National Primary Care Research Consortium

Annual Impact Report 2025

The National Multidisciplinary Primary Care Research, Policy and Advocacy Consortium brings together more than 100 leading primary care clinician researchers from universities across Australia, along with health consumers, peak representative organisations and policy partners, to design and test new models of healthcare.

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Acknowledgement of Country

The National Multidisciplinary Primary Care Research, Policy and Advocacy Consortium recognises and respects the Traditional Custodians of Country across Australia. We acknowledge their deep and ongoing connection to land, waters and community and pay our respects to Elders past and present.

Introduction

Lead Chief Investigator, Professor Michael Kidd AO

Australia has one of the very best health care systems in the world. Yet as the Federal Government's *Strengthening Medicare Taskforce Report* acknowledged in 2022, we need to build on our legacy. To address this, a Consortium of leading primary care clinician researchers was formed in 2025, funded through the Medical Research Future Fund (MRFF), with the aim of developing, testing and advising on the best models for multidisciplinary team-based (MDT) primary care. The Consortium consists of 50 Chief Investigators and 50 Associate Investigators from universities and research centres across Australia. Notably 40 of our 100 investigators are early career researchers, reflecting our commitment to building future primary care research capacity for our nation.

By the end of 2025, the Consortium was progressing well through the Establishment Phase. Five research fellows were appointed and work commenced on the processes to guide the systematic reviews that will be conducted in 2026. The inaugural Strategic Think Tank event, held during August 2025, enabled the majority of Consortium members to meet in person and discuss the future direction of our research. Following the Think Tank, research theme groups were also established, with senior researchers from the designated research centres leading each of the groups. We have also established terms of reference for each of our governance and strategic groups, risk management framework strategies, and authorship and publication guidelines.

The literature reviews undertaken by each of the research fellows will be completed over 2026 and will help direct the course of our research activity in the following years.

During the year, the Consortium communications plan was finalised, a LinkedIn page for the group launched and new branding for the Consortium developed.

The Consortium is committed to undertaking research that is responsive to consumer and community needs. We have adopted the co-design model of the NSW Government Agency for Clinical Innovation. Our significant work with the Consumers Health Forum of Australia will foster co-design in all processes of the Consortium. We have also had strong and welcome interest from other researchers, peak national organisations and Primary Health Networks to join the Consortium.

We have a huge opportunity in front of us to build on the incredible legacy of primary health care in this country. The work of this Consortium will be integral to establishing Australia as a global leader in future models of primary health care delivery in the 21st century.

Introduction

Senior Researcher, Associate Professor Margo Barr

Organising the Consortium's inaugural Think Tank was a rewarding and productive experience. One notable feature of the Consortium is the size of the group – with 50 Chief Investigators and 50 Associate Investigators, five research centres and around 30 partner organisations from across Australia.

For this reason, it was critical that we came together early on in the formation of the Consortium to meet and discuss our objectives and how we work together.

More than 80 Consortium members met in Geelong in August for a day, following the Australasian Association for Academic Primary Care (AAAPC) Conference – of which many Consortium participants are members.

For the inaugural Strategic Think Tank we chose the theme 'What are the key components of high quality comprehensive, accessible and equitable Multidisciplinary Team (MDT)-based primary care?' This is just one of the five research themes the Consortium is targeting.

The day commenced by hearing Professor Michael Kidd AO outline what success would look like for the group in five years' time (the span of the MRFF grant) and why the Consortium was launched. This was followed by presentations by each of the partner groups (the National Rural Health Alliance, the Consumers Health Forum of Australia, the Australian Commission on Safety and Quality in Health Care, and the National Aboriginal Community Controlled Health Organisation) and the First Assistant Secretary of the Department of Health, Disability and Ageing Mark Roddam. We then broke into small groups to discuss the theme of the Think Tank – the components of successful multidisciplinary primary care.

In the next session, we heard from each of the research centres about their multidisciplinary work and future research. This was followed by small group discussions which covered the other research themes of the Consortium such as models of multidisciplinary team-based primary care, outcome measures, cost effectiveness and feasibility, and implementation.

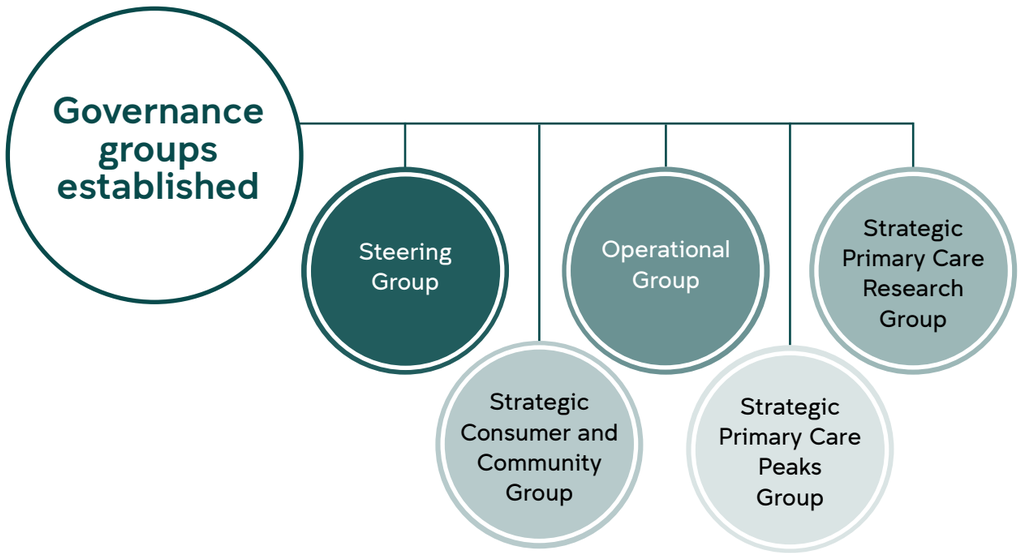
Our Think Tank concluded with Professor Kidd AO wrapping up the key takeaways from the day and our plans moving forward.

As the Consortium's Senior Researcher, I am looking forward to working together over the next five years to advance primary health care in Australia.

2025 Consortium Key Achievements

The Consortium Vision

We aim to improve health care for all Australians by bringing together researchers, health consumers and communities to create better ways of delivering primary care. Through research and real-world solutions, we are building a more accessible and connected health care system that puts people first.



2026 Consortium Plans

- Literature reviews
- Research theme groups
- Knowledge bank
- Primary Health Network Engagement
- Capacity building of Consortium members
- Translating research to the community
- Expanding skills via online workshops
- Expansion to include more researchers and organisations
- Government Engagement and Advocacy Plan

About the Consortium

Consortium Coordinating Centre

The International Centre for Future Health Systems, University of NSW is a research, policy and advocacy centre that seeks to improve health systems to deliver more equitable, sustainable, and person-centred health care for all people.

Consortium Research Centres

NHMRC in Women's Sexual and Reproductive Health in Primary Care (SPHERE) is a national research network that brings together GPs, nurses, midwives, pharmacists, researchers and consumers to improve sexual and reproductive health care in Australian primary care.

Promoting Responsive and Optimal Approaches for Collaborative Team-Based Care in the Prevention & Management of Chronic Conditions (PROACT) is a research group that focuses on improving how multidisciplinary teams work together in primary care, especially for preventing and managing chronic conditions.

NHMRC CRE for Strengthening Health Systems in Remote Australia (CRESTRA) focuses on strengthening multidisciplinary primary care in remote Australia by looking at how health systems work on the ground.

Aged Care Research & Industry Innovation Australia (ARIIA) supports better multidisciplinary care for older people by helping different health and aged care professionals work together more effectively.

The Melbourne Alliance to implement Multidisciplinary Primary care (MAMP) for cancer, mental health, family violence prevention, and child and adolescent health focuses on embedding lived experience within all aspects of mental health research, implementation and translation.

About the Consortium

Consortium Research Fellows

Dr Sharon James is an experienced primary healthcare nurse and Research Fellow focused on primary care and women's sexual and reproductive health through the development and testing of new models to enhance nurses' scope of practice and consumer experiences of care. She is an Australian Primary Health Care Nurses' Association Board Director (2022-) and has been awarded Fellowships with TUTOR-PHC 2022 (Western University, Canada) and the Oxford International Primary Care Research Leadership Programme 2024-26 (University of Oxford, UK) as well as the 2025 Sigma Emerging Leader/Researcher (Oceania).

Ashmita Karki is a public health researcher based in Alice Springs. She is in the final stages of completing her PhD, which used mixed-methods to examine health-related quality of life and mental health in individuals with Type 2 diabetes in rural Nepal. Ashmita has over seven years of experience working across health systems settings in Nepal and remote Australia. For nearly two years, she worked with Central Australian Aboriginal Congress in the capacity of Research Coordinator and brings extensive insights into remote, Aboriginal primary health care and a strong commitment to strengthening remote health systems and addressing health inequities. Ashmita will be working full time, split across the national Consortium and the related MRFF-funded project on multidisciplinary models of primary care in remote, Aboriginal contexts in the Northern Territory.

Consortium Research Fellows

Dr Catherine Stephen is a Registered Nurse, Lecturer, and Early Career Researcher at the School of Nursing, University of Wollongong. She was awarded her PhD in July 2024 for the ImPress Study, a randomised controlled trial of a nurse-led intervention to improve hypertension management in primary care. Catherine's research focuses on nurse-led intervention in general practice with a focus on blood pressure control, CVD prevention and chronic disease management. She has authored peer-reviewed publications, book chapters and has presented her work nationally and internationally. Her contributions have been recognised with multiple awards, including the UOW 3MT People's Choice Award (2023), the Rising Star Award from the Cardiac Society of Australia and New Zealand (2024), and the Early Career Researcher Award for Clinical Trials from Health Innovations (2024). Catherine is delighted to commence as a Research Fellow within the Consortium and looks forward to working as part of a team driving change in Australian primary care.

Dr Jodie Hillen is an experienced healthcare researcher. Since completing a Bachelor of Pharmacy in 1995, Jodie has been fortunate to work in a broad variety of roles contributing to better health outcomes for Australians. Her career to date has spanned clinical roles, state and national quality of care projects, pharmacoepidemiology research and aged care research. Jodie joins the ARIIA team of the Consortium and is looking forward to working with the consortium to drive the future of primary care for older Australians. Jodie is also a CI on an NHMRC MFRR grant: PHARMA-care Quality Monitoring Program (UniSA) and a Koneksi grant (UQ): Developing a dashboard for evaluating quality of mental health medicine use in acute care.

About the Consortium

Consortium Research Fellows

Dr Sandra Davidson is an experienced primary health care researcher. Her PhD explored how social relationships influence the trajectory of depressive symptoms among general practice attendees, establishing her ongoing focus on how factors outside the clinical encounter shape health outcomes. She specialises in embedding patient perspectives and lived experience into study designs to identify opportunities for intervention that might otherwise be missed. Sandra is currently a CI on two MRFF primary care grants and is a researcher on the Lancet Commission on Transforming Primary Health Care in the Post-Covid Era. She is a former NHMRC Early Career Fellow.

About the Consortium

About the Consortium

Australian Government Agencies

Australian Commission on Safety and Quality in Health Care
Australian Government Department of Health, Disability and Ageing
Australian Rural Health Care Commissioner
Cancer Australia
Commonwealth Scientific and Industrial Research Organisation (CSIRO)

Universities

University of Adelaide
Australian National University
Bond University
Charles Darwin University
Curtin University
Flinders University
Griffith University
James Cook University
Monash University
The University of New England
The University of Newcastle
The University of Notre Dame Australia
The University of Queensland
University of Adelaide
University of Melbourne
University of New South Wales
University of South Australia
University of Sydney
University of Tasmania
University of Western Australia
University of Wollongong
Western Sydney University

Peak Bodies

Aged Care Research & Industry Innovation Australia
Allied Health Professions Australia
Australasian Association for Academic Primary Care
Australian College of Midwives
Australian College of Nurse Practitioners
Australian College of Nursing
Australian College of Rural and Remote Medicine
Australian Council of Deans of Health Sciences
Australian General Practice Alliance
Australian Primary Health Care Nurses Association
Australian Psychological Society
Australian Rural Health Education Network
Cancer Australia
Central and Eastern Sydney Primary Healthcare Network
CRANAplus
Federation of Rural Australian Medical Educators
General Practice Registrars Australia
GP Supervision Australia
National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners
Optometry Australia
Pharmaceutical Society of Australia
Royal Australian College of General Practitioners
Royal Flying Doctor Service of Australia
Rural Doctors Association of Australia
Services for Australian Rural and Remote Allied Health

Chief Investigators

Dr Jason Agostino
Anisa Assifi
Professor Lauren Ball
Associate Professor Margo Barr
Dr Rebecca Bilton
Dr Jessica Botfield
Associate Professor Zoe Bradfield
Professor Alan Cass AO
Dr Vera Camoes-Costa
Professor Timothy Chen
Dr Bradley Christian
Professor Sarah Dennis
Dr Jane Desborough
Dr Elizabeth Deveny
Dr Sarah Dineen-Griffin
Professor Alexandra Edelman
Professor Elizabeth Halcomb
Dr Isabel Hanson
Professor Clare Heal
Professor Kelsey Hegarty
Professor Paul Glasziou
Dr Sharon James
Associate Professor Caroline Johnson
Dr Lisa Keay
Professor Michael Kidd AO
Dr Amy Kirkegaard
Professor Sarah Larkins
Professor Meredith Makeham
Professor Danielle Mazza AM
Dr Rita McMorrow
Professor Darryl O'Donnell
Professor David Peiris
Professor Sue Randall
Associate Professor Joel Rhee
Dr Deborah Russell
Professor Grant Russell
Professor Lena Sanci
Associate Professor Frederic Sitas
Professor Nigel Stocks
Associate Professor Elizabeth Sturgiss
Dr Sean Taylor
Professor Katharine Wallis
Professor Lucie Walters
Dr Michael Wright
Professor Nicholas Zwar

Associate Investigators

Professor Penelope Abbott
Dr Abdolvahab Baghbanian
Dr Katelyn Barnes
Associate Professor John Boffa
Dr Nattai Borges
Dr Kaara Ray Calma
Dr Winnie Chen
Dr Sharinne Crawford
Dr Libby Dai
Dr Sandra Davidson
Associate Professor Fergus Gardiner
Associate Professor Stacey George
Associate Professor Michelle Guppy
Dr Benjamin Harris-Roxas
Sam Heard
Professor Charlotte Hespe
Professor Danny Hills
Jessie Huang-Lung
Professor Rowena Ivers
Associate Professor Melissa Kang
Ms Cathelijne van Kemenade
Associate Professor Andrew Kirke
Ms Erica Kneipp
Dr Alissia Kost
Dr Renly Lim
Dr Sam Manger
Associate Professor Liz Marles
Dr Sethunya Matenge
Professor John McCallum
Dr Corin Miller
Ms Bronwyn Morris-Donovan
Dr Ashvini Munindradasa
Associate Professor Nahal Mvaddat
Dr Peri O'Shea
Professor Gregory Peterson
Professor Constance Pond
Professor Richard Reed
Dr Anurag Sharma
Dr Tin Fei Sim
Dr Sonia Srinivasan
Professor Ruth Stewart
Dr Anthony Sunjaya
Selina Taylor
Ms Susanne Tegen
Professor Samia Toukhsati
Dr Marguerite Tracy
Dr Prabhakar Veginadu
Dr Brent Venning
Dr Andrew Webster

Strategic Think Tank August 2025

Partner Presentations

Discussion with Lead Chief Investigator Professor Michael Kidd AO

Our vision is to be able to provide governments with informed, evidence-based choices around what multidisciplinary teams can achieve. This means a team of health care professionals from different fields who work together to develop high quality comprehensive care for all people.

Chief among our objectives is to demonstrate what an integrated health system will look like with an emphasis on early detection and prevention strategies. Our areas of focus include patients with mental health issues and those who live in remote and rural areas.

Our vision is a modern health care system that builds on Australia's incredible legacy of world class affordable health care for all. The Consortium will be a major national resource that supports ongoing federal, state and territory programs of primary care reform."

Tom Johnson
Director of Advocacy and Engagement
Consumers Health Forum of Australia

Mr Johnson stated that the Consumers Health Forum is the national peak body working to achieve safe, quality, timely health care and improved understanding of our health system for all Australians.

The Consumers Health Forum will contribute to the Consortium in four key ways. This includes holding training and workshop programs, a yearly research fellow internship program and the development of consumer engagement in research resources.

The Consumers Health Forum will call for expressions of interest for consumers and community groups to join the Consortium Strategic Consumer and Community Group. The Chair of this Group will represent the views of the Group at the Consortium Steering Group.

Mr Johnson said it is critical for consumers to have a voice in the development of Australia's future primary care system to ensure it is fit for purpose.

Susanne Tegen
CEO, National Rural Health Alliance

Ms Tegen stated that the National Rural Health Alliance represents 54 members of the rural health alliance network with stakeholders on the ground and communities developing solutions.

The health system that Australia boasts about is at risk unless action is taken now. The rural sector is facing the worst period in its history and the Consortium is critical to take action and halt the decline of health services in rural communities – in which 30 per cent of Australia's population live.

Multidisciplinary team care needs to address disadvantage in rural and remote areas that contributes to poorer health outcomes. This includes poorer social determinants of health, poorer access to healthcare and greater costs – largely driven by the tyranny of distance. There is also lower government health expenditure compared to people living in urban communities. These factors hinder productivity, yet rural and remote areas produce 90 per cent of Australia's food and the majority of its exports.

Partner Presentations

High quality comprehensive, accessible and equitable MDT-based primary care should be place-based and evidence based from the grassroots and data.

This means working with rural and remote communities with a collaborative, community-led approach focusing on addressing complex issues. It involves bringing together local stakeholders to understand local needs and develop tailored solutions to improving healthcare access and equity for the community.

The NRHA is partnering with the Department of Health, Disability and Ageing's Primary Care and Workforce Reviews Taskforce to coordinate a series of roundtables, to ensure stakeholders' views are heard.

There is a rural health expenditure deficit, when dollars spent between rural and urban populations on a per capita basis are compared.

Figure 1 demonstrates the decreasing service availability as remoteness increases. Taking action to close this deficit would help fund MDT-based primary care in rural Australia. Lower expenditure on services reflects lower health practitioner availability and this will continue to deteriorate as access to specialists continues to decline in rural areas.

FIGURE 1
National Health Workforce Data Set (NHWDS) data demonstrates decreasing service availability with increasing remoteness.
Source: NRHA, Department of Health and Aged Care, Royal Flying Doctor Service

Associate Professor Liz Marles
Clinical Director
Australian Commission on Safety and Quality in Health Care

Associate Professor Marles stated that the Australian Commission on Safety and Quality in Health Care is designed to provide better health outcomes and experiences for all patients and consumers. The Commission also leads and coordinates national improvements in the safety and quality of healthcare.

There are five key elements of quality health care: safe; effective; accessible; person-centred; and integrated. These elements lie at the heart of the approach of the Commission. Through the lens of quality, health care should also be equitable, efficient and sustainable.

The Commission uses data to see the extent of clinical variation from one area to another and is particularly interested when there is unwarranted variation.

Data is also collected on general practices for primary care research and quality improvement. Other data that is reviewed includes individual practitioner feedback and practice reflections. Prior investigations include the increased number of Computed Tomography (CT) scans and opioid prescriptions.

Part of the role of the Commission is the provision of standards and accreditation schemes. This includes the standards that govern all public and private hospitals, public dental clinics and those that are voluntary and applicable for any primary health care service. Clinical care standards are designed to reduce variation between practitioners and guide appropriate care.

The Commission conducted the Patient Reported Indicator Survey of 54 general practices, see Figure 2. It revealed the benefits of an ongoing patient-GP relationship including higher levels of trust and better outcomes across wellbeing, care coordination, health and social functioning.

FIGURE 2
Patient Focus - Patient Reported Indicator Survey (PaRIS)

- Australia one of 19 OECD countries participating surveying people over 45 with chronic disease
  - In the top 5 for 4 of 10 indicators (quality of care, person centred care, care coordination and physical health
  - Key Insights : GP Patient relationship
    - Continuity of care – higher positive ratings especially for coordination of care
    - Higher levels of trust associates with better outcomes and experiences in all areas
      - Wellbeing
      - Care coordination
      - Health
      - Social functioning

Dr Jason Agostino
Senior Medical Advisor
National Aboriginal Community Controlled Health Organisation (NACCHO)

Dr Agostino stated in his video presentation that the Aboriginal Community Controlled Health Organisations (ACCHO) sector provides lessons for the broader primary healthcare system. It is a unique model of care that is large in its ambition and scope and larger than most other primary care services in Australia.

Clinical service is a big part of the ACCHO model and about 60 per cent of the revenue is spent on clinical services.

“A really big point of difference is our focus on community health promotion and empowerment - to empower people to take control of their own healthcare,” said Dr Agostino.

With large complex teams, there is a specific focus on governance and NACCHO has spent the past three years improving the capability of the boards of these organisations to provide strong governance.

“For us to be effective for our patients, we need to be involved in influencing policy direction and developing partnerships with other parts of the health care system,” he said.
“That is why we’re talking to the Australian Government about funding reform and how we sustainably fund high quality care.”

ACCHOs have a big primary healthcare team including Aboriginal Health Practitioners, Aboriginal Health Workers, nurses, midwives and visiting allied health professionals, which increasingly include non-dispensing pharmacists as well as non-GP specialists.
“I have seen ACCHOs thrive or really struggle depending on the quality of the clinical governance,” he said.

The ACCHO model has healthcare professionals under the one roof rather than dispersed teams which helps them focus on the needs of the patient cohort.
Dr Agostino also said it is critical to generate data that matters to patients and advocated for the introduction of digital systems that support patient interactions while not diverting attention away from providing care.

“If we’re going to be serious about improving the health of Aboriginal and Torres Strait Islander people faster than non-Indigenous Australians, we need to be fast adopters,” said Dr Agostino.

“We need to recognise the importance of the community voice. The next five years is when change will happen in the health system, and we move from reviewing to doing. Until patients have a voice, we won’t be designing systems that meet their needs.”

Mark Roddam
First Assistant Secretary, Primary Care Division Australian Government Department of Health, Disability and Ageing

Mr Roddam stated that the Consortium, which is funded under the Medical Research Future Fund (MRFF) 2023 Multidisciplinary Models of Care grant opportunity, emerged from the Strengthening Medicare Taskforce Report. This report outlines the key priorities to modernise general practice and improve access to affordable, high-quality healthcare. The four reform priority areas are:

- Increasing access to primary care.
- Encouraging MDT-based primary care.
- Modernising primary care including investing in digital infrastructure such as My Health Record upgrades and voluntary patient registration to improve information sharing and care coordination.
- Supporting change management and reform implementation by providing funding and resources to support the primary care sector to adapt to new models.

The government's work with the Consortium falls within these priority areas. Currently, the Primary Care Taskforce Reviews Section (the Taskforce) is working with Consortium members to answer the questions set out in Figure 3.

FIGURE 3
Primary Care Taskforce Reviews Section is working with consortium members to answer these questions

"GPs are at the centre of multidisciplinary team-based primary care," said Mr Roddam. Four major reviews have provided recommendations to support the primary care reform agenda. A departmental taskforce launched at the beginning of 2025 to work with the sector and provide advice to government across the four reviews and on primary care reform. These include: Review of General Practice Incentives; Unleashing the Potential of our Health Workforce; A Better After-hours System; and Working Better for Medicare Review.

Areas of priority include redesigning funding to better enable MDT-based primary care and ensuring primary care providers can work to their full scope of practice.

Mr Roddam provided an update on the Medicare Urgent Care Clinics Program as at 4 August 2025. Medicare Urgent Care Clinics are designed to take the pressure off hospital emergency departments and give families more options to see a health care professional when they have an urgent, but not life threatening, need for care. At that time 90 of these clinics had opened with 33 in regional, rural and remote areas. During weekdays one in four visits occur after 5pm. And over one in four visits have occurred on the weekend. Most patients at these clinics are presenting with acute illness (63 per cent) and acute injuries (26 per cent). Urgent Care Clinics data shows around 11 per cent of patients revealed they did not have a usual GP or practice.

As part of the 2025-26 Budget, the Government announced a $7.9 billion investment to increase the GP bulk billing rate. This included: $5.5 billion to expand eligibility for bulk billing incentive items to all Medicare-eligible Australians; $2.4 billion to create the Bulk Billing Practice Incentive Program (BBPIP) and ongoing funding to support these measures.

BBPIP launched 1 November 2025. Participating practices must bulk bill all eligible services for all eligible patients to receive an additional 12.5 per cent loading payment on MBS benefits which is split between the GP and the practice.

The government is working with stakeholders and state and territory governments to develop a National Oral Health Plan 2025- 2034. Mr Roddam emphasised the opportunities for multidisciplinary teams in oral healthcare.

Partner Panel Discussion

Partner Panel Discussion

When asked ‘what is the key component of effective multidisciplinary primary care?’ each of the panel members had a different response. For Mark Roddam it was funding reform. This was echoed by Susanne Tegen. Associate Professor Liz Marles said a clear vision was important. Tom Johnson said it was critical that consumers have a voice especially at the evaluation stage of the process.

Mr Roddam talked about the need for data and digital reform.
“It is important to know who is interacting with the patient and caring for them,” he said. “We need all practitioners to understand how all of the different practitioners are intervening and supporting the person.”

There was an acknowledgement by the panel that ACCHOs are the gold standard in developed co-design, but funding is critical.

Another common theme was the need to design primary care with the patient in mind and to incorporate the consumer voice.

“We often talk about population health need, I think if we were truly responding to population health need and utilising solutions from the ground then we could come up with great multidisciplinary team-based care,” said Ms Tegen.

“If you reflect and ask what consumers want, this is a critical element,” said Mr Johnson.

“If we had a big vision for health, we could have one system with the patient at the centre and they could move seamlessly throughout,” said Associate Professor Marles.

“But what we are seeing is that it is hard for the GP to be considered as part of the primary healthcare team once someone gets to hospital. Once a patient goes to hospital, they should be asked ‘who is your GP?’”

The panel also discussed how multidisciplinary teams can work effectively.

“True integration involves all members of the team not just a side note,” said Associate Professor Marles. “It’s where you share the care for this particular person and actually discuss what is going on and who is doing what.”

“When you work in multidisciplinary teams you understand each other’s skill set and you get more appropriate delivery of care,” said Ms Tegen.

There were questions from the audience on whether the Federal government had approached organisations overseas where multidisciplinary care is widespread.
“We’ve had some useful conversations with Alberta and Ontario to understand their multidisciplinary team-based models,” said Mr Roddam.
“But we’re interested in the views of the Consortium members. The international evidence is certainly informing what we do but there may be more effective models and we’re keen to know what they are.”

The panel also discussed the availability of care in remote and rural areas. Mr Johnson said in rural Tasmania the issue is around access rather than affordability of health care.

“People are waiting three weeks to see a GP and then travelling 40 minutes to see another practitioner,” he said. “Our metropolitan areas are well resourced, but our rural areas are not.”

What is Effective MDT-based Primary Care?

There was a consensus among the groups that self-determination for the consumer is important. There was also a question around whether MDT relied on practitioners operating under one roof or whether consumers want services spread out due to privacy concerns. “One of the big lessons from Ontario is, you don’t have just one model you have multiplicity of models that are quite granular and offer a multiplicity of care,” said Professor Grant Russell.

“We can’t afford a country of ACCHO type models. And where ACCHO is an ideal model for Indigenous Australians there are other models that may work for urban and rural communities.”

There was an acknowledgement of the need to be cautious about team-based care as an end to itself. Team-based care may be very good for some allied health professions but not always provide optimal care for the patient.

There was consensus around that models of care are dependent on outcomes. Questions were raised about the flexibility of the system according to location-based care as well as the type of care being provided. For example, sexual reproductive health can have stigma within communities leading to difficulties if the service is offered under the same roof as other practices.

Another area discussed was the importance of sharing information among teams and ensuring respect between professions. Suggestions included specific training on team communication.

There was also discussion around the lens under which any changes to the health system must be undertaken. There was agreement that reforms must include the critical components of it being equitable, safe and affordable. Other factors include whether changes will promote the patient first, be accessible and comprehensive?

How Australia can learn from the lessons from abroad and whether there will be funding for pilot implementation of new models was also discussed within groups. The importance of identifying pockets of excellence of multidisciplinary care in Australia and investigating ways to use these examples as pilot studies was raised by one group.

Many Consortium members stressed the importance of access to data to inform policy change.

Small Group
Breakout Sessions

Key components of multidisciplinary teams

THINK BEYOND
ALL DISCIPLINES UNDER ONE ROOF

VIRTUAL INTEGRATION

ALL TEAM MEMBERS VISIBLE AND VALUABLE

NAVIGATOR
TO ASSIST PEOPLE OR INTRODUCE THEM TO OTHER SERVICES

EMPOWERED - TO SHARE INFORMATION BETWEEN PROVIDERS WITH REAL TIME ACCESS

EQUITY
IS JUST AS CRITICAL
AS ACCESS - THIS IS IMPORTANT WHEN IT COMES TO DIGITAL ACCESS OF SERVICES

PERSON-CENTRED AND EMPOWERING PATIENTS

INTERACTIVE SYSTEM

CO-LOCATION CAN HELP CONVERSATION AND CASE MANAGEMENT

NEED TO UNDERSTAND WHAT OTHER DISCIPLINES DO AND THEIR ROLES

BREAKING DOWN SILOS - BETTER COMMUNICATION
BETWEEN PARTIES AND DISCIPLINES

DIGITAL HEALTH
ESPECIALLY IN RURAL SETTINGS

HOLISTIC CARE

PLACE-BASED RESPONDING TO COMMUNITY NEEDS

SHARED DECISION-MAKING
BETWEEN LEADERSHIP AND MANAGEMENT

REFORMS TO REFLECT THE PILLARS OF PRIMARY CARE:
EQUITABLE, SAFE AND AFFORDABLE

INCLUDE INDUSTRY IN RESEARCH
ESPECIALLY IN RURAL AREAS AND COMPANIES WORKING WITH GPS

UNIVERSAL
IS THE AIM - NOT ONE SIZE FITS ALL

NOT JUST GP OR OTHER PROFESSION LED

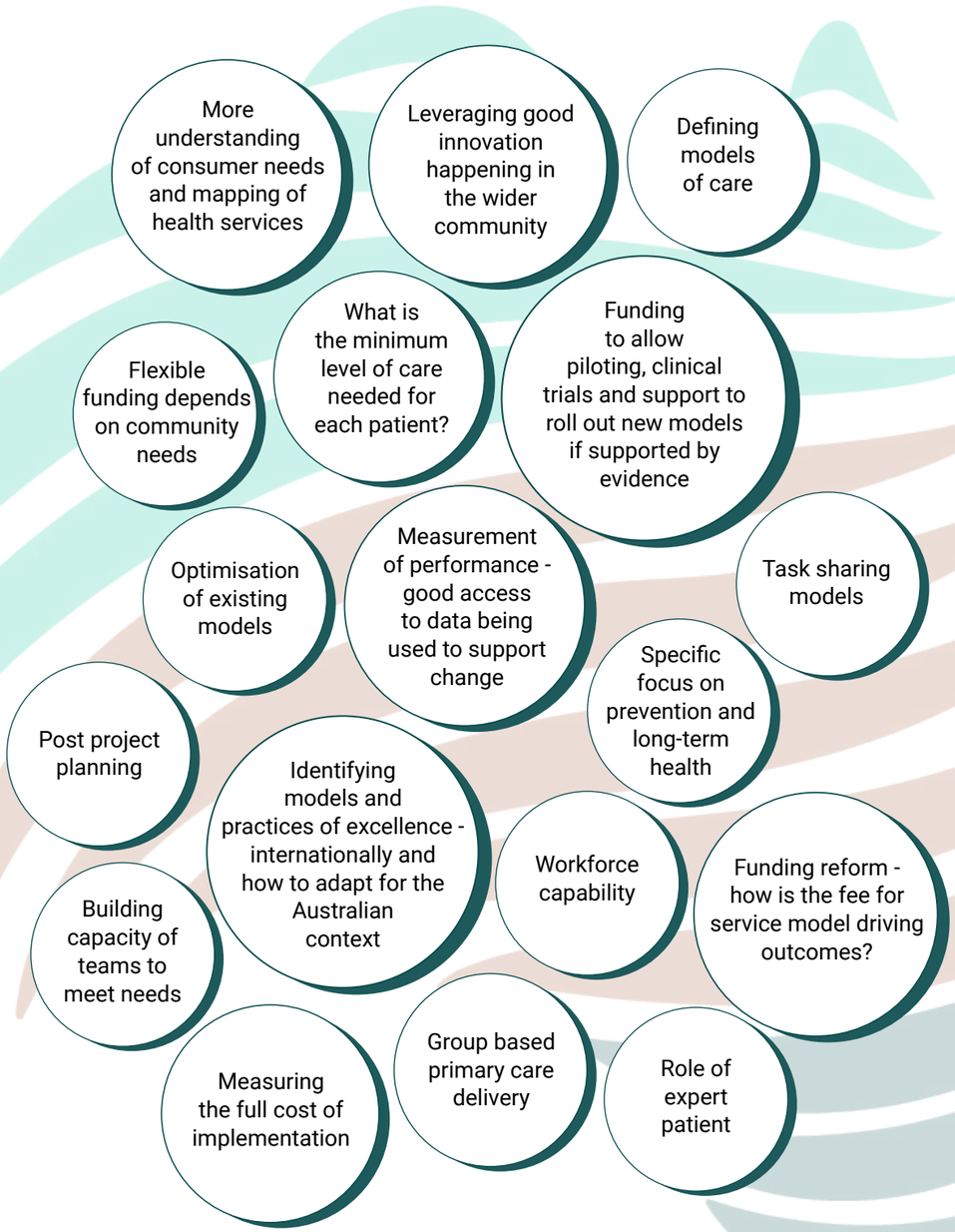
OVERSIGHT OF COMMUNICATION SYSTEMS, DATA AND DEFINED ROLES

PATIENTS HAVING A ‘HEALTH CARE HOME’
- AROUND PEOPLE’S NEEDS

SHOULD THE CONSORTIUM BUILD ON PRINCIPLES AND MODELS
ALREADY ESTABLISHED?

Small Group Breakout Sessions

Research gaps in multidisciplinary team-based care



Small Group Breakout Sessions

How the Consortium can leverage change

- Bring everyone on the journey through evidence
- Advocate for access data
- Showing how Medicare can be improved to meet the evolving needs of consumers
- A central repository for research
- Using the Consortium to ensure allied health representatives are on government advisory panels
- Consumer voice placed front and centre
- To go beyond election cycles and develop a common philosophy
- Research on what works and what doesn't - leveraging the Department in funding models and research
- Learn from high functioning teams
- Governance - the ability to speak with one voice
- Diversity of perspectives to be applied in different areas
- Tangible recommendations and evidence that can be packaged for policy makers

Research Centre Presentations

Aged Care Research & Industry Innovation Australia (ARIIA) Dr Rebecca Bilton

Dr Bilton stated the aged care sector needs evolution of the existing models which embeds best practice into the aged care sector. As more people want to age in their home, their care will be spread across all pillars of multidisciplinary care.

ARIIA has capabilities to leverage off, this includes an information hub that can be used for the Consortium's work.

"We are also very happy to partner with other organisations to help foster innovation," said Dr Bilton.

"To be inclusive, ARIIA has formed an advisory group to integrate and extend the thought leadership beyond the Consortium. This advisory group will provide broad perspectives about ageing in the community and residential care. We are happy for this group to be used as a resource by other members of the Consortium."
When it comes to the co-design of research it is important to consider the perspectives of older people.

"We want to bring the lens of the older person and draw on the broader expertise of the Consortium," said Dr Bilton. "We must clearly articulate to the wider community about why we [the Consortium] are here for the next five years."

FIGURE 4
ARIIA 'Pillar' - Contribution to the Consortium

Lens of older persons & care providers	• Comprehensive understanding of multidisciplinary primary care through the lens of
	  • Older persons
	  • Care providers: Services, Primary care and Aged care workforces

Broad scope of experience & expertise	• Draw on broad experience and expertise across the organisation in allied health, nursing, psychology, business and education
Mixed-methods expertise	• Strong mixed methods expertise and experience – Outputs shared in the ARIIA Knowledge and Implementation Hub
Co-design expertise & stakeholder-informed research	• Importance of co-design – Extensive experience in national stakeholder engagement to support stakeholder-informed research
Implementation science & knowledge sharing	• Expertise in implementation science and how to best facilitate change
Advisory Group	• Guidance provided by ARIIA's Advisory Group established for this project
Underpinned by ARIIA objectives: Sector support, service & advocacy	• Access to national network to promote findings that align with ARIIA objectives

Research Centre Presentations

NHMRC CRE for Strengthening Health Systems in Remote Australia (CRESTRA)
Associate Professor Deborah Russell, Associate Professor Alexandra Edelman and Ashmita Karki

Associate Professor Russell highlighted the importance of safety and security for workforce retention especially in remote areas. The CRESTRA team also shared there is an appetite within remote services to engage in research in partnership with other organisations.

The aims of CRESTRA include strengthening the remote health system workforce, funding, coordination and integration of systems and building research capacity.
CRESTRA works across a number of themes. They include health workforce retention, such as how to minimise avoidable staff turnover and stabilising the remote health workforce.
“The prerequisites for workforce retention are safety and security and adequate housing infrastructure,” said Associate Professor Russell.
Retention strategies under development led by Aboriginal Community Controlled Health Services include cultural orientation and training materials developed in partnership with Elders, Aboriginal employee training and development, a 12-week transition to remote area nursing, supported training and external supervision.

Other themes include remote primary health care funding and how to sustain access to care in remote communities.

“CRESTRA is developing an integrated data system to improve care integration,” said Associate Professor Russell.

Another theme is building remote research capacity. “Last year we held a workshop exploring what does remote research capacity building look like to you?” said Associate Professor Russell. “We got feedback that it is hard for remote services to engage in research but there is an appetite to do so in partnership.”

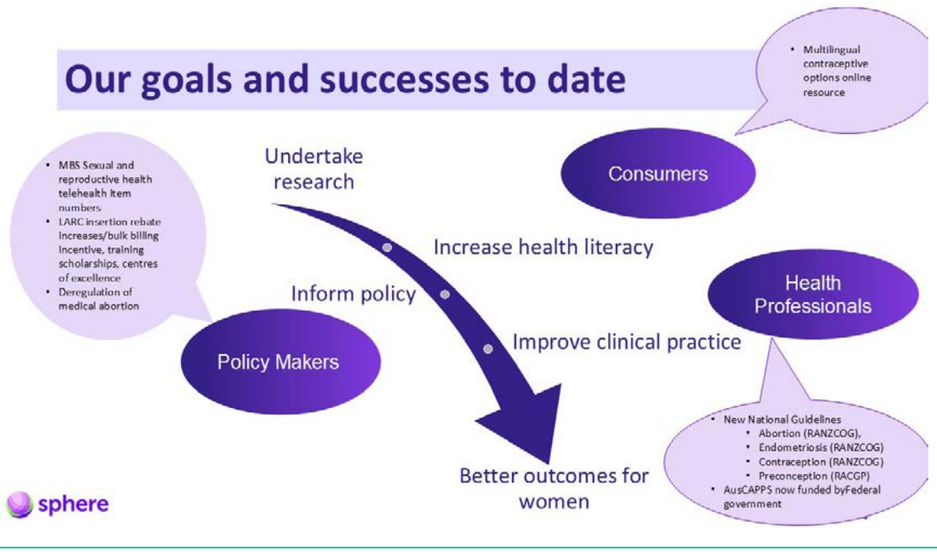
The components of effective MDT-based primary care in remote Australia are: adequate funding; fit for purpose workforce including more employment of Aboriginal community members and career pathways; governance and community participation; adequate physical and IT infrastructure including telehealth; coordination and integration of services; monitoring and evaluation – trialling and scaling up innovative models of primary care; and build remote health priorities into national policy.

NHMRC CRE in Women's Sexual and Reproductive Health in Primary Care (SPHERE) Professor Danielle Mazza AM

Professor Mazza stated that SPHERE focuses on areas that inform the delivery of women's sexual and reproductive health services. They are: building system and workforce capacity; addressing consumer needs; and using data to advance knowledge.

Figure 5 shows how SPHERE works to achieve better outcomes for women.

FIGURE 5



Professor Mazza highlighted several key areas of government focus in relation to women's health that involve multidisciplinary care in which SPHERE has an active program of research. These include:

- The role of pharmacy in expanding access to contraception. SPHERE is currently completing analysis of the MRFF funded ALLIANCE trial that has been evaluating the effectiveness of a community pharmacy contraceptive counselling and referral intervention.
- Expanded scope of practice for nurse practitioners and endorsed midwives in relation to insertion of long-acting reversible contraception (LARC) and medical abortion (MA) provision and nurse led models. SPHERE has conducted the MRFF funded ORIENT trial of a codesigned nurse led model of LARC and MA care in rural and regional general practice. Results are pending.
- The expanded scope of practice nurses when it comes to women's preconception and interconception health and chronic disease care planning.

Research Centre Presentations

- Endometriosis management is another area where new guidelines highlight the benefit of MDT-based care and involvement of pelvic physiotherapists. SPHERE has undertaken the development of EndoMP, in partnership with the RACGP. EndoMP is a codesigned web based structured care plan integrating clinician and patient resources. This plan could enhance MDT and will also provide a lot of input into the Consortium. It is funded through the National Endometriosis Action Plan by the Federal government and operating in partnership with RACGP. This program is scheduled for release in May 2026.

SPHERE also runs AusCAPPS, an online multidisciplinary community of practice involving over 3200 primary care practitioners that supports LARC and MA provision in primary care. Originally funded by a NHMRC partnership grant, AusCAPPS success has resulted in ongoing government funding and forms a key plank of the policy to support primary care in this space.

"A lot of our original research can help address the Consortium research themes particularly around how best to implement key components of multidisciplinary teams as well as their effectiveness and cost effectiveness," said Professor Mazza.

Research Centre Presentations

Melbourne Alliance to implement Multidisciplinary Primary Care (MAMP)
Professor Lena Sanci and Professor Kelsey Hegarty

The Melbourne Alliance to implement Multidisciplinary Primary care aims to integrate the evidence on implementing multidisciplinary teams from their leadership role in four national primary care research programs in: Children and Young People's Health; Safer Families (abuse and violence prevention); Mental Health; and Cancer.

The core themes across the MAMP projects are multidisciplinary teams; consumer engaged models; equitable, culturally responsive and trauma informed models that reach priority and underserved populations; and are economically evaluated and evidence driven.

"The MAMP is increasingly looking at people with lived experience as a peer workforce across its programs," said Professor Sanci.

"Our next step is integrating what we do with the work of the Consortium."

In the area of children and young people we have evidence from three MDT randomised trials – Strengthening Care for Children (SC4C) tested building GP skills and confidence with children and adolescents through co-consultation with paediatricians; it demonstrated sustained reduction of referrals to hospitals and non-GP specialists, increased confidence and cost savings in areas of disadvantage ; a tele-model trial for Rural Children (SC4RC) is underway. Also underway is a RCT of Medicare rebates for adolescent preventive screening, service navigators for Aboriginal young people with emotional distress, and peer support for parents of adolescents with mental ill-health attending general practice.

The SAFE team have implemented whole of practice MDT training, designed and tested in RCTs, to support women and children living with domestic violence to find pathways to safety. The program has trained over 5,000 practice staff over Victoria and Tasmania. A current trial (WEB) is researching a digital clinical decision support system and the addition of a peer workforce to the general practice team to assist women.

The Link-me+ model of mental health care is undergoing an implementation study in the Eastern Melbourne PHN region. Around 30 practices will be involved. Over 7000 patients have already completed triage with the Link-me prognostic tool that stratifies likelihood of mild, moderate or severe depression and anxiety in three months' time; 15 per cent were eligible for the care navigation component embedded in the general practice, 300 patients have worked with a care navigator, and 20 have 'graduated'.

The Primary Care Collaborative Cancer Clinical Trials Group (PC4) supports researchers from across Australia to develop high-quality cancer clinical trials in primary care. PC4, administered by the University of Melbourne, are actively involved in a range of research projects involving multi-disciplinary teams, broadly falling into two areas: i) screening and early detection and ii) survivorship and symptom management.

There is a strong cross-cutting theme to PC4-supported research, targeting priority populations who experience poorer cancer outcomes, including culturally and linguistically diverse communities and regional/rural patients.

Research Centre Presentations

Promoting Responsive and Optimal Approaches for Collaborative Team-Based Care in the Prevention & Management of Chronic Conditions (PROACT) Professor Sarah Dennis

Professor Dennis stated that PROACT focuses on innovative models of MDT-care for the prevention and management of chronic conditions. The Chronic Care Model focuses on moving from a reactive health system to a proactive health system that prevents and proactively manages chronic health problems in partnership with informed and activated patients.

The programs that PROACT are currently working on are: pulmonary rehabilitation to improve uptake and outcomes of comprehensive evidence-based care for Chronic Obstructive Pulmonary Disease (COPD); a pragmatic randomised control trial to digitally support self-management for inhaler device technique and medication adherence among people with COPD and comorbidities; and activating primary care COPD patients with multi-morbidity study.

Current funded projects include: solving Australia's hypertension treatment problem; an integrated multidisciplinary approach to optimising blood pressure control; implementing the evidence based cardiovascular risk reduction package HEARTS in rural and remote Australia; wearables to support healthy behaviours for type 2 diabetes; determining the impact of a new primary care model for low back pain; and Occasions of Care Explained and Analysed (OCEAN).

Proposed projects include: the Propel study involving the prevention and management for older people leveraging primary care teams; allied health and GP responses to long COVID in primary care; and the OCEAN Allied Health data study.

In the first year of the Consortium, PROACT will look at the terms of reference and the process for membership and expansion of PROACT. It will also investigate and do a systematic review of high functioning primary care teams and their criteria for success.

Workforce, Outcome Measures, Logistics and Settings

There was discussion among some of the groups on how best to utilise Primary Health Networks and use those connections and synergies. There was also discussion on capacity building of the Consortium members and expanding skills via online workshops around health economics.

Discussion around the purpose of the Consortium highlighted its role in facilitating system change and consolidating evidence to determine effective models that reflect the population, funding, and are place-based.

Scale and sustainability

Scaling, engaging partners early and identifying workforce gaps were some of the key issues raised by members. Others raised the research gaps in terms of existing models of primary care and how to optimise and measure the full costs of implementation of any new models.

There was also a discussion around the scoping or rapid review of outcome measures. Patient outcomes were identified as critical as were considering regional differences when it comes to measuring these outcomes.

The importance of unpacking key success factors within best practice models was also identified. What are the elements that make them work really well? And what are the barriers? And when it comes to high performing MDTs is it worth drawing on evidence from broader business and leadership expertise?

Members also talked about how to leverage the Consortium effectively and moving beyond just generating research. This involves translating research to the community in simple language and ensuring it comes with an implementation plan so its actionable. This plan should include elements of sustainability and health economics.

Research gaps

What are the key elements of successful models (evidence gaps)? There is a need for health economics to explore the costs associated with different types of consultations. Another area to explore is how to drive change within a system and what is the 'science of implementation' – what do good multidisciplinary teams look like either within Australia or overseas? Another area is funding reform and how is the fee for service model driving outcomes? Members also raised the possibility of creating a proper definition for 'flexible' primary care.

Small Group
Breakout Sessions

Consortium's role and potential implementation

Members highlighted the Consortium's opportunity to be a brains trust in this area and to consolidate the breath of evidence and learn from high-functioning teams. Members also highlighted the advocacy role of the Consortium to champion optimal models of care and to play a role in facilitating systems change. The rich diversity of perspectives to be applied in different areas was also highlighted among the groups.

Theme 1: What MDT-based primary care models optimise health outcomes, workforce satisfaction and experience of care?

- Clinicians sharing information – integration champions and digital access
- Wrap around services
- Chronic disease care and management – mutual obligations and responsibilities of patients
- High standards/infrastructure/resourcing/digital connectivity
- Health coaches embedded in GP practices
- Use knowledge from the non-government organisation (NGO) sector and apply across primary health networks
- Warm handovers and transitions

Theme 2: What outcome measures can be used to compare the effectiveness of different models?

- Evidence of change
- Integration of mental health and general practice
- Do any changes pass the pub test?

Theme 3: What is the cost effectiveness, feasibility, acceptability of different models

- It is difficult to cost some aspects and outcomes of MDT
- Cost of delivery and costs on the consumer side e.g. costs of the doctor and cost of getting there?
- Factor in loss of income across GP practices
- Importance of health economics in this theme
- What is cost effectiveness? Does this mean less spending? Spending in a different way?
- New models may cost more in the short term – may reveal more undisclosed chronic illness
- Review areas in which MDTs save costs e.g. territory health service reduction, aged care services
- What is already working?
- The opportunity to create better research, advocacy and links to primary health networks

Small Group Breakout Sessions

Theme 4: Scale and sustainability of different models of MDT-based care across primary care settings?

- Research must consider implementation and scalability
- What are the workforce gaps? How do we increase capacity building?
- Engage partners early to co-design and plan scaling if successful
- Consortium's role includes engaging meaningfully with institutions
- Funding reform to fund non-GP roles to deliver certain care
- Championing optimal models of care

Theme 5: What is the best approach to implementing the key components of models of care in different settings?

- Facilitate systems change
- Place-based focus
- Funding mechanisms
- Minimum level of care for all Australians
- Population and place determined
- Consolidate the breadth of evidence

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