



CONSULTATION DRAFT

Future focused primary health care: Australia's Primary Health Care 10 Year Plan 2022-2032

October 2021

This Consultation Draft has been released for the purpose of seeking the views of people and organisations with an interest in primary health care.

Please note the Consultation Draft will inform the final Primary Health Care 10 Year Plan. It does not constitute the final position of the Australian Government.

The plan will be further considered in light of feedback provided in the consultation.

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In the extensive consultations on this plan, the generous participation of people with lived experience of the health system provided insights of fundamental value. Health professionals, peak bodies, researchers and a variety of other organisations and service providers all engaged with the future of primary health care in Australia.

We, the Department of Health, acknowledge the Traditional Owners and Custodians of Country throughout Australia. We recognise the strength and resilience of Aboriginal and Torres Strait Islander people, and acknowledge and respect their continuing connections and relationships to country, rivers, land and sea. We acknowledge the ongoing contribution Aboriginal and Torres Strait Islander people make across the health system and wider community. We also pay our respects to Elders past and present and extend that respect to all Traditional Custodians of this land.

Executive Summary

Australia's health system delivers some of the best outcomes in the world, and the continuing adaptability, responsiveness and skills of the primary health care workforce play a fundamental part.

The focus of this Consultation Draft of the Primary Health Care 10 Year Plan (the plan) is on Australia's primary health care services provided through general practices, Aboriginal Community Controlled Health Services (ACCHS), community pharmacies, allied health services, mental health services, community health and community nursing services and dental and oral health services. The plan also focuses on the integration of primary health care with hospitals and other parts of the health system, aged care, disability care and social care systems. The actions outlined in this Consultation Draft plan are subject to further decisions by Government on detailed policy and financing.

The challenges and opportunities facing Australia's health system and for primary health care and primary care services within it have been extensively consulted on and examined over a two year period to October 2021.

The well-regarded Quadruple Aim framework for optimising health system performance¹ has been adopted by the Australian Government (the Government) as the overarching aims of this plan, to:

- Improve people's experience of care.
- Improve the health of populations.
- Improve the cost-efficiency of the health system.
- Improve the work life of health care providers.

The objectives of the plan are:

- **Access:** Support equitable access to the best available primary health care services.
- **Close the Gap:** Reach parity in health outcomes for Aboriginal and Torres Strait Islander people.
- **Keep people well:** Manage health and wellbeing in the community.
- **Continuity of care:** Support continuity of care across the health care system.
- **Integration:** Support care system integration and sustainability.
- **Future focus:** Embrace new technologies and methods.
- **Safety and quality:** Support safety and quality improvement.

These aims and objectives are supported by enablers: People - at the centre of care; funding reform; innovation and technology; research and data; workforce; leadership and culture.

Over the life of the plan, the ambition is for significant shifts in the way primary health care is delivered and how individuals and communities are engaged.

The foundations for reform have already been laid, in line with previous primary care strategies and reviews and recognising major shifts in the system in response to the COVID-19 pandemic and the

¹ Bodenheimer, Thomas, and Christine Sinsky. From triple to quadruple aim: care of the patient requires care of the provider. *Annals of family medicine* vol. 12,6 (2014): 573-6. doi:10.1370/afm.1713

Bush Fire, Aged Care and Disability Royal Commissions. The reforms under way which provide strong foundations cover:

- On the COVID-19 MBS-funded telehealth measures, consideration of continuing these into the future and combining this with voluntary patient registration to provide a continuity of care framework for the delivery of safe, quality care.
- Voluntary patient registration (VPR) as a platform for funding reform.
- Improving access to rural health, with continuing investments in the Stronger Rural Health Strategy.
- Closing the Gap to support quality person-centred, integrated care for Aboriginal and Torres Strait Islander people.
- Steps to improve the use of data, evaluation and research.
- Joint planning and collaborative commissioning, including to deliver on the intent of the 2020-2025 National Health Reform Agreement (NHRA).
- After hours care access to appropriate care.
- Better health care for: mental health; for older Australians; people with disability; people from culturally and linguistically diverse (CALD) backgrounds; Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) people; people in socioeconomically disadvantaged circumstances; prevention and management of chronic conditions; and parents and children in the first 2,000 days.
- Workforce strategies across a range of professions.
- Greater focus on allied health.
- Investments in emergency preparedness and response.
- Digital health infrastructure.

The plan builds on these foundations across three reform streams:

- **Stream 1 – Future focused health care:** This is about embracing the future - using the opportunity of technology to drive improvements in care access, quality, value and integration.

There are three action areas:

- A. Support safe, quality telehealth and virtual health care.
- B. Improve quality and value through data-driven insights and digital integration.
- C. Harness advances in health care technologies and precision medicine.

- **Stream 2 – Person-centred primary health care, supported by funding reform:** This stream leverages VPR as a platform for reforming funding to incentivise quality person-centred primary health care. Over time, a greater proportion of funding in primary health care will move to payments incentivising quality and outcomes and ensuring access to quality care in areas of market failure. This stream of actions will also address gaps in access to appropriate care for population groups at risk of poorer outcomes, incentivise multidisciplinary team-based care approaches and get people more engaged in preventive health and their own health care.

There are six action areas:

- A. Incentivise person-centred care through funding reform, using VPR as a platform.
- B. Boost multidisciplinary team based care.
- C. Close the Gap through a stronger community controlled sector.

- D. Improve access to primary health care in rural areas.
- E. Improve access to appropriate care for people at risk of poorer outcomes.
- F. Empower people to stay healthy and manage their own health care.

- **Stream 3 - Integrated care, locally delivered:** This stream is about delivering regionally and locally integrated health service models through joint planning and collaborative commissioning at regional and state-wide levels. Actions in this stream are designed to support local solutions, use joint planning and collaborative commissioning approaches to drive value-based care and address gaps in service delivery, and build on best-practice models and community-driven solutions. Leadership will be required across all governments, organisations and disciplines to deliver value and make these changes work.

There are three action areas:

- A. Joint planning and collaborative commissioning.
- B. Research and evaluation to scale up what works.
- C. Cross-sectoral leadership.

Actions under the Consultation Draft of this plan are subject to further Government decision-making. The intention is for the final plan to provide an agenda for primary health care reform over the next decade, providing a framework for Government decision-making at each step along the way.

To support effective implementation of the plan, an Implementation Oversight Group will be established in the first year with high-level representation from across the sector and stakeholder groups. An evaluation framework will be developed by the end of 2022, with whole-of-plan evaluations at the year 3 (2024-25) and year 6 (2027-28) points, to inform adaptations, with a final evaluation in year 9 (2030-31) to help inform future plans and strategies.

1. Introduction

1.1. What is primary health care?

Primary health care, according to the World Health Organization (WHO)/UNICEF definition, “is a whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people’s needs and as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people’s everyday environment.”²

Primary care, on the other hand, in Australia refers to those services in the community that people go to first for health care: general practices, ACCHS, community pharmacies, many allied health services, mental health services, community health and community nursing services and dental services. It is differentiated from secondary care delivered by specialists, where a referral is usually required, and tertiary care delivered in hospitals.³

This plan focuses mostly on arrangements for primary care services in Australia, but considers them in the broader context of the WHO/UNICEF definition of primary health care - taking account of the need for equitable access to health care, the need to consider the social determinants of health and the need for more emphasis on prevention. The plan also considers the interactions between primary care services, specialist and hospital services, the aged care and disability care systems, and other social support systems.

1.2. Why does primary health care matter?

Countries with strong primary health care systems are more adaptable and flexible and better able to respond to rapid economic, technological, and demographic changes, all of which have an impact on population health and wellbeing. Primary health care is essential to achieving universal health coverage and focusing on the wider determinants of health, which are crucial to improving health outcomes.⁴ Effective primary health care can improve health outcomes at a lower cost than hospital and secondary care and helps to avoid unnecessary hospitalisations. Countries with strong primary health care systems have better health outcomes.⁵

1.3. The Primary Health Care 10 Year Plan process

Australia’s health system delivers some of the best outcomes in the world. In 2021, the Commonwealth Fund ranked Australia’s health system in the top three among high-income Western countries, with the highest ranking for health outcomes and equity and the second highest ranking

² WHO and UNICEF. A vision for primary health care in the 21st century: towards universal health coverage and the Sustainable Development Goals. Geneva: World Health Organization and the United Nations Children’s Fund (UNICEF), 2018 (WHO/HIS/SDS/2018.X). Licence: CC BY-NC-SA 3.0 IGO.

³ While emergency departments and ambulance services may be the first interaction with the health system for some episodes of care, the operation of these services is not the focus of this plan. One of the objectives of this plan is to reduce demand on emergency departments and ambulance services by keeping people well in the community.

⁴ WHO, (2018), A Vision for Primary Health Care in the 21st Century. WHO, Fact Sheet, Primary Health Care, <https://www.who.int/news-room/fact-sheets/detail/primary-health-care>.

⁵ OECD 2017. Health at a glance 2017: OECD indicators. https://doi.org/10.1787/health_glance-2017-en.

for administrative efficiency.⁶ Primary care services in Australia make a significant contribution to these strong outcomes.

In August 2019, the Government commissioned the development of a Primary Health Care 10 Year Plan, as part of its Long Term National Health Plan, with the ambition of making Australia's the best health system in the world.⁷ In October 2019, the Steering Group was appointed, with representation from general practice, nursing, allied health, mental health consumers, researchers and rural health organisations, to guide the development of the 10 Year Plan.⁸ Between November 2019 and July 2021, the Steering Group and the Department of Health (the Department) conducted extensive consultations on the development of the plan. These included:

- A Consultation Group drawing in more than 100 organisations from across the health system, held in November 2019.
- More than 20 roundtables and targeted consultations with consumer, population and provider groups and on various issues for primary health care, including: consumers, rural and remote health, Aboriginal and Torres Strait Islander health, health and the first 2,000 days of life, the health of older Australians, dementia care, preventive health, general practice, nursing and midwifery, allied health, practice managers, mental health, after hours care, the health of people with disability, the health of culturally and linguistically diverse (CALD) communities, LGBTI health, Primary Health Networks (PHNs), private health insurance and future focused health care.
- Intensive targeted consultations were also held on the health of people with intellectual disability, resulting in the finalisation of the National Roadmap for Improving the Health of People with Intellectual Disability in association with this plan. Each of these roundtables and targeted consultations heard from people with lived experience and involved relevant stakeholder groups, researchers and other experts.
- The Steering Group conducted a consultation on its draft recommendations in June/July 2021, with an associated webinar and submissions process. Over 210 responses were received from interested organisations and individuals.
- The consultations highlighted many challenges and opportunities facing Australia's health system and for primary health care and primary care services within it. Some of the key messages emerging throughout the process included:

Access to appropriate care

- Aboriginal and Torres Strait Islander people overall continue to have less equitable access to appropriate, culturally safe care and significantly poorer health outcomes than other Australians. Nonetheless, the comprehensive primary health care services delivered through ACCHS provide an exemplary model for funding and delivery of primary care services in Australia.
- People living in rural and remote areas have more limited access to health care services and poorer health outcomes than people living in metropolitan areas.

⁶ Mirror Mirror 2021 – Reflecting Poorly: Health Care in the U.S. compared to other high-income countries, Commonwealth Fund 2021.

⁷ A guide to links between the Long Term National Health Plan, this plan and associated plans, strategies and frameworks is at Annex B.

⁸ Membership of the Steering Group is listed at Annex A.

- Older Australians, particularly people living in residential aged care facilities, can struggle to access quality health care, as highlighted in the Royal Commission into Aged Care Quality and Safety. More could be done to help older people living in their own homes from declining into frailty and to keep older Australians, wherever they live, out of hospital.
- People from CALD backgrounds face language, cultural and other barriers to accessing appropriate health care.
- People with disability experience higher levels of chronic and preventable diseases, face barriers to accessing appropriate care and die younger than other Australians.
- LGBTI people continue to face attitudinal and other barriers to accessing quality, appropriate care.
- People experiencing mental illness also experience poorer overall health outcomes and can experience challenges seeking and attaining care for physical health conditions.

Integrated person-centred-care

- Australia's health system is hard to navigate, particularly for parents of young children, older Australians and their carers, people with complex chronic conditions, people with disability and their carers, people from CALD backgrounds, LGBTI people, people in socioeconomically disadvantaged circumstances and people experiencing mental illness.
- People have to tell and retell their stories to each health care provider they see, with an associated burden of time, effort, frustration and in some cases reinforced trauma. While some gains have been made with the My Health Record and other electronic health record systems, digital health systems are not routinely interoperable and do not provide a comprehensive readily accessible record for patients and providers. Secure messaging among providers and between providers and patients does not routinely occur.
- Comprehensive data about what happens in primary care is not systematically available for policy and research purposes nor routinely linked with hospital and other data to improve patient experience and outcomes and health system efficiency.
- Greater specialist outreach to primary care settings and GP in-reach to hospital settings can improve patient and provider experience of care and deliver efficiencies for patients, providers and the system.
- Navigational difficulties, fractured care and lack of support for secure information sharing are also experienced at the interface between the health and aged care, disability care and other social care systems.
- With more investment in prevention and primary care services, the health system could see fewer hospital attendances and admissions.
- Strategic, collaborative commissioning approaches between PHNs and Local Hospital Networks (LHNs) under the NHRA show significant promise in delivering more integrated, value-based care pathways at local and regional level.

Funding models

- Funding models for primary care services, particularly the Medicare Benefits Schedule (MBS) fee for service structure, tend to reward volume of services provided over value and quality of care. Moving over time to more blended payments – a mix of fee for service and block payments made per patient and/or for quality and outcomes, with fee for service a lower proportion of the mix – would balance the incentives in the system.

- Greater investments in primary health care would result in savings in hospitals and other parts of the health, aged care and disability care systems. Such investments need to be guided by analysis of the best available data and evidence.
- Current funding models do not sufficiently incentivise team-based care within practices, across different practices and across the different parts of the health and related care systems.
- Funding models for allied health, nurse practitioners, nurses and others need to be better developed to support the delivery of effective, appropriate care in viable business models.
- Funding arrangements need to recognise the different business models in primary care settings – from solo and small practices through small and medium enterprises, Aboriginal Community Controlled Health Services and corporate organisations – and the different interests of corporations, practices and individual practitioners.
- Funding arrangements also need to recognise the different challenges of providing care in urban, regional, rural and remote settings.

Workforce

- Greater incentives and reduced barriers are needed to attract more medical students into general practice over other specialities.
- The primary health care workforce is maldistributed with shortages of doctors, nurses and allied health professionals in rural and remote areas. While existing programs to address this workforce maldistribution are welcome, more sustainable local community-led approaches are needed.
- Harmonisation of funding models across the health, aged care, disability care and other systems could help optimise the allocation of nurses, allied health and other workforces across different care settings.
- Leadership and cultural shifts are needed to support effective team-based care across professions in the primary health care and broader health care system and to supporting each profession to work to full scope.

Future focus

- The COVID-19 pandemic has proven the value of telehealth funded through the MBS as a vital part of the future service mix. The safety and quality of telehealth can best be assured in the context of an ongoing relationship between practice, provider and patient.
- Primary health care needs to be better integrated into emergency preparedness and response at local, jurisdictional and national level to prepare for future droughts, floods, bushfires, communicable disease outbreaks and other emergencies.
- Quality telehealth and virtual health care models carefully designed to complement and not replace face to face care, particularly in rural and remote settings, can significantly enhance access to safe, quality care.
- More support is needed for primary health care research. Best practice health system innovations at regional level, for example regional health data linkage projects, the integration of non-dispensing pharmacists in primary health care teams and aged care settings, approaches to identifying and managing domestic and family violence in primary care settings, need to be systematically evaluated and scaled up.
- Systems are needed to support the safe, quality adoption of genomics and precision medicine, point of care testing and other technologies in primary health care settings as such technologies advance and are proven cost-effective.

2. Aims, objectives and enablers

Throughout the consultation process to date, a set of aims, objectives and enablers for the plan were tested and refined and received broad support. These aims, objectives and enablers and the strategies and actions outlined in this plan build on and are consistent with previous directions in primary health care reform, including but not limited to:

- The Coordinated Care Trials of the late 1990s and early 2000s.
- The 2013 National Primary Health Care Strategic Framework.
- The recommendations of the Primary Health Care Advisory Group which reported in 2015.
- The recommendations of the Expert Advisory Group on primary care which reported in 2018.
- The 2020-2025 NHRA.

2.1. The Quadruple Aim

The Quadruple Aim is a well-regarded framework for optimising health system performance which has been recommended by the Steering Group to provide overarching aims for the plan. The Government agrees that the overarching aims of this plan are to:

1. Improve people's experience of care.
2. Improve the health of populations.
3. Improve the cost-efficiency of the health system.
4. Improve the work life of health care providers.

2.2. Objectives

The objectives of the plan are:

Access: Support equitable access to the best available primary health care services.

Close the Gap: Reach parity in health outcomes for Aboriginal and Torres Strait Islander people.

Keep people well: Manage health and wellbeing in the community.

Continuity of care: Support continuity of care across the health care system.

Integration: Support care system integration and sustainability.

Future focus: Embrace new technologies and methods.

Safety and quality: Support safety and quality improvement.

2.3. Enablers

The enablers of the plan are:

People: People need to be at the centre of care. Patient activation - motivating people to engage actively in their own health care - is essential to the success of this plan. Patient-reported experience measures and patient-reported outcome measures will become critical measures of success.

Funding reform: Funding arrangements need to change over time to better incentivise behaviours from people, providers and organisations to advance the seven reform objectives.

Innovation and technology: In implementing the plan, successful innovations that advance the aims and objectives of this plan should be identified, evaluated and scaled up. Technological advances should be assessed and where they are safe, quality and cost-effective, embraced in the system.

Research and data: Continued investment in research and data is essential to evaluating innovation and targeting investments to where they can deliver the greatest value against the aims and objectives of this plan.

Workforce: Care cannot be delivered without an appropriately trained and skilled workforce. Australia's highly trained and skilled primary health care workforce should be appropriately valued, rewarded and supported. Continued investments are needed to train and grow the workforce to meet the needs

Leadership and culture: Cultural shifts are needed across the professions to effectively deliver multidisciplinary team-based care and an integrated care system, and to enable each element of the workforce to work to full scope.

These aims, objectives and enablers, and the actions set out in the remainder of this plan, should be read in the context of and as a high level response to the Steering Group's recommendations.

The Steering Group has recommended, and the Government accepts, the following ambitions for the health care system over the life of the plan, as shown in Figure 1.

Shifts in primary health care

From ► An illness system	To ► A wellbeing system
From ► Patient management with a focus on 'what is the matter with patients'	To ► Patient activation and person-centred care with a focus on 'what matters to patients'
From ► A focus on treatment	To ► A focus on health promotion and prevention, while ensuring safe, quality care is provided when people need it
From ► Multiple independent and sometimes competing providers	To ► A coordinated and integrated multidisciplinary health care team focused on serving people (including across providers, provider-types, health care sectors and non-health sectors)
From ► A volume-based system	To ► A value-based system
From ► A fragmented system	To ► A coordinated and interconnected system

Figure 1: Shifts in Primary care

3. Foundations for reform

In line with previous reform directions and during the period of the development of this plan, which has included the COVID-19 pandemic and the Bush Fire, Aged Care and Disability Royal Commissions, the Government has been investing in a series of measures which lay important foundations for primary health care reform (see figure 2).

Foundations for primary health care reform



Figure 2: Foundations for primary health care reform

3.1. MBS-funded telehealth

In March 2020, as a core part of its response to the COVID-19 pandemic, the Government introduced for the first time national access to telehealth, by telephone and video, and across general practice, specialist and allied health services, funded by the MBS. Previously, MBS-funded telehealth was limited to rural and remote areas, and with significant conditionality. The introduction of national access to MBS telehealth has been universally welcomed as a transformational change in the delivery and funding of primary health care services in Australia. The Government will in coming months consider the future of MBS telehealth arrangements.

Over the period of the pandemic, implementation of MBS telehealth has adapted to lessons learned from the pandemic experience, and such lessons need to continue to be considered through the life of this plan.

Face to face care remains a vital part of safe, quality, comprehensive primary health care and needs to be supported and maintained. Digital-only models of care, while providing convenience in some circumstances, do not necessarily provide the same quality and safety of care and cannot deliver some care services. Such models also threaten the viability of general practices delivering face to face services, particularly in rural and remote areas. The MBS telehealth rules therefore generally require people to have had recent face to face contact with a general practice from which they are seeking telehealth services to qualify for public subsidy.

There is also recognition that in some particular circumstances, people do not wish to seek care from their usual general practice but publicly supported access to telehealth remains desirable, and exemptions supporting access to MBS telehealth with other general practices have been made available in those circumstances. These include, for example, consultations on sexual and reproductive health matters and for drug and alcohol counselling. In other circumstances, exemptions have been supported for people who do not have a usual general practice, for example for new-born children and for people experiencing homelessness.

Throughout the pandemic period, general practice has delivered over 95% of MBS telehealth services by telephone rather than video technologies. The Government continues to support the approach of delivering telehealth by telephone, recognising the difficulties of access and implementation of video technologies in some areas and for some population groups. Nonetheless, noting the importance of visual cues in patient assessment and other evidence on the quality and safety of telehealth care, video has the potential to support a higher quality of care. As access to and useability of technology improves, the Government would expect increased use of video to deliver telehealth services. Initial changes were made in July 2021 to the range of general practice MBS items claimable for telephone services and the Government will continue to monitor this issue with a view to increasing the uptake of video for telehealth service delivery.

3.2. Voluntary patient registration

To help support a future in which quality, safe MBS telehealth is delivered in the context of a continuity of care relationship between people and their usual doctor and general practice, the Government has invested over \$69 million in Services Australia since 2020 to support a future VPR system.

Consultations on the plan have contemplated a future system of VPR, based on patient choice:

- Open on a voluntary basis to all Medicare-eligible people and to all general practices accredited, or on the pathway to accreditation, against the Royal Australian College of General Practitioners (RACGP) Standards for General Practice.
- Where people who choose to participate would register with their usual general practice and nominate their usual doctor.
- With qualifying criteria for people wishing to register of three face to face visits to the practice in two years for most people, and a lesser requirement of one face to face visit for people in remote areas (Modified Monash 6 and 7) and for ACCHS. Children under 18 would not need to meet the qualifying criteria if their parent was already registered, and vice versa, to assist families to register. People would only need to visit the practice face to face once every two years to maintain registration with that practice. People could change the practice with which they are registered at any time after the qualifying number of visits or withdraw their registration at any time.
- Where the initial benefit for people of VPR would be continuing access to quality, safe MBS telehealth with the practice with which they are registered in the context of a relationship of continuity of care.
- Where care would improve over time as doctors and practices would gain a better understanding of the population of people who see them as their usual doctor and usual practice. Doctors and practices would gain initial benefits through being assured that 'usual doctor' MBS items such as health assessments, chronic disease management plans and medication reviews would be delivered to their registered patients only by the usual doctor or members of the usual doctor's practice. Over time, doctors and practices would become eligible for increasing benefits for providing quality care and improving health outcomes for their registered patient population.

The Services Australia system build has the above parameters of VPR in mind. It is proposed, subject to the consultation on this plan and the Government's decisions following the consultation, that the VPR system would open for registration in July 2022 and that MBS telehealth for general practice would become contingent on the patient being registered with the practice from 1 July 2023. The 'usual doctor' requirements for MBS health assessments, chronic disease management plans and medication reviews would also be linked to VPR for registered patients from that date.

3.3. Funding reform

Primary care services in Australia, particularly general practice, are highly dependent on fee for service arrangements subsidised through the MBS. About 10% of Government funding for general practice is linked to quality and outcomes payments through the Practice Incentives Program (PIP), the Workforce Incentive Program (WIP) and the Indigenous Australians Health Program (IAHP), while about 90% is delivered through the MBS on a fee for service basis. The Steering Group has recommended that, over time, funding models can be blended and tailored to provide the right balance of incentives to achieve person centred, high quality, integrated primary health care.

The Government has been moving to reform funding for general practice and other primary health care services over the past several years and to investing more in general practice.

3.4. Rural health

Investments in rural health to address the inequities of access to health services and poorer health outcomes among people in rural and remote Australia have been a strong focus for the Government.

In 2017 the Government appointed the first National Rural Health Commissioner to develop a new National Rural Generalist Pathway to increase access to training for doctors in regional, rural and remote Australia, to work with Government and the health sector to enhance policy and promote opportunities of careers in rural health, and to develop options for increased access to training and appropriate remuneration for rural generalists.

In 2018-19 the Government announced the Stronger Rural Health Strategy to achieve stronger rural, regional and remote health outcomes by aligning the distribution of the health workforce to areas of greatest need and building the capability of Australia's health workforce.

In 2021-22 the Government made further investments in the Stronger Rural Health strategy, including to:

- Increase the Rural Bulk Billing Incentive for rural and remote medical practice.
- Expand the Allied Health Rural Generalist Pathway to support more allied health professionals to train in rural and remote Australia.
- Continue development of the Bonded Return of Service System to support implementation of the Bonded Medical Program.
- Fund community supported rural primary care trials.
- Provide additional rural primary care training rotations for junior doctors.
- Fund innovative activities and continued professional development for rural medical specialist trainees.

Through the 7th Community Pharmacy Agreement (2020-2025) the Government is also investing significantly in rural support programs to ensure access to PBS medicines and pharmacy services for people living in rural and remote areas.

3.5. Closing the Gap

The Government is working with Aboriginal and Torres Strait Islander people, their communities, organisations and businesses to implement the 2020 National Agreement on Closing the Gap (National Agreement) at national, state and territory, and local levels. In August 2021, the Government released the Commonwealth Closing the Gap Implementation Plan detailing current and future Commonwealth actions. This will be complemented by a refreshed Aboriginal and Torres Strait Islander Health Plan aligning health policy with the National Agreement.

Commonwealth actions are under way to support the strengthening of the ACCHS sector including a four-year funding commitment to provide surety for the provision of culturally safe and appropriate primary health care services in approximately 300 clinics across Australia. Investments have been made to boost the Indigenous health workforce and provide additional training to support Aboriginal health care workers to deliver culturally safe care.

Structural changes have been made to the PIP Indigenous Health Incentive (PIP IHI) payment to improve continuity of care and health outcomes and the Commonwealth continues to invest in Aboriginal and Torres Strait Islander health research.

Other primary health care reforms under way to address Closing the Gap targets include reducing youth suicide in Aboriginal and Torres Strait Islander communities. Investments have been made to support culturally safe crisis services and initiatives under a renewed National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.

To ensure that Aboriginal and Torres Strait Islander mothers and babies get the best possible care and support for a good start to life, the Government has also committed \$45 million to a Healthy Mums and Healthy Bubs program and improving early identification of hearing and speech difficulties. The Government has also committed an additional \$254.4 million in August 2021 to infrastructure to better support the work of the ACCHS.

3.6. Data, evaluation and research

The Government's investments in the PIP Quality Improvement incentive have seen more than 5,700 general practices sharing data with their local PHNs in 2020-21 to support quality improvement activity. Over 95% of these have shared full data sets rather than the minimum required 10 PIP QI indicators. In addition to quality improvement at practice level, this data sharing provides a strong basis for population health and health system planning at regional level. The Australian Institute of Health and Welfare (AIHW) released its first report in September 2021 on the national data covering the 10 PIP QI indicators. These developments are helping to underpin work by the AIHW on a national primary care data asset.

In New South Wales (NSW), many practices and PHNs are participating in the Lumos data project, supported by the NSW Government and the Commonwealth under the NHRA. Lumos supports linkage of data at regional level to understand better what is happening to people across the health system and to drive value-based care. Linkage has started with general practice and hospital data, providing feedback to general practices on their success in diagnosing and treating patients in the community and avoiding preventable hospital attendances and admissions, with ambitions over time to bring in other aspects of the health care and social care systems into the linkage arrangements. This is the standard of effective use of data which the Government would like all regions around Australia to reach.

The Government has commissioned a consultation Regulation Impact Statement (RIS) process to examine what more can be done to strengthen primary health care data sharing arrangements for non-commercial research and policy purposes, with a report due in the second half of 2022.

The Government also continues to invest in evaluation of primary health care initiatives to inform future policy and to support the identification and scaling up of best practice. The first two stages of the Health Care Homes (HCH) [trial evaluation](#) have been published on the Department of Health website, with the final stage evaluation due in the first half of 2022. An evaluation of the COAG s19(2) rural and remote health initiative is near completion and due to report before the end of 2021. An independent review of the general practice accreditation scheme is under way and will inform future improvements. Evaluations of regional initiatives across a range of areas – enhanced primary health care for people with intellectual disability, allied health, pharmacy, palliative care, delivery of general practice services into aged care – will inform the refinement and potential scaling up of those initiatives in the future.

The National Health and Medical Research Council (NHMRC) and the Medical Research Future Fund (MRFF) continue to be the Government's main mechanisms for supporting research in health. The MRFF is investing \$45 million over 9 years in its Primary Health Care Research Initiative, with other streams of funding linked to primary health care including: the Preventive and Public Health Research initiative; the Dementia, Ageing and Aged Care Mission; Cardiovascular Health Mission; Genomics Health Futures Mission; Indigenous Health Research Fund; and Million Minds Mental Health Research Mission.

3.7. Joint planning and collaborative commissioning

The sharing and in some cases linkage of data at regional level between PHNs and LHNs, exemplified by the Lumos project discussed at 3.6 above, is supporting more effective approaches to population health needs assessments, joint planning and collaborative commissioning, consistent with the 2020-2025 NHRA.

- Every PHN region across Australia in 2021 has a joint mental health plan with its LHN counterpart(s).
- The NSW Ministry of Health, NSW PHNs and the Department have signed a joint declaration on how they will work together on joint planning and commissioning approaches, with a growing program of work.
- Victoria has been funded under the NHRA to develop data sharing arrangements and linked data sets with PHNs at regional level.
- The Department and Queensland PHNs are working with Queensland Health on data sharing and joint planning and on regional commissioning projects including, for example, strengthening primary health care services in the Torres Strait and Cape York region through Indigenous community-led commissioning.

The Commonwealth continues to invest in PHNs as a vehicle for collaboration and commissioning at regional level and, to deliver on the intent of the NHRA, will continue to pursue collaboration with each State and Territory in this way.

3.8. After hours care

The Government has continued to support after hours primary health care services to ensure access to appropriate care and reduce demand on public hospital emergency departments. This investment includes support for the healthdirect helpline in every state and territory except Queensland, subsidies for after hours GP services through the MBS, the PIP after hours incentive to encourage general practices to make after hours arrangements for their patients, the PHN after hours program to fill gaps in after hours services at regional level and arrangements for approved medical deputising services to provide after hours services. The Government will consider future policy for after hours services in the context of this plan and the 2020-21 evaluation of the PHN after hours program.

3.9. Better health care for older Australians

The Royal Commission into Aged Care Quality and Safety highlighted shortfalls in the provision of primary health care services, including general practice, mental health and allied health services, to older Australians, particularly in residential aged care facilities. The Government took significant steps in responding to the Royal Commission's recommendations in the 2021-22 Budget with a \$17.7 billion package of reforms. This included increasing access to MBS subsidies for mental health and allied health for aged care residents, improved dementia care pathways, a boost to the PIP aged care access incentive and a range of regional level supports to improve GP, allied health and palliative services in residential aged care.

Building on these reforms, the Government is looking, through this plan, to help slow the decline of older Australians into frailty and the need for home care supports and residential care, and to reduce unnecessary emergency department attendances and hospital admissions among older Australians by providing more effective primary health care in the community.

3.10. Better mental health care

As part of the 2021-22 Budget, the Government announced a \$2.3 billion investment as part of its National Mental Health and Suicide Prevention Plan. This plan will invest \$1.4 billion in high quality and person-centred treatment, which includes the development of a national network of mental health treatment centres for adults, youth and children through the Head to Health and headspace programs. This builds on the Government's significant existing investment in mental health services for Australians throughout the 2019-20 bushfires and COVID-19 pandemic. This brings the total estimated mental health spend to \$6.3 billion in 2021-22 in the Health portfolio since 2013.

Nationally, in December 2020, the National Cabinet committed to a National Mental Health and Suicide Prevention Agreement (National Agreement) being negotiated through the Health National Cabinet Reform Committee. The aim of the National Agreement is to achieve systemic, whole-of-government reform to deliver a consumer-focused mental health and suicide prevention system with joint accountability and clear funding arrangements across all governments. The National Agreement will consider recommendations from key mental health reports and inquiries, including the Productivity Commission Inquiry into Mental Health, the National Suicide Prevention Adviser's advice and the Royal Commission into Victoria's Mental Health System. The National Agreement is being developed with states and territories.

Private primary care services, particularly general practices and psychologists, continue to provide a significant proportion of mental health care. It is important therefore that this plan addresses the interface between primary care and mental health services in a one health system approach.

3.11. Better care for people with disability

Implementation of the National Disability Insurance Scheme (NDIS) has been welcomed as improving the certainty and delivery of disability supports. The provision of health care for people with disability remains the responsibility of the health system and people with disability, like all people, have a right to the highest attainable state of health.

The Government has been moving to address some longstanding inequities in health for people with intellectual disability, who face barriers to accessing appropriate care, in some cases experience discriminatory treatment and suffer poorer health outcomes and life expectancy than other Australians. In August 2021, following an extensive period of consultation with people with intellectual disability, their families, carers and advocates, clinicians, researchers, health service providers and educators, the Government released the [National Roadmap for Improving the Health of People with Intellectual Disability](#) (the Roadmap).

The Roadmap sets out a series of short, medium and long-term actions to: improve support for people with intellectual disability, their families and carers; develop better models of care for people with intellectual disability; support health professionals to deliver quality care for people with intellectual disability; improve the oral health of people with intellectual disability; improve monitoring of the health of people with intellectual disability; and ensure that the needs of people with intellectual disability are considered and met in emergency plans and responses. The Roadmap forms part of this plan.

Building on this work, the Department has established the COVID-19 Disability Advisory Committee to advise the Chief Medical Officer on the response to COVID-19 for people with disability. The Department has also established, with the Department of Social Services, a Disability Health Services Consultative Committee to provide a continuing platform to discuss and address the health needs of

people with disability. The Government is looking to this plan and Australia's Disability Strategy 2021-2031 (to be released by the end of 2021) as a basis for further work at the health-disability interface to improve the health and wellbeing of people with disability.

3.12. Better care for people from culturally and linguistically diverse backgrounds

The COVID-19 pandemic has highlighted the difficulties that people from CALD backgrounds have in accessing health care and the impact this has on health outcomes. The Department has been consulting the COVID-19 Culturally and Linguistically Diverse Advisory Committee to inform the pandemic response, and will be establishing ongoing mechanisms for consulting with CALD communities to continue to improve the health system to better meet their needs. In the 2021-22 Budget the Government made an initial investment in better primary health care for people from CALD backgrounds by improving the accessibility of the healthdirect helpline for CALD communities.

3.13. Better care for LGBTI people

LGBTI people can also face barriers and discrimination in accessing appropriate health care and continue to suffer poorer health outcomes than other Australians on several indicators. The Government has responded to the needs of LGBTI people across many areas of the health system, for example in supporting the listing of PrEP on the Pharmaceutical Benefits Scheme (PBS) and providing more flexible access to MBS telehealth for sexual and reproductive health and drug and alcohol counselling. In the aged care sector, significant progress has been made over recent years in improving the accessibility of aged care services for LGBTI people. Drawing on these examples and in consultation with the LGBTI community, the Government will consider opportunities to improve the accessibility and appropriateness of primary health care services for LGBTI people over the life of this plan.

3.14. Prevention and management of chronic conditions

Prevention is an essential part of the primary health care mix. The Government has continued to support preventive health, including through: early detection programs such as cancer screening and newborn bloodspot screening; free immunisation to protect people against disease; the National Strategic Framework for Chronic Conditions to prevent and reduce chronic conditions; the whole-of-government National Obesity Strategy to tackle overweight and obesity; a whole-of-government drug strategy to reduce, prevent and treat drug use; the National Tobacco Strategy to reduce smoking rates; the National Alcohol Strategy to prevent and reduce alcohol-related harm; education and awareness campaigns such as anti-smoking campaigns; physical activity guidelines; dietary guidelines; the Health Star Rating system; and the Healthy Food Partnership.

The Government has completed consultations on a National Preventive Health Strategy, which is due to be released by the end of 2021. Primary health care providers have an important role to play in delivering preventive health interventions and helping slow or reverse the progression of chronic disease, and the Government is looking to the actions in this plan to contribute to this.

3.15. First 2,000 days

The Government is committed to improving health outcomes for parents and children in the first 2,000 days of life, which have major impacts on the rest of people's lives. Important initiatives in this area include implementation of the former COAG Health Council's agreed 2019 policy Woman-centred care: Strategic directions for Australian maternity services, and the Government's National

Action Plan for the Health of Children and Young People 2020–2030. Following a Senate Inquiry into Stillbirth Research and Education, the Government developed a National Stillbirth Action and Implementation Plan launched in December 2020, with funding support for a range of implementation measures and significant investments in perinatal mental health. As part of the Commonwealth Closing the Gap Implementation Plan released in August 2021, the Government is making significant new investments in the Healthy Mums Healthy Bubs program in Aboriginal Community Controlled Health Services. Through this Primary Health Care 10 Year Plan, the Government is seeking to take additional actions to improve health in the first 2,000 days.

3.16. Workforce strategies

The Government recognises the critical role of a highly skilled workforce in delivering high-value primary health care services. The Government has invested significantly in teaching and training support, including general practice training and funding for Commonwealth supported places across all health disciplines; a range of measures to support nursing; implementation of the Workforce Incentive Program; and the development of the HeaDS UPP tool. Since 2018, sustained attention has been paid to rural health workforce attraction and distribution and to creating a rural generalist pathway through the Stronger Rural Health Strategy.

The National Medical Workforce Strategy is due for release by the end of 2021. This will include: collaborative national medical workforce planning; addressing geographic maldistribution; addressing imbalances between specialist disciplines, subspecialisation and generalism; improving junior doctors' work and wellbeing; growing the Aboriginal and Torres Strait Islander medical workforce; and reducing reliance on locums and international medical graduates.

The Chief Nursing and Midwifery Officer (CNMO) will lead work to develop the first National Nursing Strategy. The strategy will look at: workforce sustainability, diversity of the profession and the challenges of regional, rural and remote nursing. At the same time as the National Nursing Strategy, a Nurse Practitioner 10 year plan is to be developed, recognising the role nurse practitioners play in broader nursing career pathways and health care outcomes.

The Government is progressing a 10-year National Mental Health Workforce Strategy which is anticipated to be finalised in late 2021. This will consider the quality, supply, distribution and structure of the mental health workforce; and will identify practical approaches that could be implemented by Australian governments to attract, train and retain the workforce required to meet the demands of the mental health system in the future and ensure it is supported by a highly trained and qualified workforce.

3.17. Allied health

The Government has brought renewed focus to the allied health workforce and to the important role of allied health across the health, aged care and disability care systems. In 2019, the Government appointed a new Chief Allied Health Officer in the Primary Care Division of the Department to develop a program of work in allied health. As first steps in this program, the Government has:

- Expanded the Allied Health Rural Generalist Pathway from 2021, with investments into allied health professional training and staffing in rural and remote areas.
- Funded new MBS items for allied health professionals' participation in multidisciplinary case conferences.
- Initiated a gap analysis of allied health data.

- As part of the COVID response, supported the development of infection prevention and control protocols for allied health professions, provide some personal protective equipment support, and trialled new allied health interventions in residential aged care settings.

The Government is looking to optimise the development and utilisation of high-quality allied health in primary health care through this plan.

3.18. Emergency preparedness and response

The drought, bushfires, floods and COVID-19 pandemic of recent years have seen major investments by the Government in emergency response in the primary health care sector. Significant funding has flowed for mental health support in rural areas during the drought and in response to the bushfires, and more recently to areas affected by extended COVID-19 lockdowns. Emergency general practice and pharmacy arrangements have been activated in the bushfires and floods.

In the initial response to COVID-19, the Government had responded with \$2.3 billion in primary health care funding by the May 2020-21 Budget, including to support the temporary MBS telehealth arrangements, COVID pathology testing, electronic prescribing, the national network of general practice respiratory clinics and a range of other measures. Personal protective equipment has been deployed from the National Medical Stockpile to help address shortages in general practice, community pharmacy and allied health settings. These investments have been extended and added to at subsequent Budget updates.

The PHNs have played a vital role in supporting the primary care response. The Government is looking to this plan to help embed primary health care as a natural and critical part of emergency preparedness and response structures at regional, state and national levels.

3.19. Digital health infrastructure

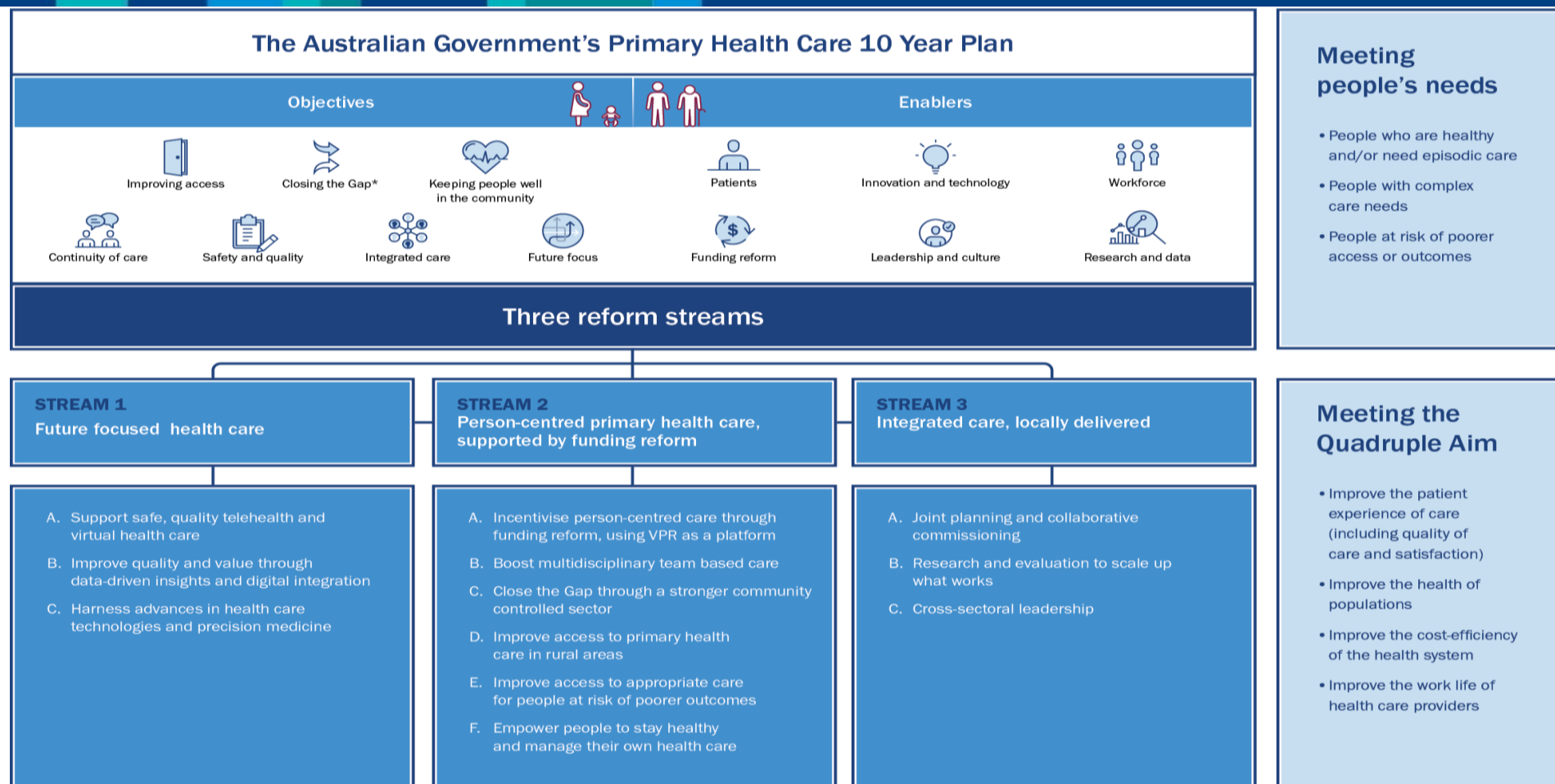
The Government supports digital health as an important integrating and enabling part of health system infrastructure. The Government has continued to invest in the operation of the Australian Digital Health Agency, the National Digital Health Strategy 2018-2022 and the roll-out and continued development of the My Health Record. The Government is looking to further developments in digital health to support implementation of this plan. As preparatory steps on two aspects of digital health relevant to this plan:

- The systems being built to implement VPR include the recording of people's registered doctor and practice on their My Health Record. This will help facilitate timely communication across the health care team, for example when someone is admitted to or discharged from hospital, their usual GP can be more readily identified and contacted
- The Government has commissioned a consultation RIS process on clinical decision support software, due to report by September 2022, to facilitate effective regulation of this fast developing area, promote quality prescribing and requesting of diagnostic imaging and pathology and prepare the ground for a future of precision medicine and genomics.

3.20. Foundations for the Primary Health Care 10 Year Plan

The initiatives set out above lay important foundations for the actions in the plan, which is set out in the next part.

4. The Government's plan for future focused primary health care



* Closing the Gap is to enable Aboriginal and Torres Strait Islander people and governments to work together to overcome the inequality experienced by Aboriginal and Torres Strait Islander people, and achieve life outcomes equal to all Australians.

Figure 3: Future Government's Primary Health Care 10 Year Plan

Stream 1: Future focused health care

Stream 1 is about embracing the future - using the opportunity of technology to drive improvements in care access, quality, value and integration.

Stream 1 covers three action areas:

- A. Support safe, quality telehealth and virtual health care*
- B. Improve quality and value through data-driven insights and digital integration*
- C. Harness advances in health care technologies and precision medicine*

Over the 10-year period:

- VPR will support continuity of relationships between general practices/ACCHS and general practitioners with the people they provide care for, establishing a quality footing for the continuation of MBS telehealth.
- Infrastructure and services to support telehealth in primary health care will converge with virtual health infrastructure used to deliver hospital in the home and other hospital outreach services.
- Progressive changes to data and digital infrastructure, including linked data, together with clinical enablers like decision support tools will support personalisation of quality care.
- The actions to be taken recognise the value of trusted, shared and timely data to inform quality improvement, achieve better individual health outcomes and improve population health.
- Combined with wider digital health initiatives, people and providers will draw on information held in My Health Record and extend use of secure electronically supported interactions.
- Services will use data to understand the health needs of registered populations, monitor outcomes and continuously improve services.
- Actions taken to support multidisciplinary teams electronically will help support more seamless system navigation and care transitions, within the health system and at the interface with aged care, disability and community services.
- Technological advances like point-of-care testing and genomics will increasingly become a routine part of primary health care services, enabling more efficient and more personalised care.

INSIGHTS FOR STREAM 1

By 2030, 56% of the Australian population will either be millennial or generation Z – collectively, they are ‘digital natives.’⁹

At 79%, most health consumers say they are more likely to select a provider who allows them to conduct healthcare interactions online or on a mobile device.¹⁰

When accessing health information, 77% of people would like their doctor to suggest health information websites; 73% have already used the internet to research a health issue, with only 6% finding an online health source they trust.¹¹

Most Australians believe doctors, hospitals and pharmacists are very trustworthy (23%) or trustworthy (47%). Almost 9 in 10 want more choice and control over their personal information.¹²

A point in time snapshot in 2016-17 showed 46% of internet users used the internet to access health services in the previous 3 months.¹³ In 2020, 88% of people believed there is a role for technology in helping manage their health and 71% of people have used technology to better manage their health.¹⁴

Over 12 million original and repeat electronic prescriptions were dispensed over 12 months following Government funding to fast track national implementation in response to the COVID-19 pandemic.¹⁵

In areas like precision medicine, 75% of Australians would be willing to use genetic testing to identify the most effective drug to treat their disease; of those people, 95% said they are willing for their results to be used to improve treatments for future patients.¹⁶

1 Action area A: Support safe, quality telehealth and virtual health care

Short term actions (1-3 years)

- Introduce a universal system of VPR for general practice, with people registering with their accredited general practice or ACCHS and nominating their usual GP, to assure a continuing relationship of care in which safe, quality MBS telehealth can be delivered, and to provide a new platform for funding reform (see stream 2, action area A)
- Consider continuing MBS telehealth for general practice and ACCHS in association with VPR

⁹ The phrase refers to generations of people who grew up with technology, including computers, mobile devices and the internet. Australian Bureau of Statistics (ABS). (2018). *Estimated Resident Population by Single Year of Age, Australia*. Australian Demographic Statistics, Time Series Spreadsheets, Table 59. Australian Bureau of Statistics (ABS). (2017). Population projections, by age and sex, Australia, Series B. Population Projections, Australia, 2017 (base) – 2066. Time Series Spreadsheets, Table B9.

¹⁰ David Rowlands, Digital Health Workforce Academy What is digital health? And why does it matter.

2 December 2019, p16. See: https://www.hisa.org.au/wp-content/uploads/2019/12/What_is_Digital_Health.pdf%3F97063

¹¹ Perillo A. Connecting consumers to their digital health: Perspectives on consumer's opportunities in the Digital Healthcare revolution: Telstra Health; See:

https://www.health.qld.gov.au/_data/assets/pdf_file/0023/441518/qcs-pp-1608-perillo.pdf

Research Australia 2020. Public Opinion Poll on Health & Medical Research & Innovation

¹² Australian Information Commissioner and Privacy Commissioner, Australian Community Attitudes to Privacy Survey 2020. Table See: <https://www.oaic.gov.au/engage-with-us/research/australian-community-attitudes-to-privacy-survey-2020-landing-page/2020-australian-community-attitudes-to-privacy-survey/>

¹³ ABS (Australian Bureau of Statistics) 2018. Household use of information technology, Australia, 2016–17. ABS cat. no. 8146.0. Canberra. ABS., Table 3 Internet users, by reasons for accessing the internet– 2016-17

¹⁴ Research Australia 2020. 2020 Public Opinion Poll on Health & Medical Research & Innovation

¹⁵ Data as at July 2021, Australian Digital Health Agency. See: <https://www.digitalhealth.gov.au/initiatives-and-programs/electronic-prescriptions>

¹⁶ Research Australia, Opinion Polling 2018, Australia Speaks! 2018: [Opinion Polling for Health and Medical Research](#).

- Consider continuing MBS telehealth for allied health, mental health and specialist care independent of registration
- Reform the eHealth PIP (ePIP) to support practice adoption of better data security, software integrating video into workflow, and decision support tools
- Further develop the evidence base and national safety and quality standards for telehealth, building on MBS Review telehealth guiding principles, with a focus on need and continuity of care
- Update education and training content and delivery and provider resources to support various forms of virtual care, including remote monitoring
- Coordinate with state and territory initiatives on telehealth and virtual care to support complementary infrastructure development
- Test and evaluate appropriate patient-end supports for people using telehealth in rural and remote communities, through ACCHS, and in aged care and disability settings
- Support extension of the healthdirect national health call centre and services directory to all jurisdictions.

Medium term actions (4-6 years)

- Adjust any changes made for telehealth to reflect emerging evidence and quality standards
- Roll out additional patient-end supports for telehealth in rural/remote, ACCHS, aged care and disability settings
- Evaluate emerging technologies for virtual care, including wearables and remote monitoring, and consider support for integration into quality practice
- Scope and develop education, training and decision supports to cover increasing use of virtual care technologies
- Work across the Commonwealth, states and territories, PHNs and with other partners, to ensure digital inclusion practices are embedded in primary health care and in communication between medical and other specialists and primary health care providers.

Future state (7-10 years)

- Telehealth and virtual health technologies are an integrated part of quality primary health care practice, with patient-end supports readily available to people who need them
- Analysis of patient reported outcomes (PROMS) and patient reported experience measures (PREMS) relating to telehealth and virtual care options are used routinely by health care providers to improve delivery of primary health care
- Security and privacy safeguards are kept up to date and in line with community expectations through engagement with people using health services, clinicians, medical researchers, industry experts, privacy advocates and the Office of the Australian Information Commissioner.

1 Action area B: Improve quality and value through data-driven insights and digital integration

Short term actions (1-3 years)

Data-driven quality improvement

- Support and scale up data development and linkage projects supporting integrated and person-centred care at regional, state/territory and national level, including through collaboration with PHNs, LHNs, state and territory governments, AIHW, ABS, ACSQHC and other bodies
- Conduct a Consultation RIS process on primary health care data and decision support software to consider whether additional regulatory approaches are required to support privacy and consent, data security, software interoperability and clinical decision support tools

- Consider the continuation of the PIP Quality Improvement (QI) incentive to further improve primary health data-driven quality improvement activities and data sharing
- Develop data strategy on allied health workforce and funding models, including progressing the AIHW Primary Health Care Data Asset project to cover development of an allied health primary care minimum dataset, pilot data collection from allied health practices
- Establish a primary health care data analytics centre of excellence to immediately leverage enhanced data sets and develop data analytics functions of value to primary health

Infrastructure, software and tools

- Develop incentives and supports for practice software to automatically code reason for visit and automatically upload appropriate summaries to My Health Record
- Consider the case for introducing software-embedded clinical decision support tools for diagnostic imaging requests, pathology and quality prescribing
- Accelerate the Australian Digital Health Agency's digital infrastructure agenda supporting primary health care, particularly to support secure messaging, software interoperability and additional My Health Record functionality
- Work with allied health software vendors and providers to develop secure messaging and software infrastructure to support allied health interaction with general practice and My Health Record, improve the interoperability of secure messaging ecosystems and support allied health practices to utilise secure messaging
- Make full use of education and training frameworks, curriculum and continuing professional development to support confident uptake of digital health solutions in primary health care settings. Ensure the needs of primary health care are given priority for action under the 2022 Digital Health Blueprint.

Medium term actions (4-6 years)

Data-driven quality improvement

- Continue to invest in data linkage projects to support better understanding of health system journeys and value-based investments
- Further develop data strategy on allied health workforce and funding models
- Further enhance clinical decision support for pathology and diagnostic imaging requests
- Continue primary health care data development so that detailed general practice data is routinely comparable nationally, linked with hospital and other care system data regionally and accessible for non-commercial research
- Building on the AIHW data asset project, scale up data collection from allied health practices

Infrastructure, software and tools

- Leverage the next Digital Health Blueprint to build capacity to share information in real-time, including interoperability of information systems within health and across sectors, particularly aged care and disability services.

Future state (7-10 years)

Data-driven quality improvement

- The enabling environment for the use of health data is trusted by health care providers and the people they partner with, so they are confident in sharing information and data to help get the desired health outcomes
- Analytics on detailed nationally comparable general practice data, securely linked with hospital and other data sets, are routinely identifying better care pathways and treatment approaches,

new system efficiencies, and insights to guide systemic re-design options; these flow through to decision support tools used every day by health professionals

- Primary health care capability is enhanced to implement proactive care for population groups informed by data
- Commonwealth bodies sustain national population based data collections to inform quality improvement, policy directions and systemic and micro level adjustments to improve health outcomes and efficiency
- People routinely put their health related information together on My Health Record, so that it can be used by multidisciplinary teams, with their consent

Infrastructure, software and tools

- My Health Record will be better integrated into clinical information systems, with useful clinical content and clinical benefit
- Improvements to digital infrastructure including clinical software, decision support tools and My Health Record supports improved consumer experience including in communication, care planning and delivery across primary care, hospitals and other care settings.

1 Action area C: Harness advances in health care technologies and precision medicine

Short term actions (1-3 years)

- Continue to develop health technology assessment approaches to support:
 - Adoption of safe, effective, quality point of care testing in primary care settings
 - Emerging and novel drug therapies, including biologics, immunotherapies and pharmacogenomics
- Update the National Health Genomics Policy Framework to address primary health care settings, including the safety, clinical utility and cost-effectiveness of genomics in primary health care
- Work with public hospital systems to establish mechanisms for specialist support to general practice on genomics and precision medicine
- Support building digital capability and use of precision medicine by adding to education, training and career pathways across the health workforce
- Engage peak organisations, professional colleges and bodies and educational institutions in developing resources for service providers.

Medium term actions (4-6 years)

- Scale up mechanisms for specialist support to general practice on genomics and precision medicine
- Support workforces in primary health care settings in training and decision supports for:
 - point of care testing
 - safe, appropriate and effective, quality use of genomics and precision medicine
 - responsible collection, storage, use and management of genomic data.

Future state (7-10 years)

- The skills and knowledge of primary health care providers and workforces, and the specialist and decision supports available, provide confidence in the routine adoption of point of care testing, other emerging technologies and models of care, genomics-related methods and advances in precision medicine
- Clinical decision support tools are supporting best practice in prescribing, point of care testing, requests for pathology and diagnostic imaging, safe use of medicines, genomics and virtual care technologies.

Stream 2: Person-centred primary health care, supported by funding reform

Stream 2 leverages VPR as a platform for reforming funding to incentivise quality person-centred primary health care. Over time, a greater proportion of funding in primary health care will move to payments incentivising quality and outcomes, and ensuring access to quality care in areas of market failure. This stream of actions will also address gaps in access to appropriate care for important population groups at risk of poorer outcomes, incentivise multidisciplinary team-based care approaches and get people more engaged in preventive health and their own health care.

Stream 2 covers six action areas:

- A. Incentivise person-centred care through funding reform, using VPR as a platform*
- B. Boost multidisciplinary team based care*
- C. Close the Gap through a stronger community controlled sector*
- D. Improve access to primary health care in rural areas*
- E. Improve access to appropriate care for people at risk of poorer outcomes*
- F. Empower people to stay healthy and manage their own health care*

Over the 10-year period:

The starting point for this stream of actions is equity: no individual or population group should be disadvantaged when accessing health care services.

VPR will strengthen the continuity of care relationship between people and their general practice/ACCHS and their usual general practitioner. Continuity of care is strongly associated with better outcomes. VPR will provide a platform for funding reform to incentivise quality care and better outcomes for important population groups at risk of poorer access and outcomes. Already the PIP Indigenous Health Incentive is changing to better incentivise outcomes for registered Aboriginal and Torres Strait Islander people. Over time, payments linked to registered patient populations will be considered as a mechanism for incentivising quality care and improved outcomes for older Australians, people experiencing mental illness, people with complex chronic disease, parents and children in the first 2,000 days of life, people with disability and people in socioeconomically disadvantaged circumstances.

Funding arrangements will continue to be reviewed to ensure that multidisciplinary team-based care becomes an embedded feature of primary health care, and each professional in the primary health care team is supported to work to their full scope of practice. There will be a strong focus on primary health care's role in Closing the Gap for Aboriginal and Torres Strait Islander people, particularly through community controlled organisations.

Rural health will also be a major focus, with systematic scaling up of innovative approaches to supporting general practice and comprehensive primary care teams in areas of market failure. This will include the development of Rural Area Community Controlled Health Services (RACCHS) providing primary health care for rural and remote communities, modelled on but not replacing the very successful ACCHS.

Best practice models of care for people with diverse backgrounds and lived experiences and at risk of poorer health outcomes will also be evaluated and scaled up. Centres of excellence will be supported not only to provide expert care but also to support other primary health care practices and professionals in providing more appropriate care. Early attention will be given to improving

primary health care services in this way for people with disability, particularly but not limited to people with intellectual disability, people from CALD backgrounds and LGBTI people.

People of all ages will be encouraged to take an active part in managing their physical and mental health and wellbeing, with distinct shifts to personalised care, prevention and early intervention, while handling episodes of illness and managing chronic conditions.

INSIGHTS FOR STREAM 2

Over **428 million MBS services** (includes 163.2 million for GP Non-Referred Attendances, 14.2 million for Allied Health, and 3.1 million for Practice Nurse) provided in one year, with total benefits of \$24.7 billion. On average, more than **8 out of every 10 visits to the GP** involved no out-of-pocket cost for people.¹⁷

Almost **50%** of people are estimated to have one or more of the 10 most common chronic conditions, with this percentage increasing to **80%** for people aged over 65.¹⁸

Chronic disease contributes to more than **1 in 3** potentially preventable hospitalisations.¹⁹

At **23%** of the total burden, mental health is the largest contributor to the non-fatal burden of chronic disease.²⁰

People living in areas of socioeconomic disadvantage have **higher rates of chronic conditions** such as diabetes, heart disease and chronic obstructive pulmonary disease (COPD).²¹

One in 7 people do not feel they could make sense of health information.²²

8 year difference in life expectancy between Aboriginal and Torres Strait Islander people and non-Indigenous Australians.²³

2 Action area A: Incentivise person-centred care through funding reform, using VPR as a platform

Short term actions (1-3 years)

- Introduce a universal system of VPR through accredited general practices and ACCHS. In recognition of the continuity of care relationship supported by VPR, provide people who register with ongoing MBS telehealth subsidies
- Link MBS services intended to be provided by people's usual doctor (e.g. chronic disease management plans, health assessments, medication reviews) to their registered practice if they are registered
- Review general practice accreditation arrangements to support an efficient, quality accreditation scheme and provide additional support to become accredited to small practices and practices serving populations at risk of poorer health outcomes

¹⁷ [Annual Medicare Statistics 2019-20](#)

¹⁸ AIHW Chronic Disease findings. See: <https://www.aihw.gov.au/reports-data/health-conditions-disability-deaths/chronic-disease/overview>

¹⁹ AIHW Chronic Disease findings. See: <https://www.aihw.gov.au/reports-data/health-conditions-disability-deaths/chronic-disease/overview>

²⁰ AIHW Chronic Disease findings. See: <https://www.aihw.gov.au/reports-data/health-conditions-disability-deaths/chronic-disease/overview>

²¹ AIHW Australia's Health 2018

²² ABS Health Literacy Survey, 2019, cited by AIHW in Australia's Health 2020.

²³ Commonwealth Closing the Gap Implementation Plan

- Move the PIP Indigenous Health Incentive to an outcomes focus (under way)
- Consider new Service Incentive Payments (SIPs) under the PIP to reward quality bundles of care for registered patient populations, starting with:
 - Older Australians to help slow decline into frailty and reduce hospital attendances, and
 - People experiencing mental illness to support holistic care
- Closely evaluate the impact of VPR and associated funding reforms from commencement
- Complete the evaluation of the HCH trial and consider findings to inform potential future funding reforms.
- Consider the development of a wound care consumables scheme.

Medium term actions (4-6 years)

- Adjust VPR, MBS telehealth and associated funding arrangements based on evaluation outcomes
- Consider over time additional SIPs and PIP incentives to support quality bundles of care and improved outcomes for additional registered populations, e.g.:
 - Parents and young children in the first 2,000 days of life
 - People with complex chronic conditions
 - People with disability, including people with intellectual disability
 - People with dementia
 - People needing palliative care
- As data development and linkage matures, transform the indicators on which the new SIPs and PIP incentives are paid to include more outcome indicators, e.g.:
 - Patient reported experience and outcome measures
 - Independently measured population health outcomes
 - Reduced use of secondary and tertiary health services.

Future state (7-10 years)

- Payments linked to VPR will be incentivising quality primary health care, including preventive care, and better health outcomes
- People will receive better care through the life course with lowered prevalence of chronic conditions, reduced progression of chronic diseases and management of factors leading to increased frailty
- Payments linked to quality and outcomes measures, rather than fee for service will contribute up to 40% of the blended payment mix.

2 Action area B: Boost multidisciplinary team based care

Short term actions (1-3 years)

- Reward allied health participation in MBS team care arrangements (under way)
- Boost the Workforce Incentive Program (WIP) practice stream to better support practices employing practice nurses and allied health workforce
- Consolidate evaluations of promising models of multidisciplinary care e.g. specialist support for general practice, nurse-led preventive health care clinics in general practice, non-dispensing pharmacist involvement in medication management in general practice and aged care – and develop mechanisms for sustainable national scale-up

- Implement the Stronger Rural Health Strategy, the National Medical Workforce Strategy, the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework, the Nursing Workforce Strategy and other workforce strategies
- Develop a National Allied Health Workforce Plan to optimise the allied health workforce and support the provision of high value care across health, aged and disability settings.

Medium term actions (4-6 years)

- Reinforce and support best practice models of midwifery-led care (including continuity of care) for the multidisciplinary team in primary care and maternity services. Develop robust postnatal guidelines to support development and growth of children in the first 2,000 days.
- Build team-based care indicators into SIP/PIP quality and outcomes payments linked to VPR, learning from evaluation of the HCH trial and other initiatives
- Continue to re-align workforce education and training programs and update accreditation and compliance standards to reflect advances in multidisciplinary models of care
- Consider progress made with targeted workforce strategies in health, aged care and disability designed to improve supply and distribution of health professionals working as part of multidisciplinary teams, and assess next steps where gaps may be affecting capability to sustain teams.

Future state (7-10 years)

- People registered with general practices and ACCHS expect to receive multidisciplinary team based care with their usual GP at the centre of a care team including nurses, allied health professionals and specialists
- Funding models incentivise and support this multidisciplinary team-based approach
- The knowledge, capabilities and skills of each team member are progressively built, through education, training, and regional, jurisdictional and national support networks and communities of practice.

2 Action area C: Close the Gap through a stronger community controlled sector

Short term actions (1-3 years)

- Implement the Indigenous Australians' Health Program (IAHP) and the National Aboriginal and Torres Strait Islander Health Plan in accordance with the principles of the National Agreement on Closing the Gap, including:
 - Continuing to increase the number of health checks under MBS 715 (Aboriginal And Torres Strait Islander Peoples Health Assessment)
 - Safe immunisation
 - Specific actions on ear, eye, renal, acute rheumatic fever and rheumatic heart disease
- Continue to build the capacity of the community-controlled health sector to support Closing the Gap
- Move over time from PHN commissioning of Aboriginal and Torres Strait Islander services to direct funding of ACCHS, starting with areas of strongest capacity
- Scope and trial Aboriginal and Torres Strait Islander community-led commissioning models for urban, rural and remote areas
- Work in partnership to support the staged transition of state/territory government run clinics in relevant areas to Aboriginal community controlled health organisations
- Scope the potential for ACCHS to extend services to include aged care and disability services

- Develop formal partnerships between PHNs, LHNs and the ACHHO sector to deliver culturally safe trauma-informed care across all primary health care services
- Educate primary health care providers on the 2020 National Agreement on Closing the Gap, Health Ministers' Cultural Respect Framework 2016-2026 and the RACGP standards for general practice on cultural safety
- Improve collection of high quality Indigenous status data in all primary health care datasets and clinical registries, to support better reporting and alignment between mainstream health and Indigenous health datasets
- Align steps taken on data with Closing the Gap Priority Reform 4 – Shared Access to Data and Information at a Regional Level and the Australian Health Performance Framework and the Aboriginal and Torres Strait Islander Health Performance Framework
- Implement the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework.

Medium term actions (4-6 years)

- Next steps to be guided by:
 - The three-yearly report on progress with the Closing the Gap Agreement due in 2023
 - The co-designed evaluation of the Indigenous Australians Health Program due in 2023
- Undertake staged implementation of Aboriginal and Torres Strait Islander community-led commissioning models that work well, are sustainable and where ACCHS and the community support the transition
- Continue to work in partnership on the staged transition of state/territory run clinics in relevant areas to Aboriginal community-controlled health organisations
- Where indicated, support extensions to the service coverage of ACCHS to areas of unmet need in and aged care and disability
- Evaluate and adjust cultural safety and trauma-informed care programs in mainstream practice
- Develop measurements for cultural safety and report on this through the Australian Health Performance Framework
- Continue development and implementation of agreed approach to collection, management and use of data relating to Aboriginal and Torres Strait Islander health outcomes to inform progress on Closing the Gap targets and outcomes
- Continue with implementation of workforce strategies covering Aboriginal and Torres Strait Islander workforces, National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan, the National Medical Workforce Strategy and the Stronger Rural Health Strategy
- Evaluate the impact of the workforce strategies on the growth of Aboriginal and Torres Strait Islander workforces
- Assess the use of combined workforces in thin markets or underserved areas, particularly with a view to alignment with aged care reforms and the maturing of the NDIS.

Future state (7-10 years)

- A stronger and more extensive community-controlled health sector is playing a pivotal role in Closing the Gap, through direct funding, community-led regional commissioning and, where appropriate, extension of services to aged and disability care
- The primary health care contribution to the National Agreement on Closing the Gap has led to sustained and measurable improvements

- Aboriginal and Torres Strait Islander people are receiving culturally safe trauma-informed comprehensive primary health care services whether they attend ACCHS or mainstream services
- The Aboriginal and Torres Strait Islander health workforce continues to grow to support the health needs of Aboriginal and Torres Strait Islander people, whether they are accessing community-controlled or mainstream health services.

2 Action area D: Improve access to primary health care in rural areas

Short term actions (1-3 years)

- Support more GP training places and enhanced GP, Nurse Practitioner and Aboriginal and Torres Strait Islander GPs training, particularly in rural Australia
- Calibrate MBS telehealth and VPR for rural and remote health contexts
- Continue and extend the Stronger Rural Health Strategy
- Evaluate the existing suite of funding supports for primary health care provision in rural settings
- Evaluate the innovative workforce trials established under the Stronger Rural Health Strategy
- Trial the establishment of rural area community controlled health organisations (RACCHOs) in Modified Monash (MM) 4-7 regions to support comprehensive primary health care teams in areas of market failure
- Establish rural and remote health as a stream of work with each State and Territory in regional joint planning and collaborative commissioning approaches under the NHRA and engage relevant non-government stakeholders. This should include coordination of telehealth and virtual health approaches.

Medium term actions (4-6 years)

- Draw on evaluation of rural funding supports, the Stronger Rural Health Strategy, innovative workforce models and RACCHO trials to adjust and embed successful models
- Implement with states and territories regional collaborative commissioning approaches in rural health to drive sustainable 'one health system' models
- Scale up allied health student placements in regional, rural and remote areas, where appropriate and considering local context.

Future state (7-10 years)

- People in rural and remote areas can access face-to-face primary health care services locally, complemented by telehealth and virtual health care services, bringing access and outcomes closer to parity with urban areas

2 Action area E: Improve access to appropriate care for people at risk of poorer health outcomes

Short term actions (1-3 years)

- Support PHNs to develop, refine and scale evidence-based models of social prescribing and system navigation supports for at-risk groups
- Develop diversity-sensitive practice accreditation frameworks to better respond to the needs of people experiencing mental illness, people with disability, people from CALD backgrounds, LGBTI people
- Use the opportunity of the VPR process to improve data on the experience of diverse population groups in primary care and the broader health system, including Aboriginal and Torres Strait

Islander people, people with disability, people in socioeconomically disadvantaged circumstances, people from CALD backgrounds and LGBTI people

- Implement the National Roadmap on Improving the Health of People with Intellectual Disability, including a new National Centre of Excellence in Intellectual Disability Health
- Consider the potential for networked centres of excellence models to improve primary health care for other population groups at risk of poorer outcomes, e.g. CALD, LGBTI
- Embed the Disability and Health Sector Consultation Committee as the core ongoing mechanism for consultation on health issues for people with disability
- Establish CALD and LGBTI advisory groups to the Department of Health to provide CALD and LGBTI views on primary health care and other health reforms
- Ensure all PHNs have mechanisms for engaging disability, CALD and LGBTI communities
- Take next steps to address the impact of language barriers on access to primary health care, including expanded access to Free Interpreter Services (TIS), Auslan interpretation and community-led approaches to improving health literacy and health system literacy.

Medium term actions (4-6 years)

- Evaluate the impact of the range of short term actions in this stream on patient experience and outcomes and adapt implementation in response
- Progress implementation of medium term measures in the National Roadmap on Improving the Health of People with Intellectual Disability
- Deliver primary health care responses to final findings and recommendations of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (final report due September 2023)
- Implement networked centres of excellence models for primary health care for CALD and LGBTI people
- Trial, evaluate and scale regional approaches to improving health care for people with disability (beyond intellectual disability), CALD and LGBTI people through PHNs and PHN-LHN collaborations
- Evaluate and refine measures to improve language accessibility of primary health care.

Future state (7-10 years)

- Everyone, no matter their background, feels welcome and respected in primary health care settings.
- General practices have better data and are better able to provide tailored care for their registered patient populations.
- Nationally networked centres of excellence are providing an important resource for information and referral for all primary care practices, improving the quality and sensitivity of care for people with intellectual disability, people from CALD backgrounds, LGBTI people.
- People from CALD backgrounds can readily access bilingual and/or interpreter-supported services delivered with cultural sensitivity.

2 Action area F: Empower people to stay healthy and manage their own health care

Short term actions (1-3 years)

- Evaluate and refine national health literacy resources available through healthdirect, NPS Medicinewise and other channels

- Support updating and implementation of RACGP Guidelines for preventive activities in general practice
- Work with professional bodies and associations to develop more systematic approach to use of health consumer feedback and patient activation tools
- Support development of patient reported measures such as PROMs and PREMS to be inclusive of diverse needs, recognise differences in lived experience and to be culturally appropriate for Aboriginal and Torres Strait Islander people
- Ensure consumer engagement in PHN governance and support PHNs to develop and implement consumer-facing regional health system literacy approaches, building on HealthPathways
- Support assessment of and consumer education about affordable health monitoring technologies
- Leverage data (see stream 1, action area B) at practice, regional, state and national level to identify best value preventive health and chronic disease management interventions in primary care
- Review the range of maternal and child health programs delivered in primary health care settings to bring renewed focus to the first 2,000 days as a critical period for preventive interventions
- Align actions with the National Preventive Health Strategy and its Health Literacy enabler.

Medium term actions (4-6 years)

- Evaluate national and PHN health literacy and health system literacy measures, review emerging evidence and implement best-practice findings
- Leverage regional primary health care data to understand and enhance the nature and level of preventive activity delivered through general practice
- Build patient reported measures into primary health care data systems and into outcomes-based payment indicators
- Work with colleges and professional bodies on expanding and refining guidelines and tools to support providers in promoting health literacy and health system literacy
- Consider case for targeted public subsidies for evidence-based cost-effective health monitoring technologies as part of value-based health care mix
- Consider targeted VPR-linked quality and outcomes payments and other potential funding reforms to support better primary health care for first 2,000 days and for people with complex chronic conditions (see stream 1, action area A).

Future state (7-10 years)

- People can readily access reliable information to keep themselves well, support management of their own care and navigate the health system
- Information is routinely available in accessible formats including plain language, Easy Read, Auslan and community languages
- Culturally appropriate information is consistently available for Aboriginal and Torres Strait Islander and CALD communities.
- People, families and carers feel confident to participate in decision-making on health care and treatment options, and, where applicable, participating in case conferences
- Cost-effective health monitoring technologies are routinely used to support self-management
- Well-targeted interventions and systems of care in the first 2,000 days are supporting the best possible start to life for everyone.

Stream 3: Integrated care, locally delivered

Stream 3 is about delivering regionally and locally integrated health service models through joint planning and collaborative commissioning at regional and state-wide levels. Actions in this stream are designed to support local solutions, use joint planning and collaborative commissioning approaches to drive value-based care and address gaps in service delivery, and build on best-practice models and community-driven solutions. Leadership will be required across all governments, organisations and disciplines to deliver value and make these changes work.

Stream 3 covers three action areas:

- A. Joint planning and collaborative commissioning*
- B. Research and evaluation to scale up what works*
- C. Cross-sectoral leadership*

This stream recognises that, supported by shared data and digital health infrastructure, jointly planned locally driven solutions can improve and extend access to better care and shift thinking about funding and business operating models.

PHNs and LHNs are best placed to understand the needs of regional and local populations, to drive bottom-up planning and to collaboratively commission services to integrate the health system locally and regionally. Consistent with the NHRA, this requires leadership from State Governments as system managers and the Commonwealth as the main funders of PHNs together to provide the authorising environment for joint planning and commissioning, supporting infrastructure, e.g. for data sharing and linkage, and sustainable funding streams.

Regional health system innovation will continue to be supported and evaluated and best practice lessons harvested for scaling up to like regions, state-wide and/or nationally. Sustainable funding for research and evaluation of primary health care systems innovation will be required to establish a virtuous cycle of continuous health system improvement.

Steps will be taken to foster leadership, inter-professional collaboration and co-design, and effective change management to support the necessary cultural shifts to support these changes.

INSIGHTS FOR STREAM 3

Of people who saw three or more health professionals for the same condition, over **57%** used GPs to **coordinate** their care²⁴ **20%** of people need access to coordinated care.²⁵

\$38.2b spent each year in the health system to care for people with chronic conditions, 39 % in public hospitals as against **4%** in allied health and **8%** on GP services.²⁶

In NSW, the state-wide **Lumos program links data from 1.3 million** patients' general practice records to other NSW health system data, under trusted safety and personal protections. There are **445 participating practices**.²⁷ This provides provide insights about care that is delivered across the healthcare continuum, particularly for integrating healthcare.²⁸

Value of integrated care for ageing populations, hospitalisation avoidance: **1.6 million** emergency department (ED) presentations are for people aged 65 and over—around **one-fifth** of the total 7.8 million presentations.²⁹

Hundreds of evidence-based, web enabled and scalable regional HealthPathways provide localised information at point of care. Publicly funded and supported by LHNs and PHNs. Aimed at General Practitioners (GPs), and used by hospital specialists, practice nurses and managers, and community and allied health providers.³⁰

For every **\$1 in health research there is \$3.90** in health benefits.³¹

Some of the main workforces involved in coordinating and integrating care: **31,000** GPs; **41,953** nurses in primary health care settings; about **200,000** allied health professionals; Aboriginal and Torres Strait Islander practitioners including those working in **143** ACCHS with 300 clinics across Australia, **31** PHNs; and **136** LHNs.³²

²⁴ ABS: Patient Experiences in Australia: Summary of Findings, 2019-20 – *Tables 1 to 3 and 22 to 24*

ABS: Patient Experiences in Australia: Summary of Findings, 2019-20 – *Tables 1 to 3 and 22 to 24*

²⁵ Hal Swerissen and Stephen Duckett, Grattan Institute, Mapping primary care in Australia, July 2018

²⁶ Productivity Commission 2021, Innovations in Care for Chronic Health Conditions, Productivity Reform Case Study, Canberra.

²⁷ See; <https://www.health.nsw.gov.au/lumos>

²⁸ Correll P, Feyer A-M, Phan P-T, *et al.* Lumos: a statewide linkage programme in Australia integrating general practice data to guide system redesign. *Integrated Healthcare Journal* 2021;3:e000074. doi:10.1136/ihj-2021-000074. Between 2016 and 2019, NSW Ministry of Health collaborated with NSW PHNs, undertaking the Lumos pilot project to explore the feasibility and value of extracting and linking data from general practice records to other health system records. Lumos programme operates with ethical approval, has been granted a waiver of individual patient consent for secondary use of de-identified health information for the purposes of health services management, including funding, planning and evaluation. The Lumos programme has been funded by the Australian Government under the Health Innovation Fund.

²⁹ AIHW Older Australia at a glance. 2016-17 data. See: <https://www.aihw.gov.au/reports/older-people/older-australia-at-a-glance/contents/health-and-aged-care-service-use/health-care-hospitals>

³⁰ For in NSW there are 465 localised pathways that cover a range of clinical and psychosocial presentations and relevant local health services for referral. For the Eastern Melbourne Primary Health Network provides access to 867 published pathways – see: <https://datastudio.google.com/reporting/829529f4-58f4-4269-854b-a7c25657822d/page/DXVp>

³¹ KPMG Economic impact of medical research, 2018, p6

³² Department of Health data; AIHW data on allied health; for LHNs, see: <https://meteor.aihw.gov.au/content/index.phtml/itemId/727027>

3 Action area A: Joint planning and collaborative commissioning

Short term actions (1-3 years)

- Systematically implement joint jurisdiction-wide planning of primary health care services in each jurisdiction, consistent with the NHRA, with Commonwealth, State/Territory, PHNs, LHNs and other stakeholders at the table. This should be underpinned by analysis of shared and linked data (see 1B above) and systems mapping, involve both top-down and bottom-up priority setting and facilitate collaborative commissioning approaches. Over time, PHNs and LHNs should be required to develop joint regional plans and collaborative commissioning approaches for:
 - Mental health stepped care pathways (in train)
 - Hospital avoidance for people in residential aged care/older people
 - Dementia care pathways
 - Rural primary and community health care services
 - After hours care pathways
 - Complex chronic condition pathways, including value-based care and hospital avoidance and outreach approaches
- Draw on the outcomes of Independent Hospital Pricing Authority trials on bundled payments for specific conditions or cohorts to lead improvements in commissioning of integrated care in out-of-hospital settings
- Extend and reinforce the use of HealthPathways as standard for all PHNs and for use across primary care settings, tailored for local level application
- Review PHN governance arrangements and commissioning processes to support more efficient and effective operation
- Integrate primary care services into local and state emergency preparedness and response arrangements, with facilitation from PHNs.

Medium term actions (4-6 years)

- Evaluate collaborative commissioning and integrated care models emerging from bilateral jurisdiction-wide planning approaches and scale up best practice
- Consider the outcomes of trials specifically funded under the 2020-2025 NHRA on integrated care in out-of-hospital settings, pooled Commonwealth and state/territory funds and bundled payments across a pathway of care, and build on or scale up successful trials
- Over time, require PHNs and LHNs to develop joint regional plans and collaborative commissioning approaches for:
 - Care in the first 2,000 days
 - the health of people with disability
 - the health of CALD communities
 - the health of LGBTI people
 - the health of people in socioeconomically disadvantaged circumstances.

Future state (7-10 years)

- Backed by Commonwealth and state/territory Governments, PHNs and LHNs are routinely co-commissioning services to improve system efficiency, fill gaps and improve patient experience and outcomes
- PHN-LHN-sponsored regional health pathways offer the best value care, drawing on networked teams from across the care system working to full scope of practice

- The health system in rural and remote areas is bolstered by PHN-LHN sponsored networked practices drawing on, and supporting, a robust local workforce
- People using health services can readily follow established pathways, with navigational supports if needed, to connect to the care they need, in the health system and with social care options
- Productive relationships continue to grow across PHNs, general practice, ACCHSs, pharmacy, allied health, mental health services, hospitals, aged care, disability and social care services to deliver integrated value-based health services meeting individual and local population health needs.

3 Action area B: Research and evaluation to scale up what works

Short term actions (1-3 years)

- Building on the MRFF Primary Health Care Research Initiative, consider potential models for a national institute for primary health care translational research
- Build a centralised repository of research and evaluation findings on primary health care system innovation
- Continue to invest in evaluation of national and regional primary health care innovations and initiatives, including implementation of the initiatives in this plan
- Identify best practice regional health system innovations and, where appropriate, scale up across like regions jurisdictionally and nationally through joint planning and collaborative commissioning approaches
- Where trials demonstrate that new approaches are not effective or cost-effective, adapt or cease and document and disseminate the lessons learned
- Build on the annual PHN national meetings to establish an annual national primary health care system conference as a platform for sharing learnings from research and evaluation of primary health care system innovations
- Establish a baseline evaluation framework and indicators for evaluation of this plan.

Medium term actions (4-6 years)

- Conduct major evaluations of the implementation and effectiveness of this plan at years 3 and 6 to guide adaptation of implementation and, where appropriate, updating of the plan
- This should include stocktakes of health system innovations at regional level and successes in scaling up approaches.

Future state (7-10 years)

- Well-funded and accessible research and evaluation on primary health care is valued as a central driver of health system improvement
- Policy-makers, professional bodies and health service commissioners and providers are routinely updated on the latest research and evaluation findings, which are presented in a way that can be readily translated into improved practice
- Best-practice innovations at regional level are routinely scaled up to like regions, across jurisdictions and nationally in a sustained cycle of innovation and improvement
- Implementation of this plan is adapted throughout by research and evaluation learnings
- Future plans and strategies are informed by a final evaluation at year 9.

3 Action area C: Cross-sectoral leadership

Short term actions (1-3 years)

- Undertake a program of communication to build broad understanding and support for the aims, objectives and key initiatives in this plan across levels of government, commissioning bodies, professional, research and stakeholder organisations
- This should include a program of presentations from leaders in different disciplines and from different stakeholder bodies to the councils of professional organisations and associations
- Continue collaboration across a broad range of organisations representing different levels of government, professional and stakeholder groups in overseeing implementation of this plan
- Reinforce continuing habits of cross-sectoral communication and collaboration at jurisdictional and regional levels through joint planning and commissioning approaches, PHN governance arrangements and the annual primary health care system conference
- Develop learning modules about the primary health care system for inclusion in professional development courses.

Medium term actions (4-6 years)

- Continue to re-align workforce education and training programs and updating accreditation and compliance standards to reflect advances in models of care
- Support early adopters of change to communicate their experiences: within and across health professional occupations, at practice level, regionally and nationally
- Enable emerging workforces to inject new expertise and skills into primary health care practices and business models.

Future state (7-10 years)

- A supportive and collaborative culture of whole of system thinking and continuous quality improvement is engendered across primary health care services, with multidisciplinary and value-based care approaches the norm.

People at the centre of care

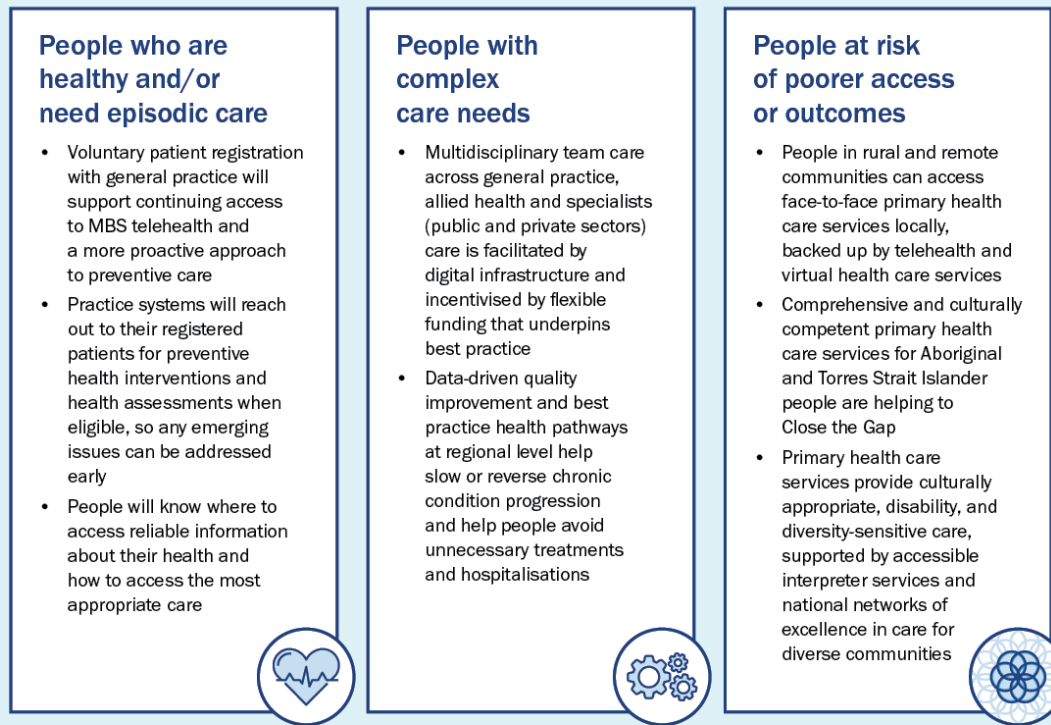


Figure 4: Looking across the streams: How the plan meets people's needs

5. Implementation

5.1. Roles and responsibilities

The Department will have lead responsibility for the implementation of this plan and manage the intersections between it and other plans, strategies and frameworks (see Annex B). The Department will work with the many organisations and people whose roles and engagement will be instrumental in achieving the changes envisaged under the plan. This includes:

- Consumer and stakeholder organisations.
- The National Aboriginal Community Controlled Health Organisation.
- Health professional bodies and associations.
- Health service providers.
- State and territory health departments.
- PHNs.
- Commonwealth health portfolio bodies including the AIHW, ACSQHC, the National Rural Health Commissioner, the National Mental Health Commission, the Aged Care Quality and Safety Commission and others.
- Other Commonwealth departments and agencies including the Department of Social Services, the National Disability Insurance Agency, the NDIS Quality and Safeguards Commission, the National Indigenous Australians Agency and others.

The Department will bring the expertise of the Chief Medical Officer, Chief Nursing and Midwifery Officer and Chief Allied Health Officer to support stewardship of relevant actions.

5.2. Oversight

A Primary Health Care 10 Year Plan Implementation Oversight Group (IOG) will be established in the first year with high-level representation from across the sector and stakeholder groups to:

- Advise on the design of key initiatives.
- Monitor progress of implementation.
- Guide evaluation.
- Advise on adaptation of the plan.
- Lead cultural change across the primary health care system.

The IOG will oversee implementation through the full 10 years of the plan, meeting twice annually or more often as required.

The Department of Health will provide annual reports on implementation to the IOG.

5.3. Evaluation

An evaluation framework, including performance indicators, for implementation of the plan will be developed by the end of the first year (2022).

Formal whole-of-plan evaluations will be undertaken at the third (2024-25) and sixth year (2027-28) points. Based on those evaluations, the IOG will provide advice through the Department to the Government on any adaptations to implementation or updates to the plan.

A final evaluation will be undertaken in year nine (2030-31) to help inform future plans and strategies.

5.4.Change management

Sustained effort will be needed to support all engaged in primary health care to carry forward the changes envisaged in this plan. This will require:

- Leadership from the members of the IOG, the professions, the PHNs and the Department.
- Concerted communication about the aims, objectives and key initiatives in this plan.
- Continuous effort to sustain a culture of collaboration across the health system.
- Systematic research and evaluation of emerging approaches.
- Systematic translation of the lessons from that research and evaluation into practice.

Annex A: Co-chairs and members of the Primary Health Reform Steering Group, 2019-2021

The Steering Group met 20 times between October 2019 and September 2021. The Steering Group was established to provide independent expert advice to the Commonwealth Department of Health on both the development of the plan and approaches to implementing VPR.

Name	Membership
Dr Steve Hambleton	GP, Co-Chair of the Steering Group
Dr Walid Jammal	GP, Co-Chair of the Steering Group
Dr Tony Bartone (to July 2020) Dr Chris Moy (from October 2020)	Australian Medical Association
Dr Harry Nespolon (to July 2020) A/Professor Ayman Shenouda (July – October 2020) Dr Karen Price (from October 2020)	Royal Australian College of General Practitioners
Dr Ewen McPhee (to October 2020) Dr Sarah Chalmers (from November 2020)	Australian College of Rural and Remote Medicine
Dr Gabrielle O’Kane	National Rural Health Alliance
Dr Dawn Casey	National Aboriginal and Community Controlled Health Organisation
Mr Adrian Carson	Institute for Urban Indigenous Health
Ms Leanne Wells	Consumers Health Forum of Australia
Professor Claire Jackson	Professor in General Practice and Primary Care Research, The University of Queensland
Ms Gail Mulcair	Allied Health Professionals Australia
Mr Phil Calvert	Australian Physiotherapy Association
Ms Karen Booth	Australian Primary Health Care Nurses Association
Ms Cathy Baynie	Australian Association of Practice Management
Dr Leanne Beagley	Mental Health Australia
Dr Nigel Lyons	NSW Ministry of Health
Dr Allison Turnock	Tasmanian Department of Health

Annex B: The Primary Health Care 10 Year Plan and associated plans, strategies and frameworks

[Australia's Long Term National Health Plan](#) (2019) is focused on making the health system better at preventing disease and promoting health, more focused on meeting people's multidisciplinary needs, more affordable, and more accessible to everyone, wherever they live and whoever they are.

Under the Long Term National Health Plan, the Government committed to developing and implementing the Primary Health Care 10 Year Plan. Here, the focus is on making primary health care person-centred, culturally safe, more accessible, and better able to provide preventive health services and manage chronic conditions.

This plan interacts with both the implementation of national or cross-jurisdictional plans, strategies and frameworks where the Commonwealth plays its part, including funding investments, and areas of health reform stewarded by the Commonwealth.

National plans, strategies and frameworks

Under the auspices of the former COAG (to May 2020) and the National Federation Reform Council there are national plans, strategies and frameworks which cover areas that can interact with and support primary health care.³³

The Commonwealth contributes funding, plays a lead role in implementation as this relates to primary health care and works collaboratively with state and territory governments.

The following are the national plans, strategies and frameworks intersecting principally with primary health care:

2020-2025 National Health Reform Agreement (together with Commonwealth/state bi-lateral agreements)

The NHRA 2020-2025 recognises that: 'responsibility for health is shared between the Commonwealth and the states, and that all governments have a responsibility to ensure that systems work together effectively and efficiently to produce the best outcomes for people, including interfaces between health, aged care and disability services, regardless of their geographic location'.³⁴

Under clause 13 of the 2020 Addendum to the NHRA, the Commonwealth is responsible for:

- Maintaining the legislative basis and governance arrangements for the key independent national bodies ("national bodies"), comprising the Australian Commission on Safety and Quality in Health Care, Australian Institute of Health and Welfare, Independent Hospital Pricing Authority and Administrator of the National Health Funding Pool.
- System management and support, policy and funding for GP and primary health care services including lead responsibility for Aboriginal and Torres Strait Islander Community Controlled Health Services (noting contributions of the states); maintaining Primary Health

³³See: <https://www.coaghealthcouncil.gov.au/Publications/Reports/ArtMID/514/ArticleID/81/Australias-National-Oral-Health-Plan-2015-2024>

³⁴Addendum to National Health Reform Agreement 2020-2025, May 2020
https://www.federalfinancialrelations.gov.au/content/npa/health/other/NHRA_2020-25_Addendum_consolidated.pdf

Networks to promote coordinated GP and primary health care service delivery, and service integration over time.

- Working with each State and with PHNs on system-wide policy and state-wide planning for GP and primary health care.
- Supporting and regulating private health insurance to enable an effective private health sector and patient choice.
- Planning, funding, policy, management and delivery of the national aged care system.
- Continuing to focus on reforms in primary care that are designed to improve patient outcomes and reduce avoidable hospital admissions.
- Functions transferred from Health Workforce Australia and the National Health Performance Authority when these organisations ceased operations on 6 August 2014 and 30 June 2016 respectively.

Under clause 10 of the 2020 Addendum to the NHRA, state and territory governments are responsible for:

- Health and emergency services through the public hospital system.
- System management of public hospitals, including ambulance and paramedic services.
- Taking a lead role in managing public health activities.
- Sole management of the relationship with Local Hospital Networks to ensure a single point of accountability in each State for public hospital performance, performance management and planning.

With the Commonwealth and the states to work in partnership to implement arrangements for a nationally unified and locally controlled health system, four strategic priorities have been agreed in the NHRA to guide further reform of Australia's health system between 2020 and 2025:

- Improving efficiency and ensuring financial sustainability.
- Delivering safe, high-quality care in the right place at the right time, including long term reforms in:
 - Nationally cohesive health technology assessment
 - Paying for value and outcomes
 - Joint planning and funding at a local level.
- Prioritising prevention and helping people manage their health across their lifetime, including long-term reforms in:
 - Empowering people through health literacy
 - Prevention and wellbeing.
- Driving best practice and performance using data and research, including long-term reforms in:
 - Enhanced health data.

2020 National Agreement on Closing Gap

In March 2019, the Commonwealth entered into a formal Partnership Agreement on Closing the Gap with the Coalition of Aboriginal and Torres Strait Islander Community-Controlled Organisations (the Coalition of Peaks) and all Australian governments to establish a new national approach to Closing the Gap.

In July 2020, all Australian governments and the Coalition of Peaks together signed the new National Agreement on Closing the Gap. This National Agreement is to be implemented through partnerships between Australian governments and the Coalition of Peaks.

The [Commonwealth Closing the Gap Implementation Plan](#) released in August 2021 covers the Commonwealth's efforts in achieving the targets in the National Agreement to 2031 and provides an overview of the Commonwealth's existing actions that contribute to Closing the Gap as well as new investment and areas of future work.

- All other parties to the National Agreement have their own plans, including state and territory governments (See: <https://www.closingthegap.gov.au/>)

Additional specific areas covered nationally, principally under the auspices of the National Federation Reform Council, include such examples as:

- Australian Health Practitioners Regulatory Agency, A National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025.
- The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Wellbeing 2017-2023.
- Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016-2026.
- Coverage of specific life stages or health needs, e.g. National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families.

Mental health and suicide prevention

The Fifth National Mental Health and Suicide Prevention Plan (2017) is being implemented. The National Federation Reform Council (replacing COAG) comprising the Prime Minister, Premiers, Chief Ministers, Treasurers and President of the Australian Local Government Association, agreed in December 2020 to collaborate on systemic, whole-of-governments reform to deliver a comprehensive, coordinated, consumer-focussed and compassionate mental health and suicide prevention system to benefit all Australians.

- This is to be carried forward through a new National Agreement on Mental Health and Suicide Prevention to be negotiated through the Health National Cabinet Reform Committee by the end of November 2021.

Additional national specific supporting plans, strategies and frameworks

A number with interactions with primary health care include:

- Healthy Mouths, Healthy Lives: Australia's National Oral Health Plan 2015–2024.
- National Digital Health Strategy 2018-2022.
- National Digital Health Framework for action 2018-2022.
- National Digital Blueprint (planned from 2022).
- National Obesity Strategy.
- National Palliative Care Strategy 2018.
- Woman-centred care. Strategic directions for Australian Maternity Services 2019.

Health reform plans, strategies and frameworks

In addition to acting within its spheres of responsibility on the national plans, strategies and frameworks, the Commonwealth is implementing actions in a number of areas material to future focused primary health care. The principal areas are outlined at figure 5.

Primary health care — overview of links to health reforms

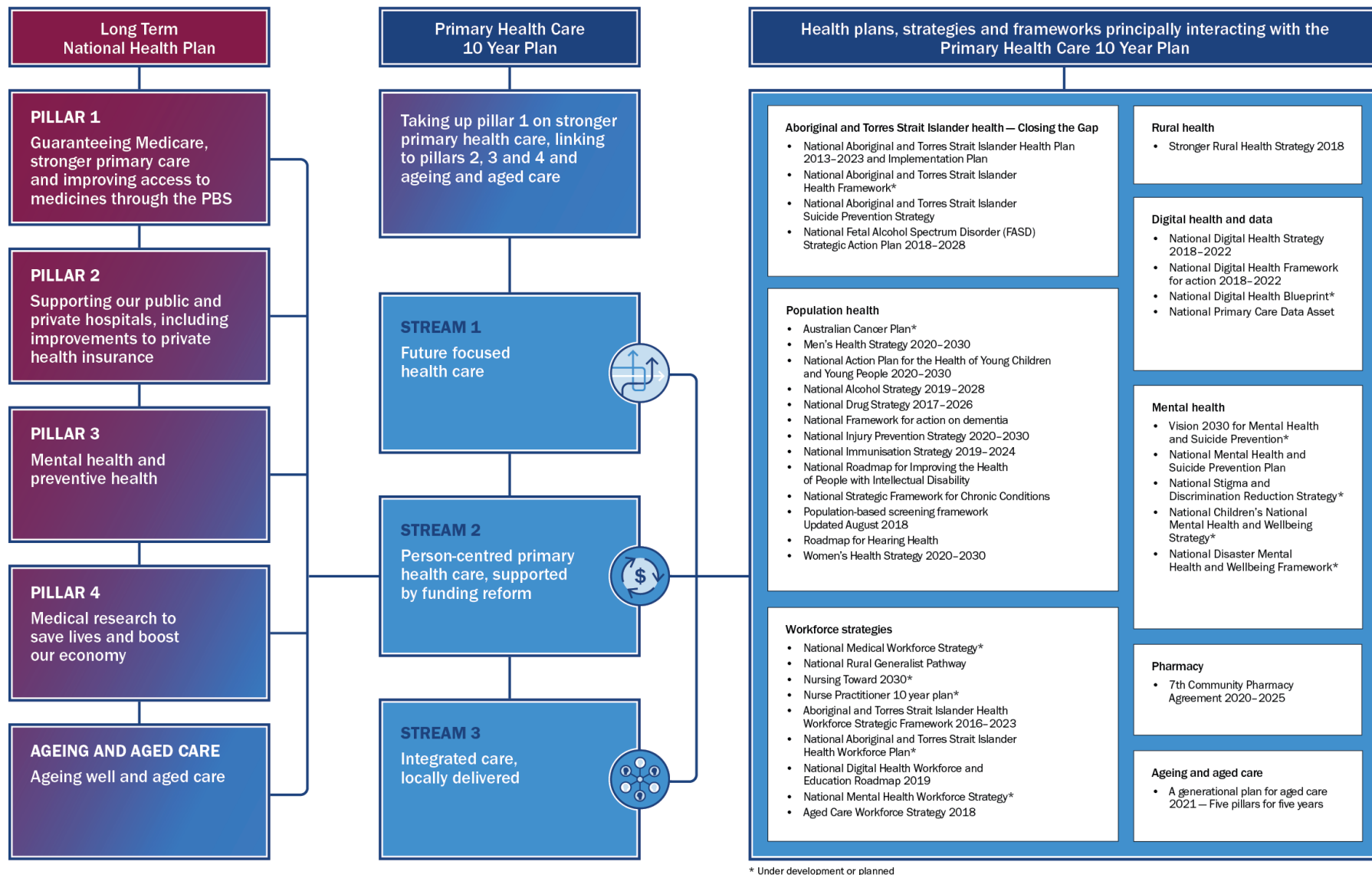


Figure 5: Primary health care — overview of links to health reforms

Abbreviations, acronyms and glossary of terms

Abbreviations and acronyms

ABS	Australian Bureau of Statistics
ACCHSs	Aboriginal Community Controlled Health Service
ACSQHC	Australian Commission on Safety and Quality in Health Care
AIHW	Australian Institute of Health and Welfare
CALD	Culturally and Linguistically Diverse
COAG	Council of Australian Governments (replaced in May 2020 by the National Federation Reform Council)
ED	Emergency Department
GP	General Practitioner
HCH	Health Care Home
IAHP	Indigenous Australians' Health Programme
ICT	Information and Communication Technology
IT	Information Technology
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
LHN	Local Health Network
MBS	Medicare Benefits Scheme
MMM	Modified Monash Model (MM1-7)
NDIS	National Disability Insurance Scheme
NHRA	National Health Reform Agreement (between the Commonwealth and states and territories)
OECD	Organisation for Economic Co-operation and Development
PBS	Pharmaceutical Benefits Scheme
PHN	Primary Health Network
PIP	Practice Incentives Program
PIPQI	Practice Incentives Program Quality Improvement
PREMs	Patient Reported Experience Measures
PROMs	Patient Reported Outcome Measures
RACGP	Royal Australian College of General Practitioners
VPR	Voluntary Patient Registration
WHO	World Health Organization
WIP	Workforce Incentive Program

Glossary of terms

Definitions	Description
Aboriginal Community Controlled Health Services (ACCHS)	A primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive and culturally appropriate health care to the community which controls it, through a locally elected board of directors. ACCHSs are principally funded by the Australian Government.
After hours	After hours services are defined by the current RACGP Standard for general practices as a service that provides care outside the normal opening hours of a general practice. It does not matter if that service deputises for other general practices, or if it provides the care within or outside of the clinic
Allied health services	Allied health professionals provide a broad range of diagnostic, technical, therapeutic and direct health services to improve the health and wellbeing of the people they support, working in a range of settings including hospitals, private practice, community health and in-home care. They are health professionals, mostly with university qualifications, that are not part of the medical, dental or nursing or midwifery professions. Allied health represents the second-largest clinical workforce in Australia, after nursing and midwifery.
Blended funding	Blended funding encompasses a combination of different funding sources and mechanisms.
Block funding	Block funding is population-based funding of service providers based on the population served and the health needs of the community. The payments are paid in a lump sum on a periodic basis.
Bundled payments	Bundled payments describe a method of payment where services, or different elements of care, are grouped together into one payment.
Chronic conditions	<p>Various terminology is used to describe chronic health conditions, including 'chronic diseases', 'non-communicable diseases', and 'long-term health conditions'. The term 'chronic conditions' encompasses a broad range of chronic and complex health conditions across the spectrum of illness, including mental illness, trauma, disability and genetic disorders. Chronic conditions:</p> <ul style="list-style-type: none"> • have complex and multiple causes; • may affect individuals either alone or as comorbidities; • usually have a gradual onset, although they can have sudden onset and acute stages; • occur across the life cycle, although they become more prevalent with older age; • can compromise quality of life and create limitations and disability; • are long-term and persistent, and often lead to a gradual deterioration of health and loss of independence; and • while not usually immediately life threatening, are the most common and leading cause of premature mortality.
Closing the Gap	The objective of Closing the Gap is to overcome the entrenched inequality faced by too many Aboriginal and Torres Strait Islander people so that their life outcomes are equal to all Australians. Progress was

	made under the Council of Australian Governments' (COAG) National Indigenous Reform Agreement (NIRA), known as Closing the Gap, starting in 2008. Acknowledging progress was too slow and had not delivered the results needed, in March 2019, the Commonwealth entered into a formal Partnership Agreement on Closing the Gap with the Coalition of Aboriginal and Torres Strait Islander Community-Controlled Organisations (the Coalition of Peaks) and all Australian governments to establish a new national approach to Closing the Gap. In July 2020, all Australian governments and the Coalition of Peaks together signed the new National Agreement on Closing the Gap.
COAG s19(2) Exemptions Initiative	The section 19(2) Exemptions Initiative is about improving access to primary care in rural and remote areas Initiative. These are exemptions under the Health Insurance Act 1973 to allow exempted eligible sites to claim against the MBS for non-admitted, non-referred professional services (including nursing, midwifery, allied and dental services) provided in emergency departments and outpatient clinic settings. Queensland, Western Australia, New South Wales, South Australia, Northern Territory and Victoria all participate in the Initiative via Memoranda of Understanding (MOUs) , with Tasmania eligible to participate. 2016-2020 MoUs were updated to a single criterion that requires an eligible public health site to be located within MMM5-7 locations.
Commissioning	A strategic approach to procurement that is informed by the baseline needs assessment undertaken by PHNs LHNs or their equivalents in a state or territory and aims towards a more holistic approach in which the planning and contracting of health care services are appropriate and relevant to the needs of their communities
Culturally and Linguistically Diverse People (CALD)	Culturally and linguistically diverse people describes and reflects people from a diverse range of cultural and linguistic backgrounds. The Australian Bureau of Statistics (ABS) indicate the CALD population by country of birth, languages spoken at home, English proficiency, cultural heritage and religious affiliation.
Determinants of health (also social determinants of health)	Determinants of physical and mental health are factors that influence how likely people are to stay healthy or to become ill or injured. The Australian Health Performance Framework identifies four broad groupings: health behaviours; personal biomedical factors; environmental factors; and socioeconomic factors. The cultural determinants of health are the protective factors that enhance resilience, strengthen identity and support good health and wellbeing. These include, but are not limited to, country, kinship, language, self-determination and cultural expression.
Digital health	Digital health is an umbrella term referring to a range of technologies that can be used to enhance the efficiency of health care delivery and make medicine more personalised and precise. It refers to health and wellbeing in a digital world. It is not separate but part of creating a connected health system and experience between health professionals to health consumers. Referring to digital health includes new or changed ways of working and the cultural impact of digital enablement. It can refer to mobile health and applications, electronic health records, telehealth and telemedicine, wearable devices, web-based analysis, email, mobile phones and applications, text messages, wearable devices,

	and clinic or remote monitoring sensors. It can extend to robotics and artificial intelligence.
Digital inclusion	Digital inclusion is about access to information and communications technology and the resulting social and economic benefits, sometimes described in terms of the ‘digital divide’ – the gap between people with effective access to digital and information technologies, in particular the internet, and those with very limited or no access at all. Access and affordability can present barriers to digital inclusion, but an individual’s digital engagement and confidence is also affected by digital literacy, perceptions of relevance, motivation and concerns about safety.
Disability	Disability is an umbrella term for impairments, activity limitations and participation restrictions, all of which can interact with a person’s health condition(s) and environmental and/or individual factors to hinder their full and effective participation in society on an equal basis with others. There are varying degrees of disability—from having no impairment or limitation to a complete loss of functioning. It can be associated with genetic disorders, illnesses, accidents, ageing, injuries or a combination of these factors. ³⁵ See also National Disability Insurance Scheme (NDIS)
Fee for service	Fee for Service is an Australian primary health care funding method that pays for individual services through patient benefits and out-of-pocket payments (e.g. MBS) Typically this is transactionally based on single episodes of service.
Genomics	Genomics is used to refer to both the study of single genes (genetics) and the study of an individual’s entire genetic makeup (genome) and how it interacts with environmental and non-genetic factors.
HeaDS UPP tool	The Health Demand and Supply Utilisation Patterns Planning (HeaDS UPP) Tool developed by the Commonwealth Department of Health is an integrated source of health workforce and services data that informs workforce planning and analysis. HeaDS UPP brings health data together to visually highlight how the community uses and accesses health services and the health workforce. It provides a single access point to workforce data from a number of data sets such the Medicare Benefits Schedule, Australian General Practitioner Training, Royal Flying Doctor Service Program, National Health Workforce data set, National Health Service Directory, and others. It will be available to a variety of government and non-government organisations involved in health workforce planning, including: Rural Workforce Agencies; PHNs; medical colleges; State and Territory governments; and Regional Training Organisations.
Health Care Home (HCH)	The HCH program was developed for patients with chronic and complex conditions to create a home base where a shared care plan is developed and implemented by a team of health care providers. A Health Care Home is an existing general practice or ACCHS that provides comprehensive primary health care, in the one place.
healthdirect	healthdirect Australia is a national, government-owned, not-for-profit organisation supporting Australians in managing their own health and wellbeing through a range of virtual health services. Their role is to work in partnership with federal, state and territory governments to help

³⁵ AIHW, People with disability in Australia 2020 in brief, p1. See: <https://www.aihw.gov.au/getmedia/7005c061-1c6e-490c-90c2-f2dd2773eb89/aihw-dis-77.pdf.aspx?inline=true>

	address key priorities and challenges across health, ageing and social service sectors.
Health literacy	Health literacy refers to the ability of people – their skills, knowledge motivation and capacity - to access, read, understand and use information about health and the health care system so as to make decisions that relate to their health.
HealthPathways	HealthPathways is a web-based portal available for point of care use by clinicians to help make assessments and manage care across primary and specialist care, all in the local context. Health jurisdictions and bodies like PHNs tailor the content of Health Pathways to reflect local arrangements and opinion. It is designed for general practice teams, including allied health and other health professionals.
Lived experienced	Lived experience is the knowledge and understanding people get when they have lived through something. It can mean being family or friends supporting someone. People with lived experience are considered experts on their lives and experiences. These insights of people brought together with the expertise, knowledge and skills of health practitioners focuses on needs of the people rather than on organisational or provider priorities.
Local Hospital Networks (LHNs)	LHNs refer to organisations which directly manage single or small groups of public hospital services and their budgets, and is directly responsible for hospital performance. An LHN can be defined as a business group, geographical area or community. Every Australian public hospital is part of an LHN. The title can vary from state to state – e.g. Queensland refers to 'Hospital and Health Services'; in Tasmania they are 'Tasmanian Health Organisations'.
Medicare Benefits Scheme (MBS)	Medicare is a national, government-funded scheme that subsidises the cost of personal medical services for all Australians and aims to help them afford medical care. The MBS is the listing of Medicare services subsidised by the Australian Government.
MMM classifications	The MMM classifies metropolitan, regional, rural and remote areas according to geographical remoteness, as defined by the ABS, and town size. It covers: MM1 Metropolitan; MM2 Regional centres; MM3 Large rural towns; MM4 Medium rural towns; MM5 Small rural towns; MM6 Remote communities; and MM7 Very remote communities. The MMM is used to determine eligibility for a range of health workforce programs, such as rural Bulk Billing Incentives, the WIP and the Bonded Medical Program.
National Disability Insurance Scheme (NDIS)	<p>The NDIS is a national scheme to provide support to eligible people who were either born with or acquire a permanent and significant disability.</p> <ul style="list-style-type: none"> • A 'permanent disability' means a person's disability is likely to be lifelong. • A 'significant disability' means a disability with a large impact on a person's ability to complete everyday activities. <p>The NDIS funds reasonable and necessary supports and services that relate to a person's disability to help them achieve their goals.</p> <ul style="list-style-type: none"> • 'Reasonable' means the support is most appropriately funded or provided through the NDIS. • 'Necessary' means something a person needs that is related to their disability.

	Early intervention features: Providing support to a person, either a child or an adult, as early as possible to reduce the impacts of disability or developmental delay and to build their skills and independence.
My Health Record	My Health Record is an online platform for storing the health information of individuals, including their Medicare claims history, hospital discharge information, diagnostic imaging reports and details of allergies and medications.
Non-dispensing pharmacists	Refers to non-dispensing pharmacists in general practice, an internationally established evidence-based approach used as part of team-based models of care. This involves a pharmacist contribution to care in a setting that is both safe and convenient for patients. Inclusion of a general practice-based pharmacist role can cover such aspects as: medication management, reducing medication-related problems and fewer adverse drug effects (including those leading to hospital admissions); and patient education services.
NPS Medicinewise	NPS MedicineWise (NPS) was established in 1998 to provide support to health practitioners to improve quality prescribing through education and prescriber feedback. Its goal is to improve the health of Australians through quality prescribing of medicines. NPS focuses on therapeutic areas where it has been shown that changes to prescribing can lead to better health outcomes for consumers.
Nurse practitioner	A nurse practitioner is a registered nurse endorsed as a nurse practitioner by the NMBA. The nurse practitioner practices at an advanced level, meets and complies with the nurse practitioner standards for practice, has direct clinical contact and practices within their scope under the legislatively protected title 'nurse practitioner' under the National Law.
Patient activation	Patient activation is the process through which health providers engage or motivate a patient to play an active role in their own health and care. This is instead of the more traditional and passive role of being 'told what to do' by a health professional
Person-centred	Person-centred describes treatment, care and support that places the person at the centre and in control of the design and delivery of their own care and considers the needs of the person's carers and family. Also referred to as person-led care.
Pharmaceutical Benefits Scheme (PBS)	The PBS is a national, Australian Government-funded scheme that subsidises the cost of a wide variety of pharmaceutical drugs, covering all Australians, to help them afford standard medications. The PBS lists all the medicinal products available under the PBS and explains the uses for which subsidies can apply.
Population health	Population health is typically the organised response by society to protect and promote health and to prevent illness, injury and disability. Population health activities generally focus on: <ul style="list-style-type: none"> • prevention, promotion and protection rather than on treatment • populations rather than individuals • the factors and behaviours that cause illness. The term can be used to refer to the health of particular subpopulations, and comparisons of the health of different populations.
Practice Incentives Program (PIP)	The Practice Incentives Program (PIP) supports general practices to make ongoing improvements to enhance capacity, improve access and provide quality health outcomes for patients.

Precision medicine	Precision medicine is a tailored approach to disease prevention and treatment that takes into account differences in people's genes, environments, and lifestyles. It is underpinned by genetic and genomic testing (sequencing), the results of which enable better prediction, prevention, diagnosis and treatment of disease.
Preventive health care	Preventive health care refers to approaches or activities aimed at preventing illness, assisting in the early detection of specific diseases and encouraging the promotion and maintenance of good health. Approaches and activities include reducing the likelihood that a disease or disorder will affect an individual, interrupting or slowing the progress of the disorder or reducing disability. Within this broad definition there are some more specific characterisations: <ul style="list-style-type: none"> • primary prevention, which reduces the likelihood of developing a disease or disorder • secondary prevention, which interrupts, prevents or minimises the progress of a disease or disorder at an early stage • tertiary prevention, which halts the progression of damage already done.
Primary health care	Whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people's needs and as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment. (<i>WHO and UNICEF. A vision for primary health care in the 21st century: Towards UHC and the SDGs.</i>)
Primary Health Networks (PHNs)	PHNs are Australian Government funded primary health care organisations which coordinate primary health care delivery and address local health needs and service gaps. Their purpose is to drive improvements in primary health care and ensure that services are better tailored to meet the needs of local communities.
Royal Commission into Aged Care Quality and Safety (Aged care Royal Commission)	The Royal Commission was established by Letters Patent issued in December 2018. The Royal Commission provided an Interim Report in October 2019 and a final report in February 2021. The Government's response to the Interim Report was provided in November 2019 and to the final report in May 2021.
Royal Commission into National Natural Disaster Arrangements (Bushfire Royal Commission)	The Bushfire Royal Commission was established by Letters Patent issued in February 2020. The Royal Commission provided its report in October 2020. The Government's response was provided in November 2020.
Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Disability Royal Commission)	The Disability Royal Commission was established by Commonwealth Letters Patent in April 2019, and State and Territory Letters Patent issued between April and August 2019. An Interim Report was published in October 2020, covering what the Royal Commission had done to 31 July 2020. Three progress report have been issued. The Royal Commission is to provide a final report by 29 September 2023.
Secondary health care	'Secondary care' is medical care provided by a specialist or facility upon referral by a primary care physician. These are usually based in a hospital or clinic, though some may be community based. They may include

	planned operations, specialist clinics such as cardiology or renal clinics, or rehabilitation services such as physiotherapy.
Social prescribing	Social prescribing, also sometimes known as community referral, is a means of enabling health professionals to refer people to a range of local, non-clinical services. The referrals generally, but not exclusively, come from professionals working in primary care settings, for example, GPs or practice nurses. Recognising that people's health and wellbeing are determined mostly by a range of social, economic and environmental factors, social prescribing seeks to address people's needs in a holistic way. It also aims to support individuals to take greater control of their own health. ³⁶
Tertiary health care	Refers to highly specialised consultative medical care, usually over an extended period of time that involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities. Examples include by-pass, renal, plastic surgery.
Value-based health care	Value is critical to supporting the delivery of effective health care. While value is often associated with the notion of cost and investment, value includes the health outcomes for a patient, through the provision of effective, high-quality and safe care that meets their needs ³⁷
Workforce Incentive Program (WIP)	The Workforce Incentive Program, part of the Stronger Rural Health Strategy, provides targeted financial incentives to encourage medical practitioners to deliver primary care services in regional, rural or remote Australia and to support eligible general practices to engage nurses, Aboriginal and Torres Strait Islander Health Practitioners and Health Workers, and eligible allied health professionals.

³⁶ King's Fund, 2017 and updated 2020, at: <https://www.kingsfund.org.uk/publications/social-prescribing>

³⁷ Value as a key concept in the health care system: how it has influenced medical practice and clinical decision-making process. Marzorati, C. & Pravettoni, G. 2017, Journal of Multidisciplinary Healthcare, Vol. 101, pp. 101-106