



**Australian Government**  
**Productivity Commission**

# Implementing innovation across the health system

INFORMATION PAPER

May 2021



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### **The Productivity Commission**

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Policy change	Expected benefits
<b>Innovations supported by the Australian Government</b>	
<ul style="list-style-type: none"> <li>The Australian Government could give more flexibility to PHNs to allocate funding (and/or provide a greater amount of flexible funding)</li> <li>Improved reporting of innovation by PHNs could be the basis for additional targeted funding to high-performing PHNs</li> </ul>	<p>Greater funding flexibility is likely to enable PHNs to sustain more innovation, including initiatives that address the needs of their population</p>
<p>PHNs could:</p> <ul style="list-style-type: none"> <li>implement <b>Nellie</b> (or equivalent outreach program for people with chronic conditions, if they believe the alternative would better suit their population)</li> <li>offer <b>Primary Sense</b> to GP practices on a commercial basis</li> </ul> <p><i>For many PHNs, additional flexibility in funding allocation would be necessary to successfully implement these programs</i></p>	<ul style="list-style-type: none"> <li>Rolling out Nellie nationally could improve self-management and reduce the number of preventable hospitalisations</li> <li>Primary Sense can improve quality of care</li> </ul>
<p>Additional options PHNs could consider: Turning Pain into Gain, GP Pharmacists</p>	<ul style="list-style-type: none"> <li>Turning Pain into Gain can improve pain management and reduce hospitalisations</li> <li>GP Pharmacists can reduce medication errors and the number of people taking an excessive number of medications</li> </ul>
<b>Innovations supported by State and Territory Governments</b>	
<p>State and Territory Governments could trial new funding approaches to deliver care for people with chronic conditions, using the lessons learned from <b>HealthLinks</b></p>	<p>Capitation can improve the support offered to high frequency hospital users in order to reduce hospitalisation rates. It can complement pooled funding between LHNs and PHNs</p>
<ul style="list-style-type: none"> <li>State and Territory Governments could continue to invest (or expand their investments) in data systems to improve health system planning</li> <li>All LHNs could have access to <b>Smart Referrals</b> (or equivalent)</li> <li>All jurisdictions could create linked datasets similar to <b>Lumos</b></li> </ul>	<ul style="list-style-type: none"> <li>Improving data flows between primary and acute care can reduce errors/waste and improve patient experience</li> <li>Linked datasets can enable better system planning and delivery of innovative programs</li> </ul>
<ul style="list-style-type: none"> <li>LHNs could implement <b>Monash Watch</b> (or equivalent outreach program for people with chronic conditions, if they believe the alternative would better suit their population)</li> </ul> <p><i>Alternative funding approaches and better use of health data could facilitate the adoption of this program</i></p>	<p>Monash Watch can reduce hospitalisation and lower costs</p>
<p>Additional options LHNs could consider: One Stop Liver Shop, Royal Perth Hospital Homeless Team, Choices, GPs with Special Interest</p>	<p>These programs can provide better management of specific diseases and more effective care for target groups</p>
<b>Collaboration between all Governments</b>	
<p>State and Territory Governments and the Australian Government could jointly create pooled funding for LHN and PHN collaborations using the lessons of <b>Collaborative Commissioning</b></p>	<p>Pooled funding provides primary healthcare organisations with funding and incentives to undertake activities that promote health and reduce hospitalisation rates</p>

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In March 2021, the Council on Federal Financial Relations asked the Productivity Commission to prepare a plan for progressing the opportunities for innovation identified in its productivity reform case study, *Innovations in Care for Chronic Health Conditions*. This paper is the response to that request.

The Commission found examples of innovation in all jurisdictions and all types of health services. All jurisdictions are implementing reforms to their health systems, intended to improve efficiency and consumer outcomes. Work has also been undertaken on alternative funding mechanisms. Progress has been slow, due the complex nature of health services and the funding mechanisms that underpin them.

The initiatives featured in the Commission’s report offer practical ways to build momentum for change and get ‘runs on the board’ — demonstrating what health services can achieve when they overcome the rigidities of existing policies and structures. While additional funding flexibility would be required to achieve broader implementation of priority programs, significant progress can be achieved without new funding.

Beyond these specific innovations, Governments could continue to advance health reform through trials of new funding settings, continued investment in priority areas such as health data, and creating stronger incentives for innovation. Taken together, these changes have the potential to mobilise health reform on multiple fronts, from supporting GPs in making better decisions to redesigning data flows between primary and acute care.

This paper has two purposes. First, it includes recommendations to improve government policies in the areas of funding, use of data and diffusion of innovation. They reflect key lessons from the experiences of people and organisations that developed and implemented the innovative programs included in the *Innovations in Care for Chronic Health Conditions* report. These recommendations are likely to support further innovation, and they complement existing work already being carried out across the health system.

Second, it presents some of the factors that would enable the broader implementation of the innovations included in the report. It is not feasible to implement them all at the same time, at the same pace, or in all jurisdictions. This reflects that reform initiatives must account for:

- the diverse needs of people in different parts of Australia, and the extent to which existing services are meeting those needs
- capacity constraints affecting health professionals, health system administrators and policymakers, who can only focus on a limited number of new initiatives at any one time
- existing reform initiatives, and the progress made in each jurisdiction
- the priorities of each primary health network (PHN) and local hospital network (LHN<sup>1</sup>) to address the health needs of the people in their specific catchment areas
- funding pressures, which vary by jurisdiction.

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<sup>1</sup> This paper uses LHN to refer collectively to organisations that manage public hospitals. These include local hospital networks, local health districts, hospital and health services, local health networks, health service providers and Tasmanian health organisations.

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Nonetheless, some of the innovations included in the Commission’s report could be considered for wider and timely implementation across Australia as they have proven outcomes and have demonstrated scalability.

Innovations that fall into this group — Nellie, Monash Watch, Primary Sense, Smart Referrals and Lumos — could be adopted by all jurisdictions. Health service organisations could still choose to implement other initiatives that comprise similar features, but these specific innovations have the potential to help a large number of people and are ready to be rolled out more widely. While not all jurisdictions may wish to copy HealthLinks and Collaborative Commissioning in their entirety, these novel arrangements offer lessons for the development of funding approaches that provide the resources and incentives to reduce avoidable hospitalisation.

Other interventions mentioned in the report have strong innovative attributes but are tailored to the needs of specific populations and health professionals. Health organisations could consider adopting these interventions or adapting some of their key elements when they are seeking to improve the care they deliver to vulnerable populations or streamline workflows.

## **Enabling wider implementation of innovation**

During the Commission’s consultation on innovative health care, nearly all stakeholders pointed to three barriers to sustainable innovation: funding structures, insufficient use of health data and slow diffusion of best practice. The recommendations below address each of these areas. Implementing the Commission’s recommendations would:

- facilitate the wider adoption of the successful innovations featured as case studies
- enhance the likelihood that a larger number of successful healthcare innovations will emerge in the future.

### **1. Make funding more flexible**

#### **Flexible funding for PHNs**

Many PHNs have developed a track record of using their flexible funding allocations to develop programs that deliver cost-effective improvements in care. Several of the successful programs featured in *Innovations in Care for Chronic Health Conditions* relied — in whole or in part — on PHNs’ flexible funds. They include Nellie (case study 1), Turning Pain into Gain (case study 2), WentWest’s General Practice Pharmacist program (case study 5), Western Sydney’s COVID-19 response (case study 8), The Collaborative (case study 10), Primary Sense (case study 11) and Collaborative Commissioning (case study 16).

But PHNs have limited flexible funding for such programs. On average, each PHN receives about \$11.5 million each year to fund improvements in the effectiveness and efficiency of

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health services, promote better health outcomes for key population groups, and also cover the PHN's operating costs. This funding represents, in aggregate, 27% of the total annual budget of PHNs (less than 0.2% of total health expenditure), but only some fraction of this is genuinely available as a source of funding for innovation.

This limited funding makes it difficult to achieve larger-scale innovation. Instead, PHNs must limit their innovation to a few chronic conditions and clinical practices, and usually at small scale. It also makes it challenging for PHNs to adopt programs that have worked well elsewhere. For example, under current funding allocations, the South East Melbourne PHN would most likely need to cease funding its Nellie program (case study 1) to have sufficient funds to adopt Primary Sense (case study 11), and vice versa. This would be a poor outcome, as both initiatives have strong potential for successful implementation throughout Australia. This suggests there should be more flexible funding for innovation and its absorption. Such flexibility could take two forms.

One option would be to allow more spending flexibility by PHNs within the current funding envelope. By definition, this would require that the Australian Government reduce the scope and level of funding for the specific activities it prescribes for PHNs. An alternative (or complementary) option is to increase the total funding of PHNs and add this to the pool available for flexible use by PHNs. While an increase in PHN budgets is more likely to secure greater innovation, allowing PHNs more flexibility within their current budgets would still be beneficial.

To achieve their intended outcomes, funding changes should encourage a culture of innovation by PHNs, promoting a purposeful pursuit of the development and adoption of innovations. This would entail changes in accountability, rewards for innovation, and a balanced focus by senior management and PHN boards on innovation. A review of PHN governance emphasised the importance of ensuring a balance in board considerations of stability and innovation in overseeing PHNs, noting the natural tendency for a focus on the former.

The primary health sector, although functional, faces numerous problems. ... the duplication, wastage and under-utilised capacity that result from poor coordination adversely impact health outcomes for patients. The primary health system is not improving community health as much as it could. PHNs exist to improve health outcomes. They are best placed to do so if they seek to innovate rather than accept the status quo.<sup>2</sup>

The *PHN Program Performance and Quality Framework* measures whether a PHN makes health system improvements and innovation. The latest report finds that 100% of PHNs achieve that goal, but given the vagueness of the criteria, the result is not surprising or useful for identifying the true scope of PHNs to be innovative. More nuanced reporting (for example, through defining specific outcomes achieved by innovation) in an amended reporting framework for PHN performance and quality would better measure the extent and quality of innovation and its diffusion among different PHNs. This would assist the

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<sup>2</sup> Duckett, S., Beaumont, M., Bell, G., Gunn, J., Murphy, A., Wilson, R. and Crowley, T. 2015, *Leading Change in Primary Care: Boards of Primary Health Networks can help improve the Australian health care system*, p. 16.

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Australian Government to see how effectively flexible funding is translating into innovation, and to identify PHNs that are under-innovating. Changes should avoid any significant increase in compliance burdens for PHNs.

There are also grounds to provide *individual* PHNs with additional untied funding if they have demonstrated a strong capacity for innovation or absorption (and adaptation) of others' innovations. In its PHN Grant Program Guidelines, the Australian Government has recognised the desirability of incentive funding for high-performing PHNs, but there does not appear to be secure funding for this function. In our case studies, the Commission came across highly innovative PHNs, whose activities benefited not just their own communities, but have had general 'spillover' benefits for other PHNs (and LHNs). Additional funding for PHNs that have a comparative advantage in successful innovation is one way of increasing the overall level of innovation in primary health care. In effect, this creates an imperative to find the adept innovators, give them resources that reflect the additional value they have created, and spread the lessons.

Such an approach recognises that while PHNs' focus should remain on strengthening integrated care in their local areas, they are also a collective institution in which some specialisation and cooperation could be valuable. For instance, some PHNs may develop specialist expertise in data use, while others in healthcare self-management. They would become centres of excellence that others could draw on. In other cases, joint ventures between PHNs could spread the fixed costs of innovation across bigger regional populations (reducing the average cost of innovation), diversify risk and aid diffusion. One of the reasons for changes to accountability and increased flexibility in PHN funding is that it would further encourage and fund the people and systems that support the dissemination of the lessons from such specialisation.

There is already recognition of the importance of cooperation through the monthly meetings of PHN CEOs and existing partnerships between PHNs. For example:

- All Victorian PHNs are jointly developing paediatric health pathways that promote better and safer care for children in general practice and that limit pressures on hospital emergency departments.
- The Victorian–Tasmanian PHN alliance and several other partners are working collaboratively to design, develop and deliver training in the use of SafeScript. This software tool was developed by the Victorian Government to allow pharmacy records for certain medicines to be transmitted to a centralised database that can be accessed by doctors and pharmacists during a consultation.
- In our case studies, Choices (case study 7) is an exemplar of an innovation that emerged from cooperation between three PHNs (which collectively comprise the WA Primary Health Alliance).

While a greater share of flexible funding to PHNs would, in its own right, reduce the financial barriers to such cross-PHN collaboration, a complementary policy option would be

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to further encourage PHN joint ventures by providing some funding earmarked for such ventures. Such an initiative could be trialled rather than universally rolled out.

There should be an expectation that additional funding for PHNs in any of the above forms produce long-run savings (for example, through reduced hospitalisations) or measurable benefits for consumers.

#### **RECOMMENDATION 1 – GREATER FUNDING FLEXIBILITY FOR PRIMARY HEALTH NETWORKS**

The Australian Government could increase the amount of flexible funding available to Primary Health Networks (PHNs) by:

- reducing the level of prescription of PHNs' activities within current budget constraints, or/and
- increasing the total funding of PHNs with this earmarked for flexible spending.

The Australian Government could also consider:

- amending the *PHN Program Performance and Quality Framework* to better measure the extent and quality of innovation and its diffusion among different PHNs
- providing individual PHNs with (modest) additional funding for innovation projects if they have demonstrated a strong capacity for innovation or absorption of others' innovations, with a funding pool set aside for this function
- trialling the provision of additional funding earmarked for joint innovation ventures among PHNs.

#### **EXPECTED OUTCOMES**

This would encourage greater and more efficient innovation in primary health care, including through joint ventures and specialisation in some areas of innovation, and by giving PHNs the discretion to allocate resources to disseminate ideas and the development of an innovative workforce.

The funding would also support the implementation of initiatives such as Nellie (case study 1), Turning Pain into Gain (case study 2) and Primary Sense (case study 11), as well as allowing PHNs to participate in LHN–PHN collaborations, such as Collaborative Commissioning (case study 16) and The Collaborative (case study 10).

## **Funding LHNs for prevention and chronic care**

Activity-based funding mechanisms, which are the predominant models used in the hospital system, reward LHNs for the number of patients they see, and the volume of treatment they provide. It is a powerful mechanism to underpin the cost-effective provision of episodic care. However, these funding mechanisms offer limited compensation for the management of



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chronic conditions<sup>3</sup> and provide insufficient incentives to engage in prevention, proactive outreach and quality improvement. This means that an LHN that works to keep people healthy and avoid the need for hospital visits will likely face a decline in revenue. (GPs can find themselves in a comparable situation because their incomes decline if they spend time on unremunerated care coordination tasks, or if successful management of chronic conditions means people need to see their doctor less often).

Initiatives that either introduce flexibility to funding allocations or support pooled funding, so that hospitals do not lose funding for undertaking effective prevention, chronic disease management and outreach activities, have demonstrated success. Examples include Monash Watch (case study 4), Choices (case study 7), Western Sydney's COVID-19 response (case study 8), Royal Perth Hospital Homeless Team (case study 9) and The Collaborative (case study 10). But these small-scale initiatives are not sufficient to meet the large and growing challenge of providing effective preventive care and keeping people with chronic conditions healthy and out of hospital.

Under the Addendum to the National Health Reform Agreement 2020–25, the Australian, State and Territory Governments have agreed to long-term reforms, including trialling blended funding models, bundled payments, refinements to activity-based funding, capitation models and outcomes-based payments. Such trials are currently underway for LHNs in New South Wales and Victoria. As HealthLinks (case study 17) demonstrates, new payment mechanisms can spur effective and sustainable innovations, such as Monash Watch (case study 4). HealthLinks has provided useful lessons about the design and implementation of capitation-based funding oriented to high frequency hospital users, and for the algorithms that underpin identification of such users.

But advancing funding reform would require greater involvement of all jurisdictions in trialling new approaches, learning from the experiences of New South Wales and Victoria and working together with the Independent Hospital Pricing Authority (IHPA). The development of funding models at the jurisdictional level would provide a pathway to scaling up to a nationally consistent capitation and pooled funding model. Developing effective funding models would also require greater use of health data (see below).

As with PHNs, the Commission found that several LHNs in different jurisdictions introduced new approaches to care or have taken an active role in collaborative efforts. The reporting frameworks of LHNs differ across jurisdictions and the extent to which they prioritise innovation varies. Consistently incorporating innovation in reporting frameworks can give LHNs an added incentive to improve their service delivery model.

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<sup>3</sup> The role of activity-based funding (ABF) in supporting preventive care is mostly limited to the hospital avoidance activities specified in the Independent Hospital Pricing Authority's General List of in-scope public hospital services. Funding these can be complex and there is limited flexibility in what activities can qualify under the hospital avoidance program. Outside ABF, hospitals receive minimal funding for preventive health.

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## **RECOMMENDATION 2 – TRIALLING INNOVATIVE FUNDING ARRANGEMENTS**

State and Territory Governments could commence (or where applicable, continue) trials of alternative funding models that provide Local Hospital Networks (LHNs) with both the flexibility and incentives to meet the care needs of people with chronic conditions. This work should draw on the experiences of HealthLinks (case study 17) and Collaborative Commissioning (case study 16).

State and Territory Health Departments could also review the performance frameworks of LHNs, to ensure LHNs consistently work towards diversifying and improving their service delivery models.

### **EXPECTED OUTCOMES**

This would encourage LHNs to develop new ways of addressing the health needs of their local communities and adopt innovations developed elsewhere. It would also support the implementation of initiatives such as Monash Watch (case study 4) and Royal Perth Hospital Homeless Team (case study 9).

Additional trials of innovative funding would contribute to broader health funding reform.

## **2. Harness data to make better decisions**

Data is one of the key enablers of health innovation and quality improvement. For example, HealthLinks (cases study 17) uses an algorithm to identify consumers at high risk of hospitalisation. The algorithm is an important part of the capitation funding model, while also helping health services to offer the right service to the right people at the right time. But even much simpler systems can lead to significant improvement. Reports that alert clinicians to potential medication safety issues or patients who need periodic reviews enable safer and more coordinated care.

The case studies featured in *Innovations in Care for Chronic Health Conditions* that focus particularly on data use — Primary Sense (case study 11), the Chronic Conditions Management Model (case study 12), Smart Referrals (case study 13) and Lumos (case study 14) — demonstrate the wide range of benefits that can be obtained from improved access and use of health data that is already routinely collected. They are part of a much larger number of data improvement projects occurring in many parts of the health system, including, for example, the Primary Insights project that will provide data analytics to PHNs.

However, the use of innovative data tools among health professionals is not widespread. While some GP practices invest in data management tools, GPs often have little time and limited financial incentives to engage in quality improvement initiatives, including greater use of data. Funding PHNs to offer tools such as Primary Sense to more GP practices and support their use can significantly increase the use of data in primary care.

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The implementation of large-scale projects that involve data sharing and linkage, such as Smart Referrals and Lumos, can be stymied by technical difficulties (with the primary and acute care data management system not ‘talking’ to each other). There are regulatory limitations on data linkages and misconceptions about privacy legislation and its implications for data sharing and governance. Overcoming these issues takes time, and often depends on building trust between different organisations. Therefore, such projects require long-term funding commitments from their respective State and Territory Governments, so they have the time to build the relationships that will underpin their success.

Using health data to its full potential can mitigate some of the inherent risks of innovation. Both HealthLinks and Collaborative Commissioning rely on modelling and analytics to estimate the costs and benefits of interventions, and identify the cohorts who would benefit most. These projects also use data to underpin detailed evaluations, which are a critical part of diffusion.

#### **RECOMMENDATION 3 – IMPROVED DATA SYSTEMS AND DATA LINKAGES**

PHNs could work with GP practices (or build on their existing efforts) to encourage them to expand the use of data on community health trends and risks. This may require additional funding from the Australian Government.

State and Territory Governments could invest (or expand their existing investments) in data systems and linkages, so that:

- systems enable electronic communication between GPs and hospitals
- linked datasets connect health data from all settings of care.

#### **EXPECTED OUTCOMES**

Better use of primary care data would enable GPs to tailor care delivery and outreach to people’s needs, while more effective data flows between GPs and hospitals would enable better care, minimise errors and assist the development of capitation funding models. Linking data would support better system planning and population health.

The broader implementation of initiatives such as Primary Sense (case study 11), Smart Referrals (case study 13) and Lumos (case study 14) would help jurisdictions to achieve these outcomes.

### **3. Encourage learning from success achieved elsewhere**

The examples in *Innovations in Care for Chronic Health Conditions* reveal the diverse avenues for achieving better health outcomes for people with chronic conditions. There are two main implications for learning arising from the case studies. First, there needs to be a systematic approach for dissemination of healthcare innovations more generally, and second, some of the case studies examined by the Commission could be adopted now or soon.

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## Moving towards a *system* for more rapid and systematic diffusion

The wider adoption of the types of innovation described in the Commission's case studies is hampered by the scarcity of information and time to consider the many competing options for system improvement and limited incentives to change practices and cultures. This reflects the design of funding arrangements (as discussed above), professional siloes and deeply rooted ways of working, which health professionals may be reluctant to change. The information useful for the wider adoption of many of the case studies must be detailed, practical, provide context, indicate roles and capabilities, set out data collection needs, describe how to create more collaborative (less siloed) and innovative professional cultures, and provide realistic timelines for adoption.

The barrier posed by inadequate information about process-oriented innovations stands in stark contrast to the substantial institutional effort spent on providing precise advice on evidence-based medical procedures, pharmaceuticals and medical technologies. A plethora of agencies undertake detailed assessments in these areas, such as the Australian Commission on Safety and Quality in Health Care (ACSQHC), the National Health and Medical Research Council (NHMRC) and for new interventions, the Medical Services Advisory Committee (MSAC) and the Pharmaceutical Benefits Advisory Committee (PBAC).

In part, the contrast reflects the different nature of the innovations exemplified by the case studies, which involve system change and the coordinated actions of a variety health professionals, funders, and officials. No single health professional can adopt any of the case studies by themselves — all involve many actors and complementary architectures, such as the software underpinning Nellie, the involvement of volunteers in Turning Pain into Gain, and the hospitals, funders and algorithm developers in HealthLinks.

Though not their primary focus, the ACSQHC and the NHMRC already play *a* role in disseminating information of this kind. The NHMRC accredits Advanced Health Research and Translation Centres, which sometimes highlight healthcare programs that have features like those of the case studies. One of its centres describes the 'Eat Walk Engage' program, which is 'a multi-faceted, multidisciplinary strategy to support the nutrition, hydration, early mobilisation, and meaningful cognitive engagement of older patients'.<sup>4</sup> However, the translation centres depend on grant funding from a range of sources, so their funding is uncertain and ongoing diffusion of good ideas is not guaranteed.

The ACSQHC is better placed to disseminate detailed knowledge on case studies of healthcare innovation (and there are no grounds for creating a new agency devoted to dissemination of innovative health care). As well as being responsible for healthcare standards, accreditation and guidelines, the ACSQHC has a legislated role in promoting, supporting and encouraging the implementation of programs and initiatives relating to healthcare safety and quality (section 9 of the *National Health Reform Act 2011*).

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<sup>4</sup> Brisbane Diamantina Health Partners 2019, *Brisbane Diamantina Health Partners NHMRC Progress Report*, June, p. 7.

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One of the ways in which it fulfills this role is by running a program of Recognition of Exemplar Practice (REP).<sup>5</sup> The program ‘is intended to facilitate the identification and sharing of information on safe and good-quality practice between organisations managing similar issues’.<sup>6</sup> When exemplar practices are identified, detailed information about them can be communicated to all health service organisations of the same type (for example, to all hospitals, day surgeries, etc). This information is also published on the ACSQHC website. So, for example, the Transition Support Service at the Royal Children’s Hospital (RCH) Melbourne has been recognised as an exemplar practice, and health services looking to emulate it can access 15 pages of detailed information about the service and how it was implemented, as well as contact details for relevant people at RCH. However, reflecting the nascency of the REP, this is the only exemplar practice highlighted by the ACSQHC at the time of publication. The ACSQHC has an annual budget of almost \$20 million, but only a small fraction of this is used for the diffusion of good practices.

The REP program is an attractive mechanism for disseminating novel health care practices throughout Australia, though it will only demonstrate good value if it covers more exemplar practices and highlights those with the greatest scope for emulation or adaptation. The REP program could be enhanced by allowing health services to nominate their own exemplar practices, rather than relying on health service assessors (accreditation agencies) as the sole channel of identification and nomination. The types of exemplar practices recognised will need to change as lessons emerge from the wider adoption of the practices.

While developing the ‘supply-side’ of information provision is an important step for greater adoption of healthcare innovation, there is also a need for a demand for that information that goes beyond the general desire of health care providers to provide high quality care. The changes to flexible funding of PHNs and shifts in hospital funding that encourage effective low-cost primary health care rather than hospital activity are a desirable complement.

A major challenge in diffusion of best practice is that it is often glacial even when there is evidence for change. As highlighted by the Royal Commission into Aged Care Quality and Safety, this is exemplified by the continuing inadequate and slow adoption of best practice in prescribing of drugs for the aged, notwithstanding that the appropriate practices are well-defined and agreed (box 1). Equally, antiquated technologies like faxes and pagers still abound in hospitals.

A key question is, therefore, how can diffusion be accelerated for the types of innovations spelt out in the Commission’s case studies (and not just for adoption of best practice medical interventions)? One option is to periodically test the effectiveness of the REP, examining

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<sup>5</sup> The ACSQHC also promotes the diffusion of innovations and good practices by publishing reports related to each of its streams of work. As part of its work in promoting person-centred health care, it published a *Review of key attributes of high-performing person-centred healthcare organisations*. This review featured eight case studies that offer further detail on the ways in which a diverse range of Australian and international health services are delivering person-centred care.

<sup>6</sup> ACSQHC (Australian Commission on Safety and Quality in Health Care) 2019, *Fact sheet 5: Recognising exemplar practice in health service organisations*, Sydney, p. 1.

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whether the information is accessible, sufficient and persuasive, and that it reaches the right groups and with reasonable take-up. Follow up on the lessons on the challenges and the drivers of successful diffusion would provide a better evidence base for subsequent efforts to promote diffusion. Diffusion should be informed by, and provide evidence for, implementation science.

However, offering information alone is unlikely to be sufficient. Over time, Governments could consider the incentives faced by health professionals and health services to change their ways of working and adopt best practice. As emphasised in the *Innovations in Care for Chronic Health Conditions* report, current innovation occurs in spite of systemic policy settings – instead of being promoted by them.

#### Box 1      **Stark lessons about slow diffusion**

While the cautious introduction of medical technologies and new drugs is often appropriate if they are not fully tested or high cost, once accepted as cost-effective, it is desirable that they are widely diffused. Rapid diffusion of knowledge about overused treatments is equally important.

A vivid example of slow diffusion of knowledge is awareness by clinicians of the appropriate prescribing of psychotropic drugs for aged people experiencing dementia, an issue highlighted in the recent Royal Commission into Aged Care Quality and Safety. Psychotropic drugs are those capable of affecting the mind, emotions and behaviour, and include anti-depressants and antipsychotic medications. There has been concern about providing such drugs to aged care residents for more than 20 years given their side effects and relative lack of efficacy. NPSMedicineWise has noted that:

The evidence for the efficacy of antipsychotic drugs in the treatment of behavioural and psychological symptoms of dementia is unconvincing. However, the drugs cause definite harm including an increased risk of death.<sup>7</sup>

However, a substantial share of aged care residents continue to be prescribed psychotropic drugs, with 60% receiving at least one in their first three months of residential care. And in up to 31% of cases, antipsychotic drugs are administered to people who have not been diagnosed with psychotic and related conditions.

There are often superior non-pharmacological alternatives to psychotropic drugs, including behaviour management services, which have been funded by the Australian Government for more than a decade. Accordingly, while such drugs have a place in aged care, inappropriate use continues despite widespread information dissemination.

There are many other patterns of clinical practice where information provision alone has been insufficient to change health professionals' behaviour (as catalogued, for example by the various Australian Atlases of Healthcare Variation issued by the ACSQHC and the AIHW).

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<sup>7</sup> Macfarlane, S. and Cunningham, C. 2021, 'Limiting antipsychotic drugs in dementia', *Australian Prescriber*, February, <https://www.nps.org.au/australian-prescriber/articles/limiting-antipsychotic-drugs-in-dementia> (accessed 11 May 2021).

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#### **RECOMMENDATION 4 – DIFFUSION OF EXEMPLAR PRACTICES**

The Australian Commission on Safety and Quality in Health Care (ACSQHC) could expand its Recognition of Exemplar Practice (REP) program to cover more case studies of promising major healthcare innovations across the Australian healthcare system.

In doing so, it could allow health services to nominate their own exemplar practices, rather than relying on health service assessors (accreditation agencies) as the sole channel of identification and nomination.

The REP program should be reviewed periodically to assess whether it is effectively translating knowledge from case studies into greater adoption.

The role of the ACSQHC in disseminating innovations could be accompanied by funding reforms that create incentives for their uptake by health service providers (recommendations 1 and 2).

#### **EXPECTED OUTCOMES**

There would be wider and faster adoption of innovative health care and further evidence-based development of new approaches for effective dissemination of such innovation.

### **Diffusing the Commission’s case studies more widely**

A range of considerations arise when contemplating the broader implementation of case studies included in the Commission’s report (summarised in table 1). Taking all of the considerations together, the case studies fall into two categories:

1. Initiatives that can be adopted relatively quickly or where they can support a pathway to more substantive reform
2. Projects that address the needs of smaller groups or solve specific problems.

Some of the initiatives mentioned in the report are excellent examples of improvements in care, but there is limited need to replicate them across Australia. For example, Western Sydney’s COVID-19 response (case study 8) addressed the unique circumstances of the start of the COVID-19 pandemic, which are unlikely to occur again in quite the same way. Similarly, the Chronic Conditions Management Model in the Northern Territory (case study 12) arose at a time when electronic health records were less well developed, and its spreadsheet-based methods are unlikely to be an ideal solution for future projects. The Institute for Urban Indigenous Health (IUIH) (case study 15) developed its model in response to, and through the efforts of, the Aboriginal and Torres Strait Islander community of South East Queensland. Local community control is an essential component of the model. Attempts to replicate it more broadly could jeopardise this key feature.

Table 1 **Case study implementation considerations**

<i>Case study</i>	<i>Would be implemented by</i>	<i>Needs funding from<sup>a</sup></i>	<i>Indicative timing</i>	<i>Already implemented elsewhere</i>
<b>Innovations that could be implemented in all jurisdictions</b>				
Nellie	PHNs	Aust Govt	Could operate Australia-wide within 2 years	UK and USA
Monash Watch	LHNs	State Govt	Could operate Australia-wide in 2–5 years	Other LHNs in Victoria
Primary Sense	PHNs	Aust Govt	Could operate Australia-wide within 2 years	Other PHNs
Smart Referrals	State Govt	State Govt	Could operate Australia-wide in 2–5 years	No
Lumos	State Govt	State Govt	Could operate Australia-wide in 5 years	No
HealthLinks	LHNs	State Govt	Could operate Australia-wide in 5 years	No
Collaborative Commissioning	LHNs and PHNs	Aust and State Govts	Could operate more widely in 5 years	No
The Collaborative	LHNs and PHNs	Aust and State Govts	Consider alongside Collaborative Commissioning	No
<b>Innovations that could be considered in specific circumstances</b>				
Royal Perth Hospital (RPH) Homeless Team	LHNs	State Govt	Could operate Australia-wide in 2–5 years	UK and USA
Choices	PHNs	State Govt	Consider alongside RPH Homeless Team	No
Turning Pain into Gain	PHNs	Aust Govt	Could operate Australia-wide within 3 years	Other PHNs
GP with Special Interest	LHNs	State Govt	Consider alongside Smart Referrals	UK and other LHNs in Queensland
One Stop Liver Shop	LHNs	State Govt	Could operate in other remote areas within 2 years and for other diseases within 5 years	No
General Practice Pharmacist Program	PHNs	Aust Govt	Could operate more widely in 2–5 years	UK

<sup>a</sup> State Govt = State and Territory Governments.



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## Initiatives that could be considered for immediate rollout

The initiatives described below should be considered for rollout in all jurisdictions. Specific health service organisations may choose equivalent programs if they believe these would be better suited for their circumstances. However, the programs included here offer the benefit of being ready for adoption and adaptation in other places. In some instances, particularly Collaborative Commissioning and HealthLinks, the desirable pace of rollout may be affected by reforms to funding design at the national level.

### Nellie (Case study 1, pp. 50–1 of the main report)

Nellie involves relatively simple technology that can be obtained ‘off the shelf’. It provides friendly text messages with reminders about daily actions to support people to manage their chronic conditions. These text messages are tailored to specific circumstances, after a consultation between the consumer and their GP. The system offers the capacity for information to be relayed back to a health professional.

Nellie has been adapted for use in Australia and rolled out by the South Eastern Melbourne Primary Health Network (SEMPHN). Initially trialled in 2016, by 2020 it was being used in about 50 general practices.

The demonstrated benefits of Nellie include better patient outcomes and experiences, and reduced use of high-cost healthcare services. Consumers have responded positively to Nellie and patient acceptance rates are high. Health professionals also benefit from using Nellie, as it enables them to provide personalised care without increasing their workload. GPs maintain control over the ways they use Nellie, and are able to focus on specific consumer groups or different aspects of health management (such as blood pressure monitoring, medication reminders, and exercise prompts).

The capacity for the scaling up Nellie has already been proven. The system was initially developed by the UK National Health Service (NHS), and later adopted by the US Department of Veterans Affairs. In the UK, Nellie’s equivalent has been assessed as one of the few successfully scaled innovations throughout the NHS and is still rapidly growing.

Broader diffusion of Nellie would see more GP practices using the software, to tailor goals for consumers and generate reminders. Evidence from Scotland suggests that diffusion is low cost and that adoption rates among general practices can be as high as 60%. If similar adoption rates were achieved for Nellie, it could ultimately be used by about 4000 Australian general practices, although this goal would likely be achieved over more than a decade, given the pace of diffusion seen in the UK. Currently, Nellie reaches a few hundred people, but the potential population covered could be over 120 000 per year. Nellie is best suited for geographical areas with reliable mobile phone coverage.

PHNs can lead implementation of Nellie given their close ties with GP practices. The Australian Government would probably need to provide some additional funding for this, as

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the amount of flexible funding available to PHNs is unlikely to be sufficient to cover new programs without compromising other successful projects.

Diffusion would best commence by using the Nellie messaging protocols developed by SEMPHN in all PHNs, and then expanding its use to people with a wider range of chronic health conditions and preventative health activities (such as blood pressure monitoring for pregnant women). There is already practical guidance for clinicians and consumers about how to use it, the types of preventive health areas where it can be used effectively, and its benefits, developed by SEMPHN and the NHS.

#### Monash Watch (Case study 4, pp. 61–2 of the main report)

Monash Watch is a telephone outreach service designed to reduce avoidable hospital admissions. The service employs ‘Care Guides’ who phone participants regularly to monitor their health and wellbeing and encourage them to make healthier choices in their daily life. Using a decision support system, the Care Guides refer people to nurses and other health professionals when they need additional help. Interim evaluation results show that Monash Watch is achieving a 20–25% reduction in hospital acute emergency bed days compared with usual care, well in excess of the 10% reduction it set out to achieve.

The Monash Watch model focuses on the 2% of patients who are at the highest risk of multiple attendances and admissions to hospital. Because these patients account for about 25% of direct health care costs, reducing hospital admissions in this cohort leads to reduced costs.

The model has expanded from its original team and location in Dandenong. Similar programs are now being implemented in other health services across Victoria, including ‘Patient Watch’ at Northern Health. It is anticipated that several thousand patients will eventually be enrolled in Patient Watch.

Consumer feedback on the program has been very positive. The model can be tailored to the different needs of different communities. In particular, because Care Guides are not clinical staff, Care Guides from the same cultural backgrounds as program participants can be hired and trained in a matter of months.

The Monash Watch model could easily be replicated in hospitals similar to those in which it is already successfully operating. However, some initial actions are needed to underpin the wider rollout of the Monash Watch model. Initial steps are:

- recruiting and training Care Guides, and
- identifying the people who would benefit most from the program.

In Victoria, the identification of relevant program participants is done using the HealthLinks algorithm (see below). All jurisdictions have the data required for similar algorithms (as this data is collected routinely in all hospitals), and have the potential to link and analyse the data in ways that identify possible participants.

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Funding may also present a barrier to the broader adoption of the Monash Watch initiative in the short term. As it is a hospital-based program, the wider adoption of the Monash Watch model would involve LHNs and State and Territory Governments. The current model is funded using capitation payments under the HealthLinks initiative. While this requires a change in how funding is allocated, there is no increase in costs associated with the service. The Commission is recommending that other jurisdictions consider trials of capitation payments (recommendation 2).

### Primary Sense (Case study 11, pp. 121–2 of the main report)

Primary Sense is data extraction and analysis software developed by Gold Coast PHN that does not require GPs to enter additional information or change their workflows. The software provides alerts to GPs about people at risk of developing cardiovascular disease, diabetes or being admitted to hospital within the next 12 months; people with high frailty scores; and those who use a large proportion of health resources. It also provides real-time medication safety alerts and optimal care prompts.

General practice staff find Primary Sense easy and intuitive to use. GPs like that messages are tailored to risk level and that, in higher-risk scenarios, they receive messages in their inbox for processing in the same way as they already receive pathology results. Practice managers and nurses like that it provides reports showing activities that should occur at patients' next visit, and reminders to recall patients based on missing interventions. Patients benefit from the reminders, and from more timely preventive care. Uptake in the Gold Coast is high — it is now being used in 83 general practices, serving 90% of the region's population.

Gold Coast PHN has already funded the development of Primary Sense, and is now looking to make it available to other PHNs on a cost-recovery basis. This means that Primary Sense can be implemented by additional PHNs within a relatively short time frame if they are willing to purchase the software and train staff to support GPs using it. However, there are similar software packages on the market, which Primary Sense will have to compete with and PHNs will have to determine whether this solution is commercially viable in their area.

### Smart Referrals (Case study 13, p. 130 of the main report)

Queensland Health's Smart Referrals uses software to streamline referrals between general practice and specialist services and improve wait times for outpatient services. Smart Referrals allows GPs to create and submit electronic referrals from existing practice software and pre-fills basic client information. The software is scalable — once it was developed and shown to work in the pilot phase in Queensland, the main expansion costs were incurred to familiarise clinicians with the software. Indeed, Smart Referrals was scaled up statewide by Queensland Health over two years following a successful trial in Brisbane in 2018, an indication of the speed of adoption of some innovative initiatives.

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Other jurisdictions are considering or working towards introducing systems that will streamline referral processes. The Smart Referral system, or the principles upon which it operates, can shed light on important features that need to be incorporated, such as giving consumers information about expected wait times for their specialist appointment.

Smart Referrals is part of a broader strategy to address long waiting times for specialists. LHNs could also tackle waiting lists by employing specially trained GPs (known as GPs with special interest), who can provide care for some people who would otherwise need to see specialists. This approach has been used successfully in Australia and overseas, and could be beneficial in regions where there are sufficient numbers of GPs to fill hospital positions. GPs with special interest are discussed further below.

#### Lumos (Case study 14, pp. 133–4 of the main report)

Lumos is a large-scale data linkage project. It brings together consumer data across primary, ambulance, acute care, cancer registry, death registry and notifiable conditions registries to enhance understanding of the consumer journey through the healthcare system and inform policy and planning. It is the largest collaboration between NSW Health and PHNs in New South Wales, and has information about two million consumer journeys. The data has been used in many ways, from identifying how specific GP practices can change their service delivery to match the needs of their community, to running complex modelling.

There are health data linkage projects in other jurisdictions (such as the WA Data Linkage system), as well as a national initiative to enhance data linkage infrastructure, as part of the Population Health Research Network. PHNs are also working to support better use of data and analytics in primary care.

What sets Lumos apart is its success in engaging a wide range of system users and building a case for ongoing use of linked data, both in the routine operation of health services and the broader planning of system reform. To achieve this, the Lumos project team had to overcome common barriers to improving the use of health data. In particular, they have addressed privacy concerns by undertaking comprehensive privacy assessments and consulting widely on the privacy protections built into the system. They have also gained and maintained the trust of data providers and users by demonstrating the value the data can deliver.

The Lumos project started in 2016, with only 40 general practices across four PHNs. The PHNs that participated in the pilot phase were able to use their existing relationships with GPs to recruit them to the project. After further development of data systems, Lumos now collects data from over 300 practices (representing all 10 PHNs in New South Wales) involved in the program. In addition to maintaining collaborative relationships, the expansion of Lumos required ongoing funding commitments to be sustained over time.

Departments of Health in all jurisdictions are progressing data projects, and these should continue, with the aim to reach the scale of Lumos. Data linkages involving multiple parts of the health system can yield insights and sustain further innovation (for instance, Lumos is used

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to develop and evaluate the Collaborative Commissioning initiative). In some cases, data linkage projects are impeded by concerns about privacy and compliance with legislative requirements. While the Lumos experience shows how these can be overcome, the Commission's *Data Availability and Use* inquiry made recommendations to create an environment that would promote further innovation. Some of these recommendations are being implemented by the Australian Government. The ongoing commitment of governments to facilitate greater use of health data (and use more data themselves) will cement community acceptance of providing and using data required to make the most of data assets.

### HealthLinks (Case study 17, pp. 161–3 of the main report)

HealthLinks is a Victorian initiative that provides more flexible funding to hospitals to test whether it leads to the delivery of more integrated and innovative care. Such care may provide better experiences and outcomes for people with chronic conditions and by design, at no additional cost to the public health system. The initiative was trialled from 2016-17 to 2018-19. For the first two years, the Victorian Government fully funded the trial, with the Australian Government joining from 2018-19. Five hospitals were participating in the program in 2020-21.

HealthLinks focuses on people with chronic and complex health conditions who are at risk of three or more unplanned hospital admissions in a 12-month period. People are identified using an algorithm applied to the Department of Health's hospitals datasets, and are enrolled in the program after an unplanned admission.

Under the HealthLinks model, participating hospitals receive funding for the enrolled cohort as a capitation grant, rather than the activity-based funding they would have received from the Australian and Victorian Governments. The capitation grant is calculated on the expected use of inpatient activity-based funding units, based on data from the previous five years.

The funding allocation to HealthLinks remains relatively small. In 2016-17, about \$40 million was converted to capitation grants (about 0.25% of the \$16 billion recurrent expenditure on Victorian public hospitals). The capitation grant must be used to cover all services provided to the cohort, including hospital inpatient admissions and the alternative HealthLinks services provided.

Capitation payments have long been suggested as a suitable mechanism to fund health services required by people with chronic conditions. There are several other options that have been trialled over time, included the bundled payment approach used to fund Health Care Homes and collaborative approaches (see below). These can be complementary given that Health Care Homes relate only to primary care services and are intended to move primary care to a 'patient-centred medical home', which is a proven model for improving consumer outcomes.

As part of the Addendum to the National Health Reform Agreement, all jurisdictions agreed to trial alternative payment mechanisms and advance funding reform. The Independent

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Hospital Pricing Authority is working on developing ways to implement such trials without penalising the participating jurisdictions. There are several practical barriers to the implementation of alternative funding models, including incomplete data collections, data linkage issues and variations in service delivery models.

However, HealthLinks shows that such trials can take place, and that the risks involved can be managed. The hospitals involved in HealthLinks have each developed different approaches to preventing hospitalisations of people with chronic conditions (such as the Monash Watch model described above), but all have achieved improvements in the care delivered and consumer experience.

All jurisdictions should consider the lessons of HealthLinks in designing their own innovative funding solutions (recommendation 2).

**Collaborative Commissioning and The Collaborative (Case study 16, pp. 159–160 of the main report, and case study 10, pp. 105–6 of the main report)**

New South Wales has taken a different approach to health funding reform, by supporting LHD–PHN partnerships to address local health priorities. These partnerships, formalised through Patient Centred Co-Commissioning Groups, are responsible for co-designing, commissioning, implementing and overseeing the initiatives. Funding for the projects is achieved by pooling funds from PHNs and LHDs, and sharing any cost savings. NSW Health provides guidance, support and short-term investment to assist in the establishment and development of the initiatives.

This initiative is relatively new. Four PHN–LHD partnerships have entered the Joint Development Phase, which involves testing, modifying and refining project proposals with support from the NSW Ministry of Health. One partnership has completed the Joint Development Phase and entered the Feasibility phase and has begun implementing the project.

The eventual aim is for all 10 PHN in New South Wales to establish Collaborative Commissioning models. The Lumos dataset (see below) has been used to build a dynamic simulation model to forecast the expected benefits and costs of care pathways, which will be used in the monitoring and evaluation of the initiative. All general practices participating in Collaborative Commissioning pathways are required to provide data to Lumos.

Collaborations between different parts of the health system are already occurring in other parts of the country, with varying degrees of formality. For example, in Victoria, The Collaborative is a partnership between North Western Melbourne PHN, Royal Melbourne Hospital and two community health service providers (cohealth and Merri Community Health Services). It was established to jointly address chronic disease in inner north and west Melbourne. The Collaborative has been in operation for over 10 years, and includes comprehensive governance arrangements. In addition, each partner commits resources to collaborative projects, demonstrating their commitment to the partnership.

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Collaborative Commissioning is designed to shift the NSW health system towards value-based health care. Such an approach could be adapted in any other jurisdiction as part of their commitment to trialling alternative funding mechanisms under the Addendum to the National Health Reform Agreement. Adaptions should take account not only of funding mechanisms, but also of governance structures, use of data and modelling, and should involve commitments to evaluation.

## **Initiatives that could be considered in specific circumstances**

The programs listed below are all proven innovations, with strong track records of improving consumer outcomes in specific situations. These programs, or their key elements of success should be considered by all health organisations facing similar circumstances — either seeking to support a specific population or improve workflows.

Royal Perth Hospital Homeless Team and Choices (Case study 9, pp. 94–5 of the main report, and case study 7, pp. 84–5 of the main report)

The Royal Perth Hospital Homeless Team works with people experiencing homelessness to improve health outcomes, reduce hospital admissions and get them access to housing. The team develops treatment plans — involving a mix of hospital and primary care — and organises follow-up appointments with clients at the GP’s practice or via its mobile clinics. The team also works closely with Choices peer workers who provide support and case management to people with complex health and social needs who are disengaged or wary of healthcare providers.

There are different models of hospital-based homeless teams — comprising different types of team members — that seek to make primary care and social supports more accessible for people experiencing homelessness. Some teams such as the Royal Perth Hospital Homeless Team include GPs, hospital doctors, practice nurses and caseworkers; while others in Melbourne and Sydney include allied health professionals. While there is no definitive evidence on the team mix that delivers the best results for people experiencing homelessness, some studies suggest that teams that include GPs — like the Royal Perth Hospital Homeless Team — are likely associated with better health outcomes for clients than other models because they focus on prevention and early intervention.

In adopting hospital-based homeless teams, jurisdictions should consider the level of demand for these services in particular areas (which may be higher in cities with large rough sleeping populations), capacity of primary care settings to treat people experiencing homelessness and the strength of the relationships between local primary care, acute care and community services. Implementation decisions should be made in consultation with State health departments, LHNs, PHNs and community services. Further, if jurisdictions determine that GPs, peer workers and caseworkers should be part of hospital-based teams, LHNs will require more flexibility to fund these roles in hospitals (recommendation 2).

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Extending the Royal Perth Hospital Homeless Team model to all principal referral hospitals and large public acute hospitals (group A and group B hospitals) would cost about \$68 million and would predominately benefit Australia's population of rough sleepers (comprising 746 000 people aged 15 years and over who have experienced rough sleeping at some point in their lives) who are frequent users of hospitals, and in particular emergency departments.

### Turning Pain into Gain (Case study 2, pp. 53–4 of the main report)

Turning Pain into Gain is a 12-month program for people with persistent pain, operated by the Gold Coast PHN. It combines one-on-one clinical assessments, a six-session education program, allied health services and goal setting. More than 600 people with persistent pain have participated in Turning Pain into Gain since 2013. Its evaluation found that participants improved their ability to undertake various day-to-day activities, including exercise, household chores, and leisure activities; and reported a 78% reduction in hospitalisations.

Following its success on the Gold Coast, the Turning Pain into Gain program is now being implemented by the Adelaide PHN and by the WA Primary Health Alliance at four sites in Western Australia. Participants access allied health services funded by the Australian Government through the Medicare chronic disease management items, but the PHN may cover additional allied health services for people who have exhausted their Medicare allocation.

Almost 1 in 5 people aged over 45 years live with chronic pain, experiencing persistent pain most days of the week. Many of them could benefit from participation in this program. This would produce several benefits as people with chronic pain have longer hospital stays and report limitations to daily activities more than others. There are large effects on employment and productivity of those affected (with one estimate suggesting the economic costs were as high as \$48.3 billion in 2018). They are three times more likely to be dispensed opioids compared with the general population, which raises concerns about drug dependence and the long-run impacts of such medications.

The program can also shorten waiting lists for specialist pain clinics so that people who need them would be able to access treatment earlier, and may also ultimately reduce the required resources for such (costly) clinics. Turning Pain into Gain has gained the trust of other health professionals; participants are referred to the program by local general practices, as well as hospital rheumatology, persistent pain, emergency and neurosurgery departments. This demonstrates the potential scale of demand. A large-scale rollout will require careful planning to ensure services are available for those who need them within a reasonable time frame.

Turning Pain into Gain can be implemented by further PHNs relatively quickly using resources that have already been developed. Funding for the program would come from the flexible funding pool of PHNs. In principle, it could also be used by LHNs, but planning processes may be more complex and take more time, assuming funding continues to be provided by the Australian Government. This barrier could be overcome if LHNs decide to invest their own resources. Another advantage of the program is that its workforce requirements are flexible; although developed by a pharmacist, it can be delivered by a range of health professionals.



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### One Stop Liver Shop (Case study 3, pp. 57–8 of the main report)

The One Stop Liver Shop is a mobile care delivery model for people with chronic hepatitis B (CHB) in a remote community in the Northern Territory. It provides all the care needed by people with CHB, where they live, in their language, and has been successful in preventing the need for hospital visits.

In 2018, the project received funding from the NHMRC to translate the Hep B Story app into an additional 10 Aboriginal languages. This will mean that 70% of Aboriginal people in the Northern Territory will have access to information about CHB in their first language.

While there are a variety of mobile health services that aim to reach remote communities, the unique aspect of the One Stop Liver Shop is in its comprehensive model of care (including bringing specialised equipment to the local community) that is also responsive to cultural needs. Such an approach can be extended to people with CHB in other remote communities, and considered for adaptation to other diseases, such as rheumatic heart disease. Extending the One Stop Liver Shop model would require diverting resources from local health services, or securing new funding from either State and Territory Governments or the Australian Government (or both). However, the health benefits of culturally responsive outreach are likely to be significant, as the people who would attend are currently accessing very limited health services.

There may be other disease-specific programs that target particular communities. They could draw on the lessons of One Stop Liver Shop, but would require additional effort to ensure they were culturally appropriate for the relevant condition, its treatment forms and location.

### GPs with Special Interest (Case study 6, pp. 79–80 of the main report)

GPs with special interest (GPwSIs) provide care to people who would otherwise need to be seen by specialists. This can:

- reduce specialist waiting lists
- facilitate better communication between primary care and hospitals
- improve discharge of consumers back to their GP.

The GPwSI model is used in multiple locations in Queensland, as well as in the UK, Netherlands, Canada and New Zealand. The Sunshine Coast Hospital and Health Service uses GPwSIs to take referrals for people who would otherwise have been on waiting lists for general surgery, dermatology, gastroenterology, gynaecology, immunology, mental health, neurology, orthopaedics, paediatrics, persistent pain, respiratory medicine and urology. Similarly, Brisbane North PHN has had success supporting GPwSIs to work alongside physiotherapists to take the pressure off the hospital pain unit. Providers work under the supervision of the pain specialist and receive referrals from GPs using the Smart Referral system (case study 13).

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Experience from Australia and overseas suggests that GPwSIs can improve access to care while achieving comparable outcomes to those achieved by specialists. There is also the potential for GPwSIs to reduce costs, although the most likely outcome is that more patients can be seen for the same cost.

GPwSIs involve a mix of State and Commonwealth funding. In the case of the Sunshine Coast program, the LHN covers about half of program costs (which are primarily staff costs) and the remaining costs are offset through the occasions of service that GPwSIs provide or via Medicare billing where appropriate. Mental health GPwSIs are also partly funded through the local PHN.

### General Practice Pharmacist program (Case study 5, pp. 74–5 of the main report)

In the General Practice Pharmacist program, pharmacists work in general practice care teams to deliver clinical services and education. Pharmacists' responsibilities can include performing medication reviews, providing medication advice to consumers, conducting clinical audits and providing education to GPs and other practice staff.

The program was initially developed by WentWest, the Western Sydney PHN in 2016 and has grown to include seven pharmacists in 24 practices, with several more about to come on board. When this occurs, pharmacists will work in about 10% of general practices in Western Sydney. International evidence suggests that uptake may continue to increase — in England the NHS is aiming to have pharmacists working in 40% of general practices by 2021.

The program has substantial benefits for consumers, as many of the medication reviews resulted in people taking fewer medications or lower doses. It was also well received by GPs, who accepted close to 90% of the recommendations made by the pharmacists.

The costs of wider implementation will depend on program uptake. If pharmacists worked at 10% of general practices, this would cost in the order of \$16 million per year. There could, however, be offsetting savings in GPs' time. One study conducted in Scotland found the inclusion of a GP-based pharmacist reduced the time GPs spent on key prescribing activities by 51%, which freed up 5 hours of GP time per week, per practice. There are also potential savings from reduced expenditure on medications, fewer medication-related preventable hospital admissions, and better health outcomes. Despite these savings, a larger rollout of the program would require some additional upfront funding from the Australian Government, so that PHNs have sufficient funding certainty to employ additional pharmacists.

Because it is run by PHNs, the General Practice Pharmacist program sidesteps concerns raised in past debates about the desirability of GPs directly employing pharmacists.<sup>8</sup>

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<sup>8</sup> In 2015, the AMA suggested that the Australian Government provide an incentive payment to GPs to employ a pharmacist (as they currently do for practice nurses). The Pharmacy Guild opposed this, claiming that this would reduce pharmacists' professional independence, and exacerbate pressures on workforce availability and the sustainability of community pharmacies.