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Submitted to Primary Health Reform Steering Group Draft Recommendations - Discussion Paper
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Introduction

1 What is your name?

Name:
Dr Phyllis Lau

2 What is your email address?

Email:
phyllis.lau@westernsydney.edu.au

3 Are you responding as an individual or on behalf of an organisation? (please specify organisation)

Organisation:
Australasian Association for Academic Primary Care (AAAPC)

4 What is your organisation type?

Peak Organisation

5 Please choose from the following list the area of primary healthcare that best describes you or your organisation?

General Practice, Nursing and/or Midwifery, Allied Health, Pharmacy, Other

5a If your response to Question 5 is Other, please state the area of primary healthcare you represent?

If your response to Question 5 is Other, please state the area of primary healthcare you represent?:
multidisciplinary primary health care researchers, clinicians and teachers

Recommendation 10

10.1 Do you agree with this recommendation?

Do you agree with this recommendation?:

Yes, there is a need to support growth in the primary health care workforce.

10.2 What do you see as the challenges in implementing this recommendation?

What do you see as the challenges in implementing this recommendation?:

Australia is limited in terms of its ability to understand the primary care workforce. It is the backbone of the health care system and a major public investment, yet despite the large gap between supply and community need, the scope of available data does not support evidence-informed decision making. A recent article by an Australasian Association of Academic Primary Care member (Russell GM et al Improving knowledge and data about the medical workforce underpins healthy communities and doctors. Med J Aust. Apr 2021;214(6):252-254 e1) highlighted many of the issues.

There have been structural and financial barriers to PHC-based allied health providing meaningful clinical placements.

Recommendation 17

17.1 Do you agree with this recommendation?

Do you agree with this recommendation?:

Yes we do.

In acknowledging the paucity of data available in the PHC sector, the Australian Institute of Health and Welfare recently highlighted how, as a result, little is known on reasons for PHC clinical contact, on recommended actions, outcomes and costs. The Australasian Association for Academic Primary Care (AAAPC) sees collection, appropriate use and robust analysis of primary care data as an enabler to many of the actions and desired outcomes of the Steering Group. Collecting data on the quality of PHC will inform continuous quality improvement. PHC indicators and measures are critical to inform person-centred care and evaluate services to ensure high quality.

Furthermore, AAAPC considers that data-driven health improvement extends beyond general practice to provide a complete picture of primary health

care activity and outcomes. We know little about the performance of privately funded allied health care, the community health sector, or on any of the measures of evidence-based PHC.

17.2 What do you see as the challenges in implementing this recommendation?

What do you see as the challenges in implementing this recommendation?:

The implementation of this recommendation has its challenges. While hopes have been held for primary care data linkage, the field is in its infancy and, although rapid changes are occurring, data collected from the primary care practice is patchy and not of consistent quality. Indeed, there is no continuous, comprehensive, nationally representative data collection from general practice electronic health records (EHRs) in any country in the world.

DATA
Although federally run initiatives such as the Practice Incentives Program collect data from primary care, the data is inconsistent in quality and characteristically challenging to access. There are minimal incentives to collect quality data at a practice level and few examples of routinely collected, policy relevant data from allied health sources. Unlike overseas, there is little consensus as to universally agreed indicators for primary care practice performance. We caution that current initiatives such as Medicine Insight focus on prescribing rather than being a comprehensive source of information or providing broader data for primary care research. Other data collection sources are driven by commercial constraints and have a web of inconsistent relationships with Primary Health Networks.

Much of the Steering Group recommendations refer back to Quadruple Aim, and moving from volume to value. AAAPC supports these frameworks in guiding reform but notes that primary care is disadvantaged in often not having evidence of direct impact of primary care interventions nor the capacity to generate such evidence because of lack of funding.

Difficulties in generating clear evidence include the fact that primary care outcomes are often long term, unpredictable and difficult to attribute and identify. This means that reform may be harder to design than in tertiary settings. A proper solution would be to focus research funding on primary care to develop this evidence which will require a broader primary care workforce and a longer funding vision than provided in current competitive grant funding such as NRMRC.

In the absence of strong clinical data – much primary reform is reduced to simple cost reductions. This reductionist approach is dangerous for the financial viability of primary care, and the long-term sustainability of attracting a primary care workforce to enact the vision within the Steering Group recommendations.

FRAGMENTATION
Data needs to be collected for the purposed of local quality improvement (at a personal, practice or local level) as well as for the purposes of quality control.

These dual purposes of data – local quality improvement, and central quality control- need to be clearly distinguished. Primary care providers need to be supported in doing QI, while feeling secure that the quality control is about ensuring patient safety and quality of care, and not purely an exercise in cost cutting. For many GPs, their main experience is the impact of their data through MBS compliance, often data mining exercises with the goal of saving money rather than improving patient care. GPs need to be able to share and learn from their clinical data, through practice networks.

17.3 Please provide any examples of utilising primary health care data collection and linkages to support continuous quality improvement (from Australia or overseas).

Please provide any examples of utilising primary health care data collection and linkages to support continuous quality improvement (from Australia or overseas). :

The closest to the vision is the patient registration data program in the Netherlands, which collects data from a carefully trained random group of GPs using standards-compliant EHR systems. The UK has the Clinical practice research datalink (CPRD) which provided anonymised primary care records for public health research for many years and now also uses primary care data in clinical trials.

In Australia:
• Some work has been done in the Patient-Centred Medical Home to establish quality indicators and measures for quality improvement, although the indicators identified are predominantly around processes and system requirements for a team-based approach to deliver quality services.
• The NSW Health Agency for Clinical Innovation (ACI) have implemented PROMS and PREMS across state-funded public services. It may be useful to look at some of the measures being implemented and whether any are suitable for PHC. This may support QI across sectors.
• The previously funded Australian Primary Care Collaboratives Program upskilled general practice staff capacity to analyse data and increased understanding in the value of data. This program was administered through Divisions of General Practice, and Primary Health Networks (PHNS) could be resourced to introduce a similar initiative, with a focus extending to the broader primary care system.
• The unique Balancing Employment and Life (MABEL) panel survey of 9–10,000 doctors per year. MABEL is used to guide the distribution of over $1 billion funding to regional health care through its use in the design of the Modified Monash Model, as well as supporting the design of rural health workforce programs.

Recommendation 18

18.1 Do you agree with this recommendation?

Do you agree with this recommendation?:

We strongly agree with this recommendation – details of its implementation have been the subject of numerous Australasian Association for Academic Primary Care (AAAPC) submissions to the government over the last 5-10 years. We continue to believe that reform related changes to the delivery of primary care services requires a vibrant PHC academic sector to evaluate, interpret and ultimately disseminate the lessons of a reform process oriented towards comprehensive, coordinated and evidence-based care.

18.2 What do you see as the challenges in implementing this recommendation?

What do you see as the challenges in implementing this recommendation?:

The major challenge to implementation is that since 2015, the academic infrastructure of PHC has been dismantled through a comprehensive withdrawal of Federal funding support. The nation's PHC funding and knowledge translation organisation, the Australian Primary Health Care Research Institute (APHCRI) closed in 2015. The Australian Primary Care Research Network (APCReN http://www.apcren.org.au) ceased active support of its network in 2015. Over a short period of time the world's largest nationally representative longitudinal study of general practice (the Bettering the Evaluation and Care of Health (BEACH) program) lost federal support, the Primary Health Care Research and Information Service (PHCRIS) has had its operations substantially curtailed. The NHMRC has, for many years, allocated barely 1% of its total allocations towards PHC specific projects, and has not provided PHC directed career support for some time. While some MRFF initiatives have been directed at primary care we have been concerned that funding has often been directed towards niche projects and/or hospital-oriented initiatives.

This sustained disinvestment has led to a downgrading in primary health care research and translation efforts in Australia, including the downgrading of research networks established by disciplines of primary care within Australian universities.

There continue to be are few opportunities for primary care researchers and an unclear career path compared with other PHC disciplines and university academic support clinician researchers. Engaging PHC practitioners, practices and patients in research is an urgent need for many of the proposed reforms within the Steering Group Recommendations which need to be supported by local evidence (from the impact of voluntary patient enrolment on continuity and quality improvement to the impact of expanded allied health provider/nursing scope on quality of care).

Many of the important reforms of primary care are driven by Medicare funding and are neither evidence based nor evaluated. GPs and primary care researchers are frustrated that even with evidence of the effect of a fee-for-service model. Research of care is often not enacted because primary care evidence is not assessed or evaluated as highly new 'innovations' such as pharmaceuticals. For example, GP-led counselling for smoking cessation and a GP-led program for weight reduction have lower cost per QALY than many medicines recently added to the PBS.

Ongoing investment in the capacity of the sector is critical. The Australasian Association for Academic Primary Care (AAAPC) is motivated to increase research capacity across primary health care, in actively engaging GPs and other clinicians to better understanding their individual and practice population data, encouraging clinician researchers to engage in research, including through support of local practice-based research networks (PBRNs), and through upskilling in research techniques and competitive grant applications.

There is an urgent need for a dedicated primary care research grant program to develop the evidence base about the efficacy and value of different primary care funding models and to better understanding what clinical outcomes are relevant and of value to clinicians and patients (as well as funders) in the Australian context. A network of aligned primary care researchers would be appropriate to spread capacity building and research skills

We have previously advocated for introducing PHC-specific research training awards for PhD scholarships, post-doctoral fellowships and practitioner fellowships to help train a cohort of individuals with internationally competitive skills in academic PHC. While we acknowledge that career support has been decreasing in all parts of Australia's research enterprise, we remind the MRFF Board that the next generation of PHC researchers are further challenged by the inability to benefit from additional salary support from teaching hospitals.
The support of PBRNs must be specifically mentioned. We continue to believe that an early priority of the reinvigoration process is in the support for Australia's PBRNs. Contrary to the commitment promised in Medical Research Future Fund (MRFF) priorities, there has been no MRFF grant opportunity to support PBRNs since its inception. Dedicated funding should be put aside for supporting PBRNs at local and national levels. The building of a comprehensive PBRN network should commence with the reinstitution of funding for the coordination, quality control and marketing activities of the a national network of existing and emerging PBRNs. Such a national network would reduce research duplication, has the potential for large linked datasets for research, address health equity issues and act as a single liaison point for the government, but all this will require sustained infrastructure investment. Additional funding would allow individual networks to help researchers, policy-makers and industry find answers to questions on both national and local health priorities.
There have been some MRFF calls for PHC research, but these have either been tightly focused, e.g. on Aboriginal and Torres Straits Islander research, or highly competitive because of the small number of projects funded. Research in primary care is expensive because of the need to work with large numbers of independent practitioners and services, which requires sustained funding over time to develop and support research networks.

The recommendations refer several times to the Australian National Institute for Primary Health Care Research Translation and Innovation. It is important that the vision for this is clearly articulated – how will it be different (or same) to the defunct APHCRI? We support the establishment of a national research institute dedicated to PHC but it must have sustainable funding, clear governance and buy-in from stakeholders from every level and discipline including medical, nursing and allied health.

This recommendation alludes to reinstating the defunct PHCRED (Primary Health Care Research, Evaluation and Development) strategy targeted at building PHC research capacity and the body of PHC research knowledge, evidence and translation. How it will be re-instated and how different (or same) will it be from its previous version must be clear. Again, this sort of investment must be sustained and longer-term.

Recommendation 20

20.1 Do you agree with this Implementation Action Plan approach?

Do you agree with this Implementation Action Plan approach?:

Yes. The recommendations such as the Australian National Institute for Primary Health Care Research Translation and Innovation, support for PBRNs, partnerships with PHNs and ACCHOs are irrelevant without an appropriate implementation plan.

We strongly support an articulated implementation plan and suggest that the best evidence of the feasibility of significant research-informed reform is that similar initiatives underpin research and innovation in several Western democracies. The UK invests in applied PHC research via the National Institute for Health Research (NIHR) and its affiliated School for Primary Care Research (http://www.spcr.nihr.ac.uk). The vision of the NIHR "to improve the health and wealth of the nation through research" specifically recognises the value of this sort of research to the national economy and to population health. (http://www.nihr.ac.uk) Canada has a specific Institute of Health Services and Policy Research and has made major recent investments in measurement in primary care through the Canadian Institute for Health Information (https://www.cihi.ca/en/) The United States funds clinical effectiveness research through the Patient-Centered Outcomes Research Institute. (http://www.pcori.org)

The NIHR Clinical Research Network, has incorporated existing primary-care research networks into national research networks in clinical areas such as cancer, stroke and mental health. In the United States, a number of successful PBRNs exist, with member practices now representing 15% of the US population. The Canadian Primary Care Sentinel Surveillance Network (CPCSSN) operates as a network of ten practice based research networks from various locations across Canada extracting primary health care data from sentinel physicians electronic medical records (EMRs) for chronic disease surveillance. Significantly CPCSSN began with a grant (since renewed) from the Public Health Agency of Canada.

As discussed in the Australasian Association for Academic Primary Care (AAAPC) response to recommendations 17 and 18, there is an urgent need to develop evidence of many of the proposed reforms encapsulated within the Steering Group Recommendations. This requires a clear commitment to a primary care data and research infrastructure to develop Australian evidence.

20.2 Do you see any challenges in implementing primary health care reform?

Do you see any challenges in implementing primary health care reform?:

High-quality research within the wider primary health care reform requires not just vision but wide and inclusive engagement and long-term funding, far greater funding than is available at present.

The Australasian Association for Academic Primary Care (AAAPC) needs to be actively involved and represented in the governance of the implementation of the plan. Initiatives need to be based on networks with local roots – based on partnerships for research at local and regional levels. Funding a single Institute based in Canberra alone will not provide the basis for successful implementation.

Additional feedback

21 Please provide any additional comments you have on the Primary Health Reform Steering Group Draft Recommendations.

Please provide any additional comments you have on the Primary Health Reform Steering Group Draft Recommendations.:

The Australasian Association for Academic Primary Care (AAAPC) welcomes the Steering Committee's aims with its draft recommendations. This level of ambition is required to realise the role that primary health care is required to play in the Australian health system now and into the future. However, further implementation and governance details are required, along with further consultation, before the plan is finalised.