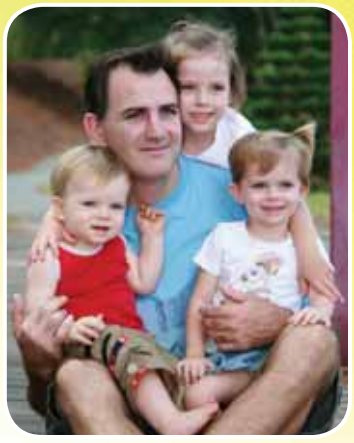
Building a 21st Century Primary Health Care System

A Draft of Australia's First National Primary Health Care Strategy



Australian Government
Department of Health and Ageing

Building a 21st Century Primary Health Care System

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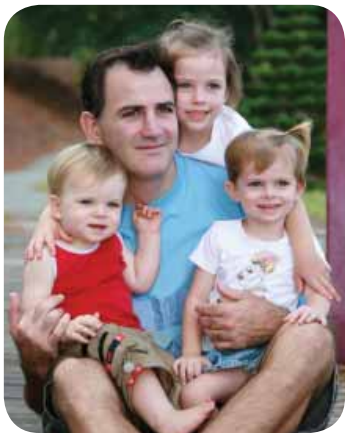

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Building a 21st Century Primary Health Care System

A Draft of Australia's First National Primary Health Care Strategy

Foreword

As Health Minister, I am pleased to be taking this significant step in releasing this draft of Australia's first National Primary Health Care Strategy.

The Draft Strategy recognises that a strong primary health care system is critical to the future success and sustainability of our health care system. Primary health care is vital to making our health system focus more on keeping people well and able to participate in life and work, rather than just looking after them when they are sick. It is an important part of addressing the current inequities in access and outcomes for some groups in our community, including Indigenous Australians and those who live in our rural areas. It is also key to addressing the future challenges of ageing and the growing burden of chronic disease, and to managing pressures on our hospitals.

Over the last year or so, there has been considerable discussion, debate and hard work to consider future directions for our health system. The importance of primary health care has emerged as a recurrent theme in these deliberations, not only in the work to develop this Draft Strategy, but also in recommendations from both the National Health and Hospitals Reform Commission and the National Preventative Health Taskforce. This reflects growing international evidence of the benefits to health systems of strong primary health care.

The Draft Strategy sets out a road map for the future – to provide Australians with a primary health care system which is among the best in the world and which is equipped to meet future challenges. Primary health care is the first point of connection with the health system and needs to be able to manage the full range of challenges that emerge, from prevention to enabling access to health services, through to managing complex chronic conditions in partnership with other health sectors.

The Draft Strategy recognises that, underpinned by Medicare, our existing system has many strengths. It builds on these strengths to harness the benefits of technology, including eHealth, and provides health care professionals with the infrastructure, equipment, skills and organisational arrangements they need to deliver 21st century primary health care to all Australians. It recognises that there is an important role for new regional primary health care organisations in ensuring that services respond to the needs and priorities of local communities and that local communities are actively involved in planning for their region.

Improving access, better managing chronic disease, a more systematic focus on prevention, accompanied by a strong framework for quality and safety are key directions for change set out in the Draft Strategy.

The Draft Strategy is not a detailed implementation plan: many of the changes proposed are complex and further discussion, informed by this Draft Strategy, will be required to determine the precise nature of changes and specific approaches to implementation.

In releasing the Draft Strategy, I would like to acknowledge and thank all those who contributed to its development, including all those who made submissions. I particularly thank Dr Tony Hobbs, who chaired the External Reference Group, together with all members of that Group who gave so generously of their time, experience and knowledge in supporting the development of this Draft Strategy and the accompanying Report.

The Hon Nicola Roxon MP
Minister for Health and Ageing

Contents

Introduction

This Draft National Primary Health Care Strategy (the Draft Strategy) provides a road map to guide future policy and practice in primary health care in Australia. It represents the first comprehensive policy statement for primary health care in Australia's history.

The Draft Strategy presents the Australian Government's views on possible future directions for a modern 21st century primary health care system. It has been prepared by the Australian Government Department of Health and Ageing, assisted by an External Reference Group of primary health care experts chaired by Dr Tony Hobbs and informed by discussion with state and territory health departments. It has been informed by the 265 submissions received in response to the Discussion Paper: *Towards a National Primary Health Care Strategy*.

The Draft Strategy is accompanied by a Report: *Primary Health Care Reform in Australia – Report to Support Australia's First National Primary Health Care Strategy* (the Report). The Report provides detailed information about the issues that emerged during the consultation process that accompanied the development of the Draft Strategy, sets out the broader context in which primary health care in Australia operates and has developed and describes many of the challenges which the Draft Strategy aims to address. The Report is designed to be read in conjunction with the Draft Strategy.

Scope of the Draft Strategy

The Draft Strategy takes a broad view of primary health care, extending beyond the 'general practice' focus of traditional Commonwealth responsibility, to include consideration of services which are the predominant responsibility of the states and territories and those entirely delivered through private providers, including those supported by private health insurance.

Recognising the growing importance and complexity of community-based care, the Draft Strategy also considers the important role of medical specialists, and the need for integration of ambulatory specialist care and primary health care.

The Starting Point for Reform

Many of the elements described in the Report that accompanies this Draft Strategy provide the context in which to consider reform of primary health care in Australia. These include:

A strong foundation

- Australians generally have good health outcomes with the second highest life expectancy in the world and a health system widely recognised as world class.
- Supported by the Medicare Benefits Schedule (MBS), most Australians have good access to affordable services provided through general practice, have a choice of provider, and have been supported in their access to many specialist and diagnostic services.
- Through agreements with states and territories, access to hospital-based services has complemented the primary health care system enabling access free of charge and 24 hours a day in an emergency and to specialist services through outpatients.

The Case for Change

Changing nature of the health system

- Significant changes to the overall health system, including developments in the acute sector and in the provision of hospital care, have placed additional demands on primary health care.
- These changes suggest the health system overall would benefit if a more systematic response from primary health care, together with more effective integration of other health sectors with primary health care, could be achieved. Primary health care services have historically been delivered in a relatively unplanned environment.

Demand pressures

- Ageing, the growing burden of chronic disease and changes to the way in which care is delivered, particularly across acute and primary health care sectors, have placed increasing pressures on the health system.
- Traditional organisational and funding structures are focussed more towards treating episodes of ill-health, rather than prevention and ongoing management of disease. As the burden of disease has moved increasingly to chronic conditions, enormous pressure has been placed on the service system.

Variable access

- There are disparities in access and outcomes across different parts of Australia and between different population subgroups, often associated with disadvantage, perhaps most significantly for Indigenous Australians.
- Some Australians do not have the health literacy skills needed to navigate the health system and are often left unsupported in their patient journey. Primary health care services do not always provide adequate and culturally appropriate support and transitions across settings are not well managed.

Poor integration

- Service delivery is characterised by multiple and fragmented funding streams, and service delivery arrangements can be inflexible and poorly coordinated, both within primary health care but also across hospitals, aged care and specialist care.

Safety and quality

- There is a lack of good information and performance measures to support primary health care professionals, consumers, funders and policy makers.
- Technological change has added costs to parts of the health system and opened opportunities to treat patients in different care settings, often without accompanying care and follow-up.
- Use of technologies including eHealth is falling behind consumer expectations, other service industries and progress in other comparable health systems.

Workforce shortages and inflexibility

- Workforce shortages exist across most primary health care professions, and are exacerbated by mal-distribution.
- Funding arrangements, rather than clinical need, can determine which services individuals access and which health professionals are involved in their care.
- Current education and training arrangements do not support the future needs of primary health care.

In summary, primary health care in Australia tends to operate as a disparate set of services, rather than an integrated service system – it is difficult for primary health care to respond effectively to changing pressures (such as demographic change, changes in the burden of disease, emerging technologies and changing clinical practice) and to coordinate within and across the various elements of the broader health system to meet the needs of an individual patient.

For individuals, the primary health care services they access and the quality of care that results can depend on where they live, their particular condition, and the particular service providers involved, as much as their clinical needs and circumstances. Many patients, particularly those with complex needs, can either be left to navigate a complex system on their own or, even when supported by their general practitioner (GP), be affected by gaps in information flows and limited ability to influence care decisions in other services.

The Future

A strong, responsive and cost-effective primary health care system is central to equipping the Australian health system to meet future challenges.

As part of a modern system, Medicare – with its underpinning principle of universal access to a patient rebate for certain health services – remains a fundamental tenet. Moving forward, the focus is to continue to rely on Medicare rebates for those things they were designed to support and do well – access to specific episodes of care for treatment of illness and ill-health.

For other aspects of care, however, the MBS is not always the most appropriate financing tool. The MBS does not enable scarce health resources to be targeted where they are most needed and cannot readily respond to emerging challenges or enable reform.

A new and more systematic approach is needed to the funding and delivery of those types of health care for which the MBS is not well suited. This approach should complement access to Medicare rebates but address system gaps and failings and drive quality and improved health outcomes.

Key to this is funding and service delivery arrangements which, within a national framework, can better respond to the needs and priorities of local communities, but remain well integrated with a 'Medicare core'.

To build such a modern primary health care system, there are **5 key building blocks:**

1. Regional integration
2. Information and technology, including eHealth
3. Skilled workforce
4. Infrastructure
5. Financing and system performance

These building blocks are essential system-wide underpinnings for a responsive and integrated primary health care system for the 21st century.

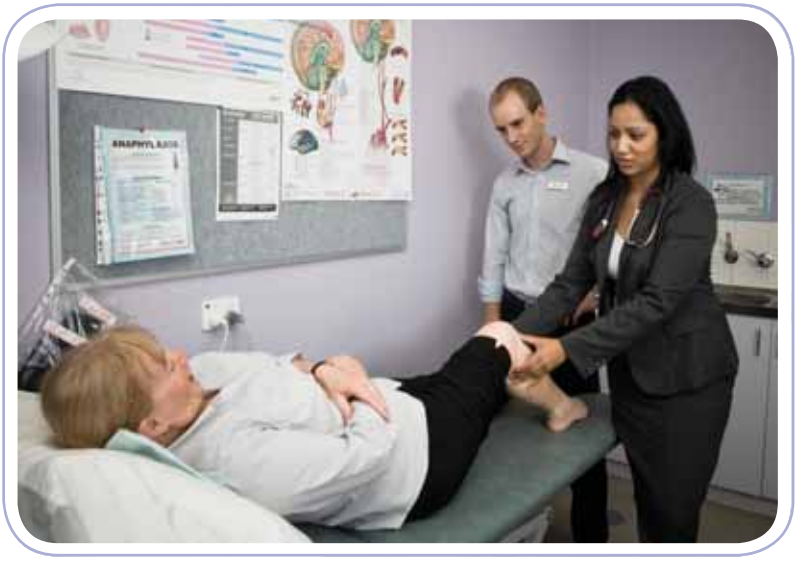
Drawing from these are **4 priority directions for change:**

- Key Priority Area 1: Improving access and reducing inequity
- Key Priority Area 2: Better management of chronic conditions
- Key Priority Area 3: Increasing the focus on prevention
- Key Priority Area 4: Improving quality, safety, performance and accountability

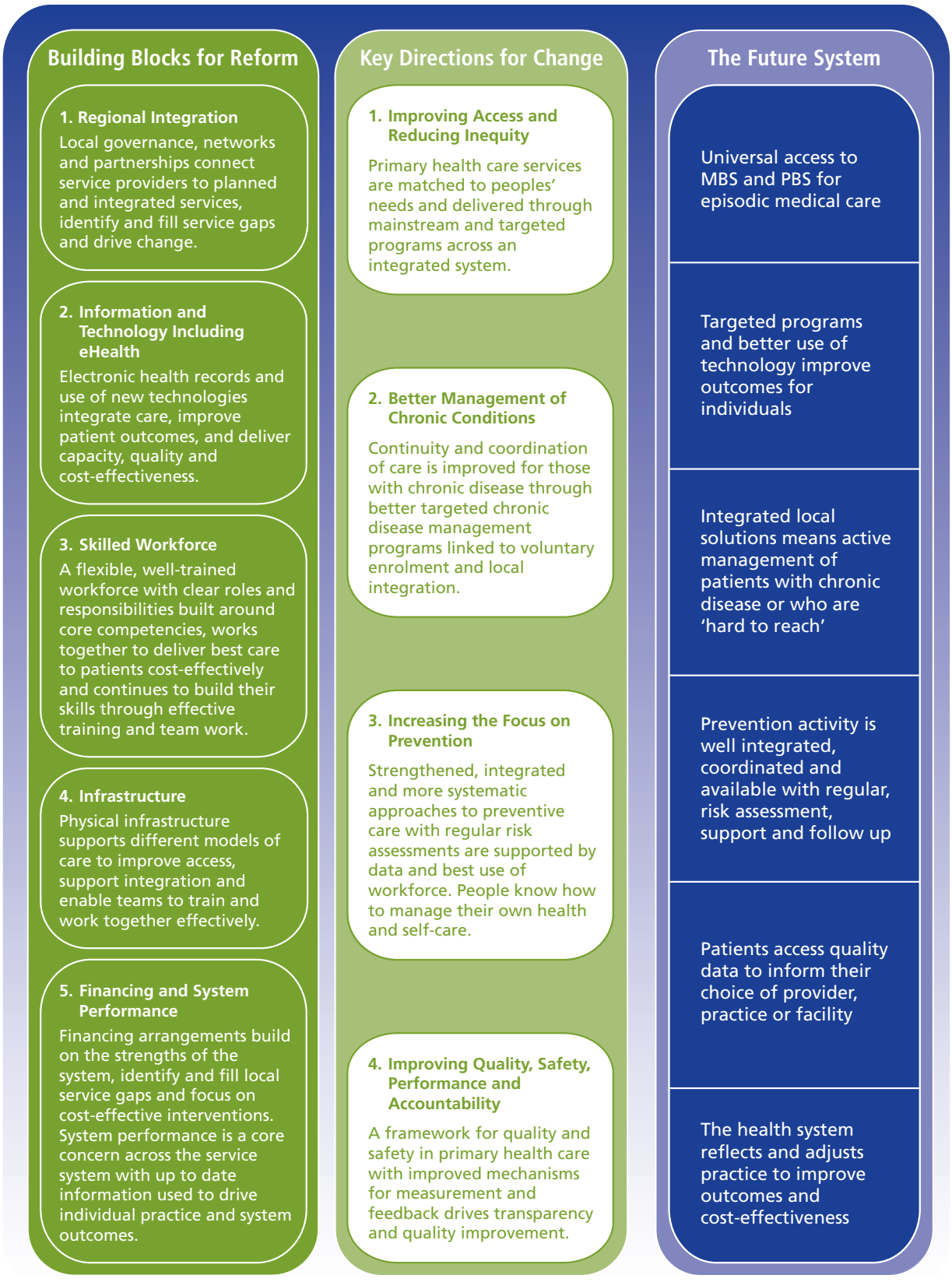
These priority directions have been identified through consultations, as the priority areas where change is most needed to set up the system of the future.

They address the shortcomings of current arrangements which most directly impact on the community and the health professionals who work in it.

Actions in all 4 priority areas are underpinned by the 5 key building blocks. The 5 key building blocks and 4 priority directions are summarised in the table on the following page.



Towards a 21st Century Primary Health Care System - A Snapshot



Building Blocks for a 21st Century Primary Health Care System

1. Regional integration

The current proliferation of primary health care services (across program types, sectors, providers and funders) makes it difficult for either patients or providers to navigate the health system with assurance and for consistent high quality outcomes to be achieved. While this is particularly the case for people with complex care needs and those with historically poor access (such as Indigenous Australians or those living in rural and remote areas) it is equally the case for people who are hard to reach, such as the homeless or those with mental health needs, those needing specialist care or those moving in and out of the hospital system.

A key challenge for primary health care reform is to better integrate and coordinate the range of organisations and service providers operating within primary health care and to better link primary health care and other sectors.

Developing networks, encouraging partnerships and establishing new integrated service delivery arrangements requires multiple changes, particularly at the local level to:

- enable collaboration and integration between local service providers to focus on the needs of individual patients;
- support service planning and monitoring of effectiveness and patient outcomes, to reduce duplication and fill gaps; and
- allow flexibility to deliver supplementary services that respond to priority local needs.

Many of these changes could be implemented through a regional governance structure with:

- strong local leadership and community engagement and support;
- clear performance expectations both in terms of identifying population needs and being accountable for progress in meeting those needs; and
- funding to drive integration, provide education and training, support change management and ensure gaps in local service delivery arrangements are filled.

Notably, regional primary health care organisations could manage supplementary funding, targeting those elements of the service system where proactive engagement has the capacity to address traditional areas of market failure, and drive improved outcomes and system efficiencies. Such areas include chronic disease management, a focus on prevention, supporting patient transitions and integrating service responses across the system (including linking to the acute and specialist care sectors).

Responsible regional primary health care organisations could also have a role in reflecting on system effectiveness and relative cost-effectiveness, informing decisions on allocative efficiency across the broader health system, and adapting service solutions to respond to emerging challenges such as changes to clinical practice and new technologies.

What will be different?

Less overlap and duplication of services, with better use of the existing workforce. Health care providers and their patients no longer having to navigate the system, trying to patch together care pathways.

2. Information and technology, including eHealth

eHealth and other technologies are key enablers for change in primary health care. eHealth will allow information to be available when and where a patient needs care, can drive communication and partnerships between providers and with patients, will reduce the risks of adverse events for consumers and, with it, reduce costs and improve patient outcomes.

Electronic information exchange, particularly individual electronic health records (IEHRs), are a strong support for multi-disciplinary primary health care collaboration and enable efficient exchange of information between the primary health care, community and specialist health care settings.

This would be a significant improvement on the current situation for clinicians and consumers, particularly those with complex or chronic health conditions and those who need to move across the service system – from a general practice to a specialist service provider or allied health professional to a hospital and back.

As Australians increasingly access online information and services through mobile and e-technologies, they expect that the health sector will operate as does other sectors, affording them similar access, efficiencies and ease of information and connection.

Consumers expect to be involved and active in their health care management, and should have access to tools to enable self-care in a structured and informed way, and assist them to navigate the health system maze effectively.

Released in December 2008, the National E-Health Strategy provides an appropriate basis to guide the development of eHealth and proposes the incremental adoption of IEHRs. The National Health Call Centre Network, a Council of Australian Governments (COAG) funded initiative, provides a good infrastructure base for other innovative uses of technology, such as proactive telephone-based self-management support of patients and online health information.

What will be different?

Patients not having to repeat their medical history to each new provider. Patients having information to help them to manage their own condition. Health care providers able to set up virtual, integrated care teams, and having accurate and timely information to support best treatment. Potential to outreach to hard to service communities with more innovative and efficient use of health workforce. Improved quality and safety.

3. Skilled workforce

It is essential that the future workforce is educated and trained to meet 21st century challenges but in a way that provides the flexibility and willingness to continually reflect on its role and place in the health care team to ensure that skilled resources are used in the most effective and efficient way as clinical practice and teams change.

Through COAG's recent investment in health workforce, community-based clinical training will expand, to provide a future workforce skilled in the delivery of increasingly complex care, in the community setting, and adept at working in multi-disciplinary teams. As a result, GP training places will increase by 33% on the cap of 600 places imposed since 2004. In 2009, the Australian Government allocated an increase of 1,134 higher education nursing places, and these are ongoing.

For the current workforce, working in a changing environment will involve greater understanding of the respective roles of other health professionals, development of arrangements for collaboration and teamwork, proficiency with technology and eHealth and enhanced skills in supporting individuals in health literacy and self-management, including changing risky lifestyle behaviours.

What will be different?

Patients having improved access to primary health care providers and better integration of their care. Providers being equipped with the skills they need, supported in learning, and able to pass on hard-earned skills to students and new graduates.

4. Infrastructure

The right physical facilities and equipment are important catalysts for new models of primary health care delivery. Multi-disciplinary services require consulting rooms for the range of team members, for group activities, for team meetings and case planning discussions. Good facilities are important to support outreach services, including services delivered by visiting specialists. The right physical infrastructure is important in extending community-based health professional education, including inter-disciplinary and virtual training opportunities. Encouraging active research within primary health care service delivery requires the right spaces and equipment to create the primary health care 'laboratory'.

New and enhanced facilities could include comprehensive primary health care services - one stop shops offering a wide range of services - or smaller enhancements to private general practices to support a broader team, teaching or visiting sessions from other health professionals.

Through the GP Super Clinics initiative, the National Rural and Remote Health Infrastructure Program and the COAG National Partnership Agreement on Hospital and Health Workforce Reform, much progress has already been made in recognising the importance of infrastructure.

What will be different?

Patients having improved convenience of access to services, including co-location of services for patients seeing multiple providers. Providers having resources to support changed training and workplace arrangements, allowing for more flexible working arrangements. Primary health care system facilitating the distribution of services and promoting service integration.

5. Financing and system performance

The right mix of financial incentives and funding arrangements is a key underpinning to ensure that service delivery models work effectively and responsively. Traditional Medicare rebates have a place in promoting reasonable access to health services for many in the population, and in underwriting general practice as small business – itself an important part of access. However, the MBS has been less effective in producing better outcomes for at-risk and hard to reach groups, in promoting collaboration across and within various parts of the health system and in adapting to changing population pressures and clinical challenges. The uncapped nature of the MBS has meant that attempts to extend coverage to address emerging health needs or under-serviced groups soon hit cost barriers resulting in artificial rules being created to contain costs.

Changes to funding arrangements need to reduce the reliance on fee-for-service, support alternative funding mechanisms that better support effective integrated teams and models of care, encourage innovation, and respond to local service gaps.

Over time, changes need to be informed by evidence, including increasing consideration of cost-effectiveness and the relative efficiency of different approaches across the spectrum of care options including self-management. The system of the future needs to use outcomes data and performance information at population, population subgroup, regional and practice levels to promote reflection about what works well and where improvements could be made. Creating a self-reflective and adaptable service system is a key to long term system sustainability and to achieve sustained improvements in patient outcomes.

What will be different?

Patients having access to a greater range of affordable services. Funding for services better aligned with need. Providers, funders and policy makers having better performance information to improve practice and monitor system performance.

Key Priority Areas

Key Priority Area 1: Improving access and reducing inequity

Key directions for change

Primary health care is delivered through an integrated service system which provides more uniform quality care across the country, actively addressing service gaps and the needs of specific population subgroups.

For patients this means: Australians will have access to well integrated primary health care services that are more available, matched to meet peoples' needs, and provide continuity of care including safe handovers between care providers. For those Australians who have specific needs or difficulties in accessing care, service delivery will be responsive to their individual needs and circumstances.

What the future looks like

- Access to core services supported by universal access to a Medicare rebate will be retained but will be supplemented by targeted local programs and collaborations across the service system.
- Through this combination of core services and targeted programs, accompanied by new funding and governance structures, primary health care services will be better integrated, will take responsibility for individual and population needs, and will address current variability in access and outcomes, including for after-hours access, traditionally under-serviced groups, and for patients in transition across the service system.
- Service delivery will proactively respond to the needs of those Australians who find it difficult to access mainstream services, or who have specific health care needs whether because of their location or demographic characteristics or health status or because of the circumstances under which they need to access care. At the same time, mainstream services will be more responsive to the needs of different groups.
- Service delivery and funding arrangements will support flexible service delivery models, promote effective and cost-effective use of technology and drive innovation by supporting information flows and workforce education and training.

What changes are needed to get there?

- Primary health care services/organisations actively monitor and implement programs to address service gaps and inequities in local communities.
- Funding arrangements support programs designed in local communities to address areas of market failure and promote connections across sectors. While design features will fit local needs, examples could include:
  - outreach programs to under-serviced populations such as people living in aged care facilities, people with physical and intellectual disabilities, and people in under-serviced regions;
  - transition services that support patients on discharge from hospital or who need to navigate across the system;
  - building team-based interventions focussed on providing joined-up and flexible services to the homeless or those with mental health needs;
  - arrangements to provide better access to primary health care after hours; and
  - building on 'Closing The Gap' initiatives, improve health outcomes for Aboriginal and Torres Strait Islander peoples.
- New infrastructure supports patient access, team work and integrated care solutions, and better uses technology and outreach services.
- Support for primary health care workforce in under-supplied areas.
- Regional organisations and service providers have the information and tools to monitor access gaps in their areas of responsibility and to respond where improvements are needed.
- Professional organisations actively encourage improved cultural awareness in service delivery.

Measurable change would be: closing the gap in health outcomes across the population with special attention to vulnerable communities.

Key Priority Area 2: Better management of chronic conditions

Key directions for change

A new approach to improve continuity and coordination of care particularly for those with chronic disease, including through a comprehensive national approach to chronic disease management, tailored and delivered locally.

For patients this means: Wherever they live, eligible individuals with chronic conditions can enrol with a practice or provider who becomes responsible for managing their care, monitoring progress and supporting self-management.

While tailored to local service systems and needs, services could include comprehensive multi-disciplinary team care, 'as needed' care coordination, sharing of information within and across providers, and self-management support including through diagnostic support tools.

What the future looks like

- A new comprehensive approach to chronic disease management which recognises that individual consultations with a GP or specialist cannot alone provide the range of integrated services needed to achieve long term management of an individual patient.
- The new approach will provide improved health care for patients with chronic disease through flexible, tailored management of an individual's health care needs with clear responsibility by their practice or provider for their management and follow-up. Arrangements would include:
  - voluntary enrolment with a health provider based on clinical need;
  - evidence-based and standardised assessment processes that identify eligible patients at various points in the service system (hospital, specialist, community health);
  - access to chronic disease management interventions, based on assessed clinical need, and delivered in line with best practice;
  - flexible service responses tailored to the mix and level of services an individual needs;
  - supported self-management using available electronic and communication tools; and
  - where appropriate, a personalised shared care plan linked to an individual's electronic health record.

What changes are needed to get there?

- Over time, realign chronic disease funding with individual and community need.
- New chronic disease management approach is collaborative and patient-focussed with consistent identification and assessment of patients and delivery of joined-up interventions.
- In consultation with professional groups improve assessment tools and protocols and incorporate available evidence to ensure effective targeting of services and cost-effective use of system resources to achieve long term health gains.
- Supported self-management, using modern tools for patients with chronic conditions that enable monitoring of health status and alerts where appropriate.
- Effective multi-disciplinary teams including appropriate use of the specialist workforce, supported by training, funding, infrastructure and technology.

Measurable change would be: for patients with chronic disease, reduction in avoidable hospital admissions and other key evidence-based clinical indicators of quality chronic disease management.

Key Priority Area 3: Increasing the focus on prevention

Key directions for change

Strengthen the existing framework for promotion, prevention and early intervention in primary health care, to encourage more systematic approaches, with regular recall and follow-up, coordinated and integrated with other preventive activities, including a focus on improving health literacy, within local communities.

For patients this means: Individuals receive regular risk assessments appropriate for their age and conditions available at multiple points of the service system (not just GPs), and are actively linked with other community-based supports and activities.

Higher levels of health literacy, starting at schools and building across the community to ensure individuals have the skills and knowledge to manage their own health and are supported in doing so. Individuals are supported to more clearly recognise their responsibilities and take positive actions to maintain their own health and well-being.

What the future looks like

- Primary health care services provide a range of preventive services to their local communities. All health providers, where they can, use evidence to promote healthy behaviours. Service delivery is supported by data and information systems, including recall and reminders, and risk assessment tools. These services are coordinated across providers in a local community to eliminate duplication and overlap, and make best use of available workforce and provider networks, including nurses, allied health and pharmacists.
- Targeted prevention activity focuses on hard to reach populations, who may not otherwise access services, and for whom investment in prevention will mean much improved downstream outcomes.
- Primary health care services are well integrated with broader prevention activities at the local level, to actively link patients with community-based supports and activities, and receive feedback on patient progress from other services as appropriate.

What changes are needed to get there?

- Health care professional organisations focus on education and training on effective preventive activities, communication of broader preventive health initiatives, uptake of tools and information systems to support preventive care.
- Changed service delivery and funding arrangements support best use of the available workforce, including for nurses, allied health, and pharmacists and responding to local needs.
- New arrangements support supplementary prevention services for individuals and practitioners, focussed on high-risk populations and those conditions and behaviours where prevention and early intervention can result in significantly improved outcomes and system wide effectiveness and cost-effectiveness.
- A focus on improving community and individual health knowledge and providing education and support to individuals to manage and improve their own health.

Measurable change would be: further reduction in lifestyle risk factors for chronic disease such as smoking and obesity, especially for vulnerable populations.

Key Priority Area 4: Improving quality, safety, performance and accountability

Key directions for change

Establish a strong framework for quality and safety in primary health care based on improved information and quality assurance systems to support measurement, feedback and quality improvement for providers and greater transparency for consumers and funders.

For patients this means: Individuals will have enough information about health providers, facilities and services to enable them to make informed choices about their care. Patient care is based on the best available evidence. Safety and quality is not compromised through poor information at patient handover, or a lack of information on performance and quality of services across different parts of the system.

What the future looks like

- Access to information on safety, quality and performance will drive continuous improvements in primary health care services and improved health outcomes for patients.
- Service providers and regional primary health care organisations have the tools to reflect on the effectiveness and cost-effectiveness of their services and to adapt to emerging challenges and population needs.
- Primary health care professionals will work within a performance framework that meets their needs, supports peer feedback and comparison as part of continuous quality improvement, and recognises the challenges of measuring performance across all aspects of primary health care.
- The providers of publicly subsidised primary health care services across the workforce will be accredited against comprehensive standards for primary health care services.
- Primary health care will be supported by research that is timely, accessible and readily applicable to policy and service delivery.

What changes are needed to get there?

- An engagement with the community and with health providers about how the effectiveness of the primary health care service system should be measured and monitored over time.
- eHealth records are able to track care and treatment of individual patients.
- Knowledge support systems and information are developed to provide practitioners with information about their own performance and the capacity to compare themselves with their peers or against best practice.
- Care delivery ensures appropriate use of the workforce – matching roles and responsibilities with 'scope of practice'.
- Agreed performance indicators are implemented across primary health care settings to drive improvements in practice and to inform consumers and policy makers.

Measurable change would be: reduction in avoidable errors attributed to safety and quality issues.

Moving to our 21st Century Primary Health Care System

The Draft Strategy sets out an ambitious agenda for change over the longer term. Progressing this level of change is significant – and will need support and engagement across the community and from health professionals.

Putting it into practice will need careful management – practical steps to build on what we currently have and what is working well, but with a clear picture of the features of the system that it is moving towards.

The Draft Strategy recognises that changes will take time - that new systems and infrastructure will be needed, that health professionals need support to develop new skills and new ways of working together, and that the quality and safety of our services must be maintained throughout. But there are some areas where the need for change is pressing - where our current system is falling short and not providing individuals and communities with the care they need.

The Draft Strategy will develop what is currently a disparate collection of interdependent services into what will become a more cohesive system, providing the opportunity to improve cost-effectiveness and drive evidence-based clinical practice, resulting in a system that is more adaptable and responsive to patients' needs. This system will need to have governance arrangements that are simple, well-understood and drive improved health outcomes for the community. It will also need to ensure that there is good articulation for both patients and health care providers with both the acute and aged care systems.

The Draft Strategy signals the commitment of the Australian Government to reform in this important area of health care. However, successful implementation of the directions identified in the Draft Strategy will require concerted and collaborative effort from many quarters.

Its implementation will not be without challenges: for health professionals and health care organisations to adopt new ways of working; for Governments to develop new approaches including to service delivery and aspects of funding; and for consumers to influence and engage with change.