Progress by Design:

Change Readiness and Breakthrough Innovation in Primary Care

June 2026

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Acknowledgement of Country

The authors acknowledge the First Peoples and the Traditional Custodians of the many lands upon which we live and work. We pay our respects to Elders past and present, and thank them for ongoing custodianship of waters, lands and skies.

Summary

The Australian Government has made a long-term commitment to reforming the Australian primary healthcare system. This recognises that existing fee-for-service models that place the general practitioner almost solely at the centre of readily reimbursable care are not suitable in many contexts. This is most apparent for patients with chronic health conditions. The focus of the reforms is to move toward multidisciplinary, integrated, team-based primary care in which primary care providers are charged with co-ordinating team-based approaches in the pro-active management of chronic conditions and disease risks.

The importance of transitioning to team-based care is well recognised. Historically, numerous initiatives to reform primary care along these lines have been trialled with limited success, outside of Aboriginal Community-Controlled Health Organisations (ACCHOs). Logistical, cultural and financial challenges in shifting individual practices to these new models of care have proven difficult to surmount, scale and sustain. There are valuable lessons from the small number of pioneering organisations, including ACCHOs, that have in different ways transitioned to team-based care.

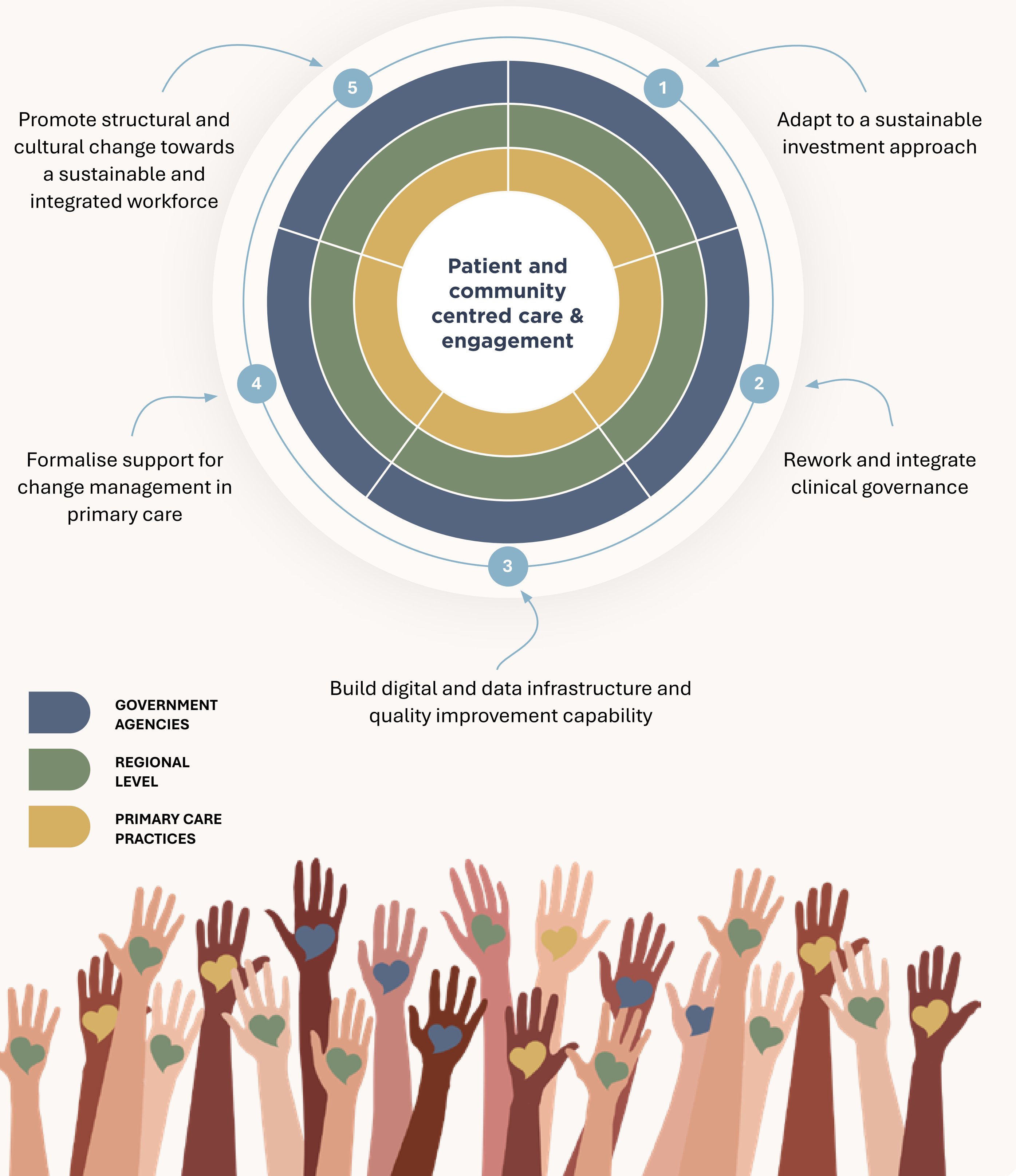
Against this background, a consultation process across primary care stakeholders was initiated, beginning with the 'Progress by Design: A Roundtable on Change Readiness and Breakthrough Innovation in Primary Care' on 5 December 2025 at The George Institute for Global Health, Health Translation Hub University of New South Wales. The Roundtable brought together clinicians and practitioners from across Australia who have been pioneering team-based care alongside ACCHOs, consumers, policymakers, and researchers. In advance of the Roundtable, a stimulus package was circulated to participants that included a summary of policy and literature on team-based care and change management in general practice settings. The task for participants was to identify strategies for individual practices to manage the changes needed to transition to more comprehensive team-based care, as well as determine the support they need along the way. This report is a synthesis of discussions held at that meeting and subsequent follow-up of key individuals and organisations.

Consultations revealed a high degree of consensus on a core principle: **Australia's primary care system holds the capability to deliver modern, team-based care. What is missing is the system architecture and leadership to support it.** Participants repeatedly emphasised that the main challenge is not lack of will, but lack of targeted funding and support to enable the transition to integrated, team-based primary care – providing the *"right care, right person, right place, right time"*.

Transforming primary care requires sector-wide changes in government policy and funding, individual practices, Primary Health Networks (PHNs), peak bodies, colleges, provider organisations, and corporate groups. Key enablers for change were identified as:

1. Adapt to a sustainable investment approach
2. Rework clinical governance to optimise multidisciplinary approaches
3. Build digital and data infrastructure and quality improvement capability
4. Formalise support for change management in primary care
5. Promote structural and cultural change towards a sustainable and integrated workforce

Patient and community centred care & engagement



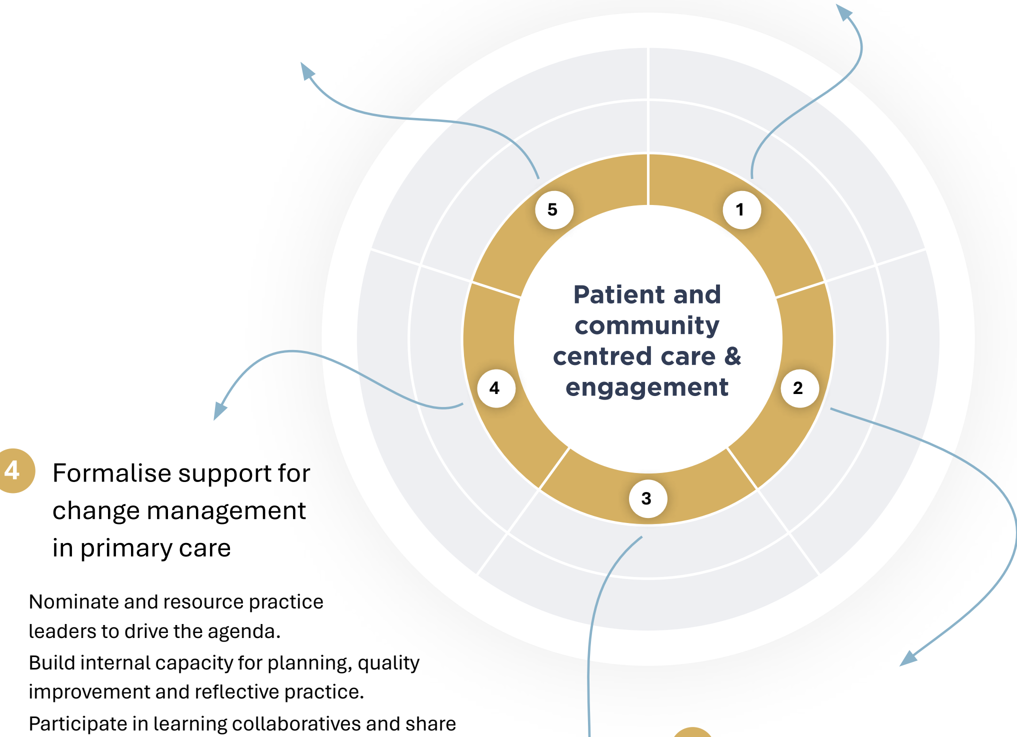
Primary care practices

5 Promote structural and cultural change towards a sustainable and integrated workforce

- Optimise delegation and teamwork towards competency-based care models.
- Move to GP-led shared-care pathways while retaining GP continuity of care.
- Create environments and workflows

1 Adapt to a sustainable investment approach

- Seek opportunities to bring in additional funding streams, e.g. research and strategic grant funds, regional, state and federal government priority grants, non-Medicare services and integrate with other local services (e.g. social, disability).
- Collaborate with other practices to share resources.
- Cross-fund services to extend other services delivered.



4 Formalise support for change management in primary care

- Nominate and resource practice leaders to drive the agenda.
- Build internal capacity for planning, quality improvement and reflective practice.
- Participate in learning collaboratives and share experiences.
- Host site visits or shadowing opportunities.
- Embed time into standard shifts to support change management activities.

2 Rework clinical governance to optimise multidisciplinary approaches

- Define staffing roles with models of care and practice pathways.
- Clarify accountability, delegation and safety.
- Adapt governance structures as teams evolve and include roles for patients, community and carers.
- Establish supervision arrangements that support expanded roles for nurses, pharmacy and allied health.
- Regularly review clinical pathways, outcomes, and risk and referral processes.
- Use clinical governance to drive a culture focused on safety, innovation and quality.
- Develop and resource leadership roles in both clinical governance and organisational/corporate governance.
- Resource efforts to use population and practice audit data to support and address population health needs.
- Use monitoring and quality improvements to fine tune.

3 Build digital and data infrastructure and quality improvement capability

- Develop internal capability through data roles which could be both clinical and non-clinical.
- Shift towards data-driven quality improvement practice, using insights for proactive outreach and care coordination.
- Embed data into daily improvement practice.
- Share data with PHNs and funders to enable ongoing improvements to funding models and models of care.

Regional level

5 Promote structural and cultural change towards a sustainable and integrated workforce

- Expanded regional workforce planning to identify local workforce gaps, support role redesign, and broker shared workforce arrangements to overcome recruitment and retention challenges, promote career pathways, and fill low FTE roles.
- Commission and integrate multidisciplinary services to ensure practices have access to broad services.
- Coordinate training of clinical leaders, peer workers, volunteers, and clinical support roles.
- Expand telehealth-enabled care and case conferencing.
- Encourage integration of workflows with other local organisations to address the social determinants.
- Explore opportunities to embed regional multidisciplinary hubs and new capital that supplement practice teams.

1 Adapt to a sustainable investment approach

- Provide local advice and guidance to implement new funding models.
- Share knowledge and facilitate service connections to promote uptake of new funding streams.
- Support sub-regional collaboration to promote cross-referring or shared staff and resources.

Patient and community centred care & engagement

4 Formalise support for change management in primary care

- Leadership development to foster collaborative environments and partnerships within and outside practices.
- Create and sustain communities of practice to share examples of success.
- Facilitate change management programs to support clinical redesign and quality improvement.
- Promote co-design efforts with other parts of the health sector and across the wider sectors (e.g. aged and disability).
- Support partnership formation and negotiations around regional planning and integrated care.
- Support practices during transition and provide protected staff time during the transition.

2 Rework clinical governance to optimise multidisciplinary approaches

- Develop role delineation and risk management frameworks.
- Establish protocols which enable shared accountability e.g. standing orders, work instructions, internal care pathways, delegation instruments and documentation and communication standards.
- Create shared governance resources to help practices adopt risk-sharing and cross-professional collaboration models.
- Support applying governance in mixed-workforce care models.
- Training and frameworks for leadership which recognise both corporate and clinical governance roles.

3 Build digital and data infrastructure and quality improvement capability

- Support for interoperable platforms, digital and data literacy training, and data capture and cleansing.
- Facilitate the use of standardised data sets, shared care plans and decision-support tools.
- Maintain regional dashboards to enable practice-level benchmarking.
- Hybrid and integrated care models that incorporate telehealth, virtual health systems, and remote monitoring.
- Data roles within or supporting practices to enhance planning and quality improvement.
- Support growth of digital maturity to reduce cyber-risk, poorly coordinated ICT expenditure and lack of take-up of modern ICT systems.

Government agencies

1 Adapt to a sustainable investment approach

- Grow practice and workforce incentive payments to facilitate GP led, team-based models of care.
- Expanded funding models that support transition to competency and team-based practice models.
- Ensure funding structures incentivise outcomes, equity, continuity, and team-based coordination.
- Provide certainty in funding and funding levels to cement trust for long-term investments, promoted by independent price and indexation setting mechanisms.
- Promote integration with other funding systems such as the NDIS and aged care.
- Project clear and considered communication strategies that engage all stakeholders appropriately.

2 Rework clinical governance to optimise multidisciplinary approaches

- Establish shared accountability structures and clear delegation and supervision requirements.
- Clear communication and documentation.
- Risk-sharing frameworks that enable confident team practice and reduced fear of penalty.
- Guidance for hybrid and remote care models.
- Clinical governance structures that enable competency driven delegation.
- Priority populations and models of care which should be adopted e.g. social prescribing, First2000 Days health.

3 Build digital and data infrastructure and quality improvement capability

- National standards for primary care data architecture, tracking and support.
- Improved My Health Record functionality and usability.
- Digital health capability-building programs and incentives that support adoption of interoperable software and modern digital architecture.
- Support for digital maturity which counters growing cyber, interoperability and AI risks must be prioritised.

4 Formalise support for change management in primary care

- Develop a strong and well-established communication strategy to ensure clear understanding of the new system.
- Support ongoing evaluation of early adopter sites and develop a national repository of implementation examples, workflows, case studies and outcome data.
- Establish cross-jurisdictional learning collaborations involving PHNs, LHDs, practices, community-controlled organisations and consumer groups.
- Provide access to workflow redesign experts, co-design methods, human factors specialists and practice change facilitators.
- Recognise exemplary leaders through awards and access to subsidised ongoing training supports including funded release to speak about their work.

5 Promote structural and cultural change towards a sustainable and integrated workforce

- Recognise the change management, operation funding and resourcing changes and time necessary to build, shift and maintain a primary care multidisciplinary team.
- Outline steps to determine and clarify where scope-of-practice legislation and regulations across jurisdictions can be harmonised, with initial considerations towards prescribing within primary care teams.
- Reduce inconsistencies and enables expanded roles.
- Support safe delegation and shared care across professions.

Patient and community centred care & engagement

Aligned with national reform directions, this report includes a summary of ideas to progress transformation to a team-based primary care system. These are:

1. Co-develop a national implementation framework
2. Launch team-based model demonstration sites based on blended funding
3. Develop a national clinical governance model for multidisciplinary primary care
4. Invest in a national primary care digital backbone
5. Create a change management support program for practices
6. Capture and translate early adopter experience

This report demonstrates that the expertise and ambition to deliver team-based primary care already exists within the sector.

However, systemwide reform needs coordinated national and local leadership, supportive resourcing and regulation, investment in both soft and hard infrastructure, practical implementation support, and mechanisms to ensure services are scaled and responsive to local needs.

This work has implications for government, peak bodies, regional coordinating organisations and providers themselves.

Background

This report aims to help primary care organisations navigate the practical challenges of implementing reform.

It is a synthesis of a roundtable discussion that brought together practitioners from across Australia who have been pioneering person-centred primary care (PCPC), consumers, policymakers, and researchers to draw out practical insights and inform national policy directions (Appendix 1). Invitees were largely drawn from practices where team-based care is already strong and growing. Following the roundtable, follow-up consultations were held with key stakeholder groups including government, peak bodies and consumers. This approach was taken to promote discussion of the question of 'how' rather than 'whether' such reform can be implemented at scale across a diverse range of practice settings.

This report contains recommended supports required by practices who have already embraced team-based care and want to do more. By focusing on those likely to move first and fastest, we sought to learn what will accelerate change, particularly among practices that have been slow to do much in the way of real team-based care.

This report contains insights and frameworks for changes, building on strategies that have already been tried and published, and supported by evidence and experience from primary care practices.

We believe these insights are crucial to help other organisations navigate the practical challenges of operating under the new funding and policy landscape — particularly with the shift away from fee-for-service payment to a blended funding model.

A policy-informed discussion

Australia's primary care sector is at a pivotal moment. The call for change is supported by extensive evidence highlighting the necessity for new ways of working and collective acknowledgement of the need for reform.

Key policy reports acknowledging the need for change include Australia's Primary Health Care 10-year Plan 2022-2032, Strengthening Medicare Taskforce Report (2022), RACGP Health of a Nation 2025, and the Review of General Practice Incentives 2024.

There is clear momentum toward systemic primary healthcare reform. The impetus for change has been created by several aspects of the current system:

- A GP-centric, fee-for-service funding model that constrains flexibility and provides little incentive for multi-disciplinary team-based care, preventative health or care coordination.
- An unsustainable service delivery model that aims to address modern day health needs with last century health system design.
- Competing interests and fragmentation that places an unfair burden on patients, carers and the health workforce.
- Limited allocated time for the local workforce to influence the improvement in healthcare delivery and performance.
- Inequity in access to care and consistently poor health outcomes for some populations.

Overcoming these historical flaws will require collective action in gearing individuals and organisations towards new ways of working. The stimulus package provided to participants ahead of the Roundtable included a high-level summary of the policy and literature space. The summary demonstrated that there are strategic reform pathways available, and the changes needed include:

- Centring patient and community voices in the care process.
- Clear goals and support for change while transitioning to team-based care at a practice level.
- Designing with a changing funding landscape in mind.
- Promoting environments that enable practices to focus on patient benefits through strengthening health outcome and continuity of care as areas of focus.
- Multi-disciplinary teams supported by improved systems, communication, and clinical oversight.
- Integrated and flexible care to address complex and mental health conditions.
- An equity focus requiring social determinant and life course approaches to prevention, care provision and service design.
- Effective use of technology and data that is secure and effectively utilised.
- Built in capacity to translate lessons into action and improved quality and comprehensive care.

On the day, further stimulus for discussion was provided through presentations from the Commonwealth Government ('State of play – current reforms, key challenges and existing knowledge gaps'), consumers and from organisational case studies (see appendix 2)

Primary care driven primary healthcare reform

This section summarises what the sector must do collectively to support and implement multidisciplinary, team-based care at scale.

Experts revealed a high degree of consensus around a key principle: **Australia's primary care system holds the capability to deliver modern, team-based care. What is missing is the system architecture and leadership to support it.**

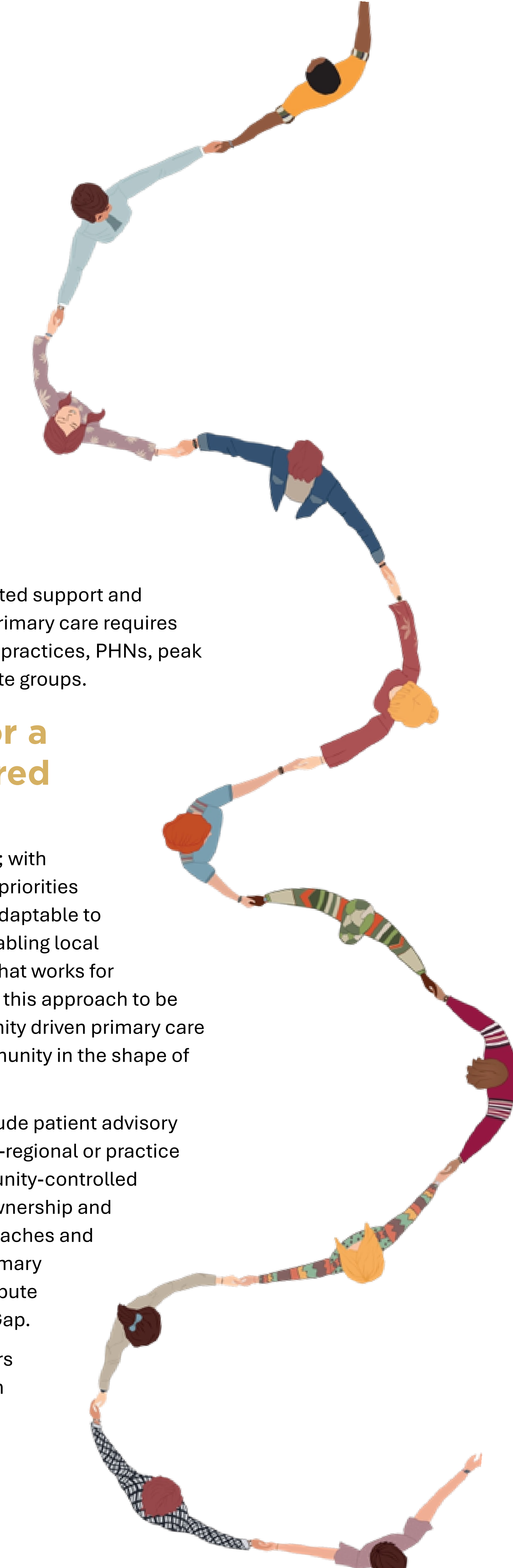
The core challenge is not lack of will, but lack of targeted support and guidance required for transformation. Transforming primary care requires sector-wide changes in government policy, individual practices, PHNs, peak bodies, colleges, provider organisations, and corporate groups.

Overarching theme: need for a community driven and centred primary health system

A patient-centred system elevates community voices; with community members involved in establishing reform priorities and service design. The reform process needs to be adaptable to and guided by local needs and context. Therefore, enabling local level leadership and ownership to develop at a pace that works for a given population and region must be prioritised. For this approach to be successful, there is a need for strengthening community driven primary care systems, which engage and involve the broader community in the shape of the local service models.

Examples of successful integration mechanisms include patient advisory committees and community advisory groups at a sub-regional or practice level. The Aboriginal and Torres Strait Islander community-controlled sector was heralded as an exemplar of community ownership and guidance in primary care. Learnings from these approaches and successes will provide critical insights on broader primary care approaches, and present opportunities to contribute meaningfully to priority reforms such as Closing the Gap.

The following sections are summarised under enablers and offer ideas on key themes identified to strengthen the primary care system, all of which require contribution from the local community.



1. Adapt to a sustainable investment approach

Australia's primary care system needs collective action and sustainable investment to unleash the potential in the new funding reforms.

The current funding model is not suitable for many contexts. It has not delivered ongoing growth in team-based care despite shortages of general practitioners and iterations in funding models largely supporting the use of nurses in general practice. The current funding model perpetuates a system that does not meet a range of critical community needs, can act as a barrier to both practice and policy change, and can contribute to inefficiencies and duplication of services. Overcoming this will require whole-of-system action while also recognising that redistributing existing Medicare funding without additional investment risks repeating past implementation failures.

Participants welcomed the Commonwealth's exploration of a gradual introduction of blended funding models, which could rebalance the current 90 per cent fee-for-service incentives toward models that reward care continuity, teamwork and proactive people-centred and comprehensive care. Ideally, such care should be GP led but not GP dependent, something current funding models emphasise.

There was recognition of the opportunities provided by a shift towards increased bundled incentive payments as a proportion of total practice funding. Additionally, block funding could be attractive for enrolled populations, enabling potential for tailoring for rural areas and under-served populations that are under-utilising Medicare at present due to shortages of providers.

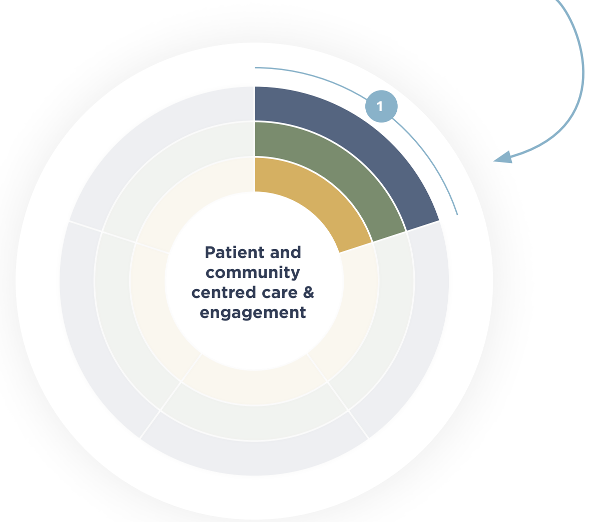
Emphasis was placed on the need for increased funding for more preventative care, social prescribing, access to allied health, pharmacy and integration with other parts of the health and social care sector.

The need for access to capital to increase digital infrastructure and provide more suitable spaces for larger teams was repeated across the room.

Finally, support for model flexibility and an opt-in approach to change processes were important to ensure implementation can be tailored to meet the local context.

Ideas for action

To adopt a sustainable approach and enable patient-centred care:



Primary care practices will need to adapt to new funding mechanisms and models to optimise patient care, workforce sustainability, and business models to meet local need. Practice actions include:

- Seek opportunities to bring in additional funding streams, which many practices may wish to consider as the funding models shift. This could include research and strategic grant funds, engagement with opportunities and priorities driven by regional, state and federal government bodies (including grants for new models of care), non-Medicare services and integrate with other local social, disability, ageing and health services including through registration as providers with the NDIS and other schemes. Although raised, reliance on increased out-of-pocket payments

as an option for covering these resourcing needs is seen as an inequitable and unsustainable long-term option. Improved core and diversified funding were preferred.

- Identify opportunities to collaborate with other practices to encourage a strength-based approach and build-in opportunities to share resources (e.g. engage with local models on shared data analysis and referral sources to streamline service delivery).
- Build and expand cross-funding approaches that bring about genuine patient-centred, wrap-around care. This may involve split business models that draw on gap fees and health insurance to extend other services delivered.

Regional level. PHNs, colleges and relevant organisations hold the strong connections with existing networks and services and are well placed to support:

- Processes to implement new funding models and provide local advice and guidance.
- Facilitate service connections and shared knowledge to promote uptake of new funding streams.
- Support sub-regional collaboration where practices partner, cross-refer or share staff and resources to ensure practices can retain and expand access to the multidisciplinary workforces required to reduce fragmented care. These may be in the form of co-design, governance, hiring and fund holding supports.

Government agencies need to collaboratively develop a clear and staged roadmap, detailing how blended funding will operate, who can opt-in, how transitions will be supported, and how outcomes will be monitored.

Suggested actions for government agencies to progress blended funding reform include:

- Grow and modernise practice and workforce incentive payments which facilitate GP led, team-based models of care. Although participation in new funding models needs to be voluntary, incentives need to be sufficient to reward transitioning practices and recognise the extra time required to deliver team-based care delivery and promote health equity.
- Establish and co-design expanded funding models that support transition to team-based, competency enabled practice models that empower multidisciplinary teams. Critical to this are clinical governance structures to enable this broader scope of practice with accountability for demonstrating improved access and comprehensiveness of care.
- Ensure funding structures incentivise outcomes, equity, continuity, and team-based coordination, supported by strong accountability measures and trust. Importantly, change needs to recognise the balance to be struck between volume and care quality in light of our growing population and rising demand for care.
- Provide certainty in funding and funding levels to cement trust and instil the confidence needed for organisations to make necessary long-term investments. Such certainty could be enhanced with independent price and indexation setting mechanisms.
- Promote integration with other funding systems such as the NDIS and aged care to enable and streamline patient care.
- Project clear and considered communication strategies that engage all stakeholders appropriately and in a timely manner.

Without concrete guidance, early adopters ready to scale up cannot make informed decisions, and system-wide reform will stall. This guidance must also consider the transitional costs practices face when redesigning care including systems creation and deployment, governance (clinical and corporate), culture, workflows, staff recruitment costs and budget planning.

2. Rework and integrate clinical governance

Current clinical governance models are not presently designed to meet the integrated, multidisciplinary team structures required for team-based primary care.

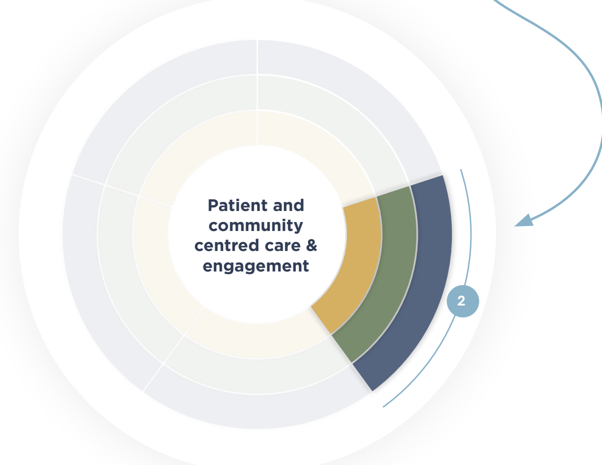
To promote operations that enable *"right care, right person, right place, right time"* it will be essential to reform and strengthen primary care clinical governance structures.

The existing traditional GP-centric contractor model where "*the GP carries the burden of responsibility"* has resulted in a fragmented clinical governance structure that centres risk on doctors and disempowers effective multi-disciplinary teams. This structure constrains delegation and limits the ability of teams—especially nurses, pharmacists and allied health practitioners—to work to their full scope.

To complement the work on governance standards for primary care underway, actions are required across the system to embed reform of the clinical governance framework. In particular, operations actions that support multidisciplinary work—covering accountability, data use and planning, risk-sharing, communication pathways, care delegation and supervision.

Ideas for action

To rework and integrate clinical governance and enable patient-centred care:



Primary care practices will need to embed new team-based clinical governance structures into everyday practice. To enable teams to work to their full capability, practices can:

- Define staffing roles within models of care and practice pathways and implement training programs and responsibility matrices which clarify accountability, delegation and safety.
- Ensure governance structures adapt as teams evolve and include roles for patients, community and carers.
- Establish supervision arrangements that support expanded roles for nurses, pharmacy and allied health.
- Conduct regular reviews of clinical pathways, clinical outcomes, clinical risk, communication pathways and referral processes.
- Stage and use clinical governance meetings and mechanisms to drive a culture focused on safety, innovation and quality.
- Develop and resource leadership roles in both clinical governance and organisational/ corporate governance.
- Resource efforts to use population data and practice audit data; and implement quality improvement and service expansion which addresses population health needs.

- Emphasise local monitoring and quality improvement so fine tuning can be guided by local change experience and patient and clinician feedback.

Regional level. PHNs, colleges and relevant organisations are well placed to supply locally appropriate template clinical governance frameworks, with responsibilities that include:

- Role delineation and risk management frameworks.
- Protocols which enable shared accountability (e.g. standing orders, work instructions, internal care pathways, delegation instruments and documentation and communication standards).
- Shared governance resources, datasets, templates and training to help practices adopt risk-sharing and cross-professional collaboration models.
- Training and support applying governance in mixed-workforces, including hybrid and virtual care models.
- Training and frameworks for leadership which recognise both corporate and clinical governance roles. This needs to reflect the intersectionality of culture, organisational performance planning and monitoring, technology adoption, and business development.

Government agencies need to accelerate development of national clinical governance guidance and coordination for multidisciplinary primary care. Key priorities noted include:

- Shared accountability structures and clear delegation and supervision requirements.
- Communicate and document expectations.
- Provide risk-sharing frameworks that enable confident team practice, reduce fear of penalty and are explicit about practice and provider roles.
- Guidance for hybrid and remote care models (e.g. telehealth, outreach, and hub and spoke work).
- Clinical governance structures that enable competency driven delegation and support which evolves over time.

These actions will provide the assurance required for both practitioners and regulators to support expanded team roles and scale up those roles in priority areas.

3. Build digital and data infrastructure and quality improvement capability

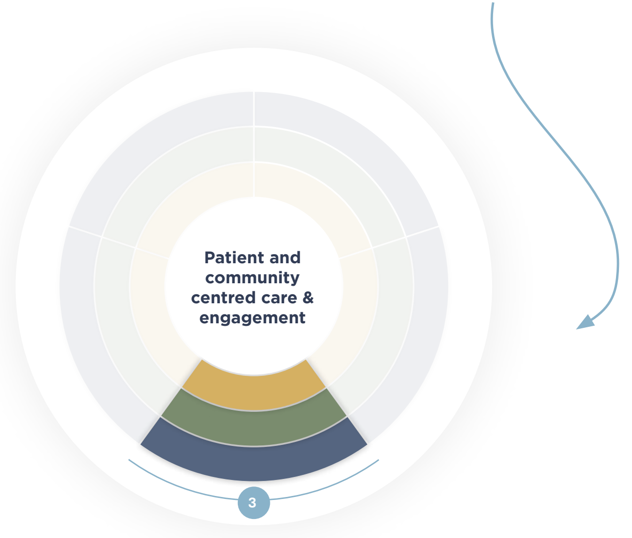
Data is a corporate resource, a clinical enabler and a quality improvement resource. Providing the correct digital and data infrastructure was recognised as an integral enabler of patient-centred care and quality improvement. Furthermore, establishing multi-disciplinary and integrated care requires integrated technology to support proactive care, population-level management, and better communication across teams. Building this infrastructure requires investment at practice and system levels to secure the collective benefits.

Participants agreed on the need for meaningful data generation and analysis roles within or linked to practices; more telehealth and hybrid models, in particular for regional and remote care and to bridge access to specialists and allied health in all locations; and decision-support tools enabling GP-led but not GP-dependent care and overall coordination of team efforts for patients with multi-morbidity.

There was a strong emphasis on the need for shared patient electronic records throughout the care pathway. Effective team-based care relies on shared, meaningful data—yet many practices lack the tools or workforce capability to use or share their data confidently.

Ideas for action

To build digital and data infrastructure and quality improvement capability and enable patient-centred care.



Primary care practices need to:

- Develop internal capability through data roles; these could explore part-time and casual roles, expanded role capacities and upskilling both clinical and non-clinical roles.
- Shift toward data-driven quality improvement practice planning and resultant care models, using insights for proactive outreach, care coordination, and population segmentation.
- Embed data into daily improvement practice—case reviews, audits and quality improvement cycles.
- Share data with PHNs and funders to enable ongoing improvement to funding models, models of care and regional planning.

Regional level. PHNs, colleges and relevant organisations can continue to strengthen their approach to provision of hands-on support and regional coordination of digital and data infrastructure. Their roles will enable practices to implement proactive, population-based planning and care models. Key supports and functions include:

- Support for interoperable platforms, digital and data literacy training, and consistent data capture and cleansing.

- Facilitate the use of standardised data sets, shared care plans and decision-support tools across practices.
- Maintain regional dashboards to enable practice-level benchmarking and identify improvement opportunities including population segmentation and analytics.
- Support expanding hybrid and integrated care models that incorporate telehealth, virtual health systems, and remote monitoring into practice workflows.
- Provide regional data support teams that help practices extract, interpret and use data.
- Data roles within or supporting practices to enhance planning and quality improvement.
- Support measurement and growth of digital maturity through ongoing assessments of digital understanding, deployment and maturity to reduce the potential for cyber-risk, poorly coordinated ICT expenditure and lack of take-up of modern ICT systems fundamental to effective shared care.

At the system level, investment in data infrastructure that provides both policy and operationally relevant information is essential. Progressing this requires continued action and investment in:

- National standards for primary care data architecture, tracking and support for growth in digital maturity in general practices.
- Improved My Health Record functionality and usability.
- Digital health capability-building programs and incentives that support adoption of interoperable software and modern digital architecture.
- Support for digital maturity which counters growing cyber, interoperability and AI risks must be prioritised. These need to be blended with reforms at the State level and support agencies to ensure our entire health and social care sectors work with the same data that is relayed to patients and populations under care.

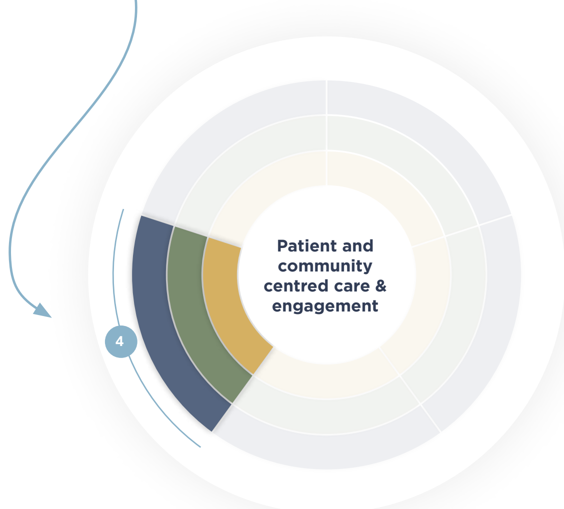
4. Formalise support for change management in primary care

Formal change management is a key ingredient missing from current primary care reform. Formalising and funding support for change management is essential to foster a learning and responsive system and should be seen as a core system capability.

Participants repeatedly noted that past reforms failed because they assumed practices could *self-implement* major change without resourcing or with limited and temporary support. There was strong agreement that the time, skills and cost required for practice-level transformation are consistently underestimated in policy design and should be explicitly addressed. Discussions emphasised that to foster a learning system across primary care reform requires deliberate organisational change: redesigning workflows, building team culture, improving communication, and supporting staff through adaptation. Without structured support for change, past reform attempts have faltered. This will include recognising and resourcing the critical role of practice leaders, both clinical and organisational, as well as a clear approach to the how and sequencing of change processes.

Ideas for action

One of the Roundtable's clearest messages was the need to capture, share, and normalise innovation in this area of change management.



Practices need support to:

- Nominate and resource practice leaders capable of driving this agenda.
- Build internal capacity for planning, quality improvement and reflective practice.
- Participate in learning collaboratives and share experiences.
- Host site visits or shadowing opportunities for other practices.
- Embed time into the standard work week for staff to support change management activities.

Regional level. PHNs, colleges and relevant organisations have key roles that build on the national change management work that the PHNs have been progressing and strengthening through locally specific and tailored actions. These require actions to:

- Develop leadership, manage change, and foster collaborative environments and partnerships within and outside practices.
- Create and sustain communities of practice that enable early adopters and new entrants to share examples of success.

- Facilitate change management programs, training, templates and tools to support clinical redesign and quality improvement efforts.
- Promote co-design efforts with other parts of the health sector (e.g. hospital focused integrated care projects) and across the wider care sectors (e.g. aged and disability) to ensure these leading practices are included in wider change and integration initiatives.
- Support partnership formation and negotiations around regional planning and integrated care with general practice more actively involved in needs assessment and co-design of co-commissioned services.
- Support practices during transition and provide protected staff time throughout the transition (this could include transitional funding supports).

There was **broad support for governments** to establish a national change management and implementation support program, including:

- A strong and well-established communication strategy to ensure clear understanding of the new system and bringing everyone onboard together.
- Ongoing evaluation of early adopter sites, publicly accessible outcomes, and creation of a national repository of implementation exemplars, workflows, case studies and outcome data.
- Cross-jurisdictional learning collaboratives involving PHNs, LHDs, practices, community-controlled organisations and consumer groups.
- Access to workflow redesign experts, co-design methods, human factors specialists and practice change facilitators.
- Recognition of exemplary leaders through awards and access to subsidised ongoing training supports including funded release to speak about their work.
- Identify priority populations and models of care which should be adopted (e.g. social prescribing, First 2000 Days health, Thriving Kids and healthy ageing).

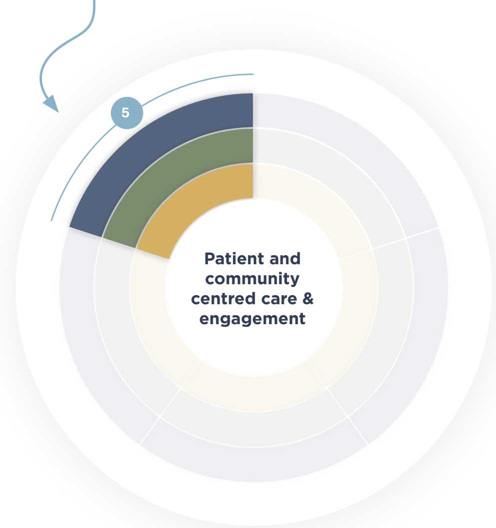
5. Promote structural and cultural change towards a sustainable and integrated workforce

Unlocking the full capability of an integrated primary care workforce that builds and sustains collaborative practice cultures, as well as managing the associated funding reforms, is a necessary shift that will take time.

Traditional models leave GPs feeling they *"carry the burden of responsibility,"* add to burnout risk and limit delegation and team functioning. Addressing this significant system challenge will require cultural change and sensitivity across all levels of the health system to adapt the working structures to an integrated and genuinely multidisciplinary structure. Ultimately, the shift will move away from GP-dependent care towards GP-led care, underpinned by a system that reinforces supportive, collective and psychologically safe environments and care. This is an environment where all team members feel confident in sharing in the responsibilities of leadership

Ideas for action

To promote structural and cultural change towards a sustainable and integrated workforce to enable team-based care



Practices need support to:

- Optimise delegation and teamwork towards competency-based care models, so roles match skills and patient needs, not traditional hierarchies.
- Move from linear, GP-dependent workflows to GP-led shared-care pathways. This involves implementing shared decision-making protocols and creating opportunities for joint problem solving and appropriate delegation while retaining GP continuity of care.
- Create environments and redesign workflows —physical or virtual—that facilitate co-location, communication and shared care, and fully utilise available multidisciplinary resources.
- Redesign appointment systems to allow for case conference discussions, shared medical appointments, proactive care blocks, preventative health planning and chronic disease reviews.
- Establish regular team huddles, case reviews and reflective practice sessions.
- Develop onboarding and induction processes that emphasise team culture and collaborative practice. This includes emphasising proactive, comprehensive care norms fulfilled through agreed internal care pathways, standing orders and other care delegations.
- Celebrate early wins and encourage continuous professional development across all roles, not only GPs, to build momentum and reinforce change.

Regional level. PHNs, colleges and relevant organisations are uniquely positioned to translate national policy into practical, local action; and have opportunities to expand their role as **regional integrators**, ensuring that practices are supported with the resources, relationships, and infrastructure needed for team-based care. That care also needs to span health and social care and address sub-regional challenges in accessing quality care.

Actions raised included:

- Expanded regional workforce planning and capability building to identify local workforce gaps, support role redesign, and broker shared workforce arrangements. These will be critical to overcome recruitment and retention challenges, expand access to other relevant services, promote career pathways, and enable individual primary care organisations to fill low FTE roles —including regional nurse practitioner, data analyst, allied health, pharmacy and mental health teams.
- Commission and integrate multidisciplinary services to ensure practices have access to allied health, pharmacy, chronic disease management, mental health support, social prescribing and culturally responsive services.
- Coordinate training of clinical leaders, peer workers, volunteers and clinical support roles, like Medical Practice Assistants, to augment the work of practicing clinicians and create greater system capacity and personalisation.
- Explore opportunities to embed regional multidisciplinary hubs and deploy new capital to fund building options that supplement practice teams without requiring each practice to employ every skill set.
- Expand telehealth-enabled and case conferencing models that connect remote communities with specialised support.
- Encourage integration of workflows, care models, information, and referrals with community-controlled organisations, local councils and NGOs to address the social determinants of health and jointly commission community development workers to facilitate resultant projects.

The Roundtable heard that the mismatch in regulations, such as drugs and poisons legislation across states and territories remains a major barrier to team-based care, limiting who can prescribe, administer or supply medications. The Department has initiated work with State and Territory regulators to align these frameworks. However, to address these and equivalent challenges, **government agencies are encouraged to** prioritise a nationally consistent scope-of-practice framework that:

- Recognises the change management, operational funding and resourcing changes and time necessary to build, shift and maintain a primary care multidisciplinary team and structure centred around quality improvement.
- Outlines steps to determine and clarify where scope-of-practice legislation and regulations across jurisdictions can be harmonised, with initial application to prescribing within primary care teams.
- Reduces inconsistencies and enables expanded roles for nurses, nurse practitioners, pharmacists and allied health including in how Medicare items are defined (e.g. Health Assessments).
- Supports safe delegation and shared care across professions.

Without aligned legislation, multidisciplinary care models will remain patchy and difficult to scale.

Recommended next steps

Based on the Roundtable insights and aligned with national reform directions, the following steps are a summary of ideas to progress the above discussion to establish team-based primary care.

1. Co-develop a national implementation framework

- Led by representatives across the care system (Department of Health with PHNs, colleges, practices, peaks, consumers), to detail the overarching approach, and explicitly detail each of the points raised in this report.
- Translate high-level reform concepts (e.g., blended funding, scope, governance) into practical guidance and tools which enable change.
- Include timelines, support structures and milestones.
- Determine roles and responsibilities at each level, recognising that multiple organisations will have overlapping and shared responsibilities within a level and that individual regions will require discrete approaches.

2. Progress incremental introduction of blended funding for team-based models

- Voluntary participation, encouraging uptake where there is clear multidisciplinary strategy, strong evaluation and shared learnings.
- Establish an independent pricing authority for primary care.
- Provide protected time and financial support for redesign of care and the environment of care both physical and digital.

3. Develop a national clinical governance model for multidisciplinary primary care

- Adaptable for small, medium and large practices.
- Cover accountability, communication, documentation, risk, and delegation.
- Embed into accreditation and quality frameworks.

4. Invest in a national primary care digital backbone

- Establish standards for shared-care plans, structured data and decision-support.
- Expand access to interoperable systems and regional digital support hubs.
- Prioritise digital inclusion for rural practices and communities.
- Invest in digital maturity uplift.

5. Create a change management support program for practices

- Provide coaching, templates, case studies, and training on clinical and organisational redesign.
- Integrate with PHN practice support programs.
- Build a sustained community of practice through additional funding for leadership roles of both clinical and corporate nature
- Fund both clinical and operational leadership roles as core practice roles.

6. Capture and translate early adopter experience

- Regularly synthesise insights from demonstrations, research and frontline learning.
- Build a structured national repository of case studies and implementation guidance **(see Appendix 3 which highlights the application of the priorities raised in relation to prevention and management of Chronic Kidney Disease).**

Conclusion

This report demonstrates that the expertise and ambition to deliver team-based primary care already exists within the sector.

The discussions highlight the strong points of agreement across the sector on actionable steps towards an integrated, multidisciplinary primary health system which can respond to rising demand and workforce shortages.

To meet changing population health needs, the reform of primary care needs to focus on a number of areas of change management that includes coordinated national and local leadership, supportive resourcing and regulation, investment in both soft and hard infrastructure, practical implementation support, improved leadership and establishing mechanisms to make primary health services responsive to local needs. To enable this transition funding uplifts will be an important element of the process.

With these elements in place, Australia can make real and genuine progress toward a primary care system that is more proactive, connected, equitable, comprehensive, and capable of meeting community expectations within the constrained workforce environment facing the health sector.

Acknowledgments

The authors would like to thank the experts actively involved in the operations of the primary health system who volunteered their time to participate in 'Progress by Design' on Friday 5 December 2025, to build collective understanding and prioritise approaches to implementation of the reform agenda. The roundtable was Co-Hosted by The George Institute for Global Health and the International Centre for Future Health Systems at the University of New South Wales, Healthicare Western Sydney, Inala Primary Care Brisbane and Next Practice Deakin ACT. It was supported by an untied grant from the AVANT Foundation.

The event was facilitated by Natasha Doherty from Ethicol.

This report was prepared by Tristan Bouckley, Maarinke van der Meulen, Gill Schierhout, Anne-Marie Fayer, David Peiris, Rosemary Calder, Natasha Doherty, Narelle Adem, Tracey Johnson and Stephen Jan.

Appendix

Appendix 1:
List of Participants

First name	Last name	Organisation
Jade	Hansen	Aboriginal Health and Medical Research Council
Kath l	Keenan	Aboriginal Health and Medical Research Council
Anna	Robinson	Access Health and Community
Michael	Bonning	Australian Medical Association
Tarek	Dale	Australian Primary Health Care Nurses Association
Mia	Dhillon	Australian Primary Health Care Nurses Association
Denise	Lyons	Australian Primary Health Care Nurses Association
Luis	Reyes	Community Representative
Lindsey	Bailie	Department of Health, Disability and Ageing
Alison	McMillan	Department of Health, Disability and Ageing
Nick	Morgan	Department of Health, Disability and Ageing
Natasha	Doherty	Ethical
Aaron	Chambers	Growlife Medical
Kali	Renata-Bergin	Healthicare
Walid	Jammal	Hills Family General Practice
Anthea	Blower	Hope Island and Homeworld Helensvale Medical Centres
Richard	Nankervis	Hunter New England and Central Coast Primary Health Network
Tracey	Johnson	Inala Primary Care
Suzanne	Williams	Inala Primary Care
Margo	Barr	International Centre for Future Health Systems, UNSW
Patricia	Davidson	International Centre for Future Health Systems, UNSW
Michael	Wright	International Centre for Future Health Systems, UNSW and The Royal Australian College of General Practitioners
Narelle	Adem	lgA Nephropathy Foundation
Megan	Callinan	Marathon Health
Lou	Sanderson	Miwatj Health Aboriginal Corporation
Kean-Seng	Lim	Mt Druitt Medical Centre, Healthicare
Caroline	Holtby	Murrumbidgee Primary Health Network
Elise	Penton	Murrumbidgee Primary Health Network
Jason	Agostino	National Aboriginal Community Controlled Health Organisation
Paresh	Dawda	Next Practice

Ray	Messom	NOUS
Michael	Tam	Primary and Integrated Care Unit, South West Sydney Local Health District Mental Health Service
Belinda	Lewis	Queensland Health
Jaspreet	Saini	Rosedale Medical Practice, Australian Medical Association and HotDoc
Dene	Creegan	Seven Springs Medical Practice
Clare	Evans	Soul Clinic
Lee	Fong	Soul Clinic
Michelle	Shareky	Stroke Recovery Association
Kevin	Wisdom-Hill	Summit Health
Tristan	Bouckley	The George Institute for Global Health
Anna	Campain	The George Institute for Global Health
Ruth	Freed	The George Institute for Global Health
Stephen	Jan	The George Institute for Global Health
Audrey	Lee	The George Institute for Global Health
Hueiming	Liu	The George Institute for Global Health
Maarinke	Van der Meulen	The George Institute for Global Health
James	Kelly	The Royal Australian College of General Practitioners
Kuljit	Singh	The Royal Australian College of General Practitioners
Fiona	Willer	The University of Queensland
Lauren	Carter	TMC Medical
Mojdeh	Moghaddami Alkami	TMC Medical
Tahli	Hattwell	TMC Medical
Rosemary	Calder	Victoria University
Stella	McNamara	Victoria University
Tyler	Nichols	Victoria University
Caroline	Pilot	Victoria University
Anne-Marie	Feyer	WentWest
Andrew	Newton	WentWest
Leanne	Wells	Consultant to WentWest
Rajat	Srivastava	Wentwest

Appendix 2: Case Studies

Rosemary Calder

Multidisciplinary team-based care in Australian general practice: Case studies

Progress by Design: A roundtable on change readiness and breakthrough innovation in primary care

5th December 2025

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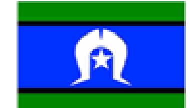
Acknowledgement of Country



Victoria University acknowledges, recognises and respects the Ancestors, Elders and families of the Bunurong/Boonwurrung, Wadawurrung and Wurundjeri/Woiwurrung of the Kulin who are the traditional owners of University land in Victoria, the Gadigal and Guring-gai of the Eora Nation who are the traditional owners of University land in Sydney, and the Yugara/YUgarapul people and Turrbal people living in Meanjin (Brisbane).

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Australia's aspirations for primary health care

- A significant number of national reviews over 30 years have examined the implications of the increasing prevalence of chronic diseases.

- Reviews have highlighted existing funding structures either create or fail to address barriers to delivering coordinated, clinically effective and efficient healthcare.

- The Productivity Commission's 2017 report, *'Shifting the Dial,'* stated:

  "Australia's messy suite of payments are largely accomplices of illness rather than wellness, only countered by the ingenuity and ethical beliefs of providers to swim against the current."

Australian health services: too complex to navigate. A review of the national reviews of Australia's health service arrangements. Calder, R; Dunkin R; Rochford C; Nichols T. Australian Health Policy Collaboration, Policy Issues Paper No. 1 2019

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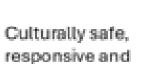
Australia's aspirations for primary health care

Integrated, consumer-centred care across providers

Value-based care focused on quality, safety and outcomes

Culturally safe, responsive and trauma-informed care



Prevention, early intervention and health promotion

These elements have been highlighted, advised, or underscored in various national reports, strategies, and declarations, such as:

- Australia's Primary Health Care 10-Year Plan 2022 – 2032
- COAG Health Council National Primary Health Care Strategic Framework, 2013
- National Aboriginal and Torres Strait Islander Health Plan 2021 – 2031
- National Safety and Quality Primary and Community Healthcare Standards, 2021

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Case studies – context and introduction

The evidence: preventive health within primary health care:

- There is increasing support for team-based approaches in promoting healthy weight, mental health, and overall wellbeing.
- Allied health professionals and primary health care (PHC) nurses have demonstrated expertise in supporting positive behavior changes among individuals at risk.
- The evidence supporting team-based care, and the acknowledgment of various health professionals' skills, could be systematically supported by MBS funding.

Preventive health in primary health care: scope and future development. A commissioned report for the Primary Health Care Reform Taskforce, September 2020. Calder, R; de Courten, M; Morgan M; Pogrmilovic, BK. AHPC, Victoria University.

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MDT based general practice profiles

Inala	Deakin
Not-for-profit organisation/charity	Proprietary limited company with 2 shareholders (lead GP with GP equity partner)
Co-located in a community health building with rent paid to Qld Health	Standalone clinic within shared building owned by an ophthalmology health service
Consult rooms designed more like hospital clinic rooms – large and purpose-built. More back of house space for research team and project team members	Purpose designed – consulting rooms are not owned by the doctor or nurse practitioner; it's the patient's room. Team goes to and moves around the patient
Co-location enables shared medical appointments with community health services	Team collaboration area behind consulting space, designed to enable natural encounters throughout the day – like the family room in a home
Separate rooms for chronic disease nurses, treatment room area, surgical and procedural spaces and collection bay for ambulances	Treatment room with ambulance access, multi-purpose non-clinical room, space for future visiting specialist consultants
Practice is attended by clients from the suburbs of Inala, Durack, Inala Heights and Richards	Practice is attended by clients from throughout the Canberra area
Large CALD patient base – 46% across 148 ethnicities	Services all specified patient population groups

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Case studies – context and introduction

The evidence: health and wellbeing in older age

- Multidisciplinary team (MDT) models involve collaboration among medical practitioners, nurses, specialists and allied health professionals to provide comprehensive care.
- Increasingly implemented in PHC to address rising prevalence of multimorbidity, frailty and functional decline in an ageing population.
- MDT models enable person-centred, coordinated, and often preventive approaches by combining the expertise of diverse health professionals.
- MDT care can lead to improvements in functional status, medication management and patient satisfaction, with some studies reporting reductions in hospitalisations and healthcare costs.

Enhanced Primary Care for Healthy Ageing: Literature Review. Pilot CH, Usmani W, Way K, Duggan M, de Courten M, Calder RV. (2025) Australian Health Policy Collaboration. Victoria University.

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Introducing MDT care

- Inala and Deakin both recognised the need for a greater focus on patients and communities, with a desire to work at a population level.
- Creating MDT care within the practice was the best way to move beyond transactional care.
- Building shared responsibility for managing complex care and improving patient outcomes.

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Inala case study - Implementation

MDT care embedded from inception – Inala is purpose designed with focus on innovation and integration with other social and community services.

Deliberate decision given high level of disadvantage and rates of disease and chronic health conditions within the community.

Multidisciplinary approach given difficulty attracting doctors.

Built a large team from the outset - mainly with clinical nurse consultants working to a higher scope of practice.

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Inala case study – key characteristics

Structural:

- Independent board with strategic oversight.
- Clinical governance committee with representation across each discipline.
- Staff are salaried.
- Practice is research active with a data driven, collaborative approach to planning staffing and models of care.

Operational:

- Culture is very team based – flat hierarchy, lack of medical superiority.
- Patient-driven focus, not doctor driven.
- Range of communication processes – monthly staff meetings and grand rounds, shared notes, clear protocols and long practice manual.

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Inala case study - evolution

- As the practice has matured, more team-based sub-specialty clinics have been incorporated (for example complex diabetes, kidney service, social prescribing).
- Continuously evolving to include further sub-specialties.
- Have had to adapt range of allied health services over time depending on short-term funding.

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Inala case study – patient population profile

46.17% CALD background

15.26% with mental health condition

34.5% (safe est.) with one or more chronic conditions requiring ongoing management

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Inala case study – workforce profile

13 GPs

6 Practice Nurses

Embedded Allied Health

Administrative Team

Total of 40 team members and associates

Charitable practice housed within a QH building

Specialising in complex care:

Ageing Well, Mental Health, Chronic Disease, First 2000 Days, Migrant and Refugee Health

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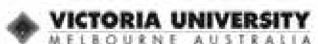
Inala case study – economic model

High proportion of patients on chronic disease care plans (2000 out of nearly 5000 patients)	High proportion of nursing workforce	As a registered charity, access to grant funding to pilot new models of care
Diversifying income streams – setting up a private billing practice in a more affluent area that will cross-subsidise the work	CEO role generates revenue – projects, consulting, software	Utilising new bulk billing incentives



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Inala case study – needs and outcome measures

- Patient needs: patient activation measure (PAM) scores.
- Outcome measures: barriers are that our systems are not designed to produce outcome measures.
- Aim to monitor practice effectiveness in providing range of appropriate health checks for patients with chronic conditions (eg diabetes.
- Have PhD researcher 8 hrs per fortnight to analyse practice datasets and produce reports.

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Deakin case study - implementation

Began as solo GP working with a nurse practitioner and a pharmacist.

MDT care evolved following recognition that one person can't manage complexity, even with other practitioners involved.

Referring out of the practice for further care felt like transactional health care – not person-centred.

Community demand for coordinated comprehensive care had increased.

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Deakin case study – key characteristics

- NEXT Deakin was established as a multidisciplinary primary care practice in 2022 - to make a positive difference to patients and community.
- GP led but not GP dependent.
- Built on shared purpose and trust, focusing on patient needs.
- Facilitated by shared notes, team huddles and structured meetings.
- Purpose designed patient-centred space and team workflow – consulting rooms are patient rooms – health team comes and goes to the patient – providing seamless, coordinated care.

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Deakin case study - evolution

Even with the purpose designed facilities, the care model started as a roles and responsibilities model – working together separately - still a bit transactional.

Matured rapidly to flexible and agile approach to care – the best person able to meet the needs of the patient at a point in time.

Trust brings it all together.

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Deakin case study – patient population profile

The Canberra region including:

- children and young people
- Aboriginal and Torres Strait Islander people
- LGBTQIA+
- CALD communities
- Older people in own homes, receiving community care and in residential care
- People with chronic and complex conditions
- People with disabilities

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Deakin case study – workforce profile

General practitioners	4 FTE – independent contractors 1 FTE – GP registrar
Geriatrician	2 days per week – independent contractor
Nurse practitioners	3.8 FTE - employed
Registered nurses	2.6 FTE - employed
Enrolled nurse	0.8 FTE - employed
Accredited MH social worker	0.4 FTE
Psychologist	½ day per week
Dietitian	1 day per fortnight
Physiotherapist	1 day per week + home visits
Oral hygienist	1 day per month
Social worker	1 FTE – PHN grant to June 2026
Pharmacist x2	0.6 FTE – 1 0.4 FTE employed; 1 independent contractor
Patient advocates	6 FTE – employed (mix of in-clinic & virtual

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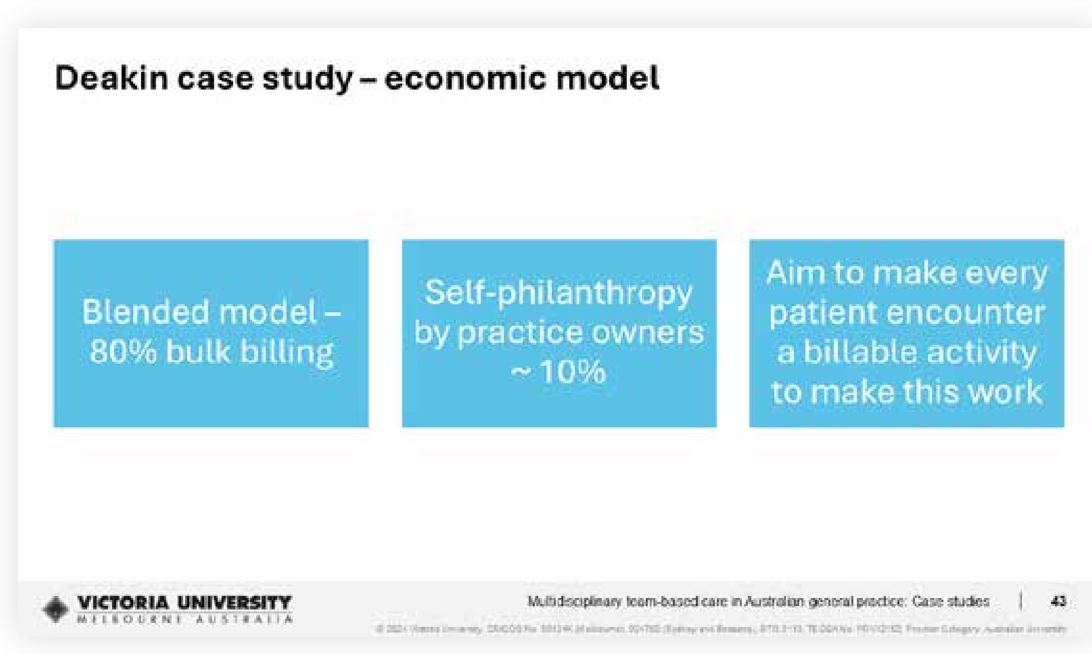

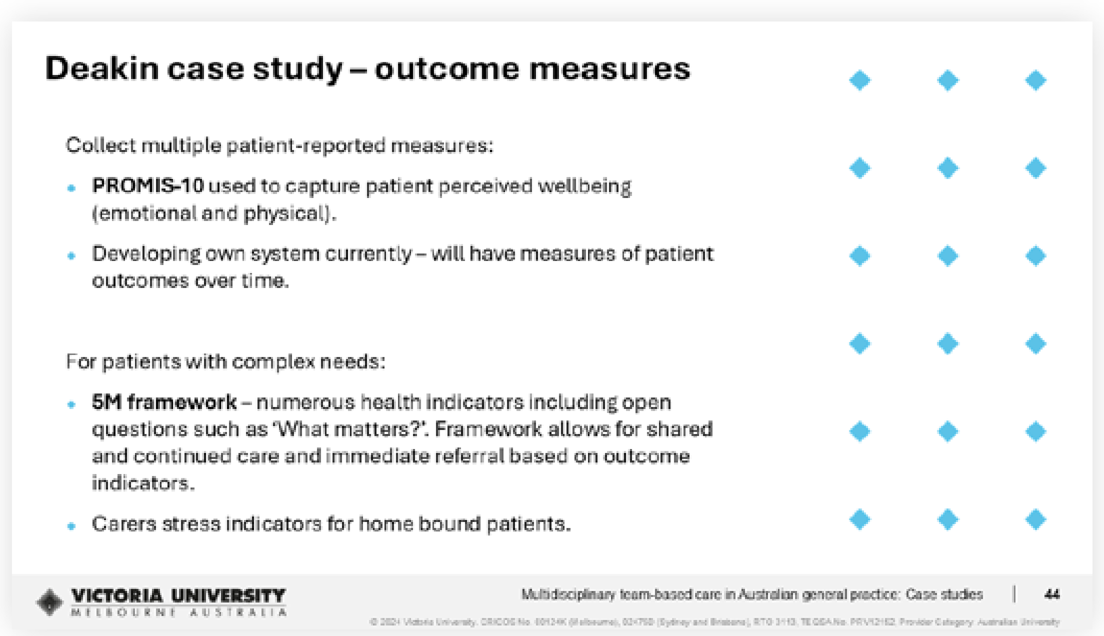

How to improve MDT care in the future

The Productivity Commission's 2017 review, *'Shifting the Dial'* said:

"Australia's messy suite of payments are largely accomplices of illness rather than wellness, only countered by the ingenuity and ethical beliefs of providers to swim against the current".

MDT care is an essential model for optimal patient care, but it is not currently viable.

The Aged Care Act 2024 provides older people with support to live well at home. Without MDT health care, that is not viable.

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How to improve MDT care in the future

Options to reduce the messiness:

- Tier based funding for chronicity and complexity.
- Capitation funding model: could provide much better care, and more care, if paid to take care of the patient – with reporting measures to demonstrate that.
- An 'options menu' for type of care model for general practices to opt into.

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Thank you

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Appendix 3: Chronic Kidney Disease as a Practical Demonstration Pathway For Team-Based Primary Care Reform

lgA Nephropathy Foundation

Aligning Kidney Health with the Progress by Design Reform Agenda

Kidney disease provides a clear example of how early detection, multidisciplinary care and data-enabled monitoring can work together in primary care.

Australia's primary care reform agenda is increasingly focused on transitioning from reactive, GP-centric models of care toward team-based, proactive, data-enabled primary healthcare systems.

Chronic Kidney Disease (CKD) provides a practical and compelling demonstration pathway for these reforms. CKD is common, costly, and frequently diagnosed late despite the availability of simple and inexpensive detection tools in primary care.

Kidney health risk can often be assessed using three key markers routinely available in primary care:

- Blood pressure
- Estimated glomerular filtration rate (eGFR)
- Urinary albumin-creatinine ratio (uACR)

Together these markers provide a practical "kidney health dashboard" that supports early detection, monitoring and risk stratification.

Importantly, several kidney diseases, including IgA Nephropathy, commonly emerge in young adults aged 18–45, meaning missed opportunities for early detection can result in decades of progressive disease before diagnosis.

Because CKD management requires coordinated care across multiple disciplines, longitudinal monitoring, and proactive prevention, it aligns strongly with the reform priorities outlined in Progress by Design. As such, CKD offers a clear opportunity to demonstrate how team-based primary care can improve patient outcomes while reducing long-term health system costs.

The Case for CKD within Primary Care Reform

CKD affects approximately 1 in 10 Australians, yet early stages are often asymptomatic. Many individuals are diagnosed only once kidney function has already significantly declined.

The consequences of late diagnosis are substantial:

- increased cardiovascular risk
- accelerated kidney failure
- dialysis or transplantation
- long-term health system costs

However, CKD progression can often be delayed or prevented through early identification and appropriate management.

Primary care is the critical setting for:

- early detection
- blood pressure management
- medication optimisation
- lifestyle interventions
- coordinated referral to specialist services

These elements align directly with the shift toward team-based, preventive primary healthcare models.

Mapping CKD to the Five Reform Enablers

1. Sustainable Investment Approach

Kidney disease highlights the value of prevention-focused investment.

CKD costs the Australian health system approximately $1.9 billion - $2.3 billion annually when patients reach dialysis or transplant, yet:

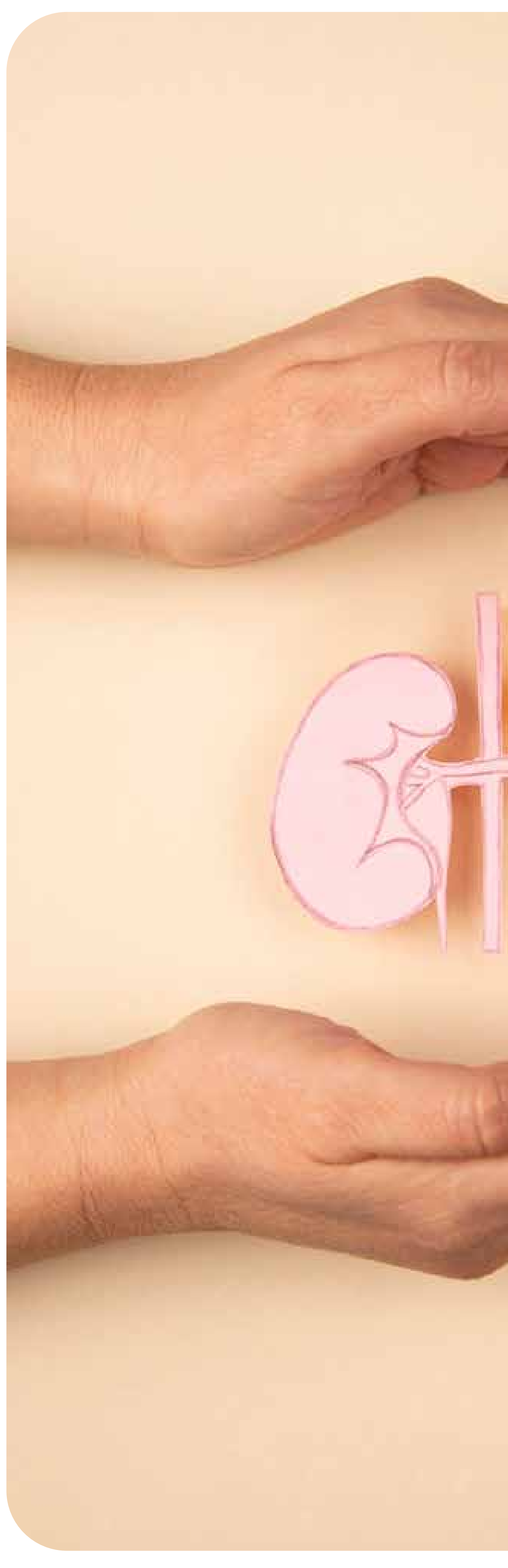
- early detection is inexpensive
- simple primary care tests (uACR + eGFR and blood pressure measurement) identify risk
- tests are widely available in primary care settings
- early treatment slows progression

Importantly, many kidney diseases, including IgA Nephropathy, often emerge in young adults aged 18–45, meaning missed opportunities for early detection can lead to decades of progressive disease before diagnosis.

Team-based primary care funded through blended models could support:

- routine blood pressure monitoring and hypertension management
- proactive CKD screening in high-risk populations
- earlier investigation of abnormal urine findings in younger adults
- medication optimisation
- lifestyle and dietary intervention and support
- coordinated specialist referral

By investing in early detection and prevention, health systems can significantly reduce long-term costs associated with kidney failure.



2. Multidisciplinary Clinical Governance

Effective CKD management requires coordinated care across multiple disciplines.

Optimal care pathways commonly involve collaboration between:

- general practitioners
- practice nurses
- pharmacists
- dietitians
- nephrologists
- allied health professionals

This aligns closely with the shift from GP-dependent care to *GP-led multidisciplinary care*.

For younger adults living with chronic kidney disease, multidisciplinary, team-based care is particularly important because management often spans several decades of life, including transitions through education, employment, family planning and long-term health planning.

Example workflow in a multidisciplinary team-based model:

- GP = diagnosis and oversight
- Nurse = monitoring and education (including blood pressure checks)
- Pharmacist = medication review
- Dietitian = renal nutrition support
- Nephrologist = specialist oversight

3. Digital & Data Infrastructure

CKD management is fundamentally data-driven and longitudinal care. Key clinical markers that can be monitored over time include:

- blood pressure
- eGFR
- uACR
- medication use

Digital infrastructure can support:

- automated identification of kidney risk within primary care systems
- patient registries
- population health segmentation
- alerts for abnormal / declining kidney function or uncontrolled blood pressure
- early referral triggers for specialist care

For younger adults, digital monitoring and longitudinal data tracking are particularly valuable because disease progression may occur gradually over many years.

Simple visual dashboards that translate these markers into clear indicators may also support shared decision-making between clinicians and patients.

4. Change Management Support

While primary care already has the tools to detect CKD early, implementation remains inconsistent.

Barriers frequently include:

- blood pressure monitoring is not always integrated into kidney risk assessment
- urine tests are underused
- early kidney disease is often missed due to delayed investigation of abnormal results
- care pathways are inconsistent and fragmented

Additionally, younger adults are often not routinely screened, despite the presence of early disease, as kidney disease is still widely perceived as a condition affecting older populations.

Because of this, many patients are diagnosed only once kidney function has already significantly declined.

Practice-level change management programs could support:

- standardised testing protocols
- consistent blood pressure monitoring and follow-up
- routine urine testing in all populations
- earlier investigation of persistent haematuria or proteinuria
- nurse-led CKD monitoring clinics
- digital alerts and structured care pathways
- team-based medication management and reviews

5. Workforce & Cultural Change

CKD care demonstrates the value of multidisciplinary, team-based models in primary care.

Instead of a GP managing everything, a multidisciplinary, team-based approach allows:

- nurses to lead CKD monitoring clinics (including BP monitoring)
- nurses to lead patient education
- pharmacists to manage and optimise medications and antihypertensive therapy
- dietitians to address and provide renal nutrition guidance and advice
- GP's to focus on clinical oversight and complex decision making

This reduces GP burden and supports more efficient use of the healthcare workforce while improving continuity of care.

For younger adults with chronic kidney disease, coordinated long-term management also helps support lifetime health planning and disease prevention, rather than episodic care once disease is advanced.

Opportunities for Demonstration Projects

CKD provides an ideal opportunity to demonstrate the practical benefits of multidisciplinary, team-based primary care models.

Potential demonstration activities could include:

- structured CKD screening protocols in primary care
- digital registries and population-health dashboards
- nurse-led monitoring clinics
- multidisciplinary medication review programs
- improved integration between primary care and nephrology services Evaluation of such models could provide valuable evidence on:
- improved early detection
- better blood pressure control
- slowed disease progression
- reduced hospitalisations and dialysis rates
- improved patient engagement and health literacy

Conclusion

Chronic Kidney Disease aligns closely with the priorities outlined in Progress by Design. It demonstrates how team-based primary care models supported by digital infrastructure, multidisciplinary governance and proactive monitoring can improve outcomes for patients with chronic disease.

By leveraging simple clinical markers such as blood pressure, eGFR and uACR, primary care systems can identify kidney risk earlier and intervene before irreversible damage occurs.

As Australia progresses toward integrated, team-based primary healthcare, CKD offers a practical and measurable demonstration pathway for reform.

As demonstration sites for team-based primary care are considered, chronic kidney disease offers a practical opportunity to illustrate how early detection, multidisciplinary care and data-enabled monitoring can be implemented in routine practice.

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