Submission to the Senate Enquiry on provision of GP and related primary health services to outer metropolitan, rural, and regional Australians

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Executive Summary

Provision of high quality primary health care is challenging across Australia. The small-scale businesses and private practices that make up primary health care in Australia are no longer sustainable outside of inner metropolitan areas, and aren't enabled to operate in ways that meet contemporary community needs. Uncompetitive remuneration, high workloads and a lack of support in primary health care in outer metropolitan, regional, rural and remote areas are leading to substantial workforce shortages.

The small adjustments and add on incentives to the primary health care funding model over the last 30 years haven't changed the underlying fee-for-service structure. Fee-for-service funding doesn't support effective team-based care or chronic disease management, isn't viable in many parts of Australia, and can't provide the flexibility and local contextual adaptation required to meet the specific challenges experienced in each area, due to a combination of workforce, geography, community need and population density.

Over the last 18 months, COVID-19 needs and restrictions have exacerbated existing problems with primary health care provision, highlighting the impact of the lack of flexibility in funding to deal with local needs. The mobilisation and responsiveness of the system has been largely down to goodwill and relationships rather than the capacity of the system.

Challenges to the provision of primary health care, and the most appropriate solutions, vary in each local area. Local knowledge, partnerships and decision making facilitate the best health outcomes for the community, but are difficult to implement within the current rigid funding structure. New funding models, including blended payments, performance based and pooled funding as well a growth in investment will allow primary health care provision to escape from the constraints of the fee for service paradigm, and enable the development of truly patient centred approaches to delivering primary health care.

Although the rigidity of the current regulatory and funding system doesn't naturally lead to effective place based and locally developed solutions, Primary Health Networks (PHN)s have facilitated regional partnerships and developed initiatives to overcome challenges and deliver high quality primary health care. With strong relationships across the local health services, as well as a deep understanding of community needs, and regional constraints, PHNs bring the community together to co-design relevant, best practice solutions. Structural change to primary health care funding will enable PHNs to facilitate, develop and implement new approaches that are responsive to the local context, tailored to local health needs and delivered through sustainable and vibrant workforce models.

Recommendations:

1. That new models of primary health care funding are investigated to incorporate blended payments, performance based and pooled funding, allowing for innovation and locally responsive models of care.
2. Investment in primary health care to develop place based solutions:
   a) To meet local primary health care workforce needs, including supporting health professionals through peer support, training & continuing educational pathways, sustainable, competitive remuneration and sustainable workloads;

b) To modernise primary health care, by developing locally responsive, patient centred models of care, co-designed with the community.

Submission Organisation

This submission focusses on three of the terms of reference of the review:

a) the current state of outer metropolitan, rural, and regional GPs and related services;
c) the impact of the COVID-19 pandemic on doctor shortages in outer metropolitan, rural, and regional Australia; and
d) other related matters, specifically offering solutions to improve provision of primary health care in outer metropolitan, regional, rural and remote areas.

TOR a) the current state of outer metropolitan, rural, and regional GPs and related services

Australia has a high quality, accessible health system and Australians generally enjoy good health. However, these overall good outcomes mask significant differences in experiences of the health system, and health outcomes across different parts of Australia, with access challenges exacerbated in outer metropolitan, regional and rural areas.

Primary health care is an important foundational building block for Australia's health system, delivering early intervention and prevention services, that help to reduce the risk of a person developing a disease, their symptoms worsening, or complications developing. For the best health outcomes, Australians should have access to a range of primary health care services, including 24-hour medical care, maternal and child health, and a variety of allied health[i]. Without strong, effective and high quality primary health care, secondary and tertiary hospitals will be overwhelmed by patients with serious acute and chronic conditions, causing significant financial and social costs to individuals and the health system. In 2017-18 alone there were 750,000 potentially preventable hospitalisations across Australia.[ii] A stronger primary health system would reduce this.

Australia's primary health care system developed through the 20th century to manage infectious disease, accidents and episodic care. It consists of a series of primarily small or medium sized, usually single discipline, private practices, alongside community health services. While Australians are living longer and have more years in good health, over the last 20 years the proportion of Australians with chronic illnesses has risen considerably[iii].

Despite nearly 30 years of Australian pilots dating back to the Coordinated Care trials, there has been only limited attempts at system wide change to better integrate the organisation of primary health care services to improve patient outcomes. Workforce role redesign and care coordination models have been established to try to address these challenges, although without structural change, significant, sustainable impacts are impossible. Primary health care provision remains broadly unchanged and isn't structured to respond to current patient needs for care coordination and ongoing chronic disease management.

Funding for primary health care is mostly fee-for-service and market driven, with a complex arrangement of funding and associated regulations from different jurisdictions, including federal, state and local governments, private health insurance, and patients themselves. Fee-for-service relies on volume of throughput for viability, meaning that comprehensive team based care and care coordination, which takes more time and may be done without the patient present, is structurally not supported. The small scale nature of primary health care provision inherently can't generate the scale of activity and capacity for sustainability in a market driven environment. Access to primary health care is improved when financial viability is not totally reliant on fee for service models, especially when there is specific funding to provide services to vulnerable or higher need groups[iv].

Primary health care is experiencing a workforce crisis. For doctors, a career in general practice is increasingly seen as less desirable, with the number of new registrars declining by almost 20% from 2016 to 2019[v], due to factors such as a lack of career progression opportunities, low financial remuneration, undervaluing of the profession and a lack of flexibility to enable part

time work, and provide after hours support.[vi] [vii] Registrars are increasingly reluctant to venture beyond inner metropolitan areas or to relocate to regional and rural areas. Locums are often used to fill staffing gaps, but this is expensive and doesn't solve the underlying workforce shortages. Recent changes to general practice training arrangements may result in a further reduction in registrar enrolments and interest in general practice as a career, while the new arrangements are confirmed and communicated.

Primary health professionals in outer metropolitan, regional and rural areas often have limited support from colleagues for supervision or peer support, feel professionally isolated, and have concerns about non-work issues such as isolation from family and friends or impacts on partners and children, which can impact recruitment and retention. Training for allied health and medical professionals generally diverts them away from rural areas, which can make it difficult for qualified professionals to move back to rural areas.

Provision of primary health care is variable across Australia, with significantly different contexts from metropolitan to remote, a variety of patient demographics and available infrastructure and support. In outer metropolitan, regional rural and remote areas, the challenges to positive patient outcomes include:

- Poor health and higher patient need in some areas
- Maldistribution of health professionals (relative to need) means that some communities don't have access to the care or service that they require at the time that they require it
- Difficulty in accessing the full team of health professionals required for care, due to cost, workforce shortages or distance
- Lack of integration between state and federal funded health services in local areas
- The lack of viability of small scale practices serving small populations especially when spread over large geographic areas
- An ageing workforce, as younger health professionals don't seem to be attracted to take on the difficulties (including financial and workload) of providing primary health care outside of inner metropolitan areas
- Changing cultural work practices. Outside of inner metropolitan areas, general practice has relied on a heavy full-time load as well as after-hours burden. The increasing proportion of part-time workers has diminished the capacity to deliver previous levels of health care
- Systematic barriers to junior health professionals coming through training outside of inner metropolitan areas
- Remote access to services (ie telehealth) is not sustainably funded

These fundamental issues, and the crisis in registrar numbers are evidence that primary health care in Australia requires wholesale, structural change. Regions that are already underserved, especially outside of inner metropolitan areas, feel a greater impact from these structural issues and the lack of a coordinated, integrated system. Below is a summary of some of the key regional challenges in provision of primary health care.

Outer metropolitan

Metropolitan areas are not homogenous, and there are substantial differences in access to primary health services between outer metropolitan growth areas and established inner and middle suburbs. Outer areas of Australia's major cities are growing at quickly, with new suburbs

and developments making up the top three fastest growing areas of almost all capital cities in Australia in 2019-20[viii]. While these areas are part of large metropolitan cities (eg, part of greater Melbourne, Brisbane or Sydney), the context for primary health care provision is very different. In general, communities living in outer metropolitan areas have poorer health outcomes, lower socio-economic status and less access to health services. Private billing models, common in primary health care, form barriers to people seeking care.

Outer metropolitan areas have fewer general practitioners, so patients have to wait longer for appointments, becoming sicker as they wait. General practitioners have little choice but to work longer hours, to see as many patients as possible, even though they are treating patients with complex needs that require more effort and resources to manage. As well, the viability of practices is reduced, as the population is reliant on bulk-billing, with a reduced capacity to pay for care. The reluctance of general practitioners to work in outer metropolitan areas means that there isn't the back up or support to spread the load and reduce burn out. The gaps may be filled by locums, but they are expensive and provide only a short term fix, not altering the underlying structural problems.

With such high community need, structural limitations on remuneration, and requirements for long work hours, recruiting general practitioners to these areas is particularly difficult. Outer metropolitan training positions are undesirable, and medical students are choosing to train in other specialities if they can't get inner metropolitan places.

In addition, both inner and outer metropolitan areas are bluntly categorised together as 'major cities' (MM1) in the Modified Monash Model adopted by the Australian Government, which together are excluded as a Distribution Priority Area for the recruitment of international medical graduates (IMG). The impact of this change in policy from 2019 has had a significant compounding effect in combination with the existing stresses on the outer metropolitan workforce. Recruitment of IMGs has long filled some of the gaps in the provision of primary health care, and helped mask the decline in registrars, to maintain a stable workforce. Often these IMGs are from the same culture and language background as the predominance of migrant communities living in these areas.

Regional and Rural

Regional and rural areas often have higher socio-economic disadvantage, poorer rates of literacy, physical activity and nutrition, older and ageing populations and greater health needs. In many areas populations are forecast to both decline and become older, requiring increased per capita health services, while struggling to maintain the population required for viable health service delivery. The high needs of regional and rural areas are often compounded by significant barriers to delivering primary health care, including:

- significant health workforce shortages, relative to both state averages and patient need,
- inability to attract and retain health care practitioners to health care settings that can't offer the career and lifestyle opportunities found in inner metropolitan areas.
- lack of viability of practices, especially with reduced throughput and fee for service funding
- patient costs. Out of pocket costs are more likely in regional and rural areas, despite patients' inability to pay

- requirements to travel large distances to access or deliver health care, and
- lack of scale, meaning that health services may not have the skills or knowledge to address community needs, including cultural factors.[ix] [x] [xi]

In addition, compared to urban health provider levels, the existing workforce is often precarious, comprised of many sole practitioners, who may be professionally isolated, and on the edge of service viability. Smaller services often lack the infrastructure, economies-of-scale and capacity that medium or large sized services have to diversify their funding sources or provide dedicated services for vulnerable populations.[iv] Some large regional centres have an adequate number of primary health care practitioners based locally (such as Geelong or Newcastle) however they are servicing the health care needs of many smaller surrounding communities. This generates access issues as travel to the larger regional centres for health care constitutes significant time, cost and transport barriers for residents of those smaller communities.

Remote

Remote areas are geographically distant from towns and cities, and contain a small, dispersed population. Typically, remote communities have populations that are generally younger than other areas of Australia, with less people over 65 years. They are more likely to live in multi-generational families. There is a higher proportion of Aboriginal people, especially in very remote areas (although most Aboriginal and Torres Strait Islander people live in metropolitan areas). People living in remote areas have significantly worse health outcomes, with rates of preventable hospitalisations and mortality significantly higher in remote areas, compared to major metropolitan cities[xii]

Providing primary health care services in remote areas is difficult. People living in remote areas are less likely to have a general practitioner nearby.[xii] Many primary health care services in remote areas are provided by remote area nurses or Aboriginal Health Practitioners, meaning that less funding is available through the MBS. Services can be funded through short term grants, although often with confusing and non-transparent application processes. In areas with low volume or throughput, a fee for service model is hard to sustain. In addition, running a clinic in remote areas can have higher costs, due to factors such as extensive travel, weather impacts, and costs in accessing IT or communication services, further impacting the ability to operate a financially viable service.[xiii] Services are also often provided by visiting practitioners, or expensive locum providers, rather than resident health practitioners.

Attracting health practitioners to remote areas can be very challenging, with practitioners concerned about both professional factors such as a lack of support, professional isolation, financial viability of their practice and career progression, as well as non-professional factors such as connections with family and friends, work or education for family members, and accommodation concerns.

TOR c) the impact of the COVID-19 pandemic on doctor shortages in outer metropolitan, rural, and regional

Over the last 18 months, COVID-19, and the associated restrictions, have exacerbated many of the existing challenges to primary health care provision. Known as the "Inverse Care Law", the availability of high quality health care tends to vary inversely with the need for it in the population served, when governed by market forces. Poor health and infectious disease are greatest in areas of high poverty, which are the areas that are least able to pay for care. This has again been demonstrated during the COVID-19 pandemic.

Practice viability has reduced, with diminished throughput due to patients avoiding less urgent, ongoing healthcare needs combined with periods of exceedingly intense demand for bulk-bill only vaccination consults, leading to high stress and burnout. The workforce crisis has deepened, with registrars reporting that their training was disrupted due to restrictions on their ability to travel to placements, a lack of patients seeking general practice services and a delay in exams, due to lockdown restrictions.[xiv] Nurses working in primary health care have reported a decrease in work hours, and related work insecurity, as well as not feeling well supported by their employers.[xv] Some of these health professionals will have left the sector, leading to further workforce shortages.

The expansion of digital health use, including telehealth, has had a varying impact on provision of services, increasing access for some community members and reducing access for others, as well as exposing the lack of digital literacy and access for clinicians, practice staff and patients. In some parts of Australia, provision of primary health care was also impacted by clinician fatigue, burnout and the change in practice also impacted on the attractiveness of primary health care as a career choice.

While primary health care practices have been a vital part of the COVID-19 pandemic response, this has relied on goodwill to mobilise and provide relevant care, rather than capacity of the system. Over time, as the needs have continued to be high, there is evidence of fatigue and reduction of goodwill. The COVID-19 pandemic response has highlighted the impact of the lack of flexibility in funding to enable local health providers to work together to deal with local needs.

TOR d) other related matters impacting outer metropolitan, rural, and regional access to quality health services: Principles to develop solutions

The contextual and population needs across communities in outer metropolitan, regional, rural and remote Australia are varied, and not only due to geography. Other factors, such as population demographics, healthcare need, population density, culture and socio-economic status influence the primary health care and resource requirements across different regions.

Flexible, innovative solutions are required to improve provision of primary health care across the diversity of communities across Australia. Place-based models provide the flexibility and adaptation at a local level to allow local communities to develop solutions that will address the specific challenges in providing primary health care in their community. Patient centred

approaches, that are responsive to community need and supported by flexible and sustainable funding, result in the development of effective, team-based primary health care.[xvi] Successful models are:

- Developed at regional level with local variations
- Co-designed with communities, to be accepted and relevant
- A collaboration of multiple funding partners at a regional level including local hospitals, state-based health offices and Primary Health Networks
- Multidisciplinary, to consider all health needs
- Actively engaging of general practitioners, recognising their central role in primary health care delivery
- Inclusive of all workforce working at the top of scope, to be most effective and efficient

Case Studies

Appendix 1: In South Burnett, the Kingaroy Stakeholder Consultative Group improved primary health care planning and recruitment of health professionals.

Appendix 2: In the Hunter, Newcastle, New England area, Medical Practice Assist staff have been trained to do routine, clinical care tasks.)

More health providers are urgently needed in regional and rural areas. Health professionals have been reluctant to take up positions in outer metropolitan, regional and rural areas for several reasons, including a lack of support and professional isolation, the risk and large upfront costs involved in moving to, and setting up in, the region, and concerns about financial viability of private practice. To attract health professionals to these areas, implemented models of care must incorporate a range of supports and incentives including:

- peer support, mentoring and supervision
- training & continuing educational pathways,
- team coordination, to facilitate and fund team based care
- support to share the stress of managing needs of complex patients and after hours care
- adequate, sustainable financial remuneration

Case Study

Appendix 3: In Wagga Wagga, a GP collaborative was established to share the responsibility for after hours care.

Appendix 4: In Western Victoria, a partnership was established to provide access to paediatricians to secondary school students.

Integration between primary, acute and sub-acute health services supports patients as they flow between different services for the care that they require, and leads to optimal patient outcomes. Integration must include more than referral and information sharing, for appropriate chronic disease management. In outer metropolitan, regional, rural and remote areas, where there are less health professionals and often a higher need, partnership or integration with

Local Health Networks can increase affordability of care for patients, as well as supporting access to a larger range of services, and support for the primary health care practitioner.[iv]

Case Study

Appendix 5: In outer metropolitan Perth, integration between hospitals and primary health increased support for COPD patients discharged from hospital, and built capacity general practices to prevent the need for regular specialist care.

Fee for service funding, even with additional incentives, is not able to support a truly patient centred model of care. Primary health care requires new funding models, including blended payments, and pooled funding as well a growth in investment, to ensure a sustainable workforce and delivery of best practice models of care. The ability to pool funding at a local level, to include a range of supports, performance based funding (with agreed patient outcomes) and income security will enable solutions that meet the specific needs of the community to be developed. Flexible funding models will enable integration with state run acute services, and provide the genuine flexibility to respond to local community needs, across the whole system, that fee for service constrains.

Case Study

Appendix 6: In Katherine, a multi-agency partnership developed a model to sustainably recruit general practitioners to the area.

PHNs s have the local knowledge of community need, and workforce supply as well as relationships with the range of health providers in the area, to facilitate the design and implementation of initiatives to overcome the local barriers to provision of primary health care. Within the current, constrained funding models and regulations, they are partnering with other organisations and clinicians in their regions to develop innovative solutions to enable high quality primary health care in the community. The provided case studies (see appendix 1-5) demonstrate some of the initiatives that have recently been implemented. With more flexible funding models, PHNs will be able to accelerate their work with local communities, co-designing pilots to improve delivery, integration and viability for local primary health care, ultimately improving health outcomes for the community. With the links between the PHNs already established, sharing of successful innovations and solutions is straightforward. Robust evaluation of implemented initiatives will allow the development of a range of best practice foundation models that can be adjusted for context.

Appendices: Case Studies

Appendix 1. Kingaroy Stakeholder Consultative Committee. Darling Downs West Moreton PHN

Identified Need

The South Burnett (approximately two hours north-west of Brisbane) is struggling to attract and maintain adequate health support staff, including in General Practice, Allied Health and Mental Health. A review of services in 2019 identified significant challenges impacting provision of healthcare in the South Burnett including:

- Practices unable to accept new patients with limited/no availability to GP appointments at some practices during in-hours and a lack of affordable (bulk-billed) primary care access after-hours
- High volume of patients who present at the Kingaroy Hospital Emergency Department for issues that are of a general nature
- Community's expectation that Kingaroy Hospital provides a 24/7 service for non-urgent matters that could be seen in General Practice.

Approach/Activity undertaken

To address the complexities around healthcare in the region, Darling Downs West Moreton PHN (DDWMPHN) convened the Kingaroy Stakeholder Consultative Group. The group comprises more than 20 interested parties in the Kingaroy region, including from South Burnett Regional Council, Queensland Health, local General Practice and Allied Health professionals, Checkup, and Health Workforce Queensland.
Engagement with the Committee used a place-based Community Development Engagement Framework. The purpose of the Kingaroy Stakeholder Consultative Community was to have the local community take ownership of the health of the community and work with professionals to find sustainable solutions.

Outcome

By focussing the committee on an overall outcome and purpose, DDWMPHN was able to move stakeholders from their silos into bigger picture thinking. The committee implemented three separate working groups. The hospital group was tasked with implementing the specific secondary care recommendations and the community working group oversaw Council's Kingaroy Town Renewal plan and activities designed to make the South Burnett an attractive place to live and work. The primary care group has taken the lead on integrated health care and has implemented the Bunya Family project (see below).
Successes include:

- The hospital achieving most actions, including attracting and retaining staff, particularly in obstetrics; introducing and imbedding an improved culture; and implementing a fatigue management program
- Council implementing a program of community and infrastructure development to attract people to the region
- Primary care working together to begin implement integrated care and leading the development of the Bunya family model of health pathway improvement
- Darling Downs Health and Hospital Service has requested the process be replicated in other local areas within the region.

Other information – Introducing the Bunya Family

DDWMPHN has implemented the "Bunya Family´ as a scenario planning tool. The Bunya Family comprises a number of avatars of family members who represent "real life" scenarios within the South Burnett. The use of the Bunya Family is based on the Welsh model of the "Jones Family" which used the family to steer conversations away from territoriality and toward improving patient care.

Appendix 2. The Medical Practice Assist Model Comes of Age. Hunter New England and Central Coast PHN.

Identified Need

In many rural and regional towns, General Practices report a lack of ability to recruit practice staff, issues of practice staff not working at the top of scope, and limitations in practice viability.

Approach/Activity undertaken

Medical Practice Assist staff are hybrid administrative and clinical assistant staff who undertake their clinical duties under the supervision of GPs or nurses in the practice. These are delegated duties assisting with clinical measurements and procedures, helping to coordinate care, managing challenging patient behaviour, applying first aid, handling specimens, and maintaining medication stocks among other duties.

HNECC PHN has partnered with the University of New England (UNE) Partnerships and funded over 150 training scholarships, as well as providing support to General Practices to implement the Medical Practice Assist model.

HNECC PHN has also run the inaugural National Medical Practice Assist Conference in March 2021.

Outcome

General Practices and their staff have reported significant benefits to patient clinical care, practice models of care, practice staff workloads, practice staff satisfaction and practice income and viability. Practices benefiting from this approach have been in urban, regional and rural localities.

Appendix 3. Wagga GP After-Hours Service. Murrumbidgee PHN.

Identified Need

Wagga Base Hospital is the regional referral hospital servicing the Murrumbidgee region. Commencing in 2003, the services was originally established to address the increasing GP-type presentations to ED due to limited access to GP in-hours as a result of significant workforce shortages. The model also facilitated shared on-call responsibilities among participating practices. Community demand for the service continues to be strong, especially in the winter months and by residents of residential aged care facilities.

Approach/Activity undertaken

The Wagga GP After-hours Service is a GP Cooperative including GPs from participating practice across the Wagga Wagga LGA. The clinic is managed by a GP Management Committee with management and administration support provided by MPHN. The clinic operates a face to face service seven days per week, 365 days per year with the hours of Monday to Friday from 7.00pm – 9.00pm, Saturdays 6.00pm – 9.00pm, and Sundays and Public Holidays 9.00am – 1.00pm and

5.00pm – 9.00pm. The service also offers an on-call service during social and unsociable hours for resident of RACFs.

Outcome

Pre-COVID, the service delivered approximately 6,000 consultations per annum. During the last 12 months, the service has introduced an option for patients to be offered telehealth appointment where clinically indicated.

Appendix 4. Doctors in Secondary Schools – Primary and Specialist Care Collaboration. Western Victorian PHN.

Identified Need

- GP Shortages in rural Victoria
- Unrecruited Doctors in Secondary School Program (DiSS)
- Young people less likely to access specialist public paediatric care
- Vulnerable population not receiving timely primary care services

Approach/Activity undertaken

WVPHN together with the partnership of Wimmera Health Care Group (WHCG) and Royal Flying Doctors Service (RFDS) provide GP consults in the DiSS program. The RFDS GP is able to travel once a month to the service and provide consults while the Practice nurse is at the school weekly, which partially meets the needs of the student population.

Integrating the service with ByFive's Strengthening Care for Children Wimmera Southern Mallee (SC4C@WSM) meant that students at the college had access to specialist paediatricians in the GP consulting room at DiSS, combining co-consultation with professional development and support.

As DiSS is closed during lockdowns, SC4C collaborated with the school to ensure the consults could go ahead with the local professionals facilitating. The collaboration with the RFDS and DiSS program involves:

- GP and PN working more closely with the school wellbeing team and referring students who are vulnerable or have an urgent need to SC4C, in a multidisciplinary and collaborative model.
- SC4C/By Five RCH paediatricians working with the school team and DiSS to educate and upskill to provide support and care to complex students in the local, everyday environment. This involves regular case-based education sessions and one-on-one short appointments between the school or DiSS staff to discuss a student case with the RCH paediatricians

Outcome

Paediatricians were made available for the time/day the DiSS program operates.

Six consultations since the collaboration began in June and there continues to be ongoing support to the service and the wider region.

Eg: a GP in Warracknabeal, last week facilitated a consult that involved himself, SC4C Paediatrician, the local school principal, the child and family, and Headspace worker. It was an extremely valuable, collaborative, multidisciplinary primary care experience that is not only best practice and care but providing invaluable upskilling and capacity building frameworks around the local professionals and capitalising on their expertise and knowledge to deliver local, evidence based and timely care in an environment familiar to the child and with minimal disruption.

Having primary care collaborating and working in real time with the school, headspace, and often allied health, supported by the paediatrician, to provide evidence-based yet tailored support and solutions is a model that really is delivering best care in the Wimmera Southern Mallee.

Other Information

DiSS Program: https://www.education.vic.gov.au/about/programs/Pages/doctors.aspx

By Five Facebook Equity Hub https://www.facebook.com/ByFiveWSM/

Appendix 5. COPD Primary Acute Integration Pilot. Perth North PHN (Western Australian Primary Health Alliance).

Identified Need

To improve the correct diagnosis of COPD and increase the capacity for community-based care. To educate patients to pro-actively manage their disease using a COPD Action Plan to reduce the incidence of presentation or admission to care in the acute setting.

Approach/Activity undertaken

WAPHA commenced discussions with Joondalup Health Campus (JHC) in 2017 regarding piloting a Primary Acute Integration project, which would improve chronic disease management through improved connection between primary and acute care. In 2018, Silver Chain was contracted to provide an integrated service for COPD patients referred by JHC to support them back into community-based care under the management of their general practitioner (GP). The aim was twofold:

- To improve disease management and reduce hospital admissions by providing post discharge care and education for individuals.
- To build capacity in general practice to enable correct diagnosis and treatment of COPD, reducing the need for regular specialist intervention in acute settings or hospital outpatient clinics.

A quality improvement activity was incorporated into the service, involving three general practices in the JHC catchment. Each practice received four in-practice education sessions facilitated by the JHC respiratory physician and Silver Chain respiratory nurse. A dashboard was developed to display deidentified data for the practice's COPD patients, updated monthly, for variables such as chronic disease management consultations (MBS item 721 CDM-GPMP), smoking status and vaccinations (influenza and pneumococcal). In addition to driving improvement via data tracking, there was an overriding intent to educate clinicians in both the primary and acute settings of the value in proactively managing patient care through the use of data.

Outcome

The combined learnings of the project led to the emergence of the concept of a primary care platform which recognised that effective community based primary care management of disease involves a number of components of care which need to be independently functional and collectively accountable. It was evident throughout the project that whilst COPD was the focus, effective management of all chronic conditions would benefit from this approach to care.

As a result of these pilot services, existing WAPHA funding into respiratory services has been restructured. From July 2021, Silver Chain and Asthma WA will deliver a new collaborative service for patients discharged from metropolitan hospitals, providing a combination of supported discharge

and community based primary care. The service will facilitate the connection of non-oxygen dependent COPD patients to primary care, including general practice, with the aim of establishing more effective care in the community and reduced hospital admissions.

Appendix 6. Shared Workforce Model Katherine NT. Northern Territory PHN.

Identified Need

Katherine, a regional town in the Northern Territory (NT), with a population of over 10,000 people lost its sole GP practice in November 2020. The practice ultimately closed as a result of market failure, due in large part to the challenges in recruiting and retaining an adequate number of GPs to sustain service delivery. The Katherine region also contains a hospital and three Aboriginal Community Controlled Health Services (ACCHS), all of which employ GPs. In addition to the general challenges in recruiting doctors to rural and remote towns, competition for labour has been a key challenge in Katherine where government-funded organisations offer salaried positions and attractive benefits such as accommodation, private practice and the Medicare-based revenue model has struggled to compete.

Through an expression of interest process, NT PHN has supported the establishment of two new private practices for the region however, these practices now face the same challenges with workforce sustainability.

Approach/Activity undertaken

NT PHN, incorporating Rural Workforce Agency NT, has been leading on a project to identify sustainable and innovative workforce models to improve the viability of private GP services in the Katherine region. NT PHN engaged heavily with key stakeholders including NT Government Health, local government, GP practice owners and the local ACCHS. Through the process a shared workforce model was identified that benefits all local health services. This model will see GPs employed by the hospital and receiving the benefits that come with public sector employment, salary, accommodation etc. These GPs will work across the different services through a shared roster. As the GP will be salaried through NT Health, the private practices will pay the GP's percentage of Medicare billings back to the hospital to support the costs associated with the employment model.

Outcome

NT PHN has funded a project officer for NT Health who will work on formalising and implementing the model with an intended start date in early 2022. The intended outcome is improved workforce sustainability by creating a unique and attractive employment opportunity and addressing the competition for labour which has significantly affected private practice sustainability.

ENDNOTES

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