggests the recommendations are designed to

¹ World Health Organisation 2016 Integrated care models: an overview
http://www.euro.who.int/__data/assets/pdf_file/0005/322475/Integrated-care-models-overview.pdf [accessed 23/06/2021]

improve the primary health care landscape yet takes a narrow and unrealistic span of primary health care. The College has consistently advocated for the need to increase accessibility and reinforce continuity of care (patient-centred care) as two key elements of comprehensive community-based primary care. For this reason, there is a clear role for physician and paediatrician care to be added under recommendation 2 in relation to the Voluntary Patient Registration (VPR) program.

Our three considerations in this context, summarised here and described more fully in the feedback below, are:

- That the Steering Group consider extending the Voluntary Patient Registration to physicians and paediatricians where ongoing treatment and condition management by physicians and paediatricians is required. This is based on the principle that the need to reinforce appropriate and beneficial continuity of care applies just as much to care provided by physicians and paediatricians as it does to care provided to GPs. This would be relevant to people (including children) with complex and chronic conditions including those groups disproportionately likely to have chronic and complex conditions such as persons with disabilities, older persons and Indigenous persons.
 - That the Steering Group consider enhancing the VPR model by recommending the introduction of a longer validity period for referrals from GPs to physicians and paediatricians for patients with chronic/complex conditions who are 'registered' under such a model. This will support a comprehensive healthcare homes-oriented approach and help consumers to overcome barriers to continuity of care and control out-of-pocket costs.
 - That the Steering Group include a recommendation that all telehealth (including phone equivalent MBS items) remain available to those GPs and physicians and paediatricians nominated through the VPR process regardless of any amendments that may be made to the current COVID-19 MBS telehealth items at the end of 2021.
- 3) Given that physicians and paediatricians have a valuable role to play in comprehensive primary health care service provision that is supported by integrated care infrastructure, we ask that **the RACP be included as members of an Implementation and oversight group** for any ongoing reform of the primary health care system.

Recommendations for the Steering Group

We provide the following recommendations to the Steering Group, to ensure that the final advice to the Australian Government on the much-needed health reform in this significant area of health care will be comprehensive and effective (not in order of importance):

- 1) Reform to the primary health sector should be premised on treating primary health care as interconnected with the social, economic and environmental factors that influence health: these critical determinants of health include housing, education, the distribution of income and wealth, and the physical environment.
- 2) While the term 'comprehensive primary health care' is used throughout the document, the scope of the recommendations does not address the demographic health care needs of patients with chronic and complex health conditions, or the provision of services not tied to hospitals. We suggest that the inclusion of physicians and paediatricians may positively enhance the development of the VPR model described under Recommendation 2.
- 3) More attention needs to be given to address the provision of effective, targeted and equitable health care to older persons, Aboriginal and Torres Strait Islander peoples, persons with disabilities (including intellectual disability), those who experience socioeconomic

disadvantage, and persons with chronic conditions in a comprehensive primary health care system.

- 4) The relationship between work and health should be specifically referenced and acknowledge the importance of occupational health. This document refers to the working conditions of health care providers but not to those of the wider population or the direct relationship between work and health. The principles of the International Labour Organisation's standards for Occupational Safety and Health and the World Health Organisation's Health For All strategy are not recognised in this set of recommendations. Australia is a signatory to these standards, and they are critical and relevant to the provision of primary health care.
- 5) Rural health requires strong and specific recommendations, particularly in relation to health workforce retention. Examples where the Steering Group could make stronger recommendations include that the Australian Government:
 - Build in incentives to provide telehealth services to under-served populations. The Government should consider an equity loading or retaining the regional and remote loading; these could be provided through MBS or non-MBS means of funding.
 - Monitor and evaluate telehealth service provision and outcomes in under-served populations to ensure that telehealth is used appropriately, rather than as an inadequate alternative to direct provision of health care services to under-served populations.
 - Introduce complementary measures such as funding videoconferencing technology packages to facilitate high quality telehealth in rural and regional areas.
 - Improve patient travel assistance schemes to ensure equity and deliver real benefit to patients.
 - Guarantee long-term funding for the Rural Health Outreach Fund which aims to improve access to physicians and paediatricians, GPs, allied and other health providers in rural, regional and remote areas of Australia.
- 6) Child health and the impact of inequities should be included within the recommendations. Many children who experience inequities in health are also disadvantaged in accessing health care (for further discussion refer RACP 2018 [Inequities in Child Health Position Statement](#)). This is an area that should be prioritised in relation to evaluating outcomes. See our comments under Recommendation 7 in the body of this document.
- 7) More detail be included on what is considered a preventive care service and what further needs to be funded by the Commonwealth. Specific actions we include are that:
 - Prevention be integrated into schools and workplaces as part of comprehensive health care approaches.
 - The Steering Group should recommend that five percent of health expenditure is committed to prevention over the next five years to 2026.
- 8) Health literacy should be given greater prominence. This would include addressing health literacy, including digital literacy, among consumers and carers, increasing the health literacy of support health care workers as a significant part of the health care workforce and prioritising strategies for disability support workers, including the intellectual disability support workforce.
- 9) Oral and dental health need to be specifically included as part of comprehensive primary health care.
- 10) Direct address of the urgent needs in palliative and rehabilitation care which are largely neglected in the document should be included.

- 11) The transitions of care from children to adult services need to be made more effective in proposals for primary health reform.
- 12) Climate change and health requires direct address, noting that it has a far-reaching impact on certain demographic groups and can have greater impact on the health and well-being of persons living in certain areas.
- 13) Inclusion of the need for digital interoperability and infrastructure as fundamental to building workforce capability and sustainability.
- 14) Clinicians making medical decisions about health care need should have access to clinical ethics support services in the community which we suggest could have seed funding from the Commonwealth Government.
- 15) We recommend that the Commonwealth Government establish and recurrently resource Primary Care Dementia Nurses positions in primary health care with the view towards deploying these positions to purpose-built dementia units for those with significant Behavioural and Psychological Symptoms of Dementia who cannot be managed by non-pharmacological means and/or are aggressive and physically able.

The RACP supports the adoption of the Quadruple Aim framework in this context of national primary health reform.

Comments on key reform recommendations

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

The WHO Declaration of Alma Ata of 1978 states that “all governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors.”² A 2010 report found that Australia did not have a comprehensive primary health care system.³ Over ten years on, we suggest that the recommendations of this paper offer a somewhat confined view of the comprehensive primary health care system.

Hospital care has a valuable function, and the aim of an integrated health care system should not be simply to ‘keep people out of hospital’, as referred to in the Discussion Paper. Rather, well-implemented integration should mean that consumers are able to access the most appropriate care without unnecessary and burdensome referrals and experience collaborative care without systemic barriers to coordinated care.

Reform to the sector should be premised on treating primary health care as interconnected with the social, economic and environmental factors that influence health: these include housing, education, the distribution of income and wealth, and the physical environment.⁴

Aboriginal primary health care services which integrate health promotion, address the social determinants of health, and include primary and referred care, are examples of good practice in this respect.⁵ Effective models of care are found in Aboriginal Controlled Community Health Organisations (ACCHOs) which exhibit the effectiveness, team engagement and continuity of care enabled by a strongly patient-centred approach.

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

The RACP supports maintaining the continuity between patients and their healthcare. The wording on this recommendation could be improved to better describe the aim of primary care-based coordinated health care and the stronger support for continuity of care. Strengthening the patient relationship with a GP practice and or specific GP is one component of such care.

If this recommendation were reframed as a coordination issue less contingent on one mechanism such as a VPR, the need to sustain continuity of care as patients transition between sites of care such as aged care facilities, palliative medicine services and disability services could be promoted.

The VPR model could be enhanced if it incorporated physicians and paediatricians where ongoing treatment and management of patients with chronic and complex conditions is involved. This would make it truly “future-focused with formalised links with a large range of multidisciplinary, wrap-around community and hospital services”, as described in the Paper.

² WHO. Declaration of Alma Ata: International conference on primary health care. Alma Ata, USSR, 6-12 September, 1978. At www.who.int/hpr/NPH/docs/declaration_almaata.pdf [accessed 24/06/2021]

³ Hurley C, Baum F, Johns J, Labonte R. Comprehensive Primary Health Care in Australia: findings from a narrative review of the literature. *AMJ* 2010, 1, 2, 147-152, Doi 10.4066/AMJ.2010.201

⁴ Swerissen H, Duckett S, Moran G. Mapping primary care in Australia. Grattan Institute. 2018 Jul 29;2.

⁵ See further discussion of the importance of these in RACP 2019 Employment, poverty and health: a statement of principles https://www.racp.edu.au/docs/default-source/advocacy-library/employment-poverty-and-health-statement-of-principles.pdf?sfvrsn=d084181a_4

The outcome of such an enhancement would be comprehensive and continuous care and better collaboration between GPs and physicians or paediatricians. Such a comprehensive VPR-based approach to primary health care would deliver the key benefits of the health care homes model while adopting principal features of the multidisciplinary model of integrated, collaborative care proposed by the College in its [Model of Chronic Care Management](#):

- It would facilitate the longer term prolonged complex treatments in primary healthcare for people with complex and chronic conditions (e.g., cardiovascular or kidney-related related multi-morbidities) including those groups disproportionately likely to have chronic and complex conditions such as persons with disabilities, older persons and Indigenous persons. Continuity of care is just as important for physician and paediatrician services as it is with respect to GP services.
- GPs would be provided with additional physician and paediatrician support in managing patients with chronic and complex needs.
- It would support the collection of data relating to health outcomes and the Quadruple Aim approach.

Within a VPR framework covering both a nominated GP and physician or paediatrician for a patient with chronic and complex needs the Steering Group should consider introducing longer referral periods between participating GPs and physicians/paediatricians. While acknowledging the important 'gatekeeper' role of the GP, we suggest providing financial incentives to encourage more communication between the participating GP and physician or paediatrician within the VPR framework (for more on this see the comments under **Recommendation 3**). This would mean that the GPs would continue to be 'in the loop' irrespective of referral periods. Short referral periods are impractical and inconvenient, especially for those less likely to be mobile. In our proposed model, a close connection could be promoted between the physician/paediatrician and the nominated GP while reducing the need for unnecessary renewals of referrals.

Health reform that increases timely service accessibility is a key component of continuity of care. Therefore, we propose that the VPR model might be enhanced by building on Action 2.1.4 that recommends continuing GP MBS telehealth rebates for persons registered with a GP and practice such that the Government consider allowing all GPs and physicians and paediatricians nominated in a VPR to continue to have access to all telehealth/phone-equivalent items irrespective of other Government decisions on the temporary MBS telehealth items.

Clarity is needed on the specifics of the VPR. Any incentives associated with this voluntary scheme need to preserve patient choice and not disincentivise high quality care for all patients. The action list refers to a 'whole of population VPR' which questions its voluntary nature; to patient registration with GP practices, ACCHOs and also GPs (GPs can be mobile), which is confusing; to a formal contractual or outsourcing relationship between the Australian Government and GP practices which needs addressing; and does not provide for freedom to change the VPR or hold more than one VPR for different reasons. For example, in the United Kingdom, GPs tend to only accept patients from their catchment area. We note here that people attend numerous primary care services for different reasons, such as to seek specific referrals and prescriptions and care for stigmatising conditions such as sexual health and blood borne viruses.

It is assumed a central registry of VPRs will be maintained by the Department of Health which is an additional function that needs to be appropriately planned for and funded by the Government.

It is also important to recognise that GP practices vary considerably in their relationships with physicians and paediatricians to whom they can refer and their capacity to coordinate and advocate on behalf of patients.

We highlight that there are differences between the VPR and the performance of an effective coordination role that might be expected from a funded public community health centre (the latter is not a medical role). GP practices are small or medium sized private businesses; GPs may work part time and move between practices and regions. In such cases, a nominated GP may not be able to provide the continuity of care required for their patients.

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

This recommendation is broad, refers to many different elements and is framed as an overarching principle. We suggest it be broken into recommendations that are more actionable. It would also be appropriate to discuss here the roles of Primary Health Networks and Local Hospital Networks. We suggest that the underlying aim is to disengage the payment for care from a physical site in order to promote work within one system.

We suggest that the overarching descriptor should not frame the aim as being to “shift funds from the secondary sector to primary care” but rather to satisfactorily resource health care where it can be efficiently provided and supported by the appropriate reforms to encourage one system. The need for these siloed terms should decrease once supported by funding reforms that incentivise a continuum of care. There has been a change over time from the services that were confined to an acute hospital setting but can be now safely administered in primary care services by a GP with support – if needed – from physicians and paediatricians. Further, secondary level expertise does not need to be hospital centric. It is therefore important that artificial barriers do not prevent consumers from receiving the right care in the right place, be it the hospital or a community setting.

Recommendation 3 is aimed at fundamental system re-orientation to support integration and deliver a one system’ focus but does not define what one system entails. Instead, references are limited to primary care and to ‘other health systems’. This framing warrants elucidation. It is also important to delineate the fund holder and the locus of accountability for this recommendation to have the weight it deserves.

One of the proposed actions is “using flexible funding for individual service providers, including block and blended payment models, and bundled payment approaches aligning financial incentives with high quality care and quality improvement at an individual and population level.” We assume what is meant by this is a move to a health service financing mechanism that better mobilises existing resources, covers non-patient facing costs and incentivises high value care. This action should also describe the specifics of how these models are flexible, innovative or blended.

A key point in this context is also that health service financing models between the Commonwealth Government and the other jurisdictions need to work in tandem so that both are sufficiently reimbursed and not incentivised to cost shift.

We note that under the VPR, GPs would be able to claim a quarterly payment per patient registered. Though this would be introduced as an enrolment MBS item, it is not activity based or ‘fee for service’; that is, it is not for a direct patient facing service but instead covers non-patient facing costs. Supporting continuity of care in the blended VPR model and recognising that continuity and integrated services can only be effective with communication between healthcare providers and other non-patient facing activities, it would be appropriate to apply the same model to physicians and paediatricians. Patients with multiple comorbidities require additional non-patient facing work, such as reviewing their records for diagnostic test results, medications etc. Therefore, additional non-patient facing costs are incurred by physicians and paediatricians in the management of these patients. For intermediate level patients, comprehensive health care models can be a strategy to reduce potentially preventable hospitalisations.

Consideration should therefore be given to applying the proposed quarterly payment provision in the same way to VPR-nominated physicians and paediatricians. This payment would also cover important non-patient facing communications with GPs which are essential to a comprehensive care approach and would address any concerns arising from a longer referral period to physicians and paediatricians.

Such a VPR approach would be able to test the effectiveness of a blended payment model where registered GPs and physicians or paediatricians continue to claim fee for service for more usual patient-facing activities and also claim a quarterly payment per patient for these equally important non-patient facing activities. We note that this approach to funding also derives from the RACP [Model of Chronic Care Management](#) though it has been adapted to fit the general MBS framework retained under the VPR (our model contemplates more systemic reform including a full capitation system).

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

We support this recommendation and note again the benefits of the RACP Model of Chronic Care Management are also applicable to the complex and multiple chronic conditions that Aboriginal and Torres Strait Islander health consumers manage. It is also relevant to those in rural and remote areas where physician and paediatrician expertise is not readily accessible.

Recommendation 5 (Local approaches to deliver coordinated care): Prioritise structural reform in rural and remote communities.

This is an area in which the Steering Group should make some strong and specific recommendations, in particular regarding the critical need to maintain and enhance accessibility to the health care workforce. This recommendation should be bolstered and tailored to respond to more rural and remote community health care needs. We note that the references to the creation of Rural Area Community Controlled Health Organisations (RACCHOs) and to “supporting local private practice and PHNs to develop local infrastructure and networks” need to be further detailed.

Australian data shows that persons living in rural and remote and/or lower socioeconomic areas, persons with disability, and Aboriginal and Torres Strait Islander persons experience higher rates of illness, hospitalisation and death compared to other Australians.⁶ Evidence also points to the value of early and directly addressing potentially preventable hospitalisations in remote areas (for example, in 2017–18, a higher potentially preventable hospitalisation rate was associated with increasing remoteness.⁷). Early chronic disease management should receive dedicated resourcing and might be delivered through innovative approaches such as the RACP Chronic Care Management Model.

The health workforce issues we highlight here are:

- Given the shortage of GPs in rural areas, the reliance of the Paper on the VPR model might create unintended problems.
- The Commonwealth Government should guarantee long-term funding for the Rural Health Outreach Fund which aims to improve access to physicians and paediatricians, GPs, allied and other health providers in rural, regional and remote areas of Australia.

⁶ Australian Institute of Health and Welfare 2020. Australia's health 2020: in brief. Australia's health series no. 17 Cat. no. AUS 232. Canberra: AIHW.

⁷ Australian Institute of Health and Welfare 2019. Rural & remote health. Cat. no. PHE 255. Canberra: AIHW. Viewed 08 January 2021, <https://www.aihw.gov.au/reports/rural-remote-australians/rural-remote-health>

- There is a relative lack outside of major cities of physicians and paediatricians and primary care professionals (non-GPs) which is a potential reason for people living in non-metropolitan areas being more likely to have visited a hospital emergency department in the last 12 months (18% in outer regional/ remote/very remote areas, 16% in inner regional areas, compared to 13% in major cities).⁸

To promote access to medical care in rural and remote communities we recommend that the Australian Government:

- Build in incentives to provide telehealth services to under-served populations. The Government should consider an equity loading or retaining the regional and remote loading; these could be provided through MBS or non-MBS means of funding.
- Monitor and evaluate telehealth service provision and outcomes in under-served populations to ensure that telehealth is used appropriately, rather than as an inadequate alternative to direct provision of health care services to under-served populations.
- Introduce complementary measures such as funding videoconferencing technology packages to facilitate high quality telehealth in rural and regional areas.
- Improve patient travel assistance schemes to ensure equity and deliver real benefit to patients. A good example is the Isolated Patients Travel Accommodation Assistance Scheme operating some thirty years ago. The benefits of a national approach to patient transport should be considered here.

The Steering Group could also consider:

- The impact of COVID-19 on rural communities. For example, we understand there are shortages of nurses in rural and remote regions because they have left to work in COVID-19 vaccination and quarantine facilities, influenced by conditions of work and pay.
- The value of establishing centres of excellence in rural areas to attract and retain clinicians who might otherwise be drawn to opportunities in metropolitan areas.

Regarding action 5.3 which recommends to “Create Rural Area Community Controlled Health Organisations (RACCHOs), broadly modelled on the ACCHO model”, this may add bureaucratic and administrative burdens even while technology and health reform remove the need for separate identification of such services. The important aspects of any such arrangements are the management by the employing body, the accountability and quality of leadership and a focus on care continuity.

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

We suggest this should read “Empowering individuals, families, workplaces, carers and communities” because the workplace is an essential part of people’s health and must be acknowledged here.

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

The RACP’s feedback on this recommendation is as follows:

⁸ Australian Institute of Health and Welfare 2020. Australia’s health 2020: in brief. Australia’s health series no. 17 Cat. no. AUS 232. Canberra: AIHW.

- Provide more detail on what is considered a preventive care service and what further needs to be funded by the Commonwealth. For example, we suggest that preventive health care should not be limited to the reference given in action 7.1 to the RACGP Red Book.
- We encourage prevention be integrated into schools and workplaces as part of comprehensive health care approaches.
- The Steering Group should take a forthright approach to preventive care and its resourcing by recommending that five percent of health expenditure is committed to prevention over the next five years to 2026.
- A health promotion approach, including the need for consumer health literacy should be included under this recommendation. A “health in all policies” approach, such as used by the Government in South Australia, is needed to improve health outcomes.
- The Steering Group should ensure that proposed reforms address the impact of inequities experienced by children on their health and health outcomes. The social determinants of health impacting the lives of many children result in an increased risk for chronic issues across their health, wellbeing and development. Many children who experience inequities in health are also disadvantaged in accessing health care. Their access to quality health care (especially specialist care) is adversely affected by social determinants of health such as geography (including living in rural and remote areas), ethnicity and socioeconomic status despite increased clinical need.⁹

Because many inequities start early in childhood and increase over time – the greater a child’s disadvantage, the worse their health, development and wellbeing – we suggest this be a target for action within the Steering Group’s recommendations. Targeted and dedicated investment and intervention through primary health during a child’s early years can not only contribute to improved child and family health and wellbeing, but offset considerable healthcare and other services costs. If not responded to early, children from under-serviced and resourced backgrounds can experience poorer health in adulthood and achieve worse educational and vocational outcomes. The impact of poor primary care delivery in childhood can be intergenerational. Ongoing research on inequities in child health is also required and we strongly encourage the Steering Committee to address this need.

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

This recommendation includes actions that would improve healthcare provider and consumer experience of primary health care, such as tailoring care to a patient’s needs, delivering multidisciplinary team care and introducing navigational supports. The 2019 [RACP Model of Chronic Care Management](#) (MCCM) addresses many of the actions covered by Recommendation 8; for example, this model is based on multi-disciplinary team care that works from one shared care plan.

The MCCM makes explicit provision for a navigator/coordinator role, includes localised clinical pathway design for key population needs and involves both PHNs and LHNs in the governance and management structure. Creating an explicit navigator role in the VPR model should be considered by the Steering Group as the specifics of the coordination/navigation function remains unclear in the Paper. This function may be beyond the GPs available time and capacity.

⁹ RACP Inequities in Child Health Position Statement 2018 <https://www.racp.edu.au/docs/default-source/advocacy-library/racp-inequities-in-child-health-position-statement.pdf>

The navigator role would be a new position for which funding would need to be allocated. The RACP's Consumer Advisory Group described the time-consuming and confusing processes which many of them and their relatives experience in trying to navigate the healthcare system. This function would be a significant improvement to disjointed health care experiences.

Other comments:

- This recommendation might be given more prominence and moved higher.
- Greater clarity is needed on what is meant by "developing National Frameworks". It is not desirable to introduce further bureaucracy that requires administration, funding and evaluation; it is better to adapt existing provisions as has been done with the National Health Reform Agreement.
- Action 8.2 refers to co-design but does not state who is involved in this process.
- A patient-centred record should follow the care pathway whether through My Health Record or through a special portal supplied for the model of chronic care management.
- Increased detail would be helpful on what is meant by tailoring services through VPR (Action 8.1).

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

For any reform to be effective, it is important that clear responsibilities and accountabilities be designated. Specifying clinical leadership roles is essential for the success of health care programs, particularly for new approaches.

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

Here we suggest:

- Include the need for digital interoperability and infrastructure as fundamental to building workforce capability and sustainability.
- Clinicians making medical decisions about health care need should have access to clinical ethics support services in the community which should have seed funding from the Commonwealth.¹⁰

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

The RACP fully supports the involvement of allied health care in comprehensive primary health care models. The mechanisms for including allied health care professionals in a multidisciplinary approach should be improved to address the limitations of the MBS Chronic Disease referral-based items. Currently, allied health professionals are subject to an isolated or scatter-gun approach to referrals that are received in the context of a siloed health system. This process offers an opportunity to include allied health in models designed for clusters of conditions or certain risk levels and to address MBS item provisions.

Within primary health care, allied health care is of value even where only single or sporadic episodes of activity are necessary. Allied health professionals currently have no ability to claim rebates for their participation in case conferencing and team care activity. This can mean care is

¹⁰ [RACP Clinical Ethics Position Statement 2020](#) (December 2020)

poorly coordinated and health and wellbeing outcomes are heavily dependent on service users' health literacy and ability to guide and manage their own care.¹¹

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

The RACP feedback on this is as follows:

- We recommend that the Commonwealth Government establish and recurrently resource Primary Care Dementia Nurses positions in primary health care with the view towards deploying these positions to purpose-built dementia units for those with significant Behavioural and Psychological Symptoms of Dementia who cannot be managed by non-pharmacological means and/or are aggressive and physically able.
- The Steering Group's recommendations 11 and 12 be reversed to put nursing before allied health.
- The Steering Group consider the coordinating role described for nurse practitioners in the RACP Model of Chronic Care Management as they might relate to action 12.8 which proposes that "PHNs and State based funders should work together to pool and realign funding and integrate community health workers, including maternal and child health, child and community nurses into primary health care based on registered population numbers and demographics. This will require leveraging the NHRA Addendum 2020-2025."
- This section should also include mention of occupational health nurses.

Recommendation 20 (Implementation)

o Ensure there is an Implementation Action Plan developed over the short, medium and long-term horizons

o Ensure consumers, communities, service providers and peak organisations are engaged throughout implementation, evaluation and refinement of primary health care reform

A key element of any reform is implementation. The Discussion Paper is not clear on whether there are priorities for implementation or whether any actions are co-dependent. Greater clarity on this issue is important for successful implementation.

Other comments

Finally, the RACP suggests further focus and inclusion of these issues:

- **Climate change and health and well-being**

Climate change has a greater impact on the health and well-being of persons living in certain areas, such as those in rural and remote areas, those in low-lying, flood or bushfire-prone areas, and persons who work outdoors.¹² Other demographic groups that are at increased risk are older persons, children, persons with existing health conditions and socioeconomically disadvantaged groups.¹³ For further discussion see also the RACP 2016 [Climate change and health position statement](#).

¹¹ Allied Health Professions Australia 2019 Position Statement: Remuneration for case conferencing participation and team care coordination by allied health professionals <https://ahpa.com.au/wp-content/uploads/2018/07/180719-MBS-Position-Statement-Case-Conferencing.pdf> [accessed 5/7/2021]

¹² Australian Institute of Health and Welfare 2020. Australia's health 2020: in brief. Australia's health series no. 17 Cat. no. AUS 232. Canberra: AIHW.

¹³ Australian Institute of Health and Welfare 2020. Australia's health 2020: in brief. Australia's health series no. 17 Cat. no. AUS 232. Canberra: AIHW.

- **Oral and dental health**

Oral and dental health need to be specifically included as part of comprehensive primary health care. Without recognition of this key aspect of health and wellbeing, we overlook a major contributor to poor health and social outcomes, especially among those from lower socioeconomic backgrounds, people in regional or rural areas, some Aboriginal and Torres Strait Islander people and those with special healthcare needs.¹⁴

- **Palliative care**

Palliative care is important to community-based health services and, with an ageing population, more Australians are using palliative care services.¹⁵ Palliative care is not addressed in the Discussion Paper.

- **Health literacy**

We have already mentioned the need for improved health literacy in primary health care in our feedback.¹⁶ Support health care workers are a significant part of the health care workforce and could further benefit from strategies that increase health literacy. Disability support workers, including the intellectual disability support workforce, should be prioritised in any such strategies.

- **Evidence based medicine approach.**

We suggest that emphasis be given to an evidence-based medicine approach as the foundation for primary health care reforms, particularly in relation to clinical care. The Discussion Paper only acknowledges the importance of evidence base twice in relation to allied health and building an evidence base for implementation of the regional vanguards. We suggest that this approach be highlighted as a principle underpinning any reform efforts of in the primary care sector.

¹⁴ Australian Institute of Health and Welfare 2021 Oral and dental health care <https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/introduction> Canberra: AIHW [accessed 20/07/2021].

¹⁵ Australian Institute of Health and Welfare 2020. Australia's health 2020: in brief. Australia's health series no. 17 Cat. no. AUS 232. Canberra: AIHW.

¹⁶ Consumers Health Forum of Australia (2020) Consumer Health Literacy Segmentation and Activation Research Project. Final Report. Canberra, Australia