



Australian General Practice Network

Submission to the 2011-2012 Federal Budget



THE AUSTRALIAN
GENERAL PRACTICE
NETWORK



AGPN represents a network of 112 general practice networks as well as eight state based entities. More than 90 percent of general practitioners (GPs) and an increasing number of practice nurses and allied health professionals are members of their local general practice network. The Network is involved in a wide range of activities focused on improving the health of the Australian community including health promotion, early intervention and prevention strategies, health service development and delivery, eHealth, data management, chronic disease management, medical education and workforce support.

AGPN aims to ensure Australians have access to an integrated, high quality health system by delivering local health solutions through general practice.

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Summary of recommendations

AGPN's budget initiatives are designed to sustain and build capacity within the primary health care system to achieve the Federal Government's vision for health reform – an accessible, integrated primary health care system with a strong focus on prevention which is achieving quality health outcomes for the Australian community.

Access to primary health care: new and enhanced services

National Primary Health Care Nursing Initiative

- \$12 million over three years for a nursing in primary health care program to deliver the primary health care nursing leadership; education and training; workforce growth and development and nurse-led service development required to underpin national health reform

Telehealth Initiative

- \$6 million over three years to implement fifteen Medicare Local based telehealth demonstration sites that leverage online consultation technologies to develop and support innovative health service delivery models, education and infrastructure support; and address access and equity issues in rural, regional and remote Australia

Rejuvenating our primary mental health care system for better access

- \$188 million over four years to respond to the Government's second term commitment to mental health and the longer-term community recovery required as part of the flood response through the implementation of a suite of integrated early intervention, community-based mental health services and support programs comprising:
 - national implementation of *Every Family* based on the evidence-based Triple P positive parenting program (\$63 million over 4 years)
 - building on the Mental Health Support for Drought Affected Communities Program to implement a *Connecting Rural Communities for Mental Health* to continue funding for the established network of Community Support Workers and promote mental health literacy and help-seeking, ensure service coordination and provide mental health and community development support to rural and regional areas experiencing climatic distress (\$40 million over 4 years)
 - establishment and evaluation of demonstration services under the *beyondblue* Mental Health Community Access Program initiative in up to five Medicare Locals, integrated with the established Access to Psychological Services (ATAPS) Program to form a regional step-up, step-down community based service (\$85 million over four years)

Coordinated Care: A Better Health and Hospitals Avoidance Program

- Complementing the existing MBS Enhanced Primary Care arrangements, this \$200 million over 4 years measure would improve the health outcomes of

eligible people with chronic and complex health problems who are most at risk of illness and social isolation by providing capacity to general practice networks and Medicare Locals to engage nurses to assist with care coordination and provision of self-management support.

Workforce

- Continuation of the Workforce Support for Rural General Practice Program at \$8.5 million over three years.

Integration for better connected care

Strengthening the critical relationships between PHCOs and LHNs - a National General Practice Liaison Officer initiative

- \$20.5 million over three years for a General Practice Liaison workforce to cement linkages and improve continuity between primary and secondary care to deliver on the goals of the National Health and Hospitals Network

eHealth change and adoption measure

- \$60 million over three years to establish an eHealth change and adoption workforce across Medicare Locals to support the rollout of the Personally Controlled Electronic Health Record (PCEHR), and to facilitate the data requirements of Medicare Local health service planning and delivery.

Aged Care Access Initiative

- Funding for one year at current levels to ensure that workforce, service links and service delivery capacity is not lost in the lead-up to the implementation of the flexible funding pool to target gaps in access to primary health care services for aged care residents from 2012-2013 as announced in last year's Budget.

Prevention: promoting healthy, productive communities

A network of healthy lifestyle workers

- \$40 million over four years for a network of healthy lifestyle workers in Medicare Locals to develop and implement primary health care action plans to promote healthy lifestyles and prevent chronic disease. The coordinators would establish intersectoral partnerships for healthy communities, increase health literacy in the primary health care setting and local communities in accord with national prevention priorities addressing tobacco, alcohol and other substance abuse and obesity set by the Australian Preventive Health Agency and deliver or coordinate the delivery of structured evidence-based lifestyle modification programs
- Diversion of already appropriated funds and development of more flexible guidelines of the COAG Type II Diabetes Prevention Program to ensure greater access to lifestyle modification programs delivered by Medicare Local healthy lifestyle workers

Quality and Safety in primary health care

Continuation and expansion of the Australian Primary Health Care Collaboratives

- Continuation of the APCC program at current funding levels over 4 years to maintain a quality and safety initiative in primary health care through Medicare Locals to ensure ongoing improvement in service delivery to regional communities
- An additional \$10.5 million over three years for additional workforce capacity to engage a greater number of primary health care providers

Establishment of the Australian Primary Palliative Care Framework

- \$2 million over two years for a landmark program to build the capacity and competence of primary health care service providers to deliver a best practice end of life care approach in Australia so that all Australians can access quality generalist palliative care in the primary care setting

Budget 2011: a pragmatic approach

AGPN and its members are committed to a prevention and primary-health care oriented health system which achieves the Federal Government's vision for the National Health and Hospitals Network – only a more accessible, integrated and high quality primary health care sector will deliver a sustainable and responsive Australian health care system.

Globally, there is evidence that organised primary health care through regional entities delivers better health outcomes. As a key building block for reform, a new system of Medicare Local (ML) primary health care organisations has the potential to better plan, organise, coordinate and integrate services in response to local community need.

General practice networks (GPNs) have been the Australian equivalent of primary health care organisations. GPNs have increasingly shifted to focus on a comprehensive primary health care agenda, expanding their focus from one of general practice support to taking action in a range of key areas spanning health promotion, workforce development and support, and health service development and delivery. Accordingly, AGPN has welcomed the Government's decision to build MLs on the established regional footprint of GPNs.

However, new enhanced structures can only do so much. The real impact of MLs and whether they can make a fundamental difference to the accessibility, coordination, integration and quality of primary health care, as well as the capacity of the primary health care setting to contribute to the Government's commitment to prevention, will be determined by a number of factors. Foremost among these will be what they have capability and capacity to do, the trust and reputation they build with governments and the community, the frameworks under which they are funded and appraised, and the levels of funding they receive.

AGPN and its members are primed and ready to implement a new system of primary health care in Australia through MLs – to lay the foundation for Australian health reform driven through regionally organised primary health care. To make a difference, AGPN and its members believe that MLs must have the mandate to operate as 'full function' primary health care organisations with responsibility for planning, coordinating, purchasing and, in some cases, delivering primary and community health care programs and services regionally. To be fully effective, MLs must have flexible funding arrangements that shift away from the programmatic style funding under which GPNs currently operate coupled with sophisticated and enabling performance and accountability frameworks, consistent with the directions inherent in the Government's commitment to new ways of working with the 'third' or not-for-profit sector.

AGPN recognises that the significant outlays for primary health care in last year's Federal Budget make available funds for a number of programs for which MLs will be responsible. However, the Government faces fresh imperatives to act to address its second term priorities for health: aged care and mental health as well as prevention now the National Preventive Health Agency has been legislated. MLs and the primary health care setting will be key enablers in driving forward action in these important domains of health.

AGPN also recognises the unprecedented fiscal pressures on the Government's bottom line due to the Global Financial Crisis and the Government's resulting commitment to its fiscal strategy and the need to offset new spending with savings. This pressure has been compounded by the imperative to fund a comprehensive response to the recent floods in order to re-build communities and vital infrastructure.

In recognition of this environment, AGPN appreciates that the Government is not in a position to commit to major new outlays in health. We do, however, urge the Government to develop and articulate its long-range vision for health. Given the substantial investments and the multiple organisations and communities of interest with a stake in making structural reform a success combined with the momentum generated around how new national and regional structures can deliver a better system, Australia cannot risk a waning health agenda. We need a clear 2-5-10 year strategic outlook that maps the maturity and growth of MLs against health policy direction and goals. Such an outlook must necessarily include a plan for the transfer and integration of State and Territory primary and community health care services.

For now, AGPN's propositions for the Budget adopt an immediate and medium horizon. Organised around a four-point strategy addressing the key pillars of the National Primary Health Care Strategy of access, integration, prevention and quality and safety, we propose:

- a series of modest, low investment-high yield immediate term measures that will consolidate ML transition by focusing their initial activities and capacities on current Government priorities and areas where the Government will be compelled to act (the flood response and community rebuilding; mental health; aged care and prevention)
- a set of additional targeted primary health care measures with phase-in spending with the majority of expenditure occurring in the fourth year as further down-payments to ensure MLs are funded for success and have capacity to have a reasonably rapid impact in the medium term.

About the Australian General Practice Network

AGPN is the national organisation representing GPNs which are made up of 112 divisions of general practice across Australia and eight state-based organisations (SBOs). AGPN and its members are collectively known as the Network. AGPN coordinates and disseminates general practice and other primary health care programs through the Networks, among them:

- Chronic disease management
- National primary mental health care initiatives
- Indigenous health
- Immunisation
- eHealth and information management
- Prevention and lifestyle modification
- Nursing in general practice
- Rural palliative care
- Quality use of medicines
- Conferences and events

GPNs represent the community-based infrastructure which enables general practice to provide services to patients in the community and in their homes. GPNs:

- deliver local health solutions through general practice to ensure all Australians have access to high quality primary health care
- increasingly directly deliver services directly to patients – particularly through allied health and nursing
- are in tune with their local communities and understand their communities' socio-health and socio-economic needs, which makes them a solid foundation for strengthening Australia's primary health care system
- are involved in a range of activities including
 - health promotion
 - early intervention and prevention strategies
 - health service development and delivery
 - medical education
 - workforce development and support
 - eHealth and other strategies to connect care.

The Network is unmatched in its locally based support services which penetrate the vast array of communities across Australia – it is the only national, state and regional/local infrastructure of its type.

The Network can do this because of the team-based multidisciplinary and multi-sector approach it has driven throughout general practice involving GPs, practice nurses and allied health professionals who are supported by information and communication technology which enables coordinated care.

GPNs are uniquely placed to deliver services where there is an identified need to tailor services and health spending by:

- increasing their role in service planning
- recruiting and supporting the workforce to meet a community's needs
- holding Federal and State/Territory funds and either commissioning directly or employing clinical staff to deliver necessary services
- linking service providers to ensure comprehensive integrated services which support and respond to the needs of communities and individuals.

The Network is already evolving to take on a comprehensive primary health care approach – recommended by recent health reform committees as necessary for delivering on the Australian Governments' various agendas – not just in health but also in equity, productivity, fiscal responsibility and family/social connectedness.

Background and Context

The time for 'delivery and decision' has come for the Australian Government in its bid to implement the biggest health reform since Medicare. A number of major health reviews conducted over the past 24 months and the support for reform by the thousands of providers working in the frontline of our health system¹ has been the impetus behind the negotiation of the National Health and Hospitals Network (NHHN) Agreement by the Council of Australian Governments (COAG). These reforms have been designed, in part, to end the cost and blame shifting between the states and territories and the Commonwealth, but more importantly,

¹ Commonwealth Fund 2009 survey

to address the shortfalls in the current system, which have been increasingly exposed as Australian's health needs and priorities have shifted with time.

Local Hospital Networks (LHNs) and ML primary health care organisations are being established as the bodies responsible for coordinating, better organising and managing the acute and primary health care sectors respectively. The establishment of the National Preventive Health Agency will begin to accelerate the focus on and investments in prevention and the next stage of the Productivity Commission's review of aged care will create debate and momentum around how the primary health care system should be organised to better promote healthy ageing and better quality services to older Australians living in the community as well as residential aged care facilities. Similarly, the Prime Ministerially mandated Mental Health Taskforce chaired by the Minister for Mental Health and Ageing will examine reform options for mental health in the lead up to further COAG discussion on this topic.

Of particular importance is the role that MLs will play in supporting a truly prevention and primary health care oriented Australian health system. There is clear evidence that the best - and only - way to create and sustain a health care system that is equitable, accessible, high in quality and patient-centred, is by better integrating and coordinating services, expanding the roles and membership of primary health care teams, establishing and promoting quality and safety protocols and involving consumers in the design and function of their health system. Central to all of this is the need to provide and maintain the necessary infrastructure and resources to operationalise these ambitious but essential reforms.

Reforms to date have been structural and financial: commitment to implementing the health reform agenda must be vigorously pursued because there are too many risks to the health and productivity of the community of a waning health reform appetite. In the follow-on from the Global Financial Crisis, it is well understood that the Government needs to make pragmatic financial decisions in the short term. Committed to economic prudence, fiscal consolidation and judicious spending, the incoming health reforms are, by design, intended to provide better health outcomes for all Australians at the same or lesser cost than the current system - i.e. to 'get more health for the money'. This will be achieved through the proposed efficiency measures, but more importantly, through the reduced strain on the health system brought about by preventive, early intervention and health promotion policies. A more efficient system will inevitably free up resources to be utilised in other problem areas. In this light, the Government has prioritised aged care, mental health, rural, remote and Indigenous health for greater resources and focus. These challenging and complex areas will be the principal responsibility of MLs to provide services in these areas with the expectation of addressing the deep, long-standing equity and equality imbalances that have become simply unacceptable. To do this, it is critical that the Gillard Government should urgently set out its blueprint and vision for health in order to provide the policy and strategic framework under which MLs should plan and develop.

It is also critical that MLs are adequately resourced to become 'full function' PHCOs, meaning they can build the capacity to identify, plan, implement and monitor their community's health needs and expectations. 'Funding for success' does not simply mean putting the right structures in place, as this is not an end in itself, but rather it means building on them to create innovative, responsive and

continually improving centres of excellence that are positioned to deliver the health care that Australians need and deserve.

For this to occur, AGPN, along with its members, envisions that MLs will be funded in a new and innovative way, to help drive a new and innovative health care system. This would include funding mechanisms that are flexible and needs-driven and locally relevant, rather than siloed, rigid and tied up in red-tape. AGPN and its members envision performance evaluations based on outcomes and consumer satisfaction, rather than on rigid service provision and budget expenditures. With these desired changes, primary health care will be positioned to deliver on the health care aspirations of the Government and the community alike, and will more importantly be positioned to deliver on the health outcomes, productivity and general social wellbeing that we as a country are striving for.

Budget priorities: funding for successful reform

AGPN's Budget submission balances a cautious approach to new spending measures with the requirement to invest further to successfully realise the objectives of the health reforms. AGPN also acknowledges that significant government spending has already been provided to support some key components of health reform. AGPN's goal in this Budget submission is to highlight those areas where further, but prudent, spending is necessary to ensure the successful delivery of the reform goals. AGPN's submission is aligned with the core building blocks of reform and key areas of change highlighted in the National Primary Health Care Strategy essential to realising the further goals of the government's ambitious health reform agenda. These areas are:

1. Access to primary health care: new and enhanced services
2. Integration for better connected care
3. Prevention: promoting healthy, productive communities
4. Quality and safety in the primary health care setting

Action in these areas will ensure that we can achieve the primary health care-led health system envisioned by government in its reform.

Access to primary health care: new and enhanced services

1.1 Supporting improved access and new models of care through a Primary Health Care Nursing Initiative

\$12 million over three years for a nursing in primary care program to deliver the primary health care nursing leadership; education and training; workforce growth and development and nurse-led service development required to underpin health reform

Funding for the current Nursing in General Practice Program was reduced this year and is set to cease on 30 June. Yet capacity to support the practice nurse workforce is fundamental to the Federal Government's reform agenda.

In addition to their clinical skills, nurses are able to effectively contribute to change management, educate consumers and health professionals (including GPs) and monitor quality and safety within general practice and primary health care settings². Nurses are also a key component in integrating health services at a local level and supporting GPs in the management of complex patients.

The goals of the ongoing and proposed health reform agenda entail increased and expanded roles for primary care nurses. Crucial areas of the National Primary Health Care Strategy are directly related to the need for a strong primary health care nursing workforce which can act in the numerous roles described above. The preventive health strategy also has as priorities multiple areas in which primary health care nurses are ideally qualified to be involved including improving access to services that provide lifestyle advice. Other announced health reform initiatives such as the Practice Nurse Incentive payment (PNIP), the planning and service development functions of MLs, the development of new models of care with a focus on teamwork, and the introduction of Nurse Practitioners (NPs) working collaboratively with other health professionals in PHC will all require broad ranging support for nurses to ensure their successful implementation.

To achieve a solid uptake of the proposed reforms and to help implement key aspects of the PHC strategy will require not only *more* primary care nurses, especially practice nurses, but also a greater leadership role in nursing. Efficient and effective national communication mechanisms through which to provide information to and about nurses, linkage and change agents on the ground at local and regional levels as well as ongoing, coordinated educational, workforce and training opportunities are all required to support the increasing numbers of nurses in primary care.

The Nursing in General Practice (NiGP) program delivered through the Network has achieved some significant results most notably supporting growth in the workforce from 4,000 in 2003 to around 9,000 nurses working in general practice in 2009. Through GPNs, this exponential growth in workforce has been supported by a range of measures such as an orientation program for new nurses, leadership, mentorship and clinical skills training, placement of undergraduate students in general practices for clinical supervision and research to provide evidence for practice nurse effectiveness.

Since 2009, however, reduced funding for the program has led to a concomitant reduction in capacity for primary health care nursing support. Not only has this had an immediate impact on support for retaining and further developing the skills of the current practice nurse workforce, it will also impede overall numbers as well as support for nurses working in primary care in the future – nurses who will take on increasingly complex roles and who will need strong leadership, good communication about new initiatives, ongoing support, education and training and a clear and well defined career pathway.

Without further resourcing for an expanded primary health care nursing program, there is a real risk of losing both the expertise and capacity of existing practice nurses as well as the capacity to actively attract more nurses to the primary health care setting. A plateauing PHC nursing workforce and associated support

² http://www.anu.edu.au/aphcri/Domain/PracticeNursing/3pp_aphcri_nurses.pdf

program will place at risk those Government primary health care reform initiatives which rely on a strong nursing network and workforce.

AGPN proposes the establishment of a four year Primary Health Care Nursing Program. The Program would be developed collaboratively with other nursing groups and would include the following domains of activity:

- national coordination, education and support for PHC nurses
- chronic disease management and prevention skills and service development (online obesity, overweight, smoking and alcohol use training tools; models of nurse led care)
- workforce support and monitoring (a biannual workforce survey, ML-based nursing coordinators)
- Primary health care integration (business models for the new PNIP; PHC nursing clinical placement coordination and development)
- Primary health care nursing career framework (develop and promote a recognised career pathway for PHC nurses)
- Quality and safety (guidelines and tools)

Featuring a national coordinator and through nursing coordinators based in each ML this program could lay the groundwork for integrating and supporting primary health care nurses into the new NHHN, help to ensure sufficient nurses to deliver on the reform initiatives such as PNIP, ensure that a career structure is in place to promote expanded roles for nurses in chronic disease management and prevention as well as in preparing a future NP workforce for nurse run clinics.

1.2 A telehealth initiative to support access to health care for regional communities

\$ 6 million over three years to implement fifteen Medicare-Local based telehealth demonstration sites that leverage online consultation technologies to develop and support innovative health service delivery models; education and infrastructure support; and address access and equity issues in rural, regional and remote Australia.

The Government's recent announcement that it will invest over \$352 million to support online consultations is a strong step forward in addressing access and equity issues in the Australian healthcare system. This is particularly the case in rural, regional and remote Australia where patients regularly have to travel considerable distances to access essential health services. Telehealth technology such as video conferencing provides the possibility to develop innovative health service delivery models that can bring these services to the patient's doorstep, regardless of their location.

The implementation and adoption of telehealth services will mean improved health care access for those most in need, as well as a decrease in presentations to emergency departments, efficient use of the time and resources of GPs and other health services, reduced travel times and transport costs and improved patient self-management. This can be achieved at a relatively low start-up and maintenance cost.

Most importantly, telehealth in addition to improving the accessibility to health services in rural and remote areas, telehealth will also improve health care access by people with physical disability or who are socially isolated, and in other areas with workforce shortages – one of the Government's main priorities for the health

reform agenda. It will also provide significant benefits for elderly and less mobile patients managing chronic conditions.

The ability for health professionals who offer online consultations via telehealth services to access Medicare Benefits Schedule (MBS) items from July 2011 also removes a considerable financial barrier to the uptake by clinicians of telehealth solutions. It is anticipated that the future availability of high speed broadband through the National Broadband Network (NBN) will remove one of the critical technical barriers - the bandwidth required to deliver a video-based consultation.

Other barriers to uptake, as evidenced by the relatively low uptake of MBS items for mental health services delivered through online consultations, exist and will need to be addressed in order to benefit from the Government's investments telehealth. In order to identify the barriers to adoption, strategies to address these barriers, and to establish successful telehealth models of care and implementation strategies AGPN proposes the funding of 15 telehealth demonstration sites across Medicare Locals.

These telehealth demonstration sites would operate in a similar fashion to the Personally Controlled Electronic Health Record (PCEHR) lead implementation sites, all of which are currently led by GPNs. The telehealth demonstration sites would deliver operational telehealth solutions in regional areas linking general practice, allied health professionals and specialists. Through this process, barriers, opportunities and successful implementation strategies would be identified with the models of care being shared with future implementation sites.

AGPN recently conducted an expression of interest process across the Network to determine levels of interest and activity in telehealth with overwhelmingly positive results. GPNs and in the future Medicare Locals are both well placed and well prepared to delivery telehealth solutions across rural, regional and remote Australia.

With the recommended funding, AGPN will:

- Deliver 15 telehealth demonstration sites across rural, regional and remote Australia; bringing together general practice, allied health and specialist services.
- Evaluate and report on the lessons learned from these implementation sites including identified barriers to uptake, opportunities and successful implementation strategies
- Develop a national telehealth education initiative, based on the above learnings and delivered through Medicare Locals that will support telehealth adoption across Australia
- Provide support for general practice and the broader primary health care sector in the adoption of telehealth solutions including support for implementation of the necessary technology and the establishment of new health service delivery models
- Provide national co-ordination of telehealth demonstration sites in order to promote interoperable systems, adherence to national standards, and the development of sustainable and scalable implementation models.

1.3 Rejuvenating our primary mental health system for community access

\$ 188 million over four years to respond to the Government's second term commitment to mental health and the longer-term community recovery required as part of the flood response through the implementation of a suite of integrated early intervention, community-based mental health services and support programs comprising:

- **national implementation of *Every Family* based on the evidence-based Triple P positive parenting program (\$63 million over 4 years)**
- **build on the Mental Health Support for Drought Affected Communities Program to implement a *Connecting Rural Communities for Mental Health* to continuing funding for the established network of Community Support Workers to promote mental health literacy and help seeking, ensure service coordination and provide mental health and community development support to rural and regional areas experiencing major emergencies and events (\$40 million over 4 years)**
- **establishment and evaluation of demonstration services under the *beyondblue* Mental Health Community Access Program initiative in up to five Medicare Locals, integrated with the established Access to Psychological Services (ATAPS) Program to form a regional step-up, step-down community based service (\$85 million over four years)**

Every Family: supporting the wellbeing of children and families

Every Family is a comprehensive, evidence-based multilevel system of parenting intervention and family support designed to promote the well being of children and families based on the Triple P Positive Parenting Program. The program would target all parents of children from birth to age 7. Successful execution of this plan will enhance developmental and mental health outcomes of children and family wellbeing.

High quality educational and clinical resources for all levels of the intervention have already been developed and evaluated. Established partnerships are in place with AGPN, its national footprint of general practice networks, and Lifeline. This initiative could be rolled out beginning 1st July 2011 at a similar cost per family as a national immunisation program.

National implementation would provide enhanced support to families through the delivery of a suite of evidence based parenting programs to parents. All parents of children from birth to age 7 would be able to access one or more levels of Triple P suited to their needs. The suite of programs offered are comprehensive and range from media and communication messages designed to normalise and destigmatise parenthood preparation and brief intervention and developmental guidance through primary health care consultations to more intensive group or individual programs for parents of children with more severe behavioural and emotional problems (including parents of children with a developmental disability).

The Initiative would build on prior Australian Government investment in measures such as KidsMatter and Communities for Children and would be implemented regionally by Medicare Locals to ensure it is integrated in the primary health care system and has appropriate links with education, childcare, family and other community services locally. Medicare Locals would engage coordinators, educators and clinicians to roll-out all facets of the program including local communication strategies, provider education and new services.

Based on evidence from over 140 evaluation studies, this initiative would enhance the health and wellbeing of Australian children and their families. It would significantly:

- Reduce the number of children who develop serious behavioural or emotional problems
- Reduce the prevalence of high prevalence mental health disorders in the general adult population
- Increase educational outcomes
- Reduce the prevalence of child abuse and neglect
- Increase workforce productivity.

Connecting Rural Communities for Mental Health

The Mental Health Support for Drought Affected Communities Initiative (the Initiative), implemented through the Network in partnership with *beyondblue*: the national depression initiative, has raised community awareness on mental health service pathways, provided education and training to business and community leaders and delivered community outreach and crisis counselling. The Initiative has proven to be an effective model of mental health intervention for individuals and families facing prolonged dry conditions and climate variability in rural and remote communities, as well as other major emergencies and events.

Drought is not the only climatic cause of trauma and hardship that affects individuals' and families'. The Victorian bushfires, the locust plague, the North Queensland cyclones and the recent floods in eastern Australia are recent reminders of the enduring impact natural emergencies and events can have on communities. They are also a stark reminder of the need to continue the necessary mental health support programs to ensure the health and wellbeing of our rural and remote residents. It is clear that individuals and families that experience such hardship – from a variety of natural disaster causes - face significant mental and physical health risk through increasing loss of economic participation, reduced social inclusion, significant financial and sentimental loss, unprecedented trauma, a diminishing quality of life and poor community connectedness.

Community Support Workers (CSWs), under the auspices of the Initiative and with the support of the Network and *beyondblue*, have become a vital workforce and important part of local service infrastructure in many rural and regional communities. CSWs have been assisting individuals and families in coping with the distress and mental health impacts that these events cause. They have been doing this primarily by:

- Acting as the link between individuals and general practice – both GPs and practice nurses - who are the primary point for accessing mental health support and referral;
- Linking with and promoting the availability of mental health programs and services provided by Government funded programs like Better Access, ATAPS and **headspace** and, recognising the comorbidity that often exists between mental and physical health problems, linking families and individuals with general health services
- Filling service gaps by informing individuals about alternative mental health services and, in many cases, directly providing services themselves such as crisis support, mental health first aid and service coordination;
- Promoting mental health literacy and increasing awareness of mental issues through local community forums, suicide awareness training etc;
- Adapting their function and approach to meet individual community needs with a focus on community development and recovery outcomes; and
- Working in partnership with both national organisations such as *beyondblue* and local providers such as Centrelink, rural financial counsellors and local governments to better integrate, plan and communicate mental health services.

Despite the mandate to work in drought affected areas, CSWs have also been delivering mental health services in rural and remote areas that have been gravely affected by other emergencies and events. An independent evaluation of the Initiative found that it was a good practice model of community engagement and mental health promotion in rural communities³. The importance of this broadened role has been driven by community need and its expansion and continuation should be a Government priority. AGPN recommends that, to better reflect its broader practical scope, the name of the Initiative be changed to '*Connecting Rural Communities for Mental Health*'. Under the current Initiative, mental health services through CSWs are also only provided in Queensland, Victoria, South Australia and New South Wales. In-line with the Government's objective of increasing access to mental health services - especially in rural and remote areas - AGPN recommends that the newly proposed initiative be broadened to include all states and territories. AGPN further recommends that all Medicare Locals with rural and regional catchments hold the funds in order to engage CSWs and that GPNs or Medicare Locals in urban flood affected areas also be supported to engage such a workforce. Funds for program continuation would also provide for workforce education, training and support in partnership with *beyondblue*. Complementing the specialist psychological services provided through ATAPS, core functions of the CSW would be to:

- rapidly respond to their communities' needs in both the immediate and long term as part of a regional solution to all climatic variations causing distress;
- Implement targeted strategies to high-risk individuals, groups and communities around suicide;

³ Juriansz D (2010) Mental Health in Drought affected Communities, Independent Evaluation Report

- Assist individuals and communities during recovery from climatic distress;
- Support rural and remote residents to help-seeking and self-management behaviours to better manage their mental health and wellbeing through promotion, awareness and education – in partnership with *beyondblue*;
- Build on mental health and suicide literacy to de-stigmatise mental health in cultural groups and communities; and
- Act as knowledge and referral brokers to put the right people in the right care at the right time and, where appropriate and suitably qualified, provide direct mental health support services (psychological therapy, crisis support and service or care coordination, for example)

beyondblue Mental Health Community Access Program (bbCAP)

Although great strides have been made since 1992 under successive National Mental Health Plans, many people with depression and anxiety disorders are still missing out on effective help, or are self-treating as best they can with no support. In particular, the introduction of Commonwealth-funded programs such as the Access to Allied Psychological Services (ATAPS) and **headspace** have dramatically changed the mental health service delivery landscape although demand for these services typically outstrips their capacity.

The *beyondblue* Mental Health Community Access Program (bbCAP) is based on a successful United Kingdom scheme operating since 2005, the Improving Access to Psychological Therapies (IAPT) program (also known as the Doncaster model). bbCAP is being designed to provide easily-accessible and affordable help to many thousands of people with depression and anxiety where it is not readily available now; to reduce demand on specialist services; and to free up specialised professionals to treat and manage more appropriate more chronic and complex mental health conditions.

The UK program offers guided self-help to people who need some psychological intervention but who do not necessarily need high-intensity support. The evaluated results are still coming in, but the promising indications are that IAPT has increased access to services for many people living in areas served by the program; helped many of its clients to manage and address their psychological conditions; and achieved recovery rates (in terms of returning to “normal” functioning as a member of the community) in less time and at less cost than a high-intensity approach. A study funded by *beyondblue* points to the feasibility of an Australian adaptation. There was overwhelming support from consumers, health professionals, state directors of mental health (or their proxies), representatives of relevant peak organisations and academics of the need for an Australian adapted version of the UK IAPT model to provide evidence-based psychological services for anxiety and depression across Australia⁴.

The proposed bbCAP program would integrate both low intensity (LI) and high intensity (HI) services and would adapt the successful elements of IAPT to Australian needs and conditions. HI services include clinical psychological,

⁴ Bennett-Levy J et al (2009). The *beyondblue* Improving Access to Psychological Therapies Project : Taking the Next Steps

medical and psychiatric support whereas LI services include structured and guided book and online based therapeutic and self management services along with support by a suitably trained and broader range of providers to help people understand their condition, self-manage and refer, assist them to comply with their treatment and improve day-to-day functioning by linking them with community networks and services. The components of the program include:

- a central service that both provides direct assistance to clients (telephone and online) and provides coordination, clinical and administrative support for local bbCAP sites and projects
- selection and establishment of up to five Medicare Local based bbCAP demonstration projects on a 'proof' of concept basis to develop and embed the model of care – these would be integrated with existing services such as ATAPS, Better Access and headspace and planned, coordinated and funded regionally by Medicare Locals
- recruitment, training and professional development of low intensity, high intensity and supervisory practitioners to work in the bb CAP service. This stream would include the design and implementation of training frameworks, curricula and an accreditation system for low intensity workers.
- an e-mental health portal to facilitate access to online evidence-based therapy and self-help and self-management support resources
- a quantitative and qualitative health service development evaluation.

Medicare Locals would implement bbCAP taking on responsibility for local promotion and marketing to the community and referrers; service provider recruitment, retention and upskilling; service development and clinical governance; and ensuring the service is integrated with established services such as ATAPS, Personal Helpers and Mentors and **headspace**. The estimated \$85 million over 4 year cost of implementation in up to five Medicare Locals, many of whom will service populations of around 500,000, would be offset by reduced demand for other 'high intensity' services by providing an additional referral pathway more appropriate to high prevalence disorders. The potential for co-investment by *beyondblue* and others could also offset overall government outlays.

Introduction of bbCAP to the Australian health system would:

- increase community awareness of mental health and promote mental health help-seeking through the right channels
- increase access to evidence-based therapies for the 60-65 per cent of consumers with mental health problems who are not currently accessing any mental health services
- improve the capacity of existing primary mental health services by reducing demand for other programs and services
- improve service linkages between health and social services

- add value to, and leverage off, the Australian Government's existing investments in Australia's primary mental health care system by strengthening it with a viable, evidence-based 'step down' service.

1.4 Coordinating Care: A Better Health and Hospitals Avoidance Program

Complementing the existing MBS Enhanced Primary Care arrangements, this \$200 million over 4 years measure would improve the health outcomes of eligible people with chronic and complex health problems who are most at risk of illness and social isolation by provide capacity to general practice networks and Medicare Locals to engage nurses to assist with care coordination and provision of self-management support.

Hospitals clearly provide an essential infrastructure and role in our current healthcare system and are the only place in which certain types of health care can and should be provided. However, admission to and use of hospital services is costly – to the system and to patients. Keeping hospital admissions to only those that are necessary is therefore an important measure in curtailing health spending and ensuring quality service delivery. In practice, a significant number of hospital admissions as well as readmissions are potentially preventable: in 2005-06, over 9% of hospital admissions were considered preventable⁵. Further, a large proportion of hospital admissions are for a relatively small number of conditions including a range of chronic conditions such as asthma, chronic obstructive pulmonary disease (COPD) pneumonia, heart disease, diabetes and depression⁵.

There is good evidence that people with chronic diseases such as these can be very well managed in the community through multidisciplinary team-based primary health care services. Such care enables people with chronic disease to access the multidisciplinary skills and expertise they need for good management of their condition, helps patients to better self manage their own condition, leads to improved outcomes for patients and results in a reduction in (avoidable) hospital admissions and readmissions.

A key factor in attaining these results is ensuring that patients can be linked with and attend appointments with all of the health care providers in the multidisciplinary team required for their care. This is a critical aspect to good chronic disease management and will become increasingly important as health care delivery moves more and more towards proactive, preventive care.

While the introduction of Medicare Locals from July 2011 will provide a regional infrastructure that can help more generally link and coordinate a range of health and health related services at the regional level, there will still be a need for an on-the-ground workforce that can work directly with patients with chronic disease to help them access and coordinate their required multidisciplinary team appointments and self-manage more effectively. There is good evidence that this coordination role has a positive impact on patient outcomes and is best

⁵ Australia's Health 2008 AIHW

performed by a non-GP care coordinator and, significantly, also leads to lower service utilisation⁶.

A network of Chronic Disease Care Coordinators could work effectively from within each Medicare Local and/or practices to provide this direct role and ensure that patients with chronic disease make and keep appointments with their multidisciplinary team professionals. In addition, the care coordinators would work with the multidisciplinary team to ensure that existing best practice tools, such as the GP Management Plan and Team Care Arrangements, already funded under the MBS, are comprehensively completed and implemented for each patient. The coordinator would then have primary responsibility for coordinating the patient's ongoing care needs and self-management support as set out in the care plan, working closely with both the care team and with the Medicare Local to fulfil this goal.

In addition to providing capacity to engage and employ a care coordination workforce, it would also include training and resources to nurses in best practice chronic disease management and team based care. This type of care coordination program could build on and extend a similar successful program currently being commenced for veterans and war widow/ers by the Department of Veterans' Affairs (DVA) and further apply the learnings from the successful Team Care Coordination Program developed by GPpartners, a Brisbane based GPN. The measure could be further extended with the provision of additional funds for service delivery and brokerage funds to the Medicare Local to enable care coordinators to organise provision of primary health care services particularly in circumstances where there are gaps in available or affordable services.

As well as providing a direct coordination service to patients, Care Coordinators would be well placed to assist newly established Medicare Locals achieve key performance targets such as:

- providing input into regional service planning by identifying areas where there are service gaps and assisting Medicare Locals to work collaboratively with other regional health service providers to ensure that good referral pathways are in place
- developing and delivering new models of team based chronic disease care
- working with GPLOs and LHNs on further avoidable hospital admissions programs.

1.5 The Workforce Support for Rural General Practice program

Continuation of the Workforce Support for Rural General Practice Program for a further three years. AGPN estimates this will cost \$8.25 million over three years.

The workforce shortages within the health sector are well known⁷. These shortages increase significantly with increasing rurality and are a particular issue

⁶ Department of Health and Ageing (2007), The National Evaluation of the Second Round of Coordinated Care Trials, Canberra: Commonwealth of Australia

⁷Productivity Commission, 2005, Australia's Health Workforce: Productivity Commission research report, Canberra: Commonwealth of Australia.

in relation to GPs where supply falls to as low as 47.1 FTE GPs per 100,000 population in very remote areas⁸ compared to 97.0 FTE GPs per 100,000 population in major cities⁹.

Yet GPs are a core part of our frontline health workforce. They are needed equally throughout Australia and their supply will become even more critical as the new health reforms place a growing focus on primary health care – value for money care that can be accessed within the community without referral. The announcement of new GP training places is a good first step towards assisting a greater general supply of GPs. However, there is no guarantee that these new GPs will move to areas where they are most needed such as rural and remote Australia. In fact, given the profile of new medical graduates, there is a low likelihood that they will elect to work in rural areas as working hours in rural communities tend to be longer and there are less employment and education opportunities for spouses and children – all important considerations for new “Gen Y” medical graduates.

The Workforce Support for Rural General Practitioners (WSRGP) program, delivered through rural GPNs, has helped address some of the GP shortages arising from the medical workforce maldistribution and is an important means of enabling rural communities to access health care. GPNs with at least five percent of their population living in rural and remote (RRMA 4-7) areas are eligible for WSRGP funding.

Through the program, participating GPNs undertake a range of activities to attract, recruit and support the rural general practice workforce (including GPs, medical students, PNs and practice managers) and their families. This includes practice support for GPs and other practice staff, provision of or sponsorship to attend education and training events for GPs, locum coordination and support, networking of provider groups and family and social support. Much of this support is provided through the employment of workforce support officers.

The program is highly valued within rural communities. In many instances GPNs subsidise the program from additional funding sources (e.g. core budgets) in order to maximise opportunities for improving access to health workforce in rural areas. It is a key component of rural GPNs’ workforce support activities and would be an important ongoing aspect of the work of Medicare Locals once GPNs and other agencies transition to these new primary health care organisations as part of the new National Health and Hospital Network (NHHN). The flexibility of the program would fit with the role and goals of Medicare Locals and would enable the program to continue to be adapted to local needs.

AGPN understands that future funding for the WSRGP program has not yet been guaranteed. However AGPN cautions that any reduction or removal of this funding would greatly exacerbate the existing challenge of getting doctors to the bush and of providing health care to rural Australians. Lack of access to an adequate frontline general practice workforce would also stymie implementation

⁸ GP supply for remote and outer regional areas are also low: 74.2 and 86.2 FTE GP per 100,000 population respectively

⁹Australian Government Department of Health and Ageing (DoHA), 2008. *Report on the Audit of Health Workforce in Rural and Regional Australia*, April 2008. Commonwealth of Australia, Canberra, at 8. These figures are based on the AIHW’s Medical Labour Force Survey 2005.

of the proposed health care reforms which rely on sufficient primary care workforce.

Integration for better connected care

2.1 Strengthening the critical relationships between MLs and LHNs: a national general practice liaison officer initiative

\$20.5 million over three years for a General Practice Liaison workforce to cement linkages and improve continuity between primary and secondary care to deliver on the goals of the National Health and Hospital Network

Most hospital episodes begin and end with care in the community yet there is a lack of coordination of care between hospitals and general practice. This gap has implications for patient safety which in turn has implications for costs to the system¹⁰. As more people need coordinated care from both sides of the primary/secondary interface good communication between general practice/primary health care and hospitals will be an increasingly important factor in quality care provision, cost of care¹¹ and patient experience¹².

The introduction of the national health and hospitals network (NHHN), as part of the ongoing health reform, will see Medicare Locals and Local Hospital Networks commencing in 2011. Recent announcements regarding the NHHN make it clear that LHNs and MLs will be required to work collaboratively "... to ensure that locally responsive and tailored care extends beyond hospital doors" and because it is well understood that coordination and integration of services are critical factors in improving continuity of care and patient outcomes. There will be a role for both LHNs and MLs in this type of integration. However, integration and service coordination require that a range of resources such as systems, tools and workforce be put in place over and above the provision of the basic NHHN infrastructure of LHNs and MLs.

In particular, improved linkages and continuity of care would be achieved through investment in shared integration programs and a skilled 'linking' workforce. Such a workforce would drive the required system and cultural changes in both the hospital and primary health care settings to develop integrative behaviours and processes at the local/regional level. A nationally connected and consistent general practice liaison officer (GPLO) workforce would provide this.

¹⁰ For an overview of the literature, see PHCRIS May 2010 research Roundup Issue 11 "Continuity and safety in care transitions: communication at the hospital/community interface <http://www.phcris.org.au/publications/researchroundup/index.php>; Accessed 7 November 2010>.

¹¹ Better coordination of care between the hospital-primary care interface can actually save costs on health through decreasing adverse incidents post hospital discharge and, in certain cases, by preventing unnecessary hospital admissions

¹² Kvamme, O.J et al (2001) Improving the interface between primary and secondary care: a statement from European Working Party on Quality in Family Practice (EQUIP) Quality in Health Care 10: 33-39

A recent literature review¹³ which identified a range of system level challenges for integrating the primary and secondary care interface showed that the role and functions of GPLOs are critical in change management and in influencing successful outcomes and systematic change at the primary-secondary care interface. GP liaison roles have been shown to reduce patient hospital usage, improve communication between sectors, increase the skills of the primary health care team, improve treatment compliance, reduce referrals to secondary care, and improve staff and patient satisfaction. GP Liaison Officers acted as change agents within their locality and worked in areas of leadership, strategy, service redesign, communication and education¹³. The roles and functions of GPLOs provide opportunities to:

- enhance the quality, efficiency and responsiveness of care
- improve the quality and safety of patient care
- address 'long wait' patients awaiting specialist outpatient appointments
- reduce referrals from primary health care to sub-acute care and hospitals
- improve communication between general practice and hospitals
- reduce the workload burden of health professionals through supporting a coordinated, integrated collaborative service delivery model
- improve efficiency, and improve health outcomes

A GPLO workforce exists to some extent in Australia already however, geographic coverage across Australia is patchy, it is nationally uncoordinated and role definitions are variable. Currently, GPLO staff comprise a mix of GPs and program officers, can be located in a variety of settings (such as hospitals, divisions and some community/area health settings) and often have a broad remit to their work. All these roles are important – however to be more effective, what is needed is a more consistent, nationally coordinated approach.

Implementing new and building on existing local general practice liaison programs would be a timely, achievable and practical approach to engaging MLs and LHNs in improvements at the primary-secondary interface. A robust program in each state would provide a framework and a workforce to develop cross sector relationships, and drive cultural change to develop integrative behaviours and processes at the local/regional level.

Increasing the authority and reach of the GPLO program would also assist in meeting national standards of care – such as elective surgery and four hour access targets for emergency departments. With increased authority, GPLOs could engage clinicians across the primary-secondary interface to develop new models of care in the community, for example, working with public specialists and GPs to design models of care in the community setting that assist in demand management of specialist services while still delivering appropriate care.

¹³ Armstrong, K. (2010) Workforce policy implications for practice: Role of the GPLO in supporting the GP-hospital interface Griffith University & General Practice Queensland

GPLOs can also play a crucial support role in the eHealth agenda, successful implementation of which will underpin a number of the broader health reform goals. The primary-secondary interface is one area where newly implemented eReferral and eDischarge systems will be especially challenged. GPLOs' skill and role in change management processes would greatly assist in instituting organisational change and ensuring the smooth running of these new systems.

Overall, State and regional-level GPLO coordination could assist in:

- Liaising with state health departments and LHNs that are the system managers for public hospitals
- Establishing a GPL network for disseminating and sharing information and innovative practices
- Facilitating systematic planning and reporting processes to MLs and LHNs and government
- Facilitating professional development and training
- Promoting collaboration and consistency between LHNs
- Facilitating consultation processes between the state health department, LHNs and GPL services on issues such as ehealth implementation

National coordination would assist in:

- sharing of resources and dissemination of successful interventions across the nation
- coordination of activities with NeHTA for implementation of referral and discharge standards, and for implementation of national KPIs for GP-hospital communication
- resourcing the National GPL conference that currently occurs through the commitment and goodwill of the General Practice Network

With national coordination and investment the GP Liaison workforce can contribute a practical and collaborative means of addressing the gap between general practice/primary care and hospitals.

AGPN therefore recommends that, as a key enabler of the health reform work around the LHN and ML interface, a GPLO workforce is funded over three years to build on and bring greater national consistency and capacity to the current GPLO network. AGPN recommends that the GPLO network consists of a national coordinator and 90 GPL units¹⁴¹⁵ with roll out of GPLs to the three smaller states/territories, all areas currently without GPL coverage and the national position in the first year, followed over one to three years by roll-out of the remaining GPLs. The latter would build on existing GPLs to attain national requirements for coverage. It is envisaged that GPLOs would continue to be housed in either GPNs, MLs and/or hospitals as a fundamental part of the overall NHHN structures – a decision that would be made locally. In keeping with the

¹⁴ A GPL unit typically consists of a part time GP with other GPLOs/support staff and possible input from other professionals. A basic GPL unit (GP – 2 days per week; Program support - 4 days pw inc overheads) costs \$200,000 per annum

¹⁵ This is an indicative estimation based on current information. Ideally the number of GPL units in each state/territory would be matched to local system requirements

new agreement between the Commonwealth and States/Territories, funding for this initiative could be split 60-40 by these levels of government respectively.

2.2 Establishing a Medicare Local eHealth change and adoption workforce as per the National eHealth Strategy to support the delivery of national eHealth solutions across primary care.

\$60 million over three years to establish an eHealth change and adoption workforce across Medicare Locals to support the rollout of the Personally Controlled Electronic Health Record (PCEHR), and to facilitate the data requirements of Medicare Local health service planning and delivery.

While Australia's healthcare system delivers some of the world's best health outcomes, growing pressures on the system means that change is required in the way health care is delivered in order to sustain these outcomes. This change requires a fundamental shift in the way information is accessed and shared across the health system; a shift towards an environment where health care consumers, carers and providers can safely and reliably access and share health information. This can only be achieved through the implementation of world class eHealth capability¹⁶.

The successful implementation of a national eHealth system that provides this world class capability - including the rollout of the Personally Controlled Electronic Health Record (PCEHR) - will be key to the success of the Government's broader health reform objectives however sufficient funding and resources will be required to achieve this.

A number of 'foundation' and communication systems have been identified in the National eHealth Strategy and in the work program of the National eHealth Transition Authority (NEHTA). The adoption of systems including unique healthcare identifiers, clinical terminologies, secure messaging and electronic medication management are essential to the development of a PCEHR and in delivering a 'patient centred' health care system.

The move towards better service integration driven through Medicare Locals will also require the implementation and adoption of these communication systems. These communication systems facilitate the transfer of information between various practices and health personnel and ensure that important health information accompanies the patient on their journey through the health system.

A change management program, supported and driven by Medicare Locals and delivered across the primary health care sector will be essential in the successful rollout of such systems.

¹⁶ http://www.health.gov.au/internet/main/publishing.nsf/Content/summary_e-health_strategy_toc~summary_e-health_strategy_chapter_1

The PCEHR rollout is a key to achieving the Government's commitment to 'patient-centred' care in its National Primary Health Care Strategy. The PCEHR will act as a point of integration, bringing together a complete picture of an individual from a number of diverse sources clinical information. This information will be derived from existing clinical information systems maintained by clinicians across both primary care and acute sectors.

As the PCEHR's short and long-term success is predicated on the availability of accurate, reliable and complete clinical information, a 'data quality improvement initiative' will be fundamental to its success. An eHealth change and adoption workforce would build on established initiatives under the eHealth Support Officers Program to achieve this.

In order to better plan, organise, coordinate and integrate services, Medicare Locals will require access to de-identified health data. This data is essential to identifying and responding to local community needs and ensuring health services are delivered in an efficient and equitable fashion. The Medicare change and adoption workforce will provide the essential information management capacity required to access, aggregate and analyse this data.

Through the eHealth Support Officers Program, AGPN and the Network have successfully prepared the ground for the rollout of national eHealth solutions such as the PCEHR. With additional capacity for an eHealth change management initiative delivered through a dedicated and expert workforce based in Medicare Locals and supported by national and state-level coordination, AGPN and the Network will:

- Ensure the successful adoption of national eHealth foundation and communication solutions such as healthcare identifiers, across general practice and the broader primary health care sector.
- Through a national data quality improvement initiative, ensure complete, accurate and trustworthy data is available to the PCEHR and to better integrate health services in response to local community needs.
- Expand eHealth practice support to other primary health care providers and services, building on the eHealth capacity and literacy that exists in general practice
- Leverage the technology necessary to achieve better service integration, population health planning and quality improvement and performance monitoring
- Implement education and awareness raising strategies across the primary care setting.

2.3 Transitioning the Aged Care Access Initiative

Funding of one year at current levels to ensure that workforce, service links and service delivery capacity is not lost in the lead up to the implementation of the flexible funding pool to target gaps in access to primary health care services for aged care residents from 2012-2013 announced in last year's Budget.

The 2010 Federal Budget announced the Government's intention to provide Medicare Locals with a flexible funding pool to target gaps in access to primary health care services for aged care recipients from 2012-13. The forerunner Aged Care Access Initiative (ACAI) commenced in 2008 and is comprised of two components: an incentive payment to GPs administered through the Practice Incentive (PIP) Program and an allied health component. The allied health component supports payment for clinical care by providers to residents of aged care facilities where these services are not otherwise funded by the Commonwealth. It is managed by the Network's SBOs who can purchase allied health services directly or, as is done in most cases, through contractual arrangements with GPNs in their jurisdictions.

The ACAI program is well established and is performing effectively to meet its objectives. Across states and territories, it has taken time to establish the relationships, service linkages and systems to support optimal program function. However, it appears that funding for this initiative will not continue in the 2011-12 financial year. This has profound implications for the effective introduction and success of the 2010 Budget measure because current service provision, allied health engagement, relationships and networks that have taken time to establish and cement will be lost. This will mean a reduction in services for residents of aged care facilities and the need for relationships and linkages to be rebuilt from 2012-13 in order to support the new measure. AGPN recommends a transition year for the ACAI program in order to bridge the introduction of the new measure.

Prevention: promoting healthy, productive communities

3.1 A network of healthy lifestyle workers to prevent chronic disease, promote healthy communities and increase health literacy

\$40 million over four years for a network of healthy lifestyle workers in Medicare Locals to develop and implement primary health care action plans to promote healthy lifestyles and prevent chronic disease. The coordinators would establish intersectoral partnerships for healthy communities, increase health literacy in the primary health care setting and local communities in accord with national prevention priorities addressing tobacco, alcohol and other substance abuse and obesity set by the Australian Preventative Health Agency and deliver or coordinate the delivery of structured evidence-based lifestyle modification programs

Diversion of already appropriated funds and development of more flexible guidelines of the COAG Type II Diabetes Prevention Program to ensure greater access to lifestyle modification programs delivered by Medicare Local healthy lifestyle workers

There is now compelling evidence that Australia will gain both short and longer-term health, social and economic benefits from making prevention a high national priority. Combined with the establishment of the National Prevention Agency, the introduction of Medicare Locals provides the ideal core infrastructure to support health promotion and prevention activity.

The primary health care setting is identified in all recent Australian health reform documentation as one of the most important sectors of the health system for prevention¹⁷. It provides essential services for all Australians, connecting care across the life course, and offers many opportunities for prevention. Primary health care also has a great capacity to care for Australians across a very wide range of disciplines, including medicine, nursing, physiotherapy, occupational therapy, dietetics, pharmacy, psychology, chiropody and naturopathy and to link the health sector with other sectors that play a role through their contribution to civil society and environmental and community wellbeing.

Each of these professions can play a role in promoting healthy lifestyles. At present however, there is no coordination of effort, no common set of priorities, no common voice for prevention across the disciplines and links to other organisations in the community are ad hoc.

AGPN proposes that a network of healthy lifestyle workers be established. This workforce would be appropriately accredited, be based in Medicare Locals and their branch offices (where they exist) with a national coordinator at the AGPN/Medicare Local national organisation to provide national support and coordination. The coordinators will be responsible for:

- Development of a primary health care action plan promoting healthy lifestyles. This would be designed by each Medicare Local to include common core elements but be tailored for delivery at the local level according to the needs of their specific population. Plans would necessarily align with state and local government health promotion and prevention plans, and would be developed in partnership with other health promotion and healthy lifestyle personnel, strengthening local action by increasing the capacity of the primary health care sector to contribute to preventive action at the local level.
- Improvements in health literacy and healthy activity in the community through both:
 - education, training and skills development in prevention strategies for health professionals, allied workers and others in the community with a role to play in preventive health.
 - local level community based health education in a range of settings (such as schools, playgroups and other early childhood settings, workplaces and local government) as well as more general health literacy work within the broader community
- Partnerships with state and local government and key community groups, clubs and non government organisations and with the lifestyle and tobacco control coordinators identified through the *Close the Gap* Indigenous Strategy, to develop and implement healthy lifestyle programs, aligned, where relevant, with the Healthy Communities and other such initiatives

¹⁷National Health and Hospital Reform Commission (NHHRC) final report; t National Preventative Health Taskforce final report, the draft National Primary Health Care Strategy and COAG's Plan for Better Health for All Australians 2006

- Local level support for national social marketing campaigns such as those for smoking cessation, responsible drinking and healthy weight
- Development of a core set of healthy lifestyle messages and activities, developed as part of the branding and communication strategy for the new Medicare Local Network.

The workers would also have a role in the direct delivery of structured evidence-based lifestyle modification programs accessing block grants made available to Medicare Locals for this purpose. These services would evolve from and replace the COAG Type II Diabetes Prevention Program and would require diversion of funding already appropriated for this Program to provide supplementary service delivery capacity to the healthy lifestyle workers.

The Type II Diabetes Prevention Program has proved that investing in a network of healthy lifestyle coordinators can drive and achieve positive, effective change in people's health behaviour. These changes have been achieved despite the current Program's uptake being hampered by narrow program eligibility criteria, restrictive accreditation standards/workforce requirements and disparate referral pathways. With a more flexible program design, including a broader range of program standards/eligibility criteria and the development/use of a user-friendly universal risk assessment tool, the healthy lifestyle workers could deliver lifestyle modification programs and improved outcomes to a far greater range of people - both those currently with and without a diagnosed chronic condition. Successful delivery of lifestyle advice to a broader range of people would require funding to develop a generic chronic disease risk assessment tool that is easy to use and apply¹⁸. This could be developed from the current, evidence based AUSDRISK assessment tool which is very user-friendly and can be used by a wide variety of people.

Quality and Safety in the primary health care setting

4.1 Continuation and expansion of the Australian Primary Health Care Collaboratives

Continuation of the APCC program at current funding levels over 4 years to maintain a quality and safety initiative in primary health care through Medicare Locals to ensure ongoing improvement in service delivery to regional communities

An additional \$10.5 million over three years for additional workforce capacity to engage a greater number of primary health care providers

Quality improvement and safety standard initiatives are a key priority for the Government under its new health reform agenda. The Australian Primary Care Collaboratives (APCC) is a well renowned and well regarded program that has been contributing to these aspects of patient care by helping GPs and primary health care providers work together to:

¹⁸ Generic risk assessment tools do exist in Australia but are complex and can generally only be used by clinicians. The development of a more user friendly generic chronic disease risk assessment tool means that non-clinicians could also use the tool, so freeing up more workforce for the program.

- Improve patient clinical outcomes
- Reduce lifestyle risk factors
- Help maintain good health for those with chronic and complex conditions
- Promote a culture of quality improvement in primary health care.

The APCC methodology has a proven track record in leading to significant improvements in quality and safety in general practice, in addition to improving general practice understanding of their practice populations and health issues. This is done through the facilitation of effective networking opportunities, which has been responsible for driving best practice by promoting a culture of sharing and learning among providers. The model gives access to, and endorses, exemplar examples of evidence-based primary care solutions, with opportunity for providers to discuss the success with those who have achieved it, while also having the flexibility to tailor a parallel solution to their communities needs.

This program already meets several of the Government's health reform priorities by:

- Developing and promoting improved quality and safety measures
- A focus on prevention and health promotion
- An emphasis on providing better patient access
- Promoting a continuous learning and development culture
- Promoting integrated care and stakeholder engagement through networking activities.

Funding for the APCC is due to terminate in June 2011, and there is currently no indication that current capacity will be maintained let alone extended, particularly in a climate where MLs will have an obligation to support quality and safety initiatives in general practice as well as other primary health care settings. There has also been no clear indication to date on the forecast linkages this program will have with the newly established Australian Commission on Safety and Quality in Health Care (ACSQHC). AGPN believes that APCC, through an AGPN and Improvement Foundation partnership, is well placed to work collaboratively with ACSQHC in its bid to develop and implement primary health care safety and quality policies. This belief is warranted by APCC's impressive track record, the fact that it already has the necessary infrastructure and expertise in place, and by its clear and appropriate vision.

To continue and expand on the quality and safety improvements that APCC has already implemented and to equip this Initiative to support the ACSQHC in developing and implementing primary health care-related quality and standards, AGPN proposes that the Australian Government provide recurrent funding for the APCC program to:

- Continue and extend the regional APCC workforce to
 - engage and support a greater number of primary health care providers and practices in the application of APCC methodology
 - inform and support the implementation of ACSQHC primary health care work areas
- Provide capacity to liaise with and build systemic links between ACSQHC, the Network, Improvement Foundation and other appropriate national

organisations such as the Royal Australian College of General Practitioners (RACGP) to operationalise the work of the ACSQHC in primary health care; to oversee the activities of the Network and ensure the implementation of evidence into practice

- Utilise APCC methodology and expertise to integrate and operationalise ACSQHC resources in a primary care context;
- Better utilise the Medicare Locals network as the structure to support the implementation of ACSQHC initiatives.

4.2 Establishment of the Australian Primary Palliative Care Framework

\$2 million over two years for a landmark program to build the capacity and competence of primary health care service providers to deliver a best practice end of life care approach in Australia so that all Australians can access quality generalist palliative care in the primary care setting

Most of the last year of a person's life is spent at home, and most health care is provided by a person's general practitioner (GP). However, providing high-quality care at the end of life is among the most complex challenges for general practitioners (GPs).¹⁹ There is evidence that the proactive involvement of GPs enables more terminally ill patients to die at home and that this is the preference of patients and their carers.²⁰ There is also widespread agreement that a high value health care system needs to be built around a primary health care focus with the primary medical responsibility being borne by the GP, supplemented by specialist teams on the basis of complexity of need.²¹ It is imperative therefore that GPs and the primary health care teams that support them are well equipped to provide care to people as they approach the end of their life.

The fundamental tenets of being equipped to provide quality care are firstly, the ability to recognise patient and carer needs as patients approach the end of life, and secondly, to provide appropriate and well coordinated care.

It is widely acknowledged that many people dying of non-malignant conditions (about 75% of those people whose death can be predicted) could significantly benefit from access to care aimed at supporting them as they approach the end of life.^{22,23,24} People in this group are often elderly and commonly have a range of progressive chronic diseases including peripheral vascular disease, chronic renal and liver disease, congestive heart failure, COPD, and dementia, along with general frailty. Most of these people are cared for at home in an *ad hoc* way by

¹⁹ Mitchell, GK et al. 2008, 'Do case conferences between general practitioners and specialist palliative care services improve quality of life? A randomized controlled trial'. *Palliative Medicine*, vol. 22, pp. 19.

²⁰ *ibid.*

²¹ National EOL Framework Forum, p. 70

²² McNamara, B et al. 2004, *op. cit.*, pp. 2.

²³ Murray, S & Sheikh, A 2008, 'Care for all at the end of life'. *BMJ*, vol. 336, pp. 958.

²⁴ Skilbeck, J & Payne, S 2005, 'End of life care: a discursive analysis of specialist palliative care nursing'. *Journal of Advanced Nursing*, vol. 51, pp. 325-34.

their GPs and sometimes by disease-based specialists, rather than palliative care services.

Providing care on the basis of needs rather than diagnosis is the overarching principle of a needs-based system of care²⁵, and is supported by current health reform policy imperatives which emphasise improved access to care - especially primary health care and improved generalist palliative care - and better management of chronic conditions and enhanced end of life care and choices^{26,27}.

The end of life for people with progressive chronic conditions is by definition the final stage of chronic disease and the Federal Government's National Primary Health Care Strategy has firmly placed general practice and primary health care at the centre of chronic disease management. The priority directions for better chronic disease management in the national primary health care strategy also support end of life care. Most notably these involve the need to develop flexible responses tailored to local service systems and needs and services that include comprehensive and multidisciplinary team care, 'as needed' care coordination, sharing of information within and across providers, and self-management support including through diagnostic support tools.²⁸

Both AGPN and Palliative Care Australia (PCA) recognise the need to build the capacity and competence of integrated primary and community care services to provide needs-based end of life care through the development of strong partnerships and networks between primary care providers, aged care services, disease specific organisations and services, and specialist palliative care services.

An exemplar model for this process - the Gold Standards Framework (GSF) - has been developed in the United Kingdom. The GSF is a systematic evidence-based approach to optimising care delivered by generalist providers for patients nearing the end of life that has as its components communication, coordination, symptom control, out-of-hours continuity, continuing education and carer support. However, differences between the UK and Australian health systems mean that the GSF needs to undergo significant adaptation for the Australian setting. Aspects of this framework have already been used in Australia through the Rural Palliative Care Program.

Developing, refining and rolling out an Australian Primary Palliative Care Framework with the following dimensions would help fulfil a number of the Australian Government's health reform objectives and is considered by AGPN and PCA to be a high priority task:

- Development of an Australian Primary Palliative Care Framework by a panel of experts in the delivery of palliative care services in primary care settings drawn from general practice, allied health, specialist community based palliative care services and the research community

²⁵ Palliative Care Australia 2005, *A guide to palliative care service development: a population based approach*, Canberra

²⁶ NHHRC Final report: p107- 111 and recommendations 54 and 57;

²⁷ PHC Strategy: key directions for change p12

²⁸ National EOL Framework Forum, p.56

- Roll out of a pilot program involving the trialling of the Framework in up to 12 Medicare Locals who can demonstrate a significant interest and capacity to undertake a pilot program. The purpose of the trials would be to ensure the workability of the framework in a range of settings and circumstances and to develop an understanding of what is universally replicable and sustainable throughout the primary health care system
- Evaluation of pilot and framework refinement. The main outcome of this stage will be an amended and refined framework that is ready for system-wide roll out.