SUBMISSION

Draft Recommendations from the Primary Health Reform Steering Group

To the Department of Health,

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Lived Experience AUSTRALIA

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Introduction

Lived Experience Australia is a national representative organisation for Australian mental health consumers and carers, formed in 2002 with a focus on the private sector. Our core business is to advocate for systemic change, empowerment of consumers in their own care, promoting engagement and inclusion of consumers and carers within system design, planning and evaluation and most importantly, advocating for consumer choice and family and carer inclusion.

Overview

Many of the recommendations are inter-dependent, i.e., their success relies on other elements also being in place or addressed. There are several statements but very little about how these will be achieved and how they will ultimately link with each other.

LEA notes the work that has come before this Reform over several years. We know the absolute necessity to have the primary care setting accessible, affordable, responsive, and integrated. LEA has noted the progress of the Primary Health Networks for example and their interface with the Local Health Networks and whether duplication arises, or service fragmentation exists.

From our own Research[1], we know that people with mental ill-health are reliant on the general practitioner (GP) for their mental health needs, as a type of 'default' mental health system where the other current services do not meet their needs, or where they are unable to access appropriate, timely, affordable services.

LEA is also aware of the work being undertaken in the preventative and early identification areas[2] particularly under Chronic Condition Management Plans which we strongly support. Many people prescribed and taking psychotropic medications require surveillance and monitoring in relation to their physical health i.e., cardiovascular disease risk, diabetes type 2, respiratory conditions, high blood pressure, obesity, etc.

Within the mental health sector, many people with a lived experience do not have a regular GP, or if they do, they do not visit them on a regular basis. Improvements can and must be made between the GP and the mental health system, i.e., sharing of discharge information, medication or medication changes etc. This is an area that requires much needed improvement to allow better services in the primary care sector, given their key role in supporting people with mental illness.

Specific responses to the Recommendations

Recommendation 1 (One system focus)

Person-centred health and care journey, focusing on one integrated system

As mentioned above, many Australians do not have a relationship with a regular primary health care provider, yet this Discussion Paper assumes they do. The bulk billing GP Plus Super Clinic initiative has meant that people attend a clinic and do not necessarily see one primary GP, rather any doctor who happened to be on at the time, as these are modelled on the walk-in, no appointment model. This disincentivises an individual to form relationships with a particular doctor and therefore they many not even attend the same clinic, hence there is no relationship, or continuity of information,

[1] The 'Missing Middle' Lived Experience Perspectives, Kaine, C & Lawn, S (2021) https://www.livedexperienceaustralia.com.au/research-missingmiddle

[2] Equallywell.org.au

person-centred care, establishment of a deeper level of trust and understanding of the person's particular needs, or their wider psychosocial circumstances that may be impacting on their health.

1.2 Dedicated funding investment and redirection:

LEA's fully supports quarantining of funding for indigenous needs, but also raises the issue of the needs of those with enduring mental illness to similarly have the funding quarantined for their purposes.

The RACGP[3] annual report notes that 65% of all consultations with a GP are psychological based. Therefore, the increasing number of people seeking support for mental ill health is growing, and funding must take this into consideration going forward.

1.3.2 Commonwealth/State shared responsibilities

LEA welcomes the co-commissioning of services to help address gaps in care, better targeting to needs in different jurisdictions, and potential duplication and waste of valuable health funding, resources, and effort.

1.3.4 Build an evidence base to enable staged implementation

LEA refers to the 10-15 vanguard regional initiatives but raises the following question –

Question: *What was learned from the many trials that have already been conducted in general practice? We note many trials, pilots, reviews etc have been undertaken previously, but what significant changes have been implemented?*

1.4.1 Staged implementation of successful models

We refer to our comments above, i.e., what has been learnt and implemented. We note the reference to 'increased access to secondary, tertiary and social care providers' mentioned here and question –

Question: *What are the implications here for NDIS links with primary care/GP and potential for peer support and social prescribing within this setting?*

Recommendation 2 (Single primary health care destination)

Formalise and strengthen the relationship of individuals, families and carers with their chosen primary health care provider and practice

LEA refers to our concerns noted above regarding a person's relationship with one health care practitioner. Unless people are supported to engage with the one practitioner, or the one 'health care home' many of the initiatives and focus of this Reform will not benefit them.

'Choice' is the corner stone of the Australian health care system, and one which sets us apart from many other world health systems. Any reform must keep this fundamental objective and right in all dealings with the health system. People choose to see a particular doctor primarily based on trust. The trusting relationship is what makes people adhere to advice, recommendations, have tests and take the medications prescribed. This also includes where a primary health care destination or home is located. It is not unusual for people to seek a practitioner outside of their geographic area, because they have formed a relationship and don't mind travelling. Trust is the motivator to travel.

LEA fully supports the strengthening of a single care destination, but it must be a person's right to choose. However, LEA draws attention to costs, which sees many individuals attending the large GP Plus Super Clinics for example, because consultations are guaranteed to be bulk billed, as the costs of attending other general practice options often carry a gap payment. This is especially relevant to

[3] RACGP Annual Report, Health of the Nation 2020

those lower socioeconomic areas, migrants, people with mental ill health or disability, those on Centrelink benefits etc. Supporting self-care, early intervention and prevention work in primary care is then difficult, with model/s that foster ad hoc response to need.

Recommendation 3 (Funding reform)

Deliver funding reform to support integration and a one system focus

3.1.2 Across sector accountability to improve patient outcomes

As the focus of our response clearly is through a mental health lens, improved arrangements, collaboration, etc are critically needed and this came across very strongly in LEA's 'Missing Middle' research, where people described lack of collaboration across services and GPs, where they either fell through the gaps, or required them to tell their stories over and over with each provider. This re-traumatises, frustrates, and makes they far less likely to engage.

3.1.4 Funding differences across sectors

LEA is very concerned about this recommendation in suggesting a re-direction of some funding from hospital-based services, mental health specifically, aged care and the NDIS. This most certainly will need to be VERY carefully considered as LEA knows there will in all likelihood, be unintended consequences. The funding for mental health already comes from a low base in consideration to other health diseases i.e., cancer, cardiac, etc.

3.2.4 Private Health Insurance (PHI)

LEA has been closely involved in reform in the Government, health insurance and private hospital sector discussions. LEA supports the greater opportunities PHI reform would allow in the delivery of more evidence-based primary care by allied health professionals. To date, legislation has been a barrier, but discussions are currently underway, to determine how PHI can be better used particularly in the preventative, early intervention areas.

3.5 patient-led

LEA supports the reporting on outcomes based on achievement of goals set by patients but is concerned about the lack of detail especially around how this will be realised amongst other reforms currently being considered.

Recommendation 4 (Aboriginal and Torres Strait Islander health)

Implementation of the National Agreement on Closing the Gap for Aboriginal and Torres Strait Islander peoples through structural reform of the primary health care systems

LEA supports this recommendation and note that ACCHOs have been in existence for approximately 50 years. The benefit of this approach is the relationship between the consumer/patient, the provider or health service and the community.

We note the benefits of this approach form much of the basis of the discussion within this Paper. The focus for the ACCHOs is individual / family / community / care provider/service and LEA strongly supports this as the ideal health system.

Recommendation 5 (Local approaches to deliver coordinated care)

Prioritise structural reform in rural and remote communities

LEA supports the recognition and approach articulated for the rural, regional, and remote communities. However, the current situation is that it is difficult to recruit and retain suitably qualified health professionals to these areas.

The establishment of RACCHOs sounds particularly useful for rural areas, but the critical issue is for the workforce issues need to be addressed. The potential for RACCHOs to provide more meaningful placement and training opportunities, linked to University programs is clearly an opportunity to build the capacity of the rural workforce and services there.

Recommendation 6 (Empowering individuals, families, carers and communities)

Support people and communities with the agency and knowledge to better self-care and manage their wellness and health within a system that allows people to make the choices that matter to them

This recommendation is very limited in detail, is aspiration based and lacks information about how these actions will be achieved. Families are the learning environments for the young and youth where self-care is largely established and habits for life are often set. This is based around the right food to eat, hygiene, self-care, health literacy, health beliefs, etc.

Therefore, LEA believes a life course approach would be useful. Many of these actions follow a traditional doctor/individual patient mindset and model but there is an overall lack of family or kinship intervention and inclusion in which health is situated. The current COVID issues for migrant communities point out that it is crucial to think beyond the limits of a 1-1 individualistic model , to a greater awareness across different sectors and groups.

Other practical points that could have been noted in this recommendation relate to recall/reminder systems being core to helping people address systems gaps and waste, efficiency, etc. This also points to the need for more individuals to register and use the MyGov website which would be a very useful communication strategy and would empower people to look to this tool to assist their wellbeing. More practical support for people to take these steps to register and use MyGov in their routine self-care is also indicated.

Recommendation 7 (Comprehensive preventive care)

Bolster expanded delivery of comprehensive preventive care through appropriate resourcing and support

LEA supports this recommendation but again, there is a lack of detail of funding, implementation etc.

A further gap in this recommendation is that there is no mention of the individual receiving a copy of their health care plans and relevant information on the disease, ailment, condition.

There is a focus on health rather than the 'Health in All Policies' approach which would also link in opportunities for prevention and earlier intervention by considering workplaces, schools, other community prevention programs, etc.

Recommendation 8 (Improved access for people with poor access or at risk of poorer health outcomes)

Support people to access equitable, sustainable and coordinated care that meets their needs

LEA again refers to comments made previously including reference to our 'Missing Middle' lived experience research findings. This is exactly what people tell LEA about their current needs which are not being met, i.e., access, which is the most significant especially in relation to mental ill health, equitable when referencing costs, gaps in service availability, high and unaffordable health insurance

premiums, coordinated and sustainable systems, and equally as crucial, health care that meets their needs.

8.1 Tailor services through VPR

Support services are much needed for individuals who are disadvantaged across many domains including mental health, disability, financial, isolation, geographic locations etc. This should be the first initiative to be looked at if Australia is to have a responsive health system.

8.2 Co-design solutions to address barriers to care

This will be crucial in addressing needs. People know what works best, what their needs are, and generally have an idea of what is needed to address the gaps in their care.

8.5 Additional coordination/navigation supports

LEA also notes that social prescribing is mentioned here in the context of navigation roles. LEA supports this approach but there is very little throughout this Discussion Paper about the family carers/ role in navigation. Families and carers play a crucial role in health care delivery including identification of issues, support, with little or no training and very little information or clinical or other supports.

LEA believes that this is an omission within this Discussion Paper that must articulate and value what families and carers do, many on a day to day, minute to minute basis.

Recommendation 9 (Leadership)

Foster cultural change by supporting ongoing leadership development in primary health care

9.1 Primary healthcare leadership

LEA notes this recommendation talks about fostering leadership in consumers, carers, and their families, but we note no related organisations are specifically mentioned in the many listed in the description overview of this action. This concerns LEA and we wonder about whether organisations such as LEA are considered important, or whether this included reference relates more to political correctness. LEA hopes this is not, but if this Discussion Paper notes the clinical colleges and organisations, and then references consumers and carers, then thought needs to be made to appropriate organisations of people with lived experience.

We would urge the consideration of this aspect going forward, and LEA would be keen to be involved in discussions.

9.2 Clinician/consumer collaboration

A strong trusting partnership approach which involved the individual / families and carers / and practitioner is the best way of bringing about real change to the health of individuals. You will note this is the approach of the ACCHO's.

9.2.9 Education and training

LEA currently offers mental health perspective training to health professionals. This is well received and provides significant insights into the need for collaboration, communication, continuity of care and co-operation between health practitioners and health services including and especially GPs. LEA keeps reverting back to the 'three-way partnership approach, the Triangle of Care[4] if you like, and believe that the health system would be that much better if this was instigated.

[4] Triangle of Care ©Carers Trust, 2010

Recommendation 10 (Building workforce capability and sustainability)

Address Australia's population health needs with a well-supported and expanding primary health care team that is coordinated locally and nationally for a sustainable future primary health care workforce

LEA has referred numerous times throughout our Submission to the workforce and any health system is reliant on the successful recruiting and retention of suitably qualified practitioners.

Greater emphasis on entry to University Medical Schools requires consideration and whether the strict entry requirements are useful in today's environment. Whilst LEA only supports the most suitable student selection, we have some concerns around some aspects in identifying the strengths etc of individuals.

Overseas trained practitioners are recruited to these areas because the can practice in 'areas of need'. However, they do so with little or no background to Australia's complex health system, with little support or mentoring, and find themselves isolated from other practitioners.

LEA further notes the work currently being undertaken in the mental health workforce area where a national strategy has been developed. LEA also refers to the 2021 Federal Budget initiatives in the mental health workforce area.

Recommendation 11 (Allied health workforce)

Support and expand the role of the allied health workforce in a well integrated and coordinated primary health care system underpinned by continuity of care

LEA supports the actions articulated within this Recommendation.

Recommendation 12 (Nursing and midwifery workforce)

Support the role of nursing and midwifery in an integrated Australian primary health care system

LEA supports the actions articulated within this Recommendation.

Recommendation 13 (Broader primary health care workforce)

Support and develop all appropriate workforces in primary health care to better support people, the existing health care workforce and achieve an integrated, coordinated primary health care system

Whilst LEA supports the actions articulated within this Recommendation, the role of peer workers is also not mentioned, other than extremely briefly, within this Discussion Paper. Peer workers play an increasingly crucial role in the delivery of mental health support. Thought needs to be given as to how this workforce can be meaningfully rolled out across other aspects of the health care system.

Supervision of non-traditional workforce will also be an issue. LEA believes it is crucial to have research to build the evidence-base for any new workforce groups within primary health settings.

Recommendation 14 (Medical primary care workforce)

Support, streamline and bolster the role of GPs (which includes Rural Generalists) in leading and coordinating care for people, while building and ensuring a sustainable and well supported medical primary care workforce

LEA supports the actions articulated within this Recommendation.

Recommendation 15 (Digital infrastructure)

Develop digital infrastructure and clinical systems to better support providers to deliver safe and effective care

LEA has provided the federal Government with data from a national survey conducted by us in Marth 2021 around the perspectives of people accessing telehealth for psychiatry consultations[5].

The response was very positive in that people want telehealth to continue[6], beyond the limitations COVID 19 has presented regarding face-to-face consultations.

LEA strongly supports the continuation of telehealth consultations.

LEA also asked the question around digital mental health services in our Missing Middle research report launched in March 2021.

This data showed that: *67 of 535 respondents who use digital resources or apps, the main reason for using these included the comparative cost of face-to-face services (21% n=53), convenience (19%, n=48), wanting to try something new (14%, n=36) it was recommended by my health professionals (13%, n=34) and dissatisfaction with other services (12%, n=30) Furthermore, consumers who accessed online resources, also accessed medication (35%, n=88) and were also accessing support from a mental health professional (34%, n=84). Consumers who commenced an online course for support but disengaged, identified the main reasons being not ready to commit (7%, n=17), and that it was no longer relevant (7%, n=17). Main comments included lack of motivation, not knowing online courses were available and concerns about privacy.*

Recommendation 16 (Care innovation)

Enable a culture of innovation to improve care at the individual / population level, build 'systems' thinking and ensure application of cutting-edge knowledge and evidence.

LEA supports the actions within this recommendation but is concerned about the establishment of yet another entity namely: an Australian National Institute for Primary Health Care Research Translation and Innovation and wonder if the funds would be better allocated to other areas of greater need in the health system. There appears to be little information about what the Institute would do.

Recommendation 17 (Data)

Support a culture of continuous quality improvement with primary health care data collection, use and linkage

LEA does understand that data is needed in a population-based approach.

[5] Telehealth Psychiatry Consultation, Kaine, C & Lawn, S (2021)

[6] Telehealth Psychiatry Consultation, Supplementary Report – Focus Groups and Individual interviews from the National Survey, Kaine, C & Lawn, S (2021)

Recommendation 18 (Research)

Empower and enable contextually relevant, translational and rapid research and evaluation in primary health care, addressing questions directly relevant to service delivery in localised context

LEA has an established Research Program as part of our operations, and therefore supports translation research which improves health systems. However, further details are required rather than broad statements.

Recommendation 19 (Primary health care in national and local emergency preparedness)

Deliver nationally coordinated emergency preparedness and response, defining Commonwealth, State and Territory roles and boosting capacity in the primary health care sector

LEA supports national coordination during emergency and other disasters including COVID 19 pandemic.

As the Discussion Paper says COVID 19 has shown ways in which health care services need to be coordinated. As COVID-19 is still affecting Australia, we are continually learning what works best in these types of situations.

However, Australia is also affected regionally by natural disasters and the service coordination seems to be better equipped at the local/regional level.

GPs and other allied health practitioners add greatly to the health workforce during these emergency times. We also see the deployment of the army in these situations also, a very much needed boost in many areas, so a largescale plan needs to be developed, and include the major players in emergency management, including clear communications so people are aware of their responsibilities and roles.

Having a communications plan implemented within this recommendation LEA believes is crucial.

Recommendation 20 (Implementation)

- Ensure there is an Implementation Action Plan developed over the short-, medium- and long-term horizons.
- Ensure consumers, communities, service providers and peak organisations are engaged throughout implementation, evaluation and refinement of primary health care reform.

LEA supports the actions within this recommendation and seeks inclusion of Lived Experience Australia as members of any oversight entity to provide advice into the implementation, prioritisation, evaluation, and refinement of the 10-Year Plan.

Conclusion

LEA is a peak mental health consumer and carer advocacy organisation; we are ready and willing to be involved in this crucial work going forward. We have much to offer, nearly 20 years of experience of membership with committees/working groups, parliamentary inquires etc in policy development, service development, evaluation, and input into the mental health reform processes from a lived experience perspective. We provide both the consumer (patient) and family (carer) perspectives, and importantly bring the issues and needs of people affected by mental ill-health to the table.

Mental ill-health is a growing factor for many Australians, especially during the COVID-19 pandemic and beyond. Mental health challenges will continue to affect people in the long term.

LEA would be pleased to clarify any points raised within this Submission.

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