Purpose

The purpose of this policy brief is to outline the value of primary health care research, and to describe the Australasian Association for Academic Primary Care's (AAAPC) preferred options for development and investment.

Audience

This policy brief is intended to provide information to, and to identify options for:

- consumer and carer groups
- interested stakeholders, including elected representatives
- research agencies and funders
- professional associations and colleges involved in primary health care
- national and state health agencies from across New Zealand and Australia
- Primary Health Networks in Australia and District Health Boards in New Zealand
- public data and statistics agencies
- universities, particularly in relation to their role in primary care research development and supporting practice based networks.

Background

What is Primary Health Care?

Primary health care is the frontline of Australia and New Zealand's health care system. It can be provided in the home or in community-based settings such as in general practices, other private practices, community health, local government, and non-government service settings for example, Aboriginal Community Controlled Health Services. Providers of primary care services include general practitioners, nurses (including general practice nurses, community nurses and nurse practitioners), allied health professionals, midwives, pharmacists, dentists, and Aboriginal health workers

The types of services delivered under primary health care are broad ranging and include: health promotion, prevention and screening, early intervention, treatment and management.

Services may be targeted to specific population groups such as: older persons, maternity and child health, youth health, people living in rural and remote areas, Aboriginal and Torres Strait Islander people, refugees, and people from culturally and linguistically diverse or low socio-economic backgrounds.

Primary health care services may also target specific health and lifestyle conditions, for example: sexual health, drug and alcohol services, oral health, cardiovascular disease, asthma, diabetes, mental health, obesity and cancer. Primary health care services will also look and operate differently as one moves from metropolitan areas to rural and remote

settings. Significant variations may relate to geography, community and population characteristics, socio-economic circumstances, infrastructure, health status, and workforce mix and availability. Health services in rural and remote areas are particularly dependent on primary health care services, particularly those provided by GPs.

Social determinants of health strongly influence the health of individuals and communities, and affect the sustainability and accessibility of health services. It is therefore important that primary health service planning and delivery recognises the influence that factors such as housing, education, employment, infrastructure and transport can have on the health of those who live in the community, and build partnerships across sectors when there is a need to address specific issues affecting a community.

Taken from Standing Council on Health. National primary health care strategic framework. Internet: Commonwealth of Australia; 2013. Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/nphc-strategic-framework. (page 6)

Examples of primary care research that has changed clinical practice

Taken from Winzenberg TM, Gill GF. Prioritising general practice research. Med J Aust 2016;205(2):55-57.

13Heal C, Buettner P, Raasch B, et al. Can sutures get wet? Prospective randomised controlled trial of wound management in general practice. BMJ 2006; 332: 1053–1056.
14Heal C, Sriharan S, Buttner PG, Kimber D. Comparing non-sterile to sterile gloves for minor surgery: a prospective randomised controlled non-inferiority trial. Med J Aust 2015; 202: 27–31. https://www-mja-com-au.ezproxy.lib.monash.edu.au/journal/2015/202/1/comparing-non-sterile-sterile-gloves-minor-surgery-prospective-randomised.
15Hegarty K, O'Doherty L, Taft A, et al. Screening and counselling in the primary care setting for women who have experienced intimate partner violence (WEAVE): a cluster randomised controlled trial. Lancet 2013; 382: 249–258.
16Hinman RS, McCrory P, Pirotta M, et al. Acupuncture for chronic knee pain: a randomized clinical trial. JAMA 2014; 312: 1313–1322.

There is also the ASPirin in Reducing Events in the Elderly (ASPREE) RCT

The Policy Context

These are presumably the areas that governments see as 'valuable'. To what extent does (the project) that AAAPC is being asked about fit into these policy areas? Also, what areas are missing from these policies - and to what extent should AAAPC lobby for them to be included?

10 Year plan for primary care - in development

A 10 year plan for primary care is being developed by the Primary Health Reform Steering Group. Representation includes RACGP, ACRRM, APNA, and others; AAAPC is not represented in this Group. As the first step in the 10-Year Plan, the Steering Group will advise on the implementation of the $448.5 million 2019-20 Budget measure, to support doctors to provide more flexible care to Australians aged 70 years and over. The next step in the consultative approach to developing the 10-Year Plan will be the establishment of a **broad-based Consultation Group with representation from across the sector** to help guide and respond to public consultations. https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/primary-health-reform-steering-group-established
Question: To what extent should AAAPC provide input into this 10 year plan?

Long term national health plan (2019)

Australia has a long term national health plan (2019) with the goal of making Australia's health system the world's number one. It has four key pillars: 1. guaranteeing Medicare and medicine access via PBS; 2. supporting hospitals; 3. prioritising mental health and preventive health; 4. investing in health and medical research. Under pillar 1, it states "Our goal is to make primary health care more patient focused, more accessible, and better able to provide preventive health and management of chronic conditions." and a priority is to implement the 10-year plan for primary care - including access to genomics testing and rollout of telehealth. A priority in pillar 3 is to "Develop and implement a 10-year National Preventive Health Strategy to better balance treatment and prevention" and to "Deliver an Indigenous Preventive Health Plan". A pillar 4 priority is "Focus on four areas: patients, researchers, translation and missions". Primary care is not mentioned in pillar 4 priorities.
Australia. Department of Health. Australia's long term national health plan to build the world's best health system. Canberra: DH; 2019
https://www.health.gov.au/resources/publications/australias-long-term-national-health-plan

National primary health care strategic framework (2013)

The National primary health care strategic framework (2013) is endorsed by the Standing Council on Health and provides a mechanism for coordinated action at the Commonwealth, state and local levels to enable a more harmonised approach in primary health care planning and service delivery. The Framework specifically builds on the National Primary Health Care Strategy, which was released in May 2010. The aim of the Framework is not to duplicate the work of the Strategy, but to bring into focus key priority areas identified in the Strategy as national challenges most in need of action that we can address over the upcoming years. The Commonwealth, states and territories have agreed to the following vision for primary health care:
National vision for primary health care
A strong, responsive and sustainable primary health care system that improves health care for all Australians, especially those who currently experience inequitable health outcomes, by keeping people healthy, preventing illness, reducing the need for hospital services and improving management of chronic conditions.

The Commonwealth, state and territory governments agree to work together to ensure the ongoing improvement and sustainability of the primary health care system with the **goal of ensuring effective, safe services for consumers aimed at providing care in the most appropriate and efficient setting, and improving health outcomes**.
The Framework will **prioritise action toward the following four strategic outcome**s, which have been identified as requiring concerted focus: • Build a consumer-focused integrated primary health care system; • Improve access and reduce inequity; • Increase the focus on health promotion and prevention, screening and early intervention; and
• Improve quality, safety, performance and accountability.
These strategic outcomes are considered to have the greatest potential to make a difference to consumers and will benefit from improved coordination of effort by governments.
"A high quality, high performing health system needs a strong, integrated primary health care system at its centre. Health systems with strong and effective primary health care can achieve better health outcomes at a lower cost, than health systems that are more focused on acute and specialist care."
Australia. Standing Council on Health. National primary health care strategic framework. Internet: Commonwealth of Australia; 2013.
https://www1.health.gov.au/internet/main/publishing.nsf/Content/nphc-strategic-framework
Questions: As above, what evidence do we have for the effectiveness of preventative activities, the management of chronic conditions and to what extent have we reduced the need for hospital services?

Primary Health Care Development Program (2017?)

The Primary Health Care Development Program (the Program) **provides funding** to support activities that improve access to quality primary health and medical services in the community.
The objectives of the Program are as follows:

- Continued improvement in general practice, allied health and other activities that will increase capacity, enhance quality care and improve access and health outcomes for patients;
- Improved access to the range and choice of medical and health care services available to target population groups including children, disadvantaged groups, Indigenous populations, and people in regional, rural and remote locations;
- Improved coordination and integration of primary and ambulatory health care;
- Enhanced education, training opportunities, and dissemination of information aimed at improving the quality and efficacy of primary health care services;
- Provision of innovative and cost-effective health and medical care, accurate advice and information about health, illness and available services, to assist people in caring for themselves and their families;
- Provision of the use of current and emerging interactive communication technology such as telephone advice lines, interactive websites and video conferencing, including telehealth;
- Supporting the establishment of the Health Care Home model, to provide continuity of care, coordinated services and a team-based approach to care of the patient; and

- Improved collaboration of health information and services to assist people living with complex and chronic conditions to help maintain good health.

The Program comprises of four annexures:

1. Primary Health Network;
2. Health Information, Advice and Counselling Services Network;
3. Primary Health Collaboration and Complex Conditions; (see also below)
4. Health Care Homes.

https://www1.health.gov.au/internet/main/publishing.nsf/Content/primary-health-care

Priorities for

1. PHNs https://www1.health.gov.au/internet/main/publishing.nsf/Content/PHN-Home

2. Health info: Activities to be supported under the Single Point of Contact for Health Information, Advice and Counselling Fund include: After Hours GP Helpline; Pregnancy, Birth and Baby Helpline; video consultation capability; National Health Services Directory; and Healthdirect Australia(nurse triage services).

3. Complex conditions: (See below)

4. Health care homes (This is a trial, now closed, that will run until 30 June 2021.) https://www1.health.gov.au/internet/main/publishing.nsf/Content/health-care-homes-professional

The Primary Health Collaboration and Complex Conditions (2016) forms part of the above Primary Health Care Development Program.

The objectives of the Program are as follows:

- Improved patient outcomes through better management of chronic and complex conditions through integrated, multidisciplinary team based care;
- Improved protocols, procedures and service delivery methods to increase efficiency within primary health care organisations and care providers;
- Better use of evidence based research and data, to support best practice care through the development and implementation of guidelines and policy advice;
- Enhanced clinical reporting and functionality (for example, data cleaning to produce valid registers and reports);
- Development of proactive, population based care initiatives in local communities;
- Increase knowledge about health care and health services amongst patients, carers and families; and
- Strengthening health care professionals' knowledge and capacity to manage chronic and complex conditions through education and training.

Priority Areas

The following priority areas were identified to achieve the fund's objectives and translate its key principles into practice:

- Prevention across the continuum;
- Early detection and appropriate treatment;
- Integration and continuity of prevention and care; and
- Self-management.

https://www1.health.gov.au/internet/main/publishing.nsf/Content/primary-collaboration

Declaration of Astana (2018)

(Replaced Alma-Ata Declaration)
We envision

- Governments and societies that prioritize, promote and protect people's health and well-being, at both population and individual levels, through strong health systems;
- Primary health care and health services that are high quality, safe, comprehensive, integrated, accessible, available and affordable for everyone and everywhere, provided with compassion, respect and dignity by health professionals who are well-trained, skilled, motivated and committed;
- Enabling and health-conducive environments in which individuals and communities are empowered and engaged in maintaining and enhancing their health and well-being;
- Partners and stakeholders aligned in providing effective support to national health policies, strategies and plans.

https://www.who.int/primary-health/conference-phc/declaration

Primary Health Care

- Primary care is essential to provide population health that is relatively low cost

Countries with a strong primary health care sector have better health outcomes and lower all-cause mortality and lower overall health costs than those with weaker primary health care systems. Australia spends about 35% of the total health budget on primary care which includes general practice, community health, other health professionals and medication. Primary care is usually the first point of contact that people have with the healthcare system. For most people this first point of contact is usually with a GP, 4 out of 5 Australians see a GP in any year. The greatest contact between the population and health care services is with primary care, it is the front line of the health system.

- Primary care is multi-disciplinary

Whilst GPs are seen as the corner-stone of the primary health care system other health professionals such as practice nurses, pharmacists, Aboriginal health workers, allied health and dentists also play an important role. Multidisciplinary team care is essential for the effective prevention and management of a range of chronic conditions throughout the lifespan. Decisions made in primary care services have important consequences for the rest of the system. This is of particular importance for the care of chronic illnesses where high quality evidence-based primary care can reduce the need for expensive hospital based care (Starfield, 2011). To fully realise the potential and value of primary care is is essential all health professionals working in primary care are using the best possible evidence to inform their management.

- Essential to attract high quality health professionals

To provide effective first point of contact care in primary care it is essential that we attract doctors, practice nurses, pharmacists, Aboriginal health workers, allied health and dentists who are highly trained and who are committed to ongoing professional development. Promoting the value, prestige and visbility of primary care is an importnat conisderation in

influencing whether high quality graduates are likely to pursue a career in primary care and general practice in particular High quality health professionals will be attracted by career structure, clear roles and prestige of the the primary care roles. It is essentail the graduates are prepared to work in parimary care. For doctors this is achieved through the vocational training program and the RACGP and practice nursing now has a framework to guide post-graduate training to ensure that nurses are fully equipped for their role. Specific primary health care training may be required for other health professionals to better integrate them into the wider primary health care team.

- Models of providing multidisciplinary primary care

The Australian government's 10-year health plan has a focus on improving primary care to make it more patient focused.

The case for PHC - put in the context of the 10-year plan
A Primary health care identity and visibility as a an option
PHC as a career option with options for involvement in research

- Patient engagement - preventive health care and health promotion

About 80% of Australians report having seen a GP in the previous year (AIHW, 2020). Of those individuals who visited a GP, an average of six visits per person were made (RACGP, 2020). In comparison, people saw a specialist an average of 0.95 times in the same year. Rates of GP attendances have been increasing steadily over the past decade (RACGP, 2020). This makes sense as GPs are typically the first point of contact a patient has with the healthcare system, and provide screening, diagnosis, preventive and treatment services. With the rates of chronic disease continuing to rise, patients require ongoing, multidisciplinary support in the community. The role of GPs and other primary health care providers in chronic disease management is to support patients to have improved quality of life while avoiding medical complications and hospitalisation. In this aspect, primary care providers are key to disease prevention and health promotion. Targeted prevention efforts, such as smoking cessation campaigns, may prevent >100 000 disability adjusted life years (DALY) in the population (ACE prevention, 2010). Many of these preventive activities can take place in the primary care setting, leading to improved patient outcomes and population health. Furthermore, the number of GPs located in a community is strongly associated with the population's health outcomes, with less all-cause mortality and increased health equity in areas with a surplus of GPs (Starbright, 2005). Therefore, increasing patients' access to and engagement with primary care services should be a health system priority.

From Grant's doc: *The greatest contact between the population and health care services is with primary care, the front line of the health system. Decisions made in primary care services have important consequences for the rest of the system. This is of particular importance for the care of chronic illnesses where high quality*

evidence-based primary care can reduce the need for expensive hospital based care (Starfield, 2011).
*Research about and within primary health care is essential to improve **clinical practice, service deliver**y, as well as **health systems**….primary care research has been described as "the missing link in the development of high-quality, evidence-based health care for populations" (van Weel et al, 2004).*
Primary health care research is vital for equitable, good quality and sustainable health care services and for improving population health.
Improvements and reforms to Australia and New Zealand's health care systems need to be based on robust evidence. In turn, the quality of that evidence depends on support from a vibrant and skilled PC research community.

General practice, pathology, pharmacy, allied health, practice nursing, community oral health, Aborignal Health Workers and ACCHO staff

Organisational partners and supports - PHNs

Vignette highting value of PHC research
Inala research - comprehensiveness of ACCHOs' PHC?

PHC Research

Despite similar healthcare spending on primary care (35%) and hospital-based care (39%), between 2014 and 2015, primary care was accessed four times as often as outpatient hospital services (AIHW, 2020). Over 27,000 general practitioners (GPs) provide care to people across Australia, yet only XX GPs are involved in research. Limited research takes place in the primary care setting. This lack of research has been attributed to limited funding, few GPs with academic backgrounds in the workforce and unclear pathways for medical students to pursue research careers (Manski-Nankervis, 2020). As GPs provide general care for a wide range of conditions, and are often the first point of contact for patients, they should be providing care that is most up-to-date and based in sound evidence. However, this is challenging when research in this space is limited.

Patient health outcomes are better when XX. The health of a community is strongly associated with the number/density of available primary care providers (Starbright). Etc. Etc.

Primary care research is clearly important for the health of our society, yet is undervalued by research funding bodies(?)/national government(?). Primary care research needs to be a national priority.

PHCRED program and outcomes

The case for PHC research

Patient engagement - preventive health care and health promotion
Patient focused - with the aim of imporving patient outcomes
Multidisciplinary
Sustainability and strategic research plan

See AMA statement https://ama.com.au/position-statement/general-practice-primary-health-care-2016

Career development - attractive career option for clinicians and researchers

Vignette highting value of PHC research

Needs to be rewritten
Clinical outcomes of an integrated primarysecondary model of care for individuals with complex type 2 diabetes: a non-inferiority randomised controlled trial

GPs with special interests working with a Beacon model of integrated care for diabetes achieved clinical outcomes that were not inferior to hospital-based specialist clinics, with greater patient satisfaction

Now also been adapted and utilised in Western Australia

Russell AW, Donald M, Borg SJ, et al.

Clinical outcomes of an integrated primary-secondary model of care for individuals with complex type 2 diabetes: a non-inferiority randomised controlled trial. Diabetologia 2018; 62: 41–52.

If we don't do the research, Pharma will do it, and what would that lead to
Prevention and chronic disease
Developmental screening
PHNs - scope to be using research to drive quality improvement agenda, enhance their organisational capacity

Options (Pros and cons) - We need to develop and identify key 3-4

Option	Pros	Cons

The role of PHN ad PHC Research Networks - ? population level implementation research	Multi-disciplinary	Might be too large Might become the focus of PC research funding at the expense of other research activities
Need to for more comprehensive PHC data. Currently there is data about use of GPs but very little about use of other PHC providers	Would provide a clearer picture of Australian PHC beyond the GP	If you wanted BEACH type data then buy-in from other health professionals
Career structure for health professionals in PHC	Make career more visible and attractive to graduates	Is it possible to have overarching framework or how do you link career frameworks from different disciplines to provide cohesive approach
Increase funding for PHC research and/or include a PHC rep in funding decisions	More research on important primary care topics which would in turn lead to better health for all (?? is this too broad)	Means shifting funding from somewhere else; Immediate cost to nation/states

Specific funding for PHC/targeted schemes for PHC - specific calls - Targeted PHC funding within calls/rounds

PHC should be a key partner in any research alliances and partnerships

Different types of PHC research - all needed (but recognising research infrastructure and stakeholders are different for all three

1. Clinical practice - needs trial infrastructure, high quality granular consultation data for research
2. Service delivery - needs data systems, quality improvement research
3. System - needs system information, insights on high-level transitions/interfaces with rest of the system, whole of PHC system research and not just general practice

Practice Based Research Network

Discussion needs to be broader than general practice to encompass pharmacy and other disciplines - health neighbourhood. Driving change and innovation through MD research

Health care homes and neighbourhoods

What research enablers beyond funding models, what kind of

Develop research leadership

Thinking of evidence building and research beyond hospital settings

Primary care data - value of things such as BEACH, MedicineInsights

Evidence Based Practice - Greatest contact for patients is with PHC, so all contact needs to be evidence informed, high quality, informed by research

PHNs need to take a stronger role in research - and enhancing their capacity to be involved in research

Final recommendation(s)

Come back to this
Visibility and identification with PHC and research within that
What essential activities are required to support this - consider PHCRED

References

From Grant's initial doc:

1. Manski-Nankervis JE, Sturgiss EA, Liaw ST, Spurling GK, Mazza D. General practice research: an investment to improve the health of all Australians. Med J Aust. 2020.

    A GP must have a good working knowledge of 167 problems to cover 85% of the conditions that they see most frequently,5 and management of multimorbidity has become the norm. The number of general practices appears to be declining, practices are becoming larger, and the proportion of GPs who are practice owners is decreasing.6 General practice research is key to optimising health care in this evolving context, but needs to be supported by the profession, funders and our professional colleges.

2. Hudon C, Chouinard M-C, Bayliss E, Nothelle S, Senn N, Shadmi E. Challenges and Next Steps for Primary Care Research. The Annals of Family Medicine. 2018;16(1):85-6.

    Conducting research to improve care for individuals with complex health care and social needs calls for complex interventions integrating services provided by health care and social professionals as well as community-based services. Taking time to develop and nurture partnerships and engage patients and other stakeholders in research allows a better understanding of each other's reality, increasing sustainability, and identification of more relevant research designs as well as process and outcome measures. Developing a common language and having access to combined health care and social services funds would help to promote this partnership.

3. Stevens RA. Recharging Family Medicine: A Perspective from the Keystone IV Conference. J Am Board Fam Med. 2016;29 Suppl 1:S15-8.

4. Van Royen P, Beyer M, Chevallier P, Eilat-Tsanani S, Lionis C, Peremans L, et al. Series: The research agenda for general practice/family medicine and primary health care in Europe. Part 6: reaction on commentaries - how to continue with the Research Agenda? Eur J Gen Pract. 2011;17(1):58-61.

5. James P, Davis A, Borkan J. The challenge to build research capacity in family medicine: is our discipline ready? Ann Fam Med. 2010;8(4):371-3.
7. van Weel C, Rosser WW. Improving health care globally: a critical review of the necessity of family medicine research and recommendations to build research capacity. Ann Fam Med. 2004;2 Suppl 2:S5-16.
9. Green LA. The research domain of family medicine. Ann Fam Med. 2004;2 Suppl 2:S23-9.

Other references

Beasley JW, Starfield B, van Weel C, Rosser WW, Haq CL. Global health and primary care research. J Am Board Fam Med. 2007;20(6):518-26.

> Research in primary care is essential to inform practice and to develop better health systems and health policies… The challenge of developing research in primary care can be met only by creating a strong infrastructure. This will include strengthening academic departments, enhancing links to researchers in other fields, improving training programs for future primary care researchers, developing more practicebased primary care research networks, and increasing funding for research in primary care.

Stange KC, Miller WL, McWhinney I. Developing the knowledge base of family practice. Fam Med. 2001;33(4):286-97.

> Borrowed and adapted knowledge is insufficient to optimize the potential of a comprehensive, integrative, relationship-centered generalist approach to improve the health of individuals, families, and communities. The knowledge base for family practice must be expanded by integrating multiple ways of knowing. This involves (1) self-reflective practice by clinicians, (2) involving the patient voice in generating research questions and interpreting data, (3) inquiry into the systems affecting health care, and (4) investigation of disease phenomena and treatment effects in patients over time.

Duckett S, Swerissen H, Moran G. Building better foundations for primary care: Grattan Institute; 2017. Available from: https://grattan.edu.au/report/building-better-foundations/.

> “Simple reforms to Australia’s health system could help save more than $320 million a year on avoidable hospital admissions and provide better care for people with diabetes, asthma, heart disease and other chronic conditions.
> The primary health system, Australians’ first point of contact for health care, was designed in and for another era and is now failing in the prevention and management of chronic disease, the heaviest burden on today’s health system.
> The government spends more than $1 billion each year on planning, coordinating and reviewing chronic disease management, yet many people with chronic conditions do not receive best care and end up having hospital stays that could have been avoided with better care....” “Recommendation 1: Pay for better data We need more information about what happens in general practice. Without data, there is no sound basis for system reform. Better data will enable realistic targets to be set for improvement in primary care.”

Heal C, Roberts G. General practice research priority setting in Australia. Australian Journal of General Practice. 2019;48(11):789-95.

> The results provide a contemporary reference point for an Australian general practice research agenda that helps prioritise and advocate for funding, and enables delivery of evidence-based patient care.

Furler J, Cleland J, Del Mar C, Hanratty B, Kadam U, Lasserson D, et al. Leaders, leadership and future primary care clinical research. BMC Fam Pract. 2008;9:52.

> To meet the increasing demands being made of it, primary care needs its own thriving research culture and knowledge base… There are special features of primary care that mean that it cannot rely solely on evidence from specialty research. In primary care problems are more diverse than those seen in specialty practice. Patients are surrounded by family, dealing with work, economic and cultural constraints.
>
> Has Table 1: **Extraordinary potential of primary care research. Innovative and pragmatic study designs and topic**s.

Glanville J, Kendrick T, McNally R, Campbell J, Hobbs FD. **Research output on primary car**e in Australia, Canada, Germany, the Netherlands, the United Kingdom, and the United States: bibliometric analysis. BMJ. 2011;342:d1028.

> Precis: Australia isn't even in the league.

Australian Institute of Health and Welfare. Australia's health 2018. Canberra: AIHW; 2018. Available from: https://www.aihw.gov.au/reports/australias-health/australias-health-2018/contents/table-of-contents. Great for data.

> Chapter 7.5 Primary health care. Australia's primary health care system faces several ongoing challenges. These include inequalities in access to effective and coordinated care, as well as increasing demand (due to an ageing population and rising levels of chronic conditions and risk factors). Yet, despite its importance, the availability of reliable high-quality data on our primary health care system is limited. This makes it difficult to assess its performance with the same rigour as applied for hospital care, and to identify and monitor areas where improvements are needed⋯ A substantial proportion of health care services in Australia are delivered in primary health care settings. In 2015–16, primary health care accounted for 35% (or $59 billion) of Australia's total health expenditure, while hospital services accounted for 39%, and referred medical services for 10% (AIHW 2017b). See Chapter 2.2 'How much does Australia spend on health care?' for more information. In 2014–15, 85% of Australians saw at least one GP in the previous 12 months, 47% saw a dentist, and 28% saw another primary health professional such as a pharmacist (8.1%), physiotherapist (8.0%) or an optician or optometrist (6.5%) (ABS 2017b). Also gives a good overview of what GPs do, and allied health.

Productivity Commision. Shifting the dial: 5 year productivity review. Canberra: Commonwealth of Australia; 2017. Available from: http://www.pc.gov.au/inquiries/completed/productivity-review/report

Recommendation 2.1 IMPLEMENT NIMBLE FUNDING ARRANGEMENTS AT THE REGIONAL LEVEL. The Australian, State and Territory Governments should allocate (modest) funding pools to Primary Health Networks and Local Hospital Networks for improving population health, managing chronic conditions and reducing hospitalisation at the regional level.

Great quote to think about for the value of research

> I am not suggesting that surgeons are recommending operations knowing that the potential risks outweigh the potential benefits. Largely, surgeons believe that they are doing the right thing, but often they are not aware of the strength (or weakness) of the supporting evidence or, what is more often the case, **there is simply no substantial or convincing scientific evidence available.** Without good scientific evidence, surgeons perceive the procedures they recommend to be effective – otherwise their colleagues wouldn't be doing them, right? Put simply, **a lack of evidence allows surgeons to do procedures that have always been done, those that their mentors taught them to do, to do what they think works, and to simply do what everyone else is doing**. (Harris 2016, pp. 1–2) [Harris, I. 2016, Surgery, The Ultimate Placebo: A Surgeon Cuts Through the Evidence, NewSouth Publishing, Sydney.]

Royal Australian College of General Practitioners. Vision for general practice and a sustainable healthcare system. East Melbourne: RACGP; 2019. Available from: https://www.racgp.org.au/advocacy/advocacy-resources/the-vision-for-general-practice/the-vision

> 2.5 Investment in general practice research is needed to improve the healthcare system. General practice research is essential to ensuring all Australians can access a highquality, effective and evidence-based primary healthcare system. In the five years leading up to 2017, primary healthcare funding comprised only 2–4% of total National Health and Medical Research Council (NHMRC) funding.32 General practice made up an even smaller proportion of this funding…. Inadequate evidence relevant to general practice hinders GPs' efforts to provide evidence-based care, as guidelines developed from research in other settings may not be appropriate for patients being managed in the community.33,34 The benefits of high-quality general practice are longer term and can be less obvious than results provided short term in a hospital setting. General practice research contributes to an essential evidence-based health system, and can bring benefits to the health system such as lower rates of hospitalisation, as well as improved blood pressure, cholesterol and asthma management. More research is required into these benefits, as well as how general practice can improve the healthcare system more broadly. A strong primary healthcare research sector linked to general practice–based research networks will increase translation of research findings into practice and ensure Australians can access high-quality, up-to-date, evidence-based care.35

AIHW (2020). Primary Health Care in Australia. FOR BACKGROUND SECTION https://www.aihw.gov.au/reports/primary-health-care/primary-health-care-in-australia/contents/about-primary-health-care

- 83% of people saw a GP in the past 12 months
- $56 billion spent on primary care (35% of all healthcare spending); 39% spent on hospital/acute care
- In 2014-15, there were 139 million non-referred GP visits, 35 million outpatient hospital visits and 10 million on admitted care

On policy briefs

https://www.anu.edu.au/students/academic-skills/writing-assessment/policy-briefs

https://publichealth.wustl.edu/wp-content/uploads/2019/08/Policy-Brief-Toolkit.pdf

Primary health providers include: • General practitioners • Dental practitioners • Pharmacists • Nurses (maternal and child health nurses, general practice nurses, home-visiting nurses, school nurses) • Allied health professionals (such as physiotherapists, occupational therapists, podiatrists, orthotists and prosthetists, optometrists, dietitians, osteopaths, chiropractors, social workers, psychologists) • Paramedics • Aboriginal health workers • ~~Complementary medicine~~ practitioners

Primary Health Networks - are they competitors for funds or allies?
From: Duckett S, Beaumont M, Bell G, Gunn J, Murphy A, Wilson R, et al. Leading Change in Primary Care: Boards of Primary Health Networks can help improve the Australian health care system: AHHA; 2015. Available from: https://ahha.asn.au/leading-change-primary-care.
Chapter 1: Background to the Primary Health System. Historically, coordination of Australia's primary health system has been weak. The PHN is the latest attempt by the Commonwealth Government to rectify this.
Chapter 3: Strategies for Change. PHNs are to act as agents for change and reform in the primary health system.
Chapter 4: The Commissioning Model. An important function of the PHN is its role in service provision. Rather than directly providing services themselves, PHNs will primarily be commissioning organisations, purchasing services in response to gaps and shortages.
Chapter 5: Engagement with Clinicians and Communities. PHNs do not work in isolation. Change of the sort PHNs will pursue cannot occur without the joint effort and support of health providers. Moreover, the right sort of change cannot be achieved unless PHNs have a strong and meaningful relationship with the communities they serve.

https://www.who.int/docs/default-source/primary-health/vision.pdf

https://gh.bmj.com/content/4/Suppl_8

Strengthening Primary Health Care Through Research: Prioritized knowledge needs to achieve the promise of the Astana Declaration

https://academic.oup.com/fampra/article/17/1/1/507652