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Policy framework for strengthening Medicare

Evidence review
Draft report

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Submitted 25 October 2024

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The MSDI Evidence Review Service (ERS) supports government, industry and others to address pressing issues in sustainability, health and other areas. The central aim of the ERS is to connect knowledge to power. We believe that research and other credible knowledge can add value to problem-solving by illuminating potential solutions as well as areas where investment may be wasted on strategies that have failed elsewhere. All ERS reviews are based on established principles of review science which we have applied across a broad array of disciplines and settings for over 10 years. Our reviews are tailored to our clients' timelines, which vary from as little as one day to several months. The ERS has a strong track record of supporting government, industry and others to address pressing issues in health, sustainability and other areas. Our recent clients include: The Royal Commission into Victoria's Mental Health System, The Royal Australasian College of Physicians, The Paul Ramsay Foundation (a leading Australian philanthropic organisation focused on addressing disadvantage), The Global Buildings Performance Network (a global network of building practitioners committed to green building) and two major Australian banks.

Declarations of Conflict of Interest
The authors have no conflicts to declare.

Citation
Kellner P, Batson A, Waddell A, & Kaufman S. *Policy Framework for strengthening Medicare Evidence Review: Draft report.* Monash Sustainable Development Institute Evidence Review Service, BehaviourWorks Australia, Monash University, October 2024.

Funding declaration
This project was funded by the Australian Government Department of Health and Aged Care.

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EXECUTIVE SUMMARY

INTRODUCTION

The Strengthening Medicare Taskforce Report was released in December 2022 and provided recommendations on improving Australia's primary care system. The Australian Government has invested significantly to realise the vision set out in the Strengthening Medicare Taskforce Report to reform primary care and build a stronger Medicare for future generations.

In response to these recommendations put forward by the Taskforce, a range of reviews have been conducted that have provided findings across a spectrum of primary care topics. To synthesise findings from these reviews and support planning to take action based on the learning in the reviews, the Department has embarked on an evidence translation project involving an Evidence Review and Policy Synthesis process. This is an interim report for the Evidence Review which responds to the following questions:

1. What are the policy opportunities / recommendations and challenges cited across the review documentation?
    a. Do the opportunities and challenges across the reviews overlap or conflict? If they agree, what specific policy options and outcomes have been suggested to best realise the opportunity? If opportunities or challenges are in conflict, what is the nature of the conflict and do the reviews suggest ways to address them?
2. Do the reviews identify any current evidence gaps that require further investigation?
    a. Do the analysts note any gaps based on their engagement across multiple reviews?

METHODS

A bespoke workflow for a thematic analysis of Department-identified review documents was designed by Monash University to respond to the above research questions.

FINDINGS

Workforce design, development and planning

Challenges / barriers

- There are a range of trends indicating that there is and will continue to be a shortfall in the number in primary care service providers.
- Poor recognition of professional skills and capabilities posed a challenge, and poor recognition can undermine interprofessional trust, multidisciplinary care, and workforce planning.
- Skills maintenance is especially challenging for self-employed or rural and remote workers.
- Lack of adequate data systems impedes workforce planning.

Policy options / opportunities / recommendations

1. Use a suite of tailored incentives to support non-GP professionals to practice in full scope.
2. Develop common interprofessional competencies (e.g. via a National Skills and Capability Framework and Matrix).
3. Establish a data-driven National Primary Healthcare Workforce Development Program.
4. Supplement and support a range of efforts to encourage primary care professionals to work in non-metro areas, including after hours.

5. "Establish an independent mechanism to provide evidence-based advice and recommendations in relation to workforce design, emerging health workforce roles and models, and major changes to scope." (per the Scope of Practice Review)

Education and training

Challenges / barriers

- Learning about primary care in pre-professional programs could be improved.
- Skills maintenance, especially for rural and remote and self-employed professionals is a challenge.
- There are unclear and inconsistent post-professional entry requirements for professionals looking to move to primary care.

Policy options / opportunities / recommendations

6. Strengthen Continuing Professional Development programs, and the incentives that support them, with particular focus on multidisciplinary practice and First Nations Healthcare.
7. Address barriers to cross-professional supervision of students, through changes to accreditation standards, Medicare Benefits Schedule rules, and the Teaching payment.

Leadership and culture

Challenges / barriers

- Key challenges were note enumerated in detail, however, leadership and culture were mentioned as a key barrier or facilitator of other recommended reforms.

Policy options / opportunities / recommendations

8. Culture and leadership approaches that support systems change.

System and/or service design

Challenges / barriers

- Complexity of the primary healthcare system was highlighted by several documents, both for providers and consumers.
- Governmental programs and policies are not keeping pace with changes being made in the sector to adapt to needs and evidence-based best practices.
- There is room to improve the structures and mechanisms that support effective clinical governance in primary care, which is less mature than it is in tertiary care.
- The reliance of many practices on incentives for financial viability may undermine the goal of incentivising specific behaviours.
- A shift away from the current general practice-centred model of care, and towards a multidisciplinary/collaborative model, may pose risks of potentially undermining team cohesion, creating scope of practice overlap between professions, and potentially create a sense of role threat.

Policy options / opportunities / recommendations

9. Integrate planning and incentives for supporting increased scope of practice, after-hours primary care, and multidisciplinary care.
10. Develop protocols for consumer awareness about after hours services and increase the tiers of the After Hours Incentive to increase accessibility of services.
11. Develop a national Urgent Care Framework that would: i) integrate data across services to ensure continuity of care; ii) manage consumers who do not have a usual

primary care provider, in the event of an urgent (or after-care) need; and iii) promote equity of access to urgent care and after-hours care to priority populations.

12. Articulate standards of quality and safety for after-hours care, both for consumers and the primary care providers, and support this further using a quality improvement incentive (either targeted at after hours care or more generally).
13. Develop a new Distribution Priority Area system including existing inputs from the National Assessment Tool but also include other inputs like wait times for general practitioners, average distance and time to travel to offices, etc.
14. Improve overseas medical practitioners end-to-end experience.
15. Direct referral pathways supported by technology that enable health professionals to make referrals within their scope and to improve access to specialists.

Monitoring, evaluation, and research

Challenges / barriers

- Several service delivery approaches were identified as potentially benefitting from becoming increasingly data driven, for instance, relating to how workforce planning occurs, as well as direct service tailoring.

Policy options / opportunities / recommendations

16. Strengthening of strategic collection, governance and use of primary health data, and ongoing research would help to better understand the effectiveness and efficiency of incentives, to establish baselines, and to support co-design, quality improvement, distribution of incentives.

Legislation and regulation

Challenges / barriers

- Highly restrictive regulation limits scope of practice in primary care.
- Lack of consistency in laws and regulations across jurisdictions can create a range of barriers to reform and practice.
- The law was found to not be keeping pace with changes in practice and emerging evidence and frequently impeding otherwise competent professionals from working to their full scope of practice.

Policy options / opportunities / recommendations

17. Develop a National Skills and Capabilities Framework (also included above) and expand the authority of Health Ministers to provide policy direction to APHRA and national boards about accreditation. The Scope of Practice review suggests using a "risk-based approach to regulating scope of practice to complement protection of title approach to enable health professionals to more consistently work to full scope of practice".
18. Review and harmonise legislation and regulation to ensure better agreement across jurisdictions or to prevent unnecessarily restricting professionals from practicing in full scope.

Funding and payment policies

Challenges / barriers

- Several documents indicated that funding and payment policies were not being used to optimally incentivise and support multidisciplinary models of care.
- Some documents also indicated that the fee for service model of care in Medicare rewards fast, episodic care and creates barriers for chronic diseases management.

- The narrowness and inflexibility of funding and payments policies was cited by some documents.
- Payments are not keeping pace with the complexity of the healthcare system, and the calculations for the payments are often not uniform.
- Some incentives may not be effectively encouraging professionals to practice in rural and remote settings.

Policy options / opportunities / recommendations

19. Introduce blended payment models (and in some cases bundled or block models) that are designed to encourage multidisciplinary delivery of care involving professionals working in full scope.
20. Strengthen after hours service provision by expanding the eligible services, adequately costing Medicare Benefits Schedule items, and increasing the tiers of payment in the After Hours incentive.

Technology and digital transformation

Challenges / barriers

- A lack of interoperability between various health records systems undermines continuity of care and information sharing between services.
- Several other issues broad issues related to data systems for both consumers and provides were noted including: underuse of My Health Record, limited visibility of patient environment in My Health Record, lack of secure messaging solutions, and lack of real time integrated patient information.
- There is a need to establish better datasets related to workforce planning.

Policy options / opportunities / recommendations

21. Improve telehealth functionality through incentives and payments, local knowledge summaries, and appropriate triage pathways.
22. Use incentives to improve data transparency and system integration, which in turn would likely support continuity of care.
23. Expand secure, usable means for data sharing and linkage that have features like real time patient information, as well as secure messaging and referrals.

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BACKGROUND, REVIEW QUESTIONS, AND METHODS

BACKGROUND

The Strengthening Medicare Taskforce Report was released in December 2022 and provided recommendations on improving Australia's primary care system. The Australian Government has invested significantly to realise the vision set out in the Strengthening Medicare Taskforce Report to reform primary care and build a stronger Medicare for future generations.

Recommendations from the Taskforce Report look to strengthen primary care in Australia towards the Quintuple Aim[1]:

- Improve people's experience of care
- Improve the health of the population
- Improve health equity
- Improve the cost-efficiency of the health system
- Improve the work life of health care providers

In response to the recommendations put forward by the Taskforce, a range of reviews have been conducted that have provided findings across a spectrum of primary care topics.

These reviews include but are not limited to (for full list of inclusions see Table 1):

Unleashing the Potential of our Health Workforce - Scope of Practice Review

- Examines the barriers and incentives health practitioners face working to their full scope of practice in primary care.

Working Better for Medicare Review

- Examines the effectiveness of current health workforce distribution levers, including policies and geographic classifications that are intended to distribute health workforce across areas that need them most.

General Practice Incentives Review

- Includes the Practice Incentives Program and Workforce Incentive Program as part of a broader effort to reform primary care funding arrangements.

After Hours Review

- Investigates the need for primary care after hours services, the current state of after hours service provision, and successful models of primary care after hours service provision.

Independent Review of Australia's Regulatory Settings Relating to Overseas Health Practitioners (Kruk Review)

- Considers ways to help ease health workforce shortages while maintaining high standards in health care quality and patient safety.

To synthesise findings and support planning to take action based on the learning in the reviews, the Department has embarked on an evidence translation project. This project involves utilising findings from various reviews related to Strengthening Medicare to create a cohesive suite of policy proposals. These proposals will serve as a guide for the Department's future policies in primary care. To this end, the Department have engaged Monash University to undertake:

- An Evidence Review
- A Policy Framework development process

[1] Please note that some key documents, for instance Australia's Primary Health Care 10 Year plan 2022-2032 utilise the Quadruple Aim, a predecessor to the Quintuple Aim. The primary difference is that equity is raised to prominence as its own aim rather than people a part of population health.

Evidence Review

The purpose of this report is to convey the findings from an evidence review that synthesised and analysed a range of documents supplied by the Department from the five above-mentioned reviews. Insights from this process sought to consolidate findings to identify cross-cutting opportunities, challenges, and gaps based on a thematic analysis. The focus of this work is primarily to identify themes where there is substantial overlap, or discordance, between multiple documents/reviews. Each of the five reviews that provide the basis for this report are very substantive works unto themselves and were developed by subject matter experts; therefore each of those works provide much more robust insights into their subject of focus. The following report articulates key topics about which multiple documents commented.

The findings are structured to comment on the following cross-cutting issues related to strengthening Medicare:

- Challenges or barriers
- Policy options or opportunities
- Facilitators
- Risks, uncertainties, and gaps

Policy Synthesis

Although it is not the focus of this report, the reader should be aware that a parallel process to develop a policy framework has been taking place. This process involves Monash University working with experts from across the Department to facilitate the development of a cohesive policy framework that can guide and support further reforms to Australia's primary care system.

The policy framework will:

- use existing policy documents to outline a cohesive vision for Australia's primary care system;
- synthesise the findings and recommendations from the reviews;
- use national and (where relevant) international evidence, develop a conceptual model or 'theory of change' that articulates how the findings and recommendations are likely to contribute to achieving the vision set out in the Strengthening Medicare Taskforce Report, including risks and uncertainties;
- leverage a structured prioritisation mechanism with Agency staff to determine the approach for implementing the recommendations (e.g., order, timing);
- consider the Quintuple Aims and how the response will most effectively contribute towards desired outcomes; and
- contextualise advice within Australia's primary care system, previously announced Strengthening Medicare reforms, and any potential policy parameters and approaches.

Upon completion of policy synthesis and consultation with Agency staff, Monash University will provide the Department a concise report outlining a policy framework synthesising review findings and articulating an approach for implementing the recommendations from the reviews. Two of four workshops related to this process had been completed at the time of writing, and the final two had yet to be scheduled.

Evidence Review Questions

The rest of this report pertains only to the Evidence Review which sought to respond to the following questions using the document set outlined in Table 1:

1. What are the policy opportunities / options / recommendation and challenges cited across the review documentation?

   a. Do the opportunities and challenges across the reviews overlap or conflict? If they agree, what specific policy options and outcomes have been suggested to best realise the opportunity? If opportunities or challenges are in conflict, what is the nature of the conflict and do the reviews suggest ways to address them?
2. Do the reviews identify any current evidence gaps that require further investigation?
   a. Do the analysts note any gaps based on their engagement across multiple reviews?

METHODS

The density, diversity, and complexity of the information across the documents included in this review is significant. To rapidly draw out high-level insights that will effectively respond to the review questions and inform the development of a policy framework to support the Department in strengthening Medicare, a bespoke methodology and workflow was designed.

Three key tools were used to identify relevant data and rapidly analyse it:

1. **An analyst reflections worksheet** was designed to capture and organise key information from each document and provide provisional analysis of the contribution of each document (see Appendix 1 for detailed content).
2. **A set coding framework for NVivo** was designed to be specific enough to accommodate all the types of information of interest to the Department in this project (see Appendix 2 for detailed content).
3. **Analysis matrices** were built to compile and analyse findings across the analyst worksheets (See Appendix 3 for a simplified version of an analysis matrix, including an 'X' where text segments were placed during the analysis).

The following provides additional detail on the purpose and development of each tool and how it supported the analysis process.

1. Analyst Reflections Worksheet

The analyst reflections worksheet sits at the core of the workflow designed specifically for this unique review. This document had several purposes:

- To re-orient analysts to the core guiding questions for the evidence review, because when reading long, well-designed reports focused on a subtopic with the broader area of inquiry, it can sometimes be difficult to remain focused on the project-level review questions rather than the questions guiding a specific document.
- To summarise the key findings of each of the included documents in a form that may provide guidance for the research team about areas of particular focus when the full review is taking place and being analysed.
- To provide the opportunity for analysts to process the information that they have just read and ensure that any analytical insights were captured in a timely fashion.
- To provide easy access to important framing information if analyst needed to remind themselves about the contents of the strengthening Medicare task force report or related information.

The instructions at the beginning of the worksheet in Appendix 1 provided additional detail about how an analyst is meant to engage with the worksheet, however it is worth mentioning here that the document encouraged them to carry with them the following guiding questions as they read and coded the documents.

Guiding questions for analysts on each document

1. What are the key findings of the document?
2. What are the recommendations of the document?

   a. Are there any risks, uncertainties, facilitators, or barriers, noted in relation to recommendations?
3. What are policy opportunities and challenges identified in the documentation?
   a. Are these aligned to any of the quintuple aims, if so which ones?
   b. Are there time horizons for these opportunities (e.g. now, next, beyond)?
   c. Who are the key cohorts/groups relevant to this (e.g. unit of the Department or others)?
   d. What are the outcomes/goal highlighted by the policy opportunities?
4. What, if any, are the policy, evidence, practice, or implementation gaps identified by the document?
5. Does the document mention any previously announced Medicare reforms?

Analysts completed the form as they navigated a document and spent substantial time directly after completing their reading and coding of the document ensuring that any valuable insights were not lost. The drafting of initial analytical insights as close to the time of data extraction is a common practice in several academic disciplines.

2. A set coding framework for NVivo

After an analyst reviewed the guiding questions and reminded themselves of the contents of the background reading in the worksheet, they then embarked on the process of coding each document using NVivo qualitative research software. A set framework (See Appendix 2) was used to code text segments within the text of all report documents so that the verbatim information from each review could be used to inform, verify, and refine the emerging high-level themes from the review.

Given the breath of information within the included documents, the research team found that it was important to build data infrastructure that both allows for high-level insights to be drawn out across documents, but also facilitate close follow-up analysis of key topics if necessary and feasible. Based on this, substantial time was spent at the outset of the project reviewing the Strengthening Medicare Taskforce Report and Primary Health Care 10 year plan 2022-2032, and devising a coding framework that was sufficiently detailed to support an effective thematic analysis, but also general and concise enough to be feasible to use. This posed a unique challenge due to the level of complexity that could be built into such a coding framework alongside the short time frame and relatively few documents that are being analysed. To ensure that the coding framework and wider workflow were fit for purpose, three experienced coders used the coding framework during the pilot phase of the evidence review to validate the coding framework in regard to its ability to support a robust analysis.

Once all documents were coded and their reflections worksheets have been completed, the coding framework was also used as a guide for analysis of the worksheets themselves. The high level of detail provided in the worksheets provided the structure for the majority of the findings in this project.

3. Analysis matrix

To rapidly identify the areas with the challenges, opportunities, and/or recommendations across the documents overlap or conflict, a series of matrices were built using spreadsheet software (See Appendix 3 for an example, however it should be noted that 4 other matrices were built to support the analysis). Key information from the analyst worksheets were organised into sheets about a particular type of insight (e.g. challenges / barriers, options /

opportunities / recommendations, etc). The rows of each sheet were then organised under an adapted list of focus areas primarily reflecting the Scope of Practice review structure[2]:

- Workforce design, development and planning
- Education and training
- Leadership and culture
- Monitoring, Evaluation, and Research
- Legislation and regulation
- Funding and payment policies
- Technology and digital transformation

The source document source was noted in the columns of the matrix (e.g. Scope of Practice Review Issues Paper 1).

Once all documents were coded and their worksheets completed, the matrices were helpful for the final analysis process, affording the research team opportunities to:

- closely explore different challenges and opportunities within focus areas as well as across focus areas;
- determine how frequently important principles and values are present in those challenges and opportunities;
- identify topics about which the analyst may need to return to the full text to draw out additional detail on policy options related to a particular opportunity or suite of reforms; and
- consider if versions of these matrices may be a very efficient way of reporting about the synthesis process within this review in a way that is succinct as well as robust. In the end, only an options / opportunities / recommendation matrix was produced (See Appendix 3), although 4 others were created to support the analysis.

CONSIDERATIONS PRIOR TO REVIEWING THE FINDINGS

This is a review of reviews

If it was not otherwise clear from earlier sections, this report describes the findings of a review of several documents produced as a part of Department-commissioned reviews. This report merely represents a synthesis and analysis of the exemplary work the dozens of experts who produced those respective documents. The findings reflect a synthesis of those experts' findings and do not necessarily reflect the views of the authors of this report.

Findings are presented primarily in a narrative format

The findings are presented primarily in a narrative format due to the diversity of data included in this review. Several insights from across the documents are "in conversation", but due to the diverse purposes of the reviews that underly this report and the various reporting formats, it was often a challenge to consolidate findings in to a concise visual format.

Many findings cut across multiple focus areas

Similar to the above comment, analyses related to a complex and multifaceted Medicare system often yield insights that may not be easily categorised into a single category. The research team has endeavoured to characterise and categorise these findings in a way that reflects their most substantive insight. For instance, if there is a recommendation focused on a funding mechanism to better incentivise multidisciplinary care taking place, a decision

[2] The research team had originally used a simplified list of focus areas, but after the pilot phase of the review, an updated list based on the structure of the Scope of Practice review was suggested. The Department was supportive of this approach.

needed to be made as to whether not that insight is focused on Funding and Payment policies, Workforce Design, or Service Design. Regardless of the categorisation of a particular insight, the research team has sought to make relationships to other categories clear.

Findings are presented in a 'traceable' manner

The research team put a good deal of emphasis on using superscripts to indicate which documents provide support for each idea or claim. The purpose of this undertaking was to support the Department in gaining an understanding of how many documents provide support for a particular claim, thereby guiding further inquiry and possibly decision-making.

INCLUDED DOCUMENTS

The documents that form the basis for this report are listed in Table 1.

The reader should be aware that one document that was analysed was not included in this version of the report. **The *First Nations Yarning Circle Consultation of After Hours Review: Final Report* was analysed but has not been included in the synthesis reported here**. This is due to the Monash University team having received guidance that the lead for this project indicated that it would be inappropriate for the report to be broken up and only parts of the information and/or quotes shared, and therefore taken out of context. **The Monash team therefore encourage the reader to access the report on the Department of Health and Aged Care website and review it in conjunction with report.** The *First Nations Yarning Circle Consultation of After Hours Review: Final Report* has findings that are consistent with several of the findings that are consistent with this report, but also highlights important matters that were not raised in other documents. Please pause your review of this report and download the ***First Nations Yarning Circle Consultation of After Hours Review: Final Report*** before continuing to read.

Table 1: Included documents

Review	Sections / Pages	Analysis status, in this report?
Unleashing the Potential of our Health Workforce - Scope of Practice Review	• Issues Paper 1 • Issues Paper 2 • Evidence review • Draft Final report	Complete, included Complete, included Complete, included Complete, included
Working Better for Medicare Review	• Final report • Appendices	Complete, included Complete, included
General Practice Incentives Review	• Literature and International Evidence Review • Effectiveness Review • Draft Final report	Complete, included Complete, included Complete, included
After Hours Review	• First Nations Yarning Circle Consultation for After Hours Review • Evaluation report • Final report	Complete, Not included Complete, included Complete, included
Independent Review of Australia's Regulatory Settings Relating to Overseas Health Practitioners (Kruk Review)	• Final report	Complete, included

FINDINGS

WORKFORCE DESIGN, DEVELOPMENT, AND PLANNING

Challenges / barriers[3]

A few broad workforce challenges were mentioned in some of the documents. For instance, there has been a decline in the number of annual domestic graduates in a range of fields including nursing, medicine, dentistry and psychology, which has resulted in an insufficient number of service providers to meet demand[1]. There has also been a decline in general practice as a preference for medical students[2]. Additionally, years-long wait times for some public specialist appointments are becoming more frequent[1]. The implications of these dynamics can be seen in a range of outcomes. In particular, the Kruk review attributes a rise in chronic diseases in part due to lack of inflow of internationally qualified health professionals, as well as missed or delayed diagnosis, and cancellation of elective surgeries[1]. Moreover, it indicated that the system is likely overusing higher cost services like locums and emergency care[1] to address the shortfalls.

The included documents indicate several challenges to effective data-driven workforce planning, for instance, there is a lack of current and sectorally integrated workforce data[1]. Another review indicated that the construction of the District of Workforce Shortage list may need revision because many stakeholders felt that it, in some cases, did not encourage professionals into the areas of most need[2].

Moreover, there are several workforce design issues that provide challenges for using a multidisciplinary care model, including, disincentives for nurses, nurse practitioners, and allied health professions working in full scope[3]. Multiple documents cited that poor recognition of professional skills and capabilities posed a challenge within the system[3–5], which can undermine interprofessional trust[4–6], multidisciplinary care[3–6], and workforce planning[5]. There was also room for improvement noted in opportunities for professionals to develop skills that support multidisciplinary care delivery[6]. Finally, the significant role that employers play in influencing professionals authority to practice and overly prescriptive regulatory requirements for accreditation were also mentioned[4] and incentives structures that are more supportive of medically-led model of service delivery were noted as challenges to moving towards a multidisciplinary model[7]. A lack of interprofessional skills and competencies recognition was a key gap particularly for unregulated or self-regulated workforces as well[4].

There are also a range of challenges to practicing in rural and remote areas, including: difficulty with using incentives to address non-monetary factors that may encourage professionals to practice in these regions, like accommodation, partner's career, and schooling; the ways in which some practitioners use exemptions to avoid 10 year moratoriums; and the restricted range of services eligible under the Procedural GP Incentive[8]. Primary care providers sometimes find it challenging to maintain and practice their skills, especially if are in a rural/remote area or self-employed[3,5].

Lastly, from the provider demand side, many internationally qualified health professionals reported a range of barriers related to migration and registration processes [1].

[3] This section primarily focuses on challenges or barriers identified by the documents reviewed. The reviews differ slightly regarding how challenges and barriers are characterised and so best efforts were made to include similar types of data in this category.

Policy options / opportunities / recommendations[4]

The following approaches to strengthening Medicare emerged from the cross-document analysis. Where there were notable outcomes and/or other details about how and why to implement an approach, they are noted in *italics* below the option.

1. Use a suite of tailored incentives to support non-GP professionals to practice in full scope[3,7,9,10].
   In relation to potential outcomes from taking this action, there is some evidence to suggest that such an approach could support increased healthcare access in rural and remote and other potentially under-served areas[11]. Moreover, if practicing in full scope receives supplemental support in addition to the above (i.e. through mentorship), it is possible that it could result in equal or better health outcomes for some cohorts[2].

2. Develop common interprofessional competencies (e.g. via a National Skills and Capability Framework and Matrix)[4–6].
   Some documents underlined that focusing on the development and accreditation of skills and capabilities was advisable[4,5].

3. Establish a data-driven National Primary Healthcare Workforce Development Program[2,5–7,10,12].

4. Supplement and support a range of efforts to encourage primary care professionals to work in non-metro areas, including after hours[2,7,9,11,12].
   The Doctor Stream (an incentive considering the needs of GPs moving to rural areas) and the Rural Advanced skills payment (an incentive encouraging doctors with advanced skills to practice in rural and remote settings) were highlighted specifically as being potentially useful to address the needs of rural and remote communities[10], though the effectiveness of these incentives was unclear. Moreover, a few detailed approaches to planning for revised distribution of internationally qualified health professional placements is described in the Working Better for Medicare Report Appendices.

5. The Scope of Practice Review recommends: "Establish an independent mechanism to provide evidence-based advice and recommendations in relation to workforce design, emerging health workforce roles and models, and major changes to scope." [5,6]

Facilitators

Across the documents a few facilitators of better workforce design were cited.

To better realise multidisciplinary care models, two documents suggested consistent and robust promotion of common interprofessional competencies and encouraging non-medical professionals into advanced practice roles[4,6]. This facilitator could be further bolstered by employers seeking to create enabling environments for multidisciplinary care delivery within and across practices[4], which relates to system design. Moreover, legislative and funding actions like making multidisciplinary care mandatory[4] or at least providing strong incentives through the Practice Stream[7], might further support this shift.

[4] Like the challenges and barriers, this section brings together data from multiple reviews that may have been presented in slightly different ways. Some reviews put forward clearly stated recommendations about specific policies or broader reforms. Whereas other reviews presented the evidence that they gathered in a manner provides suggestion or implied ways to take action based on their findings. The authors of this report have sought to characterise document-supported policy options even if they are not characterised as a “recommendation” by the review authors.

Specific to international medical graduates, developing strong cross-departmental collaborations, or instance between DoHAC and DoHA, to ensure that international medical graduates with the right skills are prioritised for regionally-focused visas and are ultimately placed in those settings[1,2] could further support workforce planning. Moreover, there is evidence from Canada that using Workplace Based Assessments (rather than desk based tests) for recruitment and training of international medical graduates may be most appropriate for assessing their capabilities, clinical reasoning, professional judgement and other skills[1].

Gaps, risks, and uncertainties

Gaps

Lack of sufficient data to evaluate the effectiveness of relevant incentives (e.g. the Rural Advanced Skills Payment)[2,10] was noted. Moreover, it is unclear what may work to incentivise an increased supply of internationally qualified professionals[1].

Three documents also noted a lack of evidence based workforce planning approaches, provided by independent advisors and capable of answering key questions about workforce dynamics (e.g. why medical students are not going into general practice)[1,2,6].

Risks and uncertainties

The only risks and uncertainties of note relate primarily to the policy options that might support increased scope of practice and a multidisciplinary care model. Namely, it is unclear how to improve lack of recognition of competencies in everyday practices[4]. Additionally, a poorly implemented shift away from a general practitioner-centred care model could lead to poor team cohesion, scope overlaps, and perceived role threat in some workplaces[4].

EDUCATION AND TRAINING

Challenges / barriers

The Scope of Practice Review Final Report found that preparation of, and support for, health professionals to practise in primary care is limited[6], especially when compared to the public hospital and health care sector. Also there is room for improvement when it comes to learning about primary care in pre-professional programs, as well as programs to support people in developing skills to become primary care professionals[6]. Poor support for early career professionals and inconsistencies in post-entry education and training prevent the development of primary care entry after professionals have already started working[5,6]. Skills maintenance, especially for rural and remote and self-employed professionals, was also cited as a challenge[6].

One document found that many professionals may struggled to access many education and training options, and that even if they are able to access them, it can be unclear if a training will be recognised[4]. It further noted that regulatory requirements for accreditation have become overly prescriptive and in some cases too numerous[4]. Unclear and inconsistent post-professional entry requirements, especially for early career professionals, were also highlighted as challenges[4,5].

Finally, specific to the Teaching Payment, it was found that the administrative burden is too high, the payment was too low, and there was only a limited incentive for quality teaching, thus further undermining the potential pool of teaching professionals[7]. Similar findings were present for other incentives.

Policy options / opportunities / recommendations

Following the analysis, the cross-cutting policy opportunities were consolidated into the following two options.

6. Strengthen Continuing Professional Development programs, and the incentives that support them, with particular focus on multidisciplinary practice and First Nations Healthcare [5–7,12].
   Ensuring that professional development programs incorporate cross-professional learning focused on primary care, collaborative care, and First Nations care is key for supporting a move towards multidisciplinary care delivery[6]. There is evidence that indicates that inter-professional training programs prepare professionals for working with medically underserved populations[11]. Moreover, the development of a post-graduate training course focused on nurses, midwives and nurse practitioners in remote and rural areas could support this. Finally, supporting the Indigenous Health Incentive, in part, by broadening and enhancing cultural safety training would could also be advised[6].

7. Address barriers to cross-professional supervision of students, through changes to accreditation standards, Medicare Benefits Schedule rules, and the Teaching payment[6,10].

Facilitators

Several documents noted that learning options should increasingly be multi-professional oriented[4,6,7,12]. Greater clarity at a system level about expectations and requirements for post-professional entry into general practice may also be of value[4]. A range of other teaching supports were mentioned including providing more protected paid time for professionals to devote to learning, provision of technical supports for learning, opportunities for supervision and mentoring, and incentives and scholarships to support learning that support practicing in full scope[4].

Additionally, better funding for teaching, training, and research in primary care could help to build a better workforce[12].

Gaps, risks, and uncertainties

None noted under this category. Several items overlap with the challenges / barriers above.

Leadership and Culture

Challenges / barriers

This section of the analysis matrices was the least populated. It was noted that cultural change on multiple system levels would be vital for successful reforms to Medicare[6]. This was characterised as both a facilitator and a barrier, and specific approaches to these cultural shifts were often not enumerated in detail.

Policy options / opportunities / recommendations

8. Culture and leadership approaches that support systems change[2,4,6].

Facilitators

The only facilitators of note for the above policy option are incorporating collaborative leadership and localised approaches into workplace culture[2].

Gaps, risks, and uncertainties

None were cited in the analyst worksheets and given the dearth of commentary on this topic, this was not the subject of follow up analysis.

SYSTEM AND/OR SERVICE DESIGN

Challenges / barriers

The complexity of the primary healthcare system was highlighted by multiple documents, both related to general practice incentive programs[7,10] as well as specific to the after hours system[3,9]. Systems are perceived to be challenging to navigate for some primary care providers, as well as consumers. Regarding consumers, the complexity of the health system may disproportionately affect several key cohorts for whom access, affordability, or understanding of the system may already be an issue[9].

The General Practice Incentives review highlighted the current incentive structures were not keeping pace with changes in the sector and could do a better job of helping to address issues pertaining to workforce shortages, increasing costs, and the shift from general practitioners moving from small to large business models[10]. The same review also noted that there were too many programs that overlapped, making it difficult to know which incentive was best for a given context[7,10].

There was also room for improvement noted in relation to the structures and mechanisms to support effective clinical governance and risk management in primary care settings – these settings were seen to be less mature than their tertiary care counterparts[6].

The General Practice Incentives review also found that many practices rely on incentive payments for financial stability, which may undermine the goal of incentivising specific behaviours via specific incentives programs[10].

Continuity of care and lack of information sharing were noted as key challenges for the after hours system[3,9]. One document found that because some incentives are not linked to consumer health outcomes data, these data cannot be used to support quality improvement efforts[10].

The availability and accessibility of allied health service after hours, was seen as an area for improvement by the after hours review, because these factors were found to shape if and how consumers seek care[3]. More generally, wide-scale consumer education of after hours care services may be needed to divert consumers to the appropriate care services[3].

Policy options / opportunities / recommendations

9. Integrate planning and incentives for supporting increased scope of practice, after-hours primary care, and multidisciplinary care[3,7,9,10].
   The Practice Stream of WIP could provide alternative incentive structures to prioritise multidisciplinary care[10]. Additionally, the GP Age Care Access Initiative incentive under PIP could also be adjusted to better reflect practicalities related to provision of Aged Care services and better monitoring of the impact of incentives in reducing the burden from this community on hospitals[10].

10. Develop protocols for consumer awareness about after hours services and increase the tiers of the After Hours Incentive to increase accessibility of services[3,9,10].
    Consumers would benefit from more comprehensive information about after hours services that include information about payment structure; navigator programs, information campaigns, wait time estimates, and search engine optimisation for information resources[3]. An outcome of the After hours review was also the

suggestion of a roadmap for delivering after-hours services for rural and remote settings that is codesigned with communities[9].

11. Develop a national Urgent Care Framework that would: i) integrate data across services to ensure continuity of care; ii) manage consumers who do not have a usual primary care provider, in the event of an urgent (or after-care) need; and iii) promote equity of access to urgent care and after-hours care to priority populations[9].

12. Articulate standards of quality and safety for after-hours care, both for consumers and the primary care providers, and support this further using a quality improvement incentive (either targeted at after hours care or more generally)[3,6,9,10].

13. Develop a new Distribution Priority Area system including existing inputs from the National Assessment Tool but also include other inputs like wait times for general practitioners, average distance and time to travel to offices, etc[2].

14. Improve overseas medical practitioners end-to-end experience[1,11].

15. Direct referral pathways supported by technology that enable health professionals to make referrals within their scope and to improve access to specialists[5,6].

Facilitators

As suggested above, incentives can play a particular role in implementing multidisciplinary care[7,8], especially for some key target cohorts (e.g. via the General Practice in Aged Care incentive)[7]. Overall, practices need to implement person-centred principles that are focused on quality, trust and transparency[1]. Additionally, the development of clinical governance mechanisms in primary health care settings[4] was also suggested as a key facilitator for improved primary care services.

Streamlining processes to register international medical graduates that balances the need for efficiency with a priority towards community safety[1] could also support improved access to services.

Gaps, risks, and uncertainties

Gaps

There are clear practice gaps in after hours care for rural and remote communities, for various vulnerable communities, and for those in need of mental healthcare services[9].

The research team also had a few reflections on this topic. Namely, some reviews do not address ways to move away from low-value care, especially in an evidence-based manner. Part of such a shift could be accomplished via incentives. Relatedly, one analyst reflected that transitioning to a more sustainable (health, environment, financial, social) health system is unlikely unless general practitioners can be supported to provide wrap around care that prioritises lifestyle interventions and wellbeing first (which require more time, patient-anchored funding instead of activity-based funding, and incentives to build capability in behaviour change and lifestyle determinants of health). Additionally, the integration of incentives across primary, secondary, and tertiary care may make a more sustainable system in the long term.

Risks and uncertainties

Two key uncertainties were cited. First, it is unclear what the opportunity cost would be for taking no action to reform the Medicare system as Australia's needs are changing[4]. Second, it is unclear how workplace practices, policies, and procedures may affect a process to move towards a multidisciplinary care model[4].

MONITORING, EVALUATION, AND RESEARCH

Challenges / barriers

More broadly, several service delivery approaches were identified as potentially benefitting from becoming increasingly data driven, for instance, relating to how workforce planning occurs, as well as direct service tailoring efforts like ensuring that after hours services being driven by data about high-demand times of day or the needs of key cohorts[1,3].

The General Practice Incentives review observed that for several incentives programs that the lack of clear linkage between an incentive and consumer health outcomes makes it difficult to understand if they are effective[7]. Some specific insights included that the Quality Improvement incentive could have better feedback mechanisms for PHNs, the GP Aged Care Access incentive may benefit from strengthening the systems ability to monitor reduced hospital admissions, and Rural Advanced Skills Incentive lacks comprehensive impact data[7].

Although additional information about data and technology are listed in a later section of this report, it may be valuable to note here that there are several barriers to better digital integration via My Health Record, for instance, those related to ease of use, security concerns, or workplace cultures[11].

Policy options / opportunities / recommendations

16. Strengthening of strategic collection, governance and use of primary health data, and ongoing research would help to better understand the effectiveness and efficiency of incentives, to establish baselines, and to support co-design, quality improvement, distribution of incentives[2,3,7–9,11].
    Targeted research about specific populations and places could better inform service design, and would help services be more patient-centred and responsive to the needs of specific places and groups of people[3]. Placing particular focus on early evening hours (e.g. peak period between 6 and 8 pm) should be an important design consideration[3].The After Hours review suggested to better use of existing administrative data, and/or the linkage of data across emergency departments, Health direct Australia, and After hours primary care providers[3]; this can both support continuity of care, as well as quality improvements efforts. The scope of practice final report also found that improved workforce data and planning was required to improve the system[11].

Facilitators

None noted.

Gaps, risks, and uncertainties

There are evidence gaps related to data sharing across jurisdictions[1,9]. Moreover, there is no national data set on allied health[1]. Finally, one review noted that there is a research gap in relation to how equity is impacted by practitioners working in full scope[11] and specifically if and how practicing in full scope would help to improve access to culturally safe services[11].

LEGISLATION AND REGULATION

Challenges / barriers

Overall, the findings from the scope of practice review indicates that highly restrictive regulation limits scope of practice in primary care[4,5]. The law was found to not be keeping pace with changes in practice and emerging evidence[5,11] and frequently impeding otherwise

competent professionals from working to their full scope of practice[4]. The National Registration and Accreditation Scheme is well regarded but could still strengthened, developed, and modernised to ensure that more health professionals can practice in full scope. For instance, considering authorising by activity rather than profession name, as well as a process of endorsing advanced skills, could support achieving these goals[4–6].

A number of legislative and regulatory settings outside of National Registration and Accreditation Scheme limit health professionals practicing in full scope. Additionally, the lack of regulation for workforces becoming increasingly important to health was also noted[4].

Lastly, consistency of legislation and regulations across jurisdictions, for instance related to Drugs and Poisons, can create a range of barriers to effective reforms and practice[4,5].

Provisional themes related to policy options / opportunities / recommendations

After a provisional analysis of the included documents to date, the following provisional policy options / opportunities were identified:

17. Develop a National Skills and Capabilities Framework (also included above) and expand the authority of Health Ministers to provide policy direction to APHRA and national boards about accreditation. The Scope of Practice review suggests using a "risk-based approach to regulating scope of practice to complement protection of title approach to enable health professionals to more consistently work to full scope of practice"[4–6].
    Adjusting legislation and regulation, as well as education and training and employer practices to enable health professionals practicing in full scope is advised[4–6]. This would also involve strengthening and standardising the regulatory model for professionals currently operating outside of National Registration and Accreditation Scheme[6].

18. Review and harmonise legislation and regulation to ensure better agreement across jurisdictions or to prevent unnecessarily restricting professionals from practicing in full scope [4–6].

Facilitators

Acknowledging the overlaps between scopes of practice and ensuring that approaches to named professions and protected titles are aligned on Commonwealth, and state and territory levels within legislation[4] would support practitioners practicing in full scope; harmonisation across jurisdictions about referral authority would support this goal as well[4]. Creating an appropriate authorising environment for self- and un-regulated workforces[4] would provide regulatory support for full scope of practice.

Gaps, risks, and uncertainties

Although several of the reviews included substantial engagement with stakeholder groups in their methodologies, the analysts reflected that some reviews could have placed more emphasis on the need for consumer inclusion in policy development as a key component of reform efforts.

Additionally, some uncertainties at play on this topic are: how to prioritise proposed reforms, determining, whether or not a risk based approach to scope of practice will sufficiently prevent harm; and identifying ways to ensure that regulatory changes adequately consider their impacts across multiple domains[4].

FUNDING AND PAYMENT POLICIES

Challenges / barriers

Generally, the fee for service model of care in Medicare rewards fast, episodic care and creates barriers for chronic diseases management [6,11].

Several documents indicated that funding and payment policies were not being used to optimally incentivise and support multidisciplinary models of care[3–5,10]. The narrowness and inflexibility of funding and payments policies was cited by some documents[3–5]. In particular, the lack of flexibility in General Practice Management Plan arrangements[4] and the need for After Hours incentives to better encourage equitable service provision[3] were noted. One document also indicated that the amount of funding available for the Medicare system in general may not be sufficient[4].

The General Practice Incentives Review cited that complexity of incentives programs being a barrier to optimal use, as well as incentives programs' lack of alignment with the current health policy landscape[10]. Payments are not keeping pace with the current complexity of the healthcare system, calculations for payments are not uniform, and are specific to various performance, consumer, or qualification metrics[10]. Additionally, smaller practices, particularly those in rural areas, lack the administrative capacity to fully participate in general practice incentives[3,10]. Administrative burdens for some incentives are seen to be too high, for instance the Indigenous Health Incentive and the ehealth incentives[7,10]. Generally, Incentives could be unified and simplified[7,10]. Some incentives also need to be better linked to consumer health outcomes as well[10].

Additional alignment between the General Practice Incentives and Scope of Practice Reviews was identified in relation to the amounts different professions can claim for Medicare Benefits Schedule items is listed in both documents as a barrier (in the full report, a closer exploration of the Practice Stream and Scope of Practice Review "Option 7 - Funding and payment models that incentivise multidisciplinary care teams working to full scope of practice" will take place)[5,10]. In reference to after hours care, the costs that some GPs pass on to consumers was also seen as a barrier to improving care[3]. Medicare Benefits Schedule payment rules and inadequate digital infrastructure also restrict of health professionals' ability to make direct referrals within their scope [5]

Finally, some incentives may not be effectively encouraging health professionals to practice in rural and remote settings[7]. There is insufficient data to understand the impact of the Rural Advanced Skills Incentive[7].

Policy options / opportunities / recommendations

19. Introduce blended payment models (and in some cases bundled or block models) that are designed to encourage multidisciplinary delivery of care involving professionals working in full scope[3–9].

20. Strengthen after hours service provision by expanding the eligible services, adequately costing Medicare Benefits Schedule items, and increasing the tiers of payment in the After Hours incentive[3,7–10].

Facilitators

Generally, using more flexible approaches to funding across settings and professions[4,7] would support some of the options above. Moreover, developing incentives that support multidisciplinary care teams could supplement both the options above because this funding will be more tailored to consumers with complex care needs[4,7]. Finally, two documents

suggested developing funding that focuses on activities rather than the profession that performs it[4,7].

In addition to a range of funding enhancements, ensuring that international medical graduates and nurses and nurse practitioners in rural and remote settings are eligible for some forms of funding could further support success[12].

Gaps, risks, and uncertainties

Gaps

There is a need to for more evidence related to blended funding models and how they share quality outcomes in multidisciplinary settings. The Scope of practice evidence review notes the following key findings (see report for a full summary against each of the review questions):

- There exist evidence gaps related to blended funding models on quality outcomes in multidisciplinary settings related to: CAPs improving quality of care, as well as for or against the impacts of P4P or CAPs on health equity[11].
- There exist evidence gaps on the effectiveness of different payment methods on preventive care for people with complex chronic disease related to: the impact of P4P or financial incentives in general practices on chronic disease outcomes[11].
- There is limited and mixed evidence that P4P measures were effective, but there is a need for more evidence about the level of payments required to affect provider behaviour (dose-response relationships) and the mechanisms by which they should be administered[11].

Risks and uncertainties

A key uncertainty relates to a lack of knowledge about which funding reforms would be most acceptable to various stakeholder groups[4]. Additionally, similar to the legislative risks, it is important to consider how funding reforms would affect other domains, e.g. legislation, education and training, and workforce planning – and/or conversely how actions in those other domains may increase the impact of a funding reform[4].

TECHNOLOGY AND DIGITAL TRANSFORMATION

Challenges / barriers

A lack of interoperability between various health records systems undermine continuity of care and information sharing between after hours and other services[3,7], as well as among services more generally[3–5,10].

A range of additional issues were cited by the Scope of Practice Review, which include: underuse of My Health Record, limited visibility of patient environment in My Health Record, lack of secure messaging solutions, and lack of real time integrated patient information[4].

Finally, as noted above, there is a need for multiple new data sets to be established. There is a lack of current, sectorally integrated workforce data to support workforce planning[1]. Moreover, there is no single nationally consistent allied health dataset[1]. There is also a need to gain data that provide an indication of the effectiveness of various schemes to encourage appropriate distribution of professionals across jurisdictions[1].

Policy options / opportunities / recommendations

21. Improve telehealth functionality through incentives and payments, local knowledge summaries, and appropriate triage pathways[3,4,7,9,10].

22. Use incentives to improve data transparency and system integration, which in turn would likely support continuity of care[3,7].

23. Expand secure, usable means for data sharing and linkage that have features like real time patient information, as well as secure messaging and referrals[2,6–9].

Facilitators

Improvements to telehealth should be accompanied by support for technological literacy and connectivity for both consumers and providers[9]. Telehealth should also be understood as a complement and supplement to in-person care and not a replacement for it[9] – especially in rural and regional and after hours contexts[3].

Employers can play a key facilitation role by enabling, supporting, and encouraging digital integration[4,6,7]. Workplace-wide action has been found to have the potential to address barriers to interprofessional communication[6].

Risks

Key risks related to technological reforms were: data breaches of sensitive personal information, ensuring that improvements and new functions are kept up to date, the process of identifying new and emerging risks, and inequitable access to digital systems across care teams (e.g. nurses may have different access than general practitioners)[4].

Lack of consumer consultation about design features that influence trust, uptake and appropriate use is also a concern[4].

CONCLUDING REMARKS

A discussion of the findings has not been provided in this report because the research team understand that the findings described here and those from the workshop series will be combined to provide the basis for a final report that syntheses these sources of data to produce an evidence-supported policy framework to strengthen Medicare. A more detailed discussion of these findings as they relate to the other data gathered for this project, and in reference to the final policy framework output, will be provided at that time.

INCLUDED REFERENCES

1. Robyn Kruk AO. Independent review of Australia's regulatory settings relating to overseas health practitioners: Final Report. Canberra: Australian Department of Finance; 2023.

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3. Allen + Clarke Consulting. Evaluation to support the review of primary care after hours programs and policy: draft findings report. Canberra: Australian Department of Health and Aged Care; 2024.

4. Australian Department of Health and Aged Care. Unleashing the potential of our health workforce - scope of practice review: Issues paper 1. Canberra: Australian Department of Health and Aged Care; 2024.

5. Australian Department of Health and Aged Care. Unleashing the potential of our health workforce - scope of practice review: Issues paper 2. Canberra: Australian Department of Health and Aged Care; 2024.

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7. Australian Department of Health and Aged Care. General Practice Incentives Review [Draft Final Report]. Canberra: Australian Department of Health and Aged Care; 2024.

8. Kidd M, Rhee J, Sharma A, Harris-Roxas B, Harris M, van Kemenade C, et al. Review of General Practice Incentives - International Evidence and Literature Review Report. Sydney: University of New South Wales. Faculty of Medicine and Health; 2024.

9. Australian Department of Health and Aged Care. A better after-hours system: 2023-24 review of after-hours primary care programs and policy. Canberra: Australian Department of Health and Aged Care; 2024.

10. KPMG. Effectiveness review of general practice incentives. Sydney; 2024 p. 152.

11. Australian Department of Health and Aged Care. Unleashing the potential of our health workforce - scope of practice review: Literature review. Canberra: Australian Department of Health and Aged Care; 2024.

12. Knight S, Reid M. Working better for Medicare review: report of the independent lead reviewers. Canberra: Australian Department of Health and Aged Care; 2024.

APPENDIX 1 - ANALYST REFLECTIONS WORKSHEET

Analyst reflections sheet - INSTRUCTIONS - TEMPLATE
For each document you review, please copy this template and fill in accordingly
Purpose: *This sheet is designed to capture an analyst's high level insights provided by a document relevant to the research questions below.*

Instructions/Suggestions/Comments:

- The first time you review a document, please take as much time as required to familiarise yourself with the preliminary reading/awareness items and the guiding questions below, as well as the coding framework in the NVivo file.
- The 'analyst reflections sheet' is meant to be a companion and guide to the process of coding your document and preparing it for analysis.
- It may be helpful to familiarise yourself with the overall insights of the document by
  - first reading/coding the executive summary and recommendations, and then
  - moving to the body of the document to gain a more detailed perspective
- Please complete the 'reflections sheet' as soon as you can after coding your allocated document (or indeed, populate it while you work if that works for you).
  - Ideally, we want to capture your analytical insights when they are still 'fresh' in your mind, i.e. before you turn your attention to something else, go home for the day, etc.
  - Insights can be concisely stated as long as there is sufficient detail and context to understand your text
  - Reference specific page numbers with verbatim quote or for items your deem likely to require a return to the original text

Preliminary reading/awareness:

- Strengthening Medicare taskforce Report
- Primary Health Care 10 Year Plan
- The Quintuple Aim
  - Improve people's experience of care
  - Improve the health of the population
  - Improve health equity
  - Improve the cost-efficiency of the health system
  - Improve the work life of health care providers
- Purpose of Strengthening Medicare Taskforce:
  - improving patient access to general practice, including after hours
  - improving patient access to GP-led multidisciplinary team care, including nursing and allied health
  - making primary care more affordable for patients
  - improving prevention and management of ongoing and chronic conditions
  - reducing pressure on hospitals.

Guiding Questions (all to be read in the context of Strengthening Medicare):

6. What are the key findings of the document?
7. What are the recommendations of the document?
   a. Are there any risks, uncertainties, facilitators, or barriers, noted in relation to recommendations?
8. What are policy opportunities and challenges identified in the documentation?
   a. Are these aligned to any of the quintuple aims, if so which ones?
   b. Are there time horizons for these opportunities (e.g. now, next, beyond)?
   c. Who are the key groups relevant to this (e.g. unit of the Department or others)?
   d. What are the outcomes/goal highlighted by the policy opportunities?
9. What, if any, are the policy, evidence, practice, or implementation gaps identified by the document?
10. Does the document mention any previously announced Medicare reforms?

11. If you have read more than one document, what have you found in terms of how this document aligns with or contradicts the other document (s)

Analyst reflections sheet - DATA - TEMPLATE

Analyst name and date reviewed:

Title of document:

Description of and/or Purpose of the document (less than 5 sentences):

What are the key findings of the document?

What are the recommendations of the document? (risks, uncertainties, facilitators, or barriers?)

Summary of most important policy opportunities or challenges. (What are the key policy options/issues? Relevant quintuple aim, time horizon, group? Anything else important?) **Are there any key policy outcomes mentioned?**

What, if any, are the policy, evidence, practice, or implementation gaps identified by the document? ALSO, do you observe that there might be other policy gaps not stated?

Does the document mention any previously announced Medicare reforms that merit noting in relation to the above questions? Why do you consider this important?

If you have read more than one document, are there any key points of alignment or disagreement between this and the other document(s)?

After coding this document, should there be any updates that need to be made to the coding framework?

Any other important notes - either analytical or about the research process?

APPENDIX 2 - CODING SCHEME

Name
Actors for policy change
ACCHOs
Clinicians and allied health
consumers
Government
Other
Private providers and systems
Communicating or enacting change
How
Which channels
Who
Framework examples
Gaps
Evidence
Implementation
Other
Education
Policy
Practice
Key findings
Levers of Change
Funding models
Infrastructure
Legislation
Other
Systems
Levers of change (all that apply)
Education and training
Funding models
Infrastructure
Leadership and Culture
Legislation and regulation
Other
Systems and service design
Technology
Nice to know
Acronyms
Glossary

Name
Relevant legislation
Relevant previous reform
Policy barrier
Policy challenges
Policy facilitator
Policy opportunities or option
Benefits
Policy outcomes
Priority populations
CALD
First Nations Australians
LGBTIQA+
Other
People with a disability
Rural and Remote
Quintuple aims
Care experience
Cost efficiency
Health equity
Population health
Provider work life
Recommendations
Relevant previous reform
Risk or Uncertainty
Tactics for change
Taskforce purposes
access to GPs, including after hours
chronic conditions
modernizing primary care
multidisciplinary care
primary care affordable
reducing pressure on hospitals
Time horizons
Beyond
Next
Now
Values (optional)
Accessible
Affordable

Name
High-quality
Integrated
Low-value
Other
Person-centred
Safe
Sustainable
Values-based

APPENDIX 3 – OPTIONS / OPPORTUNITIES / RECOMMENDATIONS ANALYSIS MATRIX (SIMPLIFIED)

Options / Opportunities / Recommendation	AH-Evaluation Report	AH-Final	SoP-Issues Paper 1	SoP-Issues Paper 2	SoP-Evidence Review	SoP-Draft Final Report	GPI-Effectiveness	GPI-Literature & Evidence	GPI-Draft Final Report	WBfM-Report	WBfM-Appendices	Kruk review
Workforce design, development and planning												
1. Use a suite of tailored incentives to support non-GP professionals to practice in full scope.	X	X			X		X		X		X	
2. Develop common interprofessional competencies (e.g. via a National Skills and Capability Framework and Matrix).			X	X		X						
3. Establish a data-driven National Primary Healthcare Workforce Development Program.				X		X	X		X			X
4. Supplement and support a range of efforts to encourage primary care professionals to work in non-metro areas, including after hours.		X			X				X	X	X	
5. "Establish an independent mechanism to provide evidence-based advice and recommendations in relation to workforce design, emerging health workforce roles and models, and major changes to scope. "				X		X						
Education & Training												
6. Address barriers to cross-professional supervision of students, through changes to accreditation standards, MBS rules, and the Teaching payment.						X	X					
7. Strengthen Continuing Professional Development programs, and the incentives that support them, with particular focus on multidisciplinary practice and First Nations Healthcare.				X		X			X	X		

Options / Opportunities / Recommendation	AH-Evaluation Report	AH-Final	SoP-Issues Paper 1	SoP-Issues Paper 2	SoP-Evidence Review	SoP-Draft Final Report	GPI-Effectiveness	GPI-Literature & Evidence	GPI-Draft Final Report	WBfM-Report	WBfM-Appendices	Kruk review
Leadership and culture												
8. Culture and leadership approaches that support systems change.			X			X					X	
Service Design												
9. Integrate incentives that support after-hours primary care, increased scope of practice, and multidisciplinary care.	X	X					X		X			
10. Develop protocols for consumer awareness about after hours services and increase the tiers of the After Hours Incentive to increase accessibility.	X	X					X					
11. Develop a national Urgent Care Framework to i) integrate data across services to ensure continuity of care; ii) manage consumers who do not have a usual primary care provider, in the event of an urgent (or after-care) need; and iii) promote equity of access to urgent care and after-hours care.												
12. Articulate standards of quality and safety for after-hours care, both for consumers and the primary care providers. Support this further with Quality improvement incentive.	X	X				X	X					
13. Develop a new DPA system including existing inputs from the NAT but also include other inputs like wait times for GPs, average distance and travel time.										X		
14. Improve overseas medical practitioners end-to-end experience.					X							X
15. Direct referral pathways supported by technology to enable health professionals to make within-scope referrals and to improve specialist access.				X		X						

Options / Opportunities / Recommendation	AH-Evaluation Report	AH-Final	SoP-Issues Paper 1	SoP-Issues Paper 2	SoP-Evidence Review	SoP-Draft Final Report	GPI-Effectiveness	GPI-Literature & Evidence	GPI-Draft Final Report	WBfM-Report	WBfM-Appendices	Kruk review
Monitoring, Evaluation, and Research												
16. Strengthening of strategic collection, governance and use of primary health data, and ongoing research would help to better understand the effectiveness and efficiency of incentives, to establish baselines, and to support co-design, quality improvement, distribution of incentives.	X				X			X	X		X	
Legislation and regulation												
17. Develop a National Skills and Capabilities Framework (also included above) and expand the authority of Health Ministers to provide policy direction to APHRA and national boards about accreditation. Use a "risk-based approach to regulating scope of practice to complement protection of title approach to enable health professionals to more consistently work to full scope of practice."			X	X		X						
18. Review and harmonise legislation and regulation to ensure better agreement across jurisdictions or to prevent unnecessarily restricting professionals from practicing in full scope.			X	X		X						

Options / Opportunities / Recommendation	AH-Evaluation Report	AH-Final	SoP-Issues Paper 1	SoP-Issues Paper 2	SoP-Evidence Review	SoP-Draft Final Report	GPI-Effectiveness	GPI-Literature & Evidence	GPI-Draft Final Report	WBfM-Report	WBfM-Appendices	Kruk review
Funding mechanisms and payment policy												
19. Introduce blended payment models (and in some cases bundled or block models) that are designed to encourage multidisciplinary delivery of care involving professionals working in full scope.	X	X	X	X		X		X	X			
20. Strengthen after hours service provision by expanding the eligible services, adequately costing MBS items, and increasing the tiers of payment in the After Hours Incentive.	X	X					X	X	X			
Technology and Digital Transformation												
21. Improve telehealth functionality through incentives and payments, local knowledge summaries, and appropriate triage pathways.	X	X	X				X		X			
22. Use incentives to improve data transparency and system integration, which in turn would likely support continuity of care.	X								X			
23. Expanding secure, usable means for data sharing and linkage that have features like real time patient information, as well as secure messaging and referrals.		X			X			X	X		X	