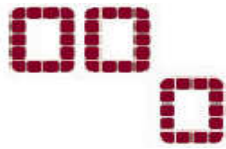


# Moving Forward Together: Strengthening Primary and Ambulatory Care in WA

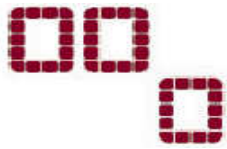


Conference Proceedings Report  
September 2008



## **Moving Forward Together – Strengthening Primary and Ambulatory Care in WA**

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## **Welcome to Country**

## **Kim Collard**

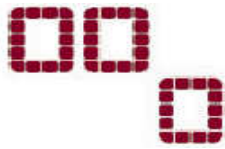
Kim Collard, a Nyoongar community representative, welcomed both Ministers: Hon. Nicola Roxon MP, and the Hon. Jim McGinty MLA, along with all participants in attendance, to Government House. He acknowledged that we were all sitting on Nyoongar land, and that his ancestors would be happy to see people sitting and talking about primary health care in Western Australia. He wished everyone well in their deliberations whilst they were on Nyoongar land, and requested that during our deliberations we could focus upon closing the health gap between indigenous and non-indigenous people, then people in the indigenous communities would welcome today's deliberations. Kim urged participants to keep in mind the Aboriginal Community Controlled Health Organisations during our deliberations, and remember they are the first point of call for aboriginal people. We all have a great deal to learn from these organisations, as well as ensuring that linkages are made within primary care. For us the talk is over, the time is now for action.

## **Welcome and Overview of the Day**

## **Dr Simon Towler, Department of Health WA**

Dr Simon Towler thanked Kim and acknowledged the Nyoongar nation upon whose land we were on today, and in keeping with Kim's wishes, that today's session would be focused, productive and would lead to actions. On behalf of the Department of Health WA, Dr Towler welcomed Hon. Minister Roxon, Hon. Minister McGinty, and the Acting Director General Dr Peter Flett. He particularly wanted to welcome everyone in attendance at the conference, by the beginning of this week we had over one hundred and ninety six people requesting to attend today's session, with over a hundred people in attendance. Dr Towler expressed his thanks to everyone for giving their efforts, time and their commitment to working with us and helping move forward together to help strengthen primary care.

Dr Towler spoke of how, the past two years health networks have been working on Models of Care: they extend from before hospital admission to after hospital admission; to the care of the patient when they are dying; and in particular with thoughts given to the care of the family and those in need. He acknowledged how, worldwide it is understood that primary care represents an outstanding investment in improving health quality, and in engaging with the community. He stated how in the new world, with a focus upon wellness and staying well for life, primary care is a very important component of what we do – the work in the Models of Care acknowledge that. State Health is committed to working with primary care to improve the quality of care where they have responsibilities: child and adolescent care; in rural and remote communities, in trying to meet the special needs of people where access to great services provided by General Practitioners may not be as readily achieved; and they are committed to working in partnership to ensure that services are provided within these difficult environments. He commented on how in WA, we know that any investment in primary care is a good investment, we know that improving the care in the community results in less demand on hospitals, and we know that today's event provides a unique opportunity with the people who are speaking, and in the deliberations that follow, to really get to the issues that everyone here today views as important. Dr Towler then introduced Dr Peter Flett, Acting Director General for Health.



**Dr Peter Flett**

**Acting Director General for Health, Department of Health WA.**

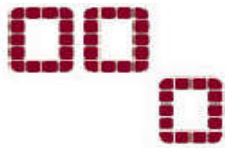
Dr Flett also acknowledged the Nyoongar people whose land upon which we stand, and both Ministers Roxon and McGinty for being in attendance and supporting today's session. Dr Flett shared his experiences of growing up in a country town in Australia, where the General Practitioner was a very important individual – Dr Flett cleaned his car every Saturday morning and commented on how 'for once he could bill him for the job'. He expressed how, forty years on, not much has changed and the GP is still an important individual. He did however point out that what is different is the expectation of patients – wanting treatment in a timely manner. He stated how to achieve this in WA is turning into a problem, where we are four hundred doctors short compared to other states. The consequence of this is that people are told to wait up to three weeks for an appointment, who then choose to access care via the Emergency Departments. Dr Flett stated how we have gone on long enough each doing our own thing and the time is right to work together to address the issues of easing the burden on Emergency Departments, and the doctors. Dr Flett provided an undertaking that the Department of Health will be involved in all discussions on moving the situation forward. He stated that today is an opportunity to plan for the future and he looked forward to hearing the outcomes. Dr Flett went on to introduce Hon. Nicola Roxon MP.

**Hon. Nicola Roxon MP      Minister for Health and Ageing**

Minister Roxon thanked Dr Flett for the introduction and for the invitation to attend today's forum. She thanked Kim Collard for the Welcome to Country and acknowledged the traditional owners of the land. She acknowledged her colleague, the Hon. Jim Mc Ginty, for supporting her in the transition to Government, and in leading some of the difficult reform discussions that have happened. She also thanked both Drs Flett and Towler, along with representatives from primary care organisations, Divisions of General Practice, doctors, nurses and other health professionals who were present at today's event.

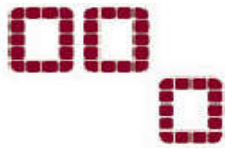
Minister Roxon stated that primary care is an important topic for the community and for the Federal Government, where they have committed to some major reform in the health system. She commented on how there is clear evidence that the system is not coping with current challenges, and that there is a lack of confidence that the system is equipped to meet future challenges. She commented on how we need to look creatively and differently about how an ageing population and chronic disease issues can be met in future. Primary health care is the frontline, and she stated that if we want to deliver on those issues we need to make sure investments in primary care are in the top order of our considerations. Minister Roxon outlined key areas of the reform agenda including:

- **Development of a National Primary Care Strategy:** where we can look at ways of better rewarding disease prevention, ways that we can promote evidence-based management of chronic disease, whilst also supporting patients with chronic disease to manage their conditions. There is a much greater focus on multidisciplinary team-based care required, accompanied by the need to address the growing need for access to other health professionals like practice nurses and allied health workers. She outlined how the primary health care that we are aiming for should be high



quality, cost effective, evidence based and coordinated with other forms of care such as hospital specialists and aged care services. A comment was made that if we don't get the connections right between the different types of services provided we won't improve the patient experience and probably won't get better health outcomes long term.

- Funding is important in ensuring these linkages, and one of the things currently underway is a **review of the Medicare Benefits Schedule Primary Care items**, with the aim of producing a simpler primary care item structure, less red tape and providing more support to prevention.
- **Addressing Workforce issues:** Minister Roxon stated that the solution has to be not to just train more doctors, but to use our health resources (our health workers) in a much smarter way. That will mean new models for service provision and more flexible roles for our health care workers. She emphasized that this was not to be seen as an attack on the role of the GP, nor on medical standards within primary care. It was about acknowledging the specialist skills and knowledge GPs have, but recognising that some of the work that they are undertaking is less complex and could be safely undertaken by other highly qualified and capable members of the health care team. She stated that nurses and other allied health workers, along with health professionals such as pharmacists, could play a greater role in primary care, if the system allows and encourages them to do so. She spoke of how we need to find a way to ensure that members of the community can receive the right care, in the right place and at the right time. She went on further to describe the Nurse Practitioner role, as one that has been used for some time in the UK, US and New Zealand. In Australia the role was introduced in the early 1990's, yet we still only have about 200 Nurse Practitioners who are mainly working in remote and rural communities. Minister Roxon stated that nurse practitioners have the opportunity to use their skills more extensively, and to meet some of the demands of the health services, but we need to make it more attractive to become a nurse practitioner and that means recognising their skills. She also described how in the US there is an established role of the Physician Assistant, increasingly providing services to smaller communities under the overall guidance of a medical practitioner. Physician Assistants are about to be trailed in Australia with Queensland announcing a twelve-month pilot scheme to increase healthcare to areas affected by workforce shortages. She described how we need to open our minds to news models of service and not to compartmentalise our thinking on specific roles.
- The **GP Superclinics** component are, she described, further evidence of the Commonwealth's commitment to primary care, and they are going to have a key role in the National Primary Care Strategy. The first consultation was held in Wanneroo the previous night, with another taking care in Midland that evening. There are 31 GP Superclinics committed to across the country. Within WA, \$5million has been committed to each clinic with this figure being matched by the State Government, which, she feels, reflects the joint vision to implementing a multidisciplinary working and team-based care in those communities. By facilitating team-based care between private providers such as GPs, allied health, and other community-based services that may be funded by State providers, GP Superclinics will provide an opportunity to focus upon areas of preventative health and chronic disease. Minister Roxon stated



that key to the Federal Government's commitment, was the training of health professionals, and described it as "a real priority for us". She went on further to state that "we think that these Superclinics that are properly designed and supported, will provide an opportunity to expand multidisciplinary training. We need these Superclinics to be the workplace of choice for new graduates".

Minister Roxon concluded by stating that the Commonwealth is committed to revitalising primary health care and giving the means it needs to do a good job to protecting Australia in terms of health and health outcomes. She acknowledged that achieving significant change is always going to be a challenge, yet the debate cannot be postponed any longer, stating that "the problems have been building up and they will otherwise engulf us if we don't act now". She described the Commonwealth Government as committed to achieving reform, whilst also being committed to consultation to ensure that they get the changes right, and how they will therefore work alongside other Governments to improve the health outcomes for all Australians. Minister Roxon reiterated that she was looking forward to hearing the outcomes from today's debate, and to working with everyone in the coming months and years to help make these changes a reality.

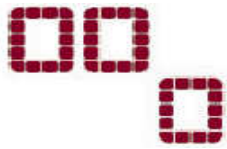
#### **Hon. Minister Jim McGinty MLA Minister for Health**

Minister McGinty thanked the Nyoongar people whose land upon which we stood, the Hon. Minister Roxon, and the many, many distinguished guests who were within the room. Minister McGinty urged Minister Roxon not to lose the passion for health reform, and to remain committed to addressing the funding issues that underpin the reform.

Minister McGinty spoke of the extensive initiatives that were underway across the State, including those that focused upon smoking thereby ensuring that the State remained a leader in the fight against tobacco. He stated how addressing the health gap between indigenous and non-indigenous is a priority area for the State, and that primary care can play a major role in this.

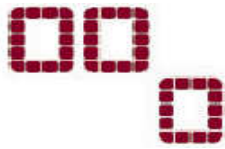
Minister McGinty spoke of his great optimism for health reform for the future, particularly in light of initiatives that were currently under discussion at both national and state levels. Such topic areas included:

- **Workforce issues:** in cooperation with the Commonwealth, how described how we need to focus upon these issues and find innovative means to redress the problems.
- **Mental health** is another issue that he stated focus' prominently on our agenda. He spoke of how access to psychiatrists and physiologists is limited across the State, and how more community-based care is required to ensure that people are kept well in the community and out of the hospital. Primary care also has a key role to play in these reforms.
- **Outpatient care** is another area for reform, where, he described there is a great opportunity for services to be provided in a non-hospital environment.



- **Access to Emergency Care** is growing, and he described how the limited access to primary care services has a knock on effect to the acute sector. He spoke of how “we need a joint approach to tackling these issues”.
- **Aged care** – Minister McGinty commented on how, in WA, we have a shortage of 2000 plus beds and consequently older people are more often inappropriately taking up acute beds and impacting on the public system. He felt that in association with the Commonwealth Government, we need to find a solution

Minister McGinty concluded that “all of these issues impact on both primary and acute care. Health reform is therefore critical for everyone here today and for the entire community”.



## **Questions from the Floor**

### **Dr Tim Leahy, Aboriginal Health Council of WA**

Two questions were raised by Dr Leahy: one that focused upon the increase in the GP salaries offered to GPs in WA Country Health System, which has led to disparities offered by the Aboriginal Health Services, and another that focused upon the limited mechanisms available for increasing funding to Aboriginal Health.

Both Ministers acknowledged the current situation, spoke of having shared optimism of investing in Indigenous Health, whilst also looking at extending mainstream services that provide services to Indigenous communities. They acknowledged the unsustainable and extraordinary wage rates offered to current service providers, and spoke of how the issue is being considered by the Health Reform Commission.

### **Dr Robert Newton, Edith Cowen University, Vario Health Institute**

Dr Newton described how chronic disease management and prevention is a major issue facing the State, but lifestyle change advice funded under the Medicare system varies across the professions. He asked how is the Medicare reform going to redress this? He also described how exercise as a medical treatment is offered internationally, where they are integrating exercise as part of primary care, and asked how high on the agenda are the wage disparities between Medicare rebate for dietetics and exercise physiologists?

Minister Roxon spoke of how these issues were on the agenda but she held an open mind as to whether we need to expand the Medicare rebate, or if there were other funding mechanisms that were more appropriate for the service. Through the National Primary Care Strategy and through the National Health and Hospital Reform Commission they need to look at the best tools for addressing this issue.

### **Gavin Frost, University of Notre Dame**

Made a statement of how he was delighted to be able to inform the audience that they were about to graduate the first cohort of medical practitioners, at least a third of whom had shown their intentions to work within general practice.

Ministers Roxon and McGinty, along with Dr Flett, were thanked for their time.

Audio files of both Ministers speeches are available on the health networks website <http://www.healthnetworks.health.wa.gov.au/home>

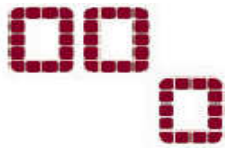
## **Guest Speakers**

### **Dr Rachel Hammond**

### **Rural GP, Chair WA GP Network**

Dr Hammond provided an overview of how, within her rural practice, team working and adopting a multidisciplinary approach was the way forward.

She identified a typical patient journey, and identified the numerous care providers involved in their journey. Consequences of applying a multidisciplinary approach to patient care included:



having to overcome the multiple funding sources; communication management and limits of technology; increased specialisation (with few generalists); and politics and turf wars.

She went on further to speak of the need for:

- Sustainable models with local flexibility, taking into account sensibilities of local businesses;
- Integration and co-operation at local level between GP Networks, Hospitals and Community (Public) Health;
- True integration of information management systems;
- Community input in discussions; and
- Voluntary patient registration to allow for better co-ordination and continuity of care for chronic illness.

### **Dr Shiong Tan**

### **Metropolitan GP, GP Advisor to Department of Health WA**

Dr Tan's presentation focused upon general practice as a personalised medical service – and requested that the audience remember that health care is personal, totally private and needs to be appropriate and personalised.

He went on to provide an overview of the demographics facing the State, along with a review of health expenditure growth to accompany the increase in demand for services. He asked were we investing in health or were we merely treating ill health? Integration between service providers was identified as a key way forward to ensure a more effective primary care system. He raised a number of questions for the audience to ponder- which services should we link, to coordinate or to integrate to what end? What are the trade offs? Who is the integrator? He stated how we need to find answers to these questions before we can progress the debate of creating an integrated, coordinated primary health care system.

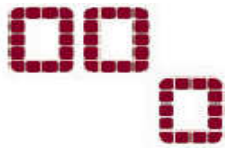
Copies of the presentations of both speakers are available on the health networks website <http://www.healthnetworks.health.wa.gov.au/home>

### **Michelle Kosky**

### **Health Consumers' Council**

Michelle Kosky spoke of the importance of the establishment of a Primary Care Network with need to: focus upon change within primary care; and to ensure better integration and coordination of services between hospital and primary care services. Her hopes were that a Primary Care Network would confront head on, the current issues facing primary care and identify positive ways forward.

She spoke of the successes of primary care planning in New Zealand, and that we could look to their approach as a possible way forward in addressing strategic issues for this State. She commented that "a partnership approach is the way forward, and only then can we add value to the primary and ambulatory care debates facing Western Australia".



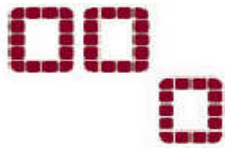
## **Creating a Primary Care Issues Wall**

Following from the presentations, participants were asked to write down two key issues that they felt impact on primary care in WA. They were then asked to write down their:

- The first most important issue on a blue post it note; then
- Their second issue on a green post it note.

Participants were then asked to stick their post it notes on an Issues Wall. All issues were then grouped into key themes. Each workshop group was then allocated a theme to discuss. Participants were assigned to one of 13 working groups who participated in the exercise over a fifty minute period. Following on from the workshop exercise, each group then provided feedback on their key issues to the wider audience, specifying what they felt should be key action areas to be addressed within WA.

Copies of the workshop notes and key discussion points follow. Each section identifies: the initial issues posted for each topic area (defining first and second priority issues); the key barriers facing the topic area; and possible ways forward to help overcome the barriers. Two key areas for action were then identified.



## Group 1 Aged Care

### Key issues facing Aged Care and Primary Care in WA

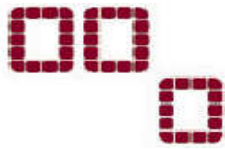
- Aged Care Medical support to Aged Care Facilities.
- Aged care facility's super clinics won't meet the need
- How to increase GP investment in residential care and how can DoHWA facilitate this and improve liaison with these GP's
- GP's and delivery service to residential aged care
  
- Ease of access to aged care services i.e.; entry points, assessment; duplication
- Funding of Nurse Practitioners into Aged Care Team (State/Federal)
- Funding in Aged Care facilities weighted to behaviour not clinical care – so limited focus on clinical knowledge and skills.
- Aged care and ED presentation that can be prevented by better GP/allied health intervention.

### Key Barriers facing Aged Care – 'GPs in Residential Aged Care Facilities and Community'

- Attraction
- Financial Remuneration
- Pharmacy Supply - Different rules
- Issues for Pharmacists
- Aged care struggles to support MDT(multi disciplinary team) (e.g. allied health)
- Lack of care co-ordination (especially in the community)
- Lack of co-ordination information
- After Hours access to GP's

### Key Enablers

- Redesign Pharmacy/GP prescription Process
- Section 100
- Elevate the status of medicine of old age
- Champions
- Post –graduate course in aged care
- Improve remuneration (Medicare)
- Increase Nurse Practitioner
- Develop aged care panel concept
- Not disease silos (note clinical networks)
- Support ACD (advanced care directions) opportunities
- Residential Care Line
- Rural issues



## Groups 2 & 8 Workforce

### Key issues facing Workforce and Primary Care

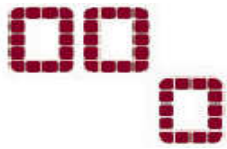
- Nurse practitioner leading primary health reform
- The need to address workforce shortages across all disciplines– in particular allied health
- Workforce facilitating training and teaching students and graduates
- Workforce accredited training - intra-professional learning.
- Lack of incentives for GP to take on medical students and promote General Practice and Primary Health Care in a positive note
- Having a clear measurable defined outcome that health teams can work toward
- Workforce shortage and wait time for patients.
- The need for workforce reform
- Addressing Workforce in Primary care — how to attract and retain all members of primary care team
- Innovation in workforce
- Sustainable appropriate workforce
- A peace treaty in tribal workforce of health professionals
- Maintaining a person (client centred) approach with a diminishing workforce.
- Expanding the role of allied health and community pharmacies in primary care
- Training modules/components in specific health programs – aboriginal health & drug and alcohol – for training doctors and trained doctors.
- Increased use of non-GPs in primary care issues.

### Barriers to addressing workforce issues in primary care

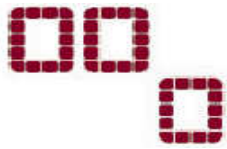
- A lack of an infrastructure to build and support workforce especially in outer metro where workforce matters most for whole of primary care workforce
- Mal-distribution of workforce & high turnover in unpopular areas
- How to implement models of care at regional level?
- The need to break down barriers inherent in funding models
- Shortage across all disciplines – need to quantify need
- Distance
- PC integration in rural/remote → DWNS salary
- PNS best use of limited resource – poorly supported and unsupervised
- Worklife balance and competing with life style
- Schooling/opportunities available
- Training of professionals
- Individuals working 'in silos'
- Territorial behaviour
- Entrenched positions

### What will enable us to move forward?

- Re focus on patient/carer
- Out of hours care



- Redistribute resources: CIP costs 0.8—1 million/year  
1:700 Nedlands  
1:4000 Merriwa
- Inter-professional learning
- Undergraduate training
- Post graduate training of Health Care Practitioner's
- Role Innovation
- Pilots
- Protocol driven (increase safety and clinical governance)
- Redefine general practice / decrease amount of stress and burn out
- Increase the scope for more 'exciting work'
- Generation 'Y' professional attrition



## Groups 3 & 7

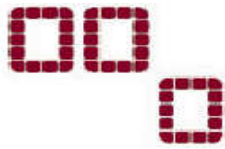
## Integration of Primary Care and Acute Care

### Key issues facing Integration - Primary Care and Acute Care

- Coordination of “complex care” across primary/acute interface
- Seamless transition from primary to tertiary health and back again
- Primary Care integration in rural/remote
- Better integration across all levels of government service delivery
- Moving from primary care competition to collaboration
- Improving opportunities of multidisciplinary care within primary care, including better linkages between hospitals and primary care through outreach and inreach models
- Primary Care Planning
- General practitioner “admitting” rights to tertiary hospitals
- IT integration – how do we ensure tertiary and PC systems talk to each other and enable sharing of essential information
- Remove the barriers to developing primary care team (including Nurse Practitioners) regarding funding, rules, government, provider numbers etc.
- Better integration of mental health care into primary health care system
- Team care arrangements
- Genuine consumer participation
  
- Primary care presentations in Emergency Departments
- Primary care modules of integration
- More effective integrative primary care and hospital services
- Role of ambulatory care in primary care
- Enhanced Communication between primary & secondary/tertiary levels
- Integration of Nurse Practitioners into aged care team
- Planning an integrated community based primary care model
- Enabling current providers of community care programs to become significant players in the future development of primary care
- Support for GP management of acute illness

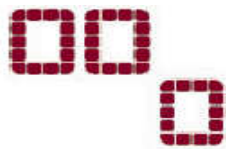
### Barriers impacting on better integration between primary and acute care sectors

- Formal communication: recognition of role of GP’s, limited GP liaison
- Lack of awareness of other service providers - “out of sight, out of mind”
- Perceptions of other services
- No mechanism/process/funding to achieve integration
- ‘Lip service’ given to joint decision-making
- Genuine partnership resource allocation
- Lack of funding incentives for GP to be involved
- Gaps in the management of services
- Don’t learn from history.



## Solutions:

- The necessity to focus upon customer needs, with efforts made to increase Patient/consumer access and awareness
- Include people who are part of the system in designing the solution and develop 'pragmatic solutions'
- Mechanisms of consultation that should take into account the GP/patient relationship
- Dichotomy of acute/ED versus primary care – acute sector is perceived as 'more sexy/more exciting'. We need to change the concept/idea of primary care as 'being an important area'.
- The need to measure/monitor primary care outcomes
- The need to grow the non-government sector:
  - A need to address the IT/Communication information systems between all sectors – particularly with the current costs associated with the limited communication between agencies/sectors for instance tests and consults – which places the patient in the 'communicator' role
  - A need to address the issues of limited capacity within the community health sector
- Genuine conversation and consultation with community – increases capacity and capability to talk and plan. Resources are however required to run appropriate level of consultation
- Current funding models divide rather than support partnerships – this could be addressed by State/Government discussion groups
- Sharing workforce and supporting workforce collaboratively
- Real planning of NGO' sectors
- Funding of projects and programs that work on integration as a goal.
- Adequate investment in change management over time.
- Prioritise integration area
  - ATSI
  - Complex co-morbidity conditions
  - Mental health
  - Aged/hospital/GP/Community interface



## Group 4 Funding

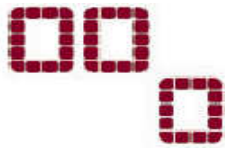
### Key issues facing Funding of Primary Care

#### Funding:

- Incentives for GPs to engage
- Integrated/less integrated funding models (fragmented funding)
- Investment for properly adequate & sustainable population health ie prevention of preventable diseases
- Access to primary care - ways to fund team members to help GP to free up time to see more patients.
- Need for quality framework in primary care (not built into fee—for—service model)
- Financial disincentives for providers
- Incongruence between GP private business “marketing” and population needs and priorities ie barriers of planning for equity access primary care.

#### Funding Models MBS:

- Funding model reform GP’s — care plan (program)) funding for enrolled clients with chronic disease
- Complexity of MBS
- Aligning the disparate funding models involved
- Flexible funding
- A strong coordinated (positively discriminatory) approach/plan for indigenous peoples’ health
- Remove barriers to GPs O.P.D.s accessing Medicare
- Reducing proportion of care delivered by fee—for—service
- Better remuneration for GP’s
- Funding of AMS — especially Doctors
- Primary Health Care strategy for WA and a mechanism for its delivery including mandated authority and budget.
- Lack of access to MBS/PBS item numbers by nurse practitioners and other suitably qualified allied health workers.
- Cost to patients especially as “private” services eg radiology bulk bill less.
- Federal/State funding reform
- Silos of funding broken down
- Complexity of Medicare items – discourage actual time spent with patients
- Lack of focus on funding for prevention of chronic diseases in the primary care items
- Will private enterprise in community arena be actively involved in future planning
- Funding to adequately provide service
- Improved funding for initiatives which ease the Emergency Dept burdens & Presentations/representations
- Equity/parity between GP & specialist Medicare rebates
- Can funding be made more flexible?
- Funding to follow need not advantage
- Getting cross sector collaborative planning and joint funding
- Recognising existing resources capabilities & capacities available in community sector
- State Govt Investment in Primary Care delivery



- **Funding issues and associated barriers**
- Complexity and inflexibility of funding streams
- Different funding approaches has issues → blended funders
- Integration: Community priorities (chronic disease management) versus patient profile.
- Stop/start of program funding (e.g. immunisation, aged care)
- Disconnect in decision making federal and state.
- Competition not linking
- Funding for clinical training in GP.

#### **What will enable us to move forward:**

- Collaborative discussions
- Primary health care planning (Federal and State)
- Systems to facilitate info flows → across sectors
- (enhanced efficiency) [simplify]
- Blended funding, flexible funding for clinical training
- Agreement on definition/scope of primary care and agreed priorities and alignment of funding incentives
- Clarify practitioner roles.

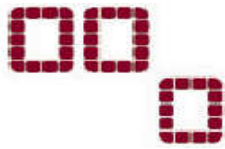
#### **Priorities for Action**

##### **Action 1:**

Agreed Primary Care strategy recognising and defining roles and responsibilities and agreed priorities with appropriate funding sharing.

##### **Action 2:**

Flexibility to increase capacity to meet needs. \$\$\$\$\$\$



## Group 5 IM & T

### Key issues for IM & T in Primary Care

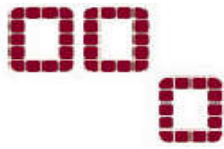
- Sharing Patient information/Shared health records
- Electronic medical record with joint access
- Improve electronic communication between private providers and hospitals (public and private)
- Communication and consultation with all groups
- Responsive communication systems between health services and primary care
  
- IM&IT and role in primary care
- Voluntary patient registration
- IT/IM Database, linkage, B/W, hospitals and primary care
- Information systems that link WA health services and aboriginal community controlled health services (and general practice)
- Improved integration of data reporting mechanisms into primary care through IT enhancement
- System Communication, universal patient medical/ID number, systems of communication, system for priority of access to primary care

### **Barriers facing IM & T within primary care**

- Lack of framework – governance, privacy, concert
- System architecture that includes primary care technology – GP diversity; complexity, cost
- Confidentiality/privacy legislation
- No national governance/policy framework
- No common data standard

### **Solutions:** (actions)

- Network (link) existing data sources (not megasolution) especially GP access to State Health Pathology, Imaging, and Discharge Summaries
- Unique patient identifier to link state
- Public education program
- Initial focus on state based system
- Inclusion of allied health
- Security/authentication system
- Develop governance and technical framework



## Group 6 Team Primary Care?

### Key Issues in regards to Team Primary Care

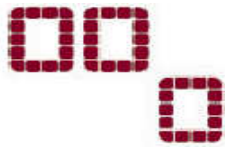
- Primary care is it GP's? or is it a team? Let's be honest and define it.
- Integration of "holistic health teams"
- Community medication
- Stop seeing GPs as the 'owner-operators' of primary care
- Siloed health professions unwilling to work in care teams.
- How to get true multidisciplinary care into primary health.
- Fragmentation of community aged care services.
  
- The role that Pharmacists and pharmacy can and do play in primary care
- Incentives to promote team work in primary care (esp. role of practice nurses)
- Reduction of duplication of care i.e. more cost effective use of various primary care services.
- Team approaches within general practice

### Barriers to enabling a Team Primary Care approach?

- Individuals still working in silos
- Some health professionals are unwilling to adopt a team approach to their working practice
- The nature of the funding model( especially fee for service) results in
- Perverse disincentive to refer
- Costs for patients in 'gaps'
- Remunerations doesn't reflect time cost (some items)
- Duplications of documentation
- Patients having to negotiate their way through communication – transfer of info "IT hole"
- Adopting a team approach takes time to develop and to undertake within everyday practice
- Workforce
- Education & training – segregated model not trained to be a team member & operating independent business
- Lack of Federal mandate around IT/IM
- Lack of IT capacity especially in rural areas which limits the ability to communicate effectively with other team members

### What will enable us to move forward?:

- IT/IM –
  - Mandated
  - Elect, info transfer
  - Directories of services to (decision/support) act as bridge
- Modification of training models
- Use of IM/IT simulation



- Training to work as a team
- Coordination of practice/work experience across training sector
- Training throughout year
- Develop a Primary Health Care Strategy/Framework for WA and implement (that will inform future decisions and quality planning).
- New funding models - possibly mixed for instance block funding for districts with consideration for populations –e.g. “indigenous” incentives for team work.
- Possible collocation of services locally (community-based)
  - Voluntary patient enrolment

**Key Action areas:**

1. Develop a strategic framework for the delivery of primary health care services in WA (e.g. including funding models). Strategies for integration (e.g. IM/IT) service delivery models, workforce training and education.
2. Primary Health Care Unit within WA Health given the mandate and resources to implement the strategic framework for primary health care (as developed in 1)

## Group 9 Preventative Health

### Key issues facing preventative health in primary care

- The need to focus on the social determinants of health
- The need to change the focus from acute to prevention/wellness model
- Keeping people as well as possible for as long as possible, in the community "wellness model".
- We need health neighbourhoods as well as effective health care system.
- The need to redefine what we mean by "health" (ie more than just the absence of disease.)

### Barriers

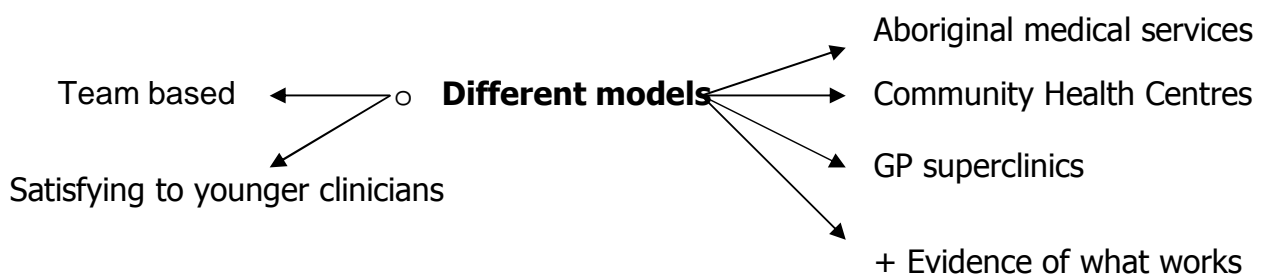
- Fee for service
- Requirements for GP referral onto other team members
- No population lists

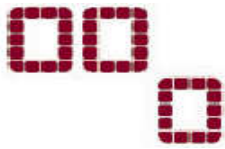
### ENABLERS:

- Be clear about model [Q: who is the best captain?]
- Can do prevention across continuum
- Acknowledge Primary care is greater than general practice
- Team based care necessary but not sufficient for shift to prevention
- Prevention needs to be targeted to groups and areas of high need.

### Action Areas

- Policy WA wide on Primary Care
- Implementation of different models of health





## Group 10

## Engagement

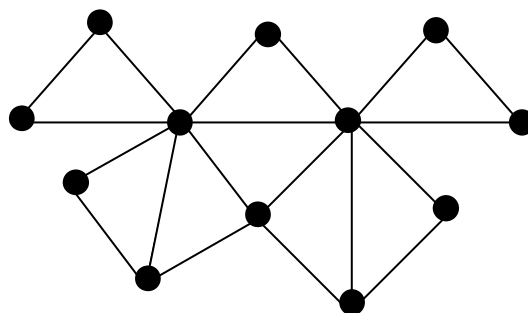
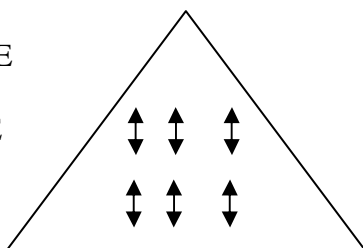
### Key issues for engagement in primary care

- Engagement of General Practice with respect to strategic health care planning.
- Family carers are recognised for the significant contribution that they make not only for the patient but to the care team and should therefore be included and consulted.
- Involvement of primary care in population health outcomes.
- Developing sustainable partnerships and encouraging collaboration between health service providers, Government, NGO's and consumers
- The need to drive the agenda from community consumer perspective
- There will be trade offs
- Change from medical model to consumer/health provider partnership
- Community locations for care.

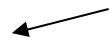
### Key barriers to achieving engagement

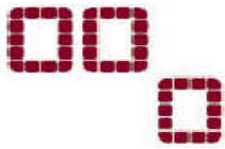
- Medical engagement in a patient centred approach rather than medical/hospital centric
- ACCHO's are example of how model can work, how to engage those with experience and success to contribute to develop + NB ACCHO working for community: ideal
- PURPOSEFUL identification of who are key players and have ongoing dialogue – adaptive
- Community contributes to what they need – not one size fits all
- Promoting positive models = informing, education = do we know what we don't know.
- Engaging broadly – outside of health professionals taking a consumer – community view will broaden the discussion, offer new creative or different solutions.  
Consumers — community and other agencies
- To engage RELEVANCE needs to be clear:

OUTSIDE  
THE  
SQUARE



Permission for  
time, resource





## What will enable us to move forward?:

- Inform discussion with information, clear messages about:
  - Key health issues, lifestyle choices and what are key determinants of health;
  - Importance of community relevance;  
Promote positive models of consumer/ community engagement and focussed services that are working
- Engage – diverse - ongoing dialogue
- Part of engagement and information is to enable consumers and community to know what is acceptable and what is not
- Cultural and community sensitive engagement.
- Learn how to communicate.

## Key action areas:

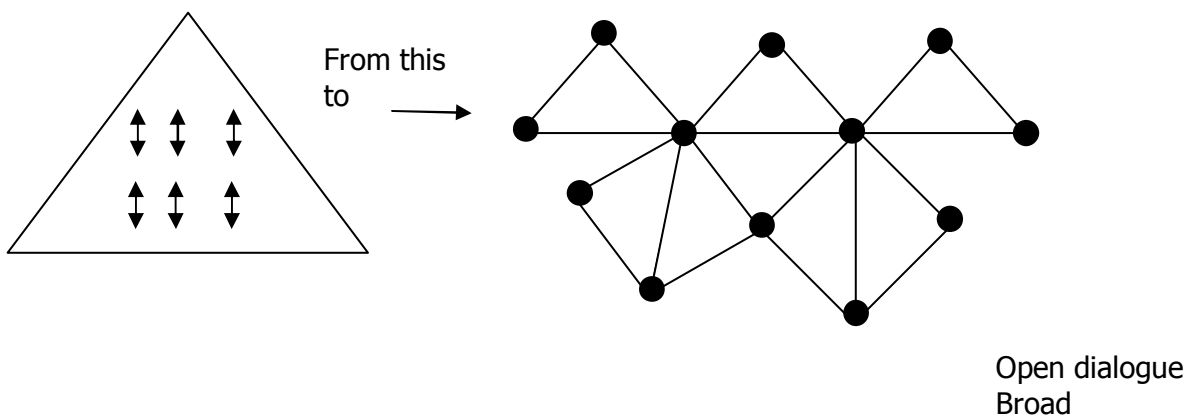
### Action 1:

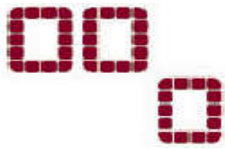
Inform discussion with information, clear messages about:

- Key health issues, lifestyle and environmental determinants of health;
- Promote positive models of consumer – community focussed services that are working
- Consumer/community drivers for improvement; and
- Engaging community-consumer-health and non health sector – ‘engage broadly’

### Action 2:

Resource engagement as important, promoting purposeful dialogue that is ongoing, that incorporates learning and continuous improvement and encourages thinking outside the square.





## Group 11 Role of State and Primary Care

### Key issues about the State and Primary Care

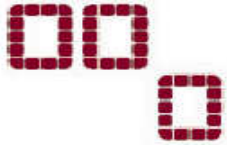
- Need for a WA Primary Care Strategy
- Patients should be in the centre of any model of care
- Development of terms between State and Commonwealth
- The need to align evidence into practice
- Changes in gate keeping roles
  - GP's
  - Allied health
  - Generalist vs specialist
- State/Commonwealth funded and private. Need for common performance indicators for private and public services.
- Super clinics – clash with existing practices
- The need to broaden the range of service offered by GP's
- Quality assurance and Clinical Governance
- Inclusion of sexual health in the primary care agenda
- The need for clarity around the roles of each stakeholder
- Clear articulation of state policy for primary care
- WA Health to determine what primary care space they are in
- State/Federal/duplication of service eg chronic disease management teams x2 or x 3.
- Absent or suboptimal inclusion of exercise in primary health care.

### Key barriers facing the role of the State and primary care

- Quality of funding
- No Primary Health Care Strategy

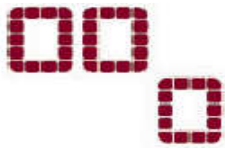
### What will enable us to move forward?:

- Get a WA primary health care strategy with long term vision/commitment regional focus looking at particular needs:
- Workforce
- Training e.g. practice nurses
- Pool funds as a trial e.g. for patient centred care
- Start with aged care as a starting point – in some areas MBS doesn't work
- Make it tailored to regional areas
- Agree on quality key performance indicators
- Clarify role of WACHS ED or - pay for discussion
- Recognise role as one of leaders /INVOLVED in Aboriginal Health. Reduce duplication e.g. two officers of Aboriginal health
- Funding mechanisms that meet the need
- Adopt some principles for action for instance: no blame, respect, praise and thanks
- For WA Health to ensure the development of the Primary Care Strategy be adopted on Senate principles.



### **Key areas for Action**

- Establishment of a managed health network - shared electronic health records
- Remove MBS disincentives to quality care
- Development of innovative models of care.



## Group 12 Chronic Disease management

### Key issues for Primary Care and Chronic Disease Management

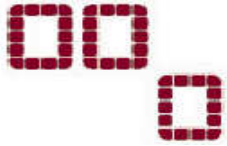
- Review/promote "whole of care: fro chronic disease patients in the MBS system to allow multi team care to work better.
- Is there a single ambulatory care model?
- Chronic condition self management programs
- Connected chronic disease management (inc mental Health) i.e. primary care secondary care
- Maximise self care options
- Governance of process teams – i.e. how does the Chronic Disease Management team "HOLD" together to deliver outcomes?
- Managing multiple morbidity in a patient centred model of care
- Converting public perspective to self responsibility, independence and hospital aversion.

### Key barriers for implementation of Chronic Disease Management in Primary Care

- Not continuous care
- Not managed care across the system
- Pts not active participant
- Divergent funding streams
- Compartmentalised care - Lots of initiatives – not connected
- Not a whole picture –there are levels of duplication and gaps in the system
- No framework to work within
- Lots of effort
- Communication – information management
- Urban and rural/ remote different i.e. primary care – health community.

### What will enable us to move forward?

- Patient centred focus – care plan – passport
- By empowering client/consumer/patient
- By providing choices for consumer – buy in – educated
- web based care plan – systemised
- user friendly electronic health record – Goldfields
- universalised
- Have same state bureaucratic flexibility that commonwealth offers
- Get over privacy paranoia
- LEADERSHIP commitment to primary health care
- Understanding long-term investment partnerships with all care givers.



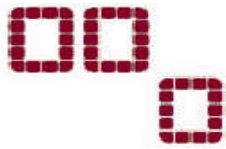
## **Key Action Areas**

### **Action 1**

Developments of Care plans are key: they need to be web based; with funding tied to it, and service providers accountable for them.

### **Action 2**

Increase the number of health care providers who can provide the right care, in the right place, at the right time, for the right disease (for instance Better Outcomes in Mental Health Model)



## Key Issues facing Country/Indigenous Health in WA

### Country/Indigenous Health

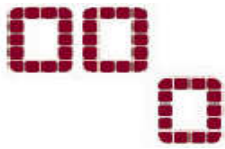
- Aboriginal Health – sustainable funding mechanism and planning
- Aboriginal Health
  - the need for improved access for patients
  - the necessity to improve capacity
- Allied health provision of services remote areas
- More country GPs and funding
- Aboriginal Health integration with cultural health methods
- Development of EP clinics in south regions in/c Cockburn, Armadale, Rockingham
- PC and Aboriginal Health
- Workforce in Aboriginal Health
- Primary care positive investment discrimination for the disadvantaged
  - Aboriginal people
  - lower socio economic etc.
- Primary Care models for Kimberly + Pilbara
- Rural Workforce shortage
- Aboriginal health – sustainable funding mechanism and planning
- How to deliver yet more health care in the bush. It's the same health professionals. Something has to give/reduce.

### Key barriers facing Indigenous/Country Health

- Definition of primary care
- The reality of health status disparity
- Rural / area health workforce
- Indigenous health workers
- Rural demographics
- Cost of rural service
- Access
- Multiple fragmentalised providers
- The need for a more centralised assessment and planning approach to be applied– at both macro and micro levels

### What will enable us to move forward:

- Different Health Care models
- Different rural pressures
- Difficulties for rural students practice
- Single practitioner towns
- Office of Health and Safety risks in Rural and remote areas



- Professional education/support
- IT – E-health + Communications
- Model of rural practice

## Key Areas for Action


### Action 1:

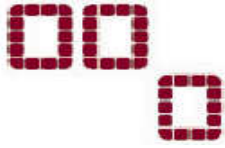
Themes:

- 1 understanding “cultural” issues and partnerships with communities
- 2 multiple providers and funders
- 3 workforce
- 4 comms/access/ICT

### Action 2:

Moving forward:

- Collaborative planning 
  - Speedy implementation
  - Communities/share learning
  - Providers – known gaps
  - Funders quick wins
  - Rural/metro evaluation a must
- Workforce incentives / reduce barriers
  - Money - IMGS
  - Housing - MBS access
  - Prof education/ support
  - Individual training



## **The Next Steps      The Way Forward for Primary Care in WA**

Dr Simon Towler thanked everyone for their time and efforts made throughout the morning. He spoke of how there were many innovative ideas proposed from amongst the attendees, and how people were committed to moving the agenda forward.

The formation of a Primary Care Health Network had been proposed. Dr Towler requested that all those who were interested in forming, developing and playing an ongoing role in the new Network, would have the opportunity to do so by registering their details on a form and placing it in the box provided. He provided assurances that everyone who had attended today's event would hear soon about the new Primary Care Health Network and its development. He once again thanked everyone who had participated in making the day's event successful.

### **Evaluation**

Participants were requested to complete an evaluation form which focused upon: the event; individuals reasons for attending; how they felt about the event; and suggestions for future events.

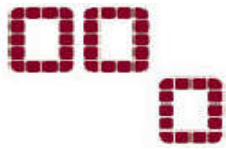
The majority of respondents provided positive feedback about the event, signalling that it was a "fabulous step forward", "timely", and "stimulating". Participants indicated that they were very satisfied/ satisfied with the outcomes of the event, with the majority indicating that the discussion was valuable. Participants felt they were able to contribute to the discussions, and that the workshops provided a valuable opportunity for talking together 'across boundaries'.

A number of participants did however, express their frustration at some of the initial speakers, signalling that the event had turned into a 'political love-in', was 'bland', and that both Ministers had utilised the platform for electioneering. Others signalled their disappointment at the limited time available for questioning of the Ministers, and that by leaving early on in proceedings it was a missed opportunity for both Ministers to hear from others what is going on primary care.

Some participants described how the event had focused too much on GP's; with no speakers assigned to cover community organisations or local Government and their role in Primary care.

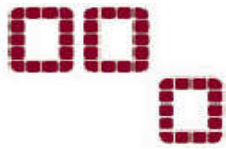
Suggestions for future events included a greater emphasis on Aboriginal health; mental health; and preventative health issues, signalling the need for an all day event rather than a morning session.

A large number of participants indicated their desire for action, specifying after years of discussing the issue, that that the event had 'reignited' their hopes for change to occur and that they were committed to helping move the agenda forward.

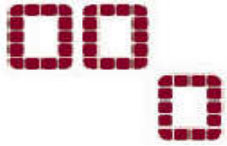


## Appendix 1 – Conference Delegates

Ms	Hope	<b>Alexander</b>	Health Consumer's Council
Ms	Angela	<b>Anderson</b>	White Oak Home Care Services
Ms	Louise	<b>Appleton</b>	Hall & Prior
Ms	Belinda	<b>Bailey</b>	Cancer Council WA
Ms	Kerryn	<b>Barton</b>	SMAHS
Dr	Janice	<b>Bell</b>	WAGPET
Mr	Tim	<b>Benson</b>	Health Consumer's Council
Dr	Scott	<b>Blackwell</b>	Primary Care Network/ Clinical Senate
Mr	Mark	<b>Burrows</b>	Rockingham Kwinana Peel Group
Mr	Noel	<b>Carlin</b>	WACHS
Mr	Stephen	<b>Carmody</b>	Silver Chain
Mr	Chris	<b>Carter</b>	WA GP Network
Mr	Peter	<b>Cook</b>	Rockingham Kwinana Division of General Practice
Ms	Deborah	<b>Costello</b>	Injury Control Council of WA
Dr	Maree	<b>Creighton</b>	Princess Margaret Hospital
Mrs	Kathryn	<b>Devereux</b>	NMAHS Chronic Disease Management Team
Mrs	Kirsten	<b>Devereux</b>	Hall & Prior Residential Aged Care Organisation
Ms	Carol	<b>Douglas</b>	SCGH
Ms	Samantha	<b>Dowling</b>	WA GP Network
Mrs	Roslyn	<b>Elmes</b>	Sir Charles Gairdner Hospital
Prof	Jon	<b>Emery</b>	University of WA
Dr	Penny	<b>Flett</b>	Brightwater Care Group
Dr	Peter	<b>Flett</b>	Department of Health WA
Mr	Nick	<b>Francis</b>	Rural Health West
Professor	Gavin	<b>Frost</b>	School of Medicine, University of Notre Dame Australia
Dr	Jacquie	<b>Garton-Smith</b>	Royal Perth Hospital
Mrs	Kate	<b>Gatti</b>	WACHS
Ms	Peta	<b>Gillies</b>	The Bethanie Group Inc
Ms	Terina	<b>Grace</b>	Osborne GP Network
Ms	Allison	<b>Hailes</b>	WA Local Government Association
Dr	Rachael	<b>Hammond</b>	WA GP Network
Mr	John	<b>Harvey</b>	The Pharmaceutical Council of WA
Dr	David	<b>Hurley</b>	Endocrine Health Network
Mrs	Marani	<b>Hutton</b>	SMAHS
Professor	Moyez	<b>Jiwa</b>	Curtin University of Technology
Mrs	Lyn	<b>Jones</b>	Silver Chain
Mr	Terry	<b>Keating</b>	Goldfields Esperance GP Network
Dr	Jenny	<b>King</b>	KPMG
Dr	Glen	<b>Koski</b>	Perth Primary Care Network
Ms	Michele	<b>Kosky</b>	Health Consumer's Council
Ms	Patricia	<b>Langdon</b>	WA AIDS Council



Ms	Caroline	<b>Langston</b>	HRIT WACHS
Dr	Robyn	<b>Lawrence</b>	Department of Health WA – Director General's Division
Mr	John	<b>Leaf</b>	Department of Health WA - Finance
Dr	Tim	<b>Leahy</b>	Aboriginal Health Council of Western Australia
Ms	Karen	<b>Lennon</b>	WA Health
Mrs	Grace	<b>Ley</b>	WACHS - Midwest
Mr	Scott	<b>Lisle</b>	South Metropolitan Area Health Service
Ms	Mary	<b>Lonergan</b>	White Oak Home Care Services
Ms	Tara	<b>Ludlow</b>	Carers WA (Inc)
Dr	Geoff	<b>Masters</b>	WACHS
Mr	Christopher	<b>McGowan</b>	Silver Chain
Ms	Lynne	<b>McHale</b>	Carers WA
Mr	Jeff	<b>Moffet</b>	WACHS
Ms	Paola	<b>Morellini</b>	NMAHS
Ms	Megan	<b>Morris</b>	Department of Health & Ageing - Canberra
Professor	Robert	<b>Newton</b>	Edith Cowen University – Vario Health Institute
Miss	Malvina	<b>Nordstrom</b>	Royal Australian College of General Practitioners
Mrs	Lyn	<b>O'Brien</b>	South Metropolitan Area Health Service
Ms	Kathleen	<b>O'Connor</b>	WA Cancer & Palliative Care Network
Ms	Nicole	<b>O'Keefe</b>	Department of Health & Ageing – WA State Office
Dr	Steve	<b>Patchett</b>	Department of Health WA – Mental Health
Mr	Mark	<b>Petrich</b>	WACHS
Mr	Alan	<b>Philp</b>	Department of Health & Ageing - WA State Office
Mr	Brian	<b>Piercy</b>	Department of Health WA – Aged Care
Dr	Mark	<b>Platell</b>	South Metropolitan Area Health Service
Mr	Michael	<b>Prendergast</b>	Australian Medical Association Western Australia
Ms	Suzanne	<b>Ralston</b>	Injury Control Council of WA
Ms	Julie	<b>Rennison</b>	NMAHS Chronic Disease Management Team
Ms	Christa	<b>Riegler</b>	Fremantle GP Network
Mrs	Elizabeth	<b>Rohwedder</b>	Department of Health WA - HRIT
Mr	Wayne	<b>Salvage</b>	Department of Health WA - Director General's Division
Ms	Gae	<b>Sawyer</b>	WA General Practice Network
Ms	Jayne	<b>Senior</b>	WACHS
Mr	Kevin	<b>Shanks</b>	Rockingham Kwinana Division of General Practice
Ms	Anna	<b>Sinclair</b>	Department of Health and Ageing– Office of Aboriginal & Torres S
Ms	Julie	<b>Skevington</b>	Fremantle GP Network
Dr	N (Sri)	<b>Srigandan</b>	Canning Division of General Practice
Ms	Genevieve	<b>Stone</b>	WACHS
Mr	Craig	<b>Szucs</b>	WA GP Network
Mr	Ian	<b>Taylor</b>	Rural Health West
Dr	Sandra	<b>Thompson</b>	Centre for International Health, Curtin University
Dr	Simon	<b>Towler</b>	Department of Health WA – Health Policy & Clinical Reform
Mr	Matthew	<b>Tweedie</b>	Canning Division of General Practice
Ms	Di	<b>Twigg</b>	Department of Health WA - Office of the Chief Nursing Officer



Mr	Tim	<b>Van Bronswijk</b>	The Pharmaceutical Council of WA
Assoc. Prof	Paul	<b>Van Buynder</b>	Department of Health WA
Mr	John	<b>Van der Post</b>	Sir Charles Gairdner Hospital
Ms	Melissa	<b>Vernon</b>	WACHS
Assoc.Prof	Alistair	<b>Vickery</b>	University of WA
Dr	Roger	<b>Warne</b>	Inner City Aged Care Services
Professor	Robin	<b>Watts</b>	Curtin University of Technology
Dr	Tarun	<b>Weeramanthri</b>	WA Department of Health
Professor	Anne	<b>Wilkinson</b>	Edith Cowen University
Dr	Marianne	<b>Wood</b>	Royal Perth Hospital
Miss	Claire	<b>Woolfitt</b>	Fremantle GP Network
Dr	Peter	<b>Wynn Owen</b>	Swan Kalamunda Health Service



# Delivering a **Healthy WA**

Healthy Workforce • Healthy Hospitals • Healthy Partnerships • Healthy Communities • Healthy resources • Healthy Leadership

