GPEx
INNOVATIVE SOLUTIONS FOR PRIMARY CARE

Pricing Framework for Australian Public Hospital Services 2025-26

GPEx submission to the Independent Health and Aged Care Pricing Authority Consultation Paper

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7 June 2024

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Executive Summary

Recommended reforms to the primary and tertiary care interface are not readily occurring

The 2023 mid-term review of the Addendum to the National Health Reform Agreement 2020-2025 recommended that models of care that operate at the interface between primary and tertiary care need to be established. While the Commonwealth and the States have committed to working in partnership to drive the effective integration of health services to enhance care coordination for people with chronic and complex needs, this is not readily occurring.

Shared Care addresses the challenge

Shared Care, which is grounded in joint responsibility and collaboration for planned care between specialists, often hospital-based and primary care providers, has demonstrated benefits for individuals receiving stabilised care and people with chronic and complex needs and answers this challenge.

Hundreds of thousands of Australians living with chronic or complex conditions frequently access public hospital services – and increased implementation of Shared Care models offers a proven way to enhance access to localised, high-quality community-based care and alleviate pressure on the public hospital system.

Expansion of Shared Care is limited by small but significant barriers

Right now, barriers to funded coordination are hindering further development, expansion and broad implementation of Shared Care models. While national health funding models cover patient care costs, essential operational expenses such as program oversight, coordination of care and clinician training and accreditation, are not currently covered and are unlikely to be prioritised by health departments or hospitals in the current climate.

The National Pricing Framework can enhance care coordination by enabling Shared Care

GPEx has a long history of coordinating shared care. Our stakeholders involved in hospital-based care continually tell us that having a class and price for the program coordination costs of shared care programs would remove a key barrier to broad and sustained implementation and management of Shared Care.

Aligned to the current impetus to investigate and sustainably invest in models of care that can identify and respond to emerging gaps and make the best use of scarce resources, it is our position that the Independent Health and Aged Care Pricing Authority (IHACPA) should investigate the inclusion of Shared Care in the General List of In-Scope Public Hospital Services and the establishment a class and price for the program coordination costs of shared care services pathways, training, accreditation, navigation and governance and quality assurance.

GPEx requests that **IHACPA considers**:

1. including Shared Care in the **General List of In-Scope Public Hospital Service**s;
2. establishing a **class and price** for the **program coordination costs** of shared care services **training**, **accreditation** and **quality improvement**.

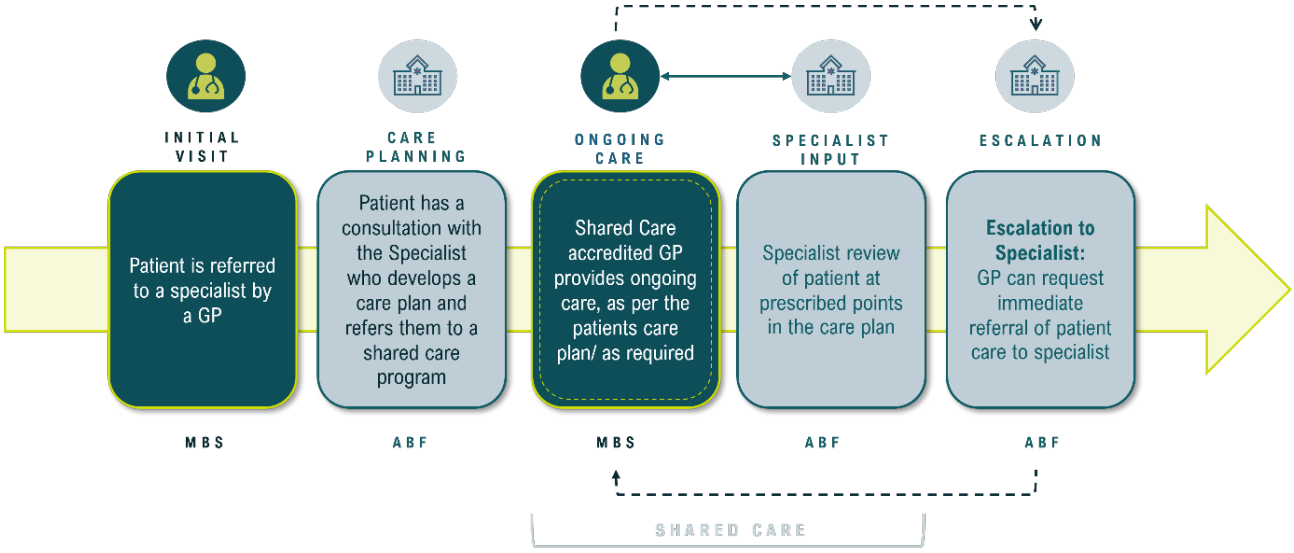
About Shared Care | What is it and why it's important

Operating and Funding Model

The Shared Care Model is centred on establishing joint responsibility and collaboration for planned care between a specialist, often hospital-based and a General Practitioner (GP) or other primary care provider. Both the specialist and the primary care provider maintain ongoing involvement in patient care and, in doing so, share information and clinical responsibilities and involve the patient in the process. As such, Shared Care presents an opportunity for people to receive the benefits of oversight by specialists combined with continuity of care and management of their care by generalists. Shared care is already delivered in several settings, for example pregnant women are able to access Obstetric Shared Care in most states and territories but is not yet normalised in the management of other conditions.

Shared Care currently sits across the two main health care funding models in Australia. As depicted in Figure 1, a typical GP Shared Care pathway involves a patient, following a referral to and assessment at a specialist outpatient clinic (Tier 2 Activity Based Funding (ABF) separation), being identified as clinically suitable to receive their ongoing care from an accredited GP under a Shared Care program. All visits to the GP under the Shared Care Program are then funded through the Medicare Benefits Schedule (MBS). A patient will typically have follow-up appointments or, where required, escalations of care, at the referring public hospital in an outpatient setting. Overall, the number of interactions with the public system is greatly reduced, for equivalent care outcomes, as compared to a standard hospital care pathway.

Figure 1: Typical GP Shared Care Operating Model and Funding Streams



Benefits of Shared Care

Patients

There are several advantages for patients who elect to receive their care under a Shared Care model:

- Continuity of care with their local primary care provider, who may already know them and their medical history[1].
- Localised access and holistic support with current and longer-term care needs, inclusive of secondary prevention and beyond the scope of the shared care program[2].
- Increased flexibility and reduced waiting time through attending a local clinic at a time suitable to the patient[3].
- High quality health outcomes[4].
- Access to review by specialist teams when the need arises and care at the right place at the right time[5].

Clinicians

Importantly, Shared Care also provides clinicians with a framework to connect with other clinicians across services and thereby improve the quality of care delivered through:

- Clearly delineating roles and responsibilities across the care team,
- Developing and implementing structured management plans,
- Clear intersectoral communication channels which enhance advice and information exchange between healthcare providers and patients, and
- The ability to seek rapid escalation of care to a specialist team as required[6].

Public Health System

The benefits of Shared Care for the public health system include:

- reductions in unnecessary hospital presentations, admissions or outpatient appointments driving cost savings and releasing hospital capacity[7].
- improved information sharing across primary and tertiary settings[8].
- reduced duplication of efforts[9].
- maximised utilisation of scarce resources[10].
- higher levels of follow-up care, reduced representations and increased patient adherence to treatment[11].

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[1] Karen Charlton, Catherine Lucas, Lucy Brown, Erin Brock and Leanne Cummins, "Review of patient satisfaction with services provided by general practitioners in an antenatal shared care program", *Australian Family Physician* 44 no. 5 (2015).

[2] Bogda Koczwara, Kate White, Jon Emery, Geoff Mitchell, Danielle Mazza, Patsy Yates and Julia Fallon Ferguson, "Principles Statement: Shared Care" *Cancer Research in Primary Care* (2016).

[3] Ibid 1.

[4] Yvette D. Miller, Jessica Tone, Sutapa Talukdar and Elizabeth Martin, "A direct comparison of patient-reported outcomes and experiences in alternative models of maternity care in Queensland, Australia", *PLoS ONE 17 (2022).*

[5] RACGP, "Shared Care Model between GP and non-GP specialists for complex chronic conditions" (2024).

[6] Ibid.

[7] Fiona Crawford-Williams and Rebecca Haddock, "Integrating shared care teams into cancer follow-up care models" *Deeble Institute for Health Policy Research no. 46* (2022).

[8] Smith SM, Cousins G, Clyne B, Allwright S, O'Dowd T, "Shared care across the interface between primary and specialty care in management of long-term conditions", *Cochrane Database* (2017).

[9] Ibid 5.

[10] Ibid 5.

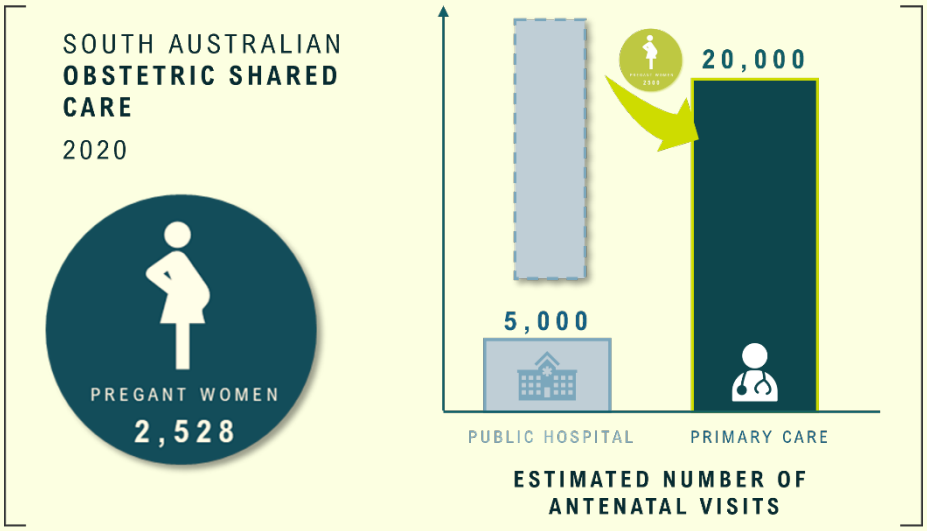
[11] Ibid 10.

Shared Care also offers the potential for better integration of the management of comorbidities, secondary and tertiary prevention and a more streamlined delivery of health care which has the potential to result in additional system level savings[12].

Case Study: Obstetric Shared Care

Of the 1,000 maternity models of care reported to be in use across Australia in 2023, 15% were categorised as a Shared Care model, second only to the standard public hospital midwifery model of care. South Australia's Obstetric Shared Care program has been in operation since 2002, with the model now well embedded and embraced by the system and patients alike.

Under a typical Obstetric Shared Care model, low risk pregnant women receive 8 of their standard 10 antenatal visits from their GP rather than in a public hospital outpatient setting. In 2020, 18,461 women gave birth in South Australia[13]. Of these, 2,528 (13.7%) received their antenatal care from one of the 667 GPs accredited to the SA Obstetric Shared Care Program[14]. Based on the standard model outlined above, the estimated reduction in hospital based antenatal visits in 2020, due to the Obstetric Shared Care program, was 20,000.



Findings from research on Australian Obstetric Shared Care models include the following:

- In comparison to standard public care, women in GP Shared Care were more likely to:
- have one person coordinating their pregnancy care and decisions
- report having their care providers talk to them with kindness, and
- report having care providers respect their decisions[15].
- Infants born to women who received GP Shared Care had significantly lower rates of admission to NICU and preterm birth (anticipated to be due to the suitability criteria for participation in shared care)[16].
- Overall, women reported being highly satisfied with GP Shared Care, with the exception of long waiting periods experienced when attending the two public antenatal clinic appointments[17].

[12] Ibid 5.
[13] Wellbeing SA, "Pregnancy Outcome in South Australia 2020" (2022).
[14] Ibid.
[15] Ibid 4.
[16] Ibid 4.
[17] Ibid 1.

Expanding the use of Shared Care | Opportunities and barriers

Opportunities to Expand Shared Care

Numerous opportunities have been identified for broader implementation of Shared Care which would strengthen the availability of high-quality care in the community, reduced waiting time for care, enhance intersectoral collaboration and free up valuable hospital capacity[18] - including in chronic disease management, cancer care and mental health. While there are current examples of Shared Care programs for these conditions, access to these programs is not equitable or consistent across Australia.

Chronic Disease Management

Chronic conditions are the leading cause of illness, disability and death in Australia. 50% of Australians have at least 1 chronic condition and 60% of Australians over 65 years have more than one[19]. The five most common chronic conditions include mental and behavioural conditions, back problems, arthritis, asthma and diabetes[20].

Effective and efficient long-term management of complex, chronic diseases is one of the greatest and most costly health-related challenges facing the health system[21]. Commonly, people who develop complex, chronic conditions are referred and receive care from one or more tertiary specialist teams, with responsibility for the different aspects of that persons care left unallocated, often resulting in fragmented care[22]. Evidence suggests that integration of such health care, using a Shared Care Model, may be an effective option to efficiently coordinate and support continuity of care across different services and conditions[23]. Evidence has also shown that better clinical outcomes can be achieved for patient with chronic conditions through using integrated patient centred models that maximise the time, skills and strengths of each team member[24].

Cancer care

The estimated number of newly diagnosed cancer cases in Australia in 2022 was 162,000[25] and it is estimated that over 1 million Australians are currently living with cancer or are in remission[26]. Improvements in medical treatment and ageing populations are driving an increase in the number of cancer survivors worldwide[27]. In Australia the chance of survivorship is approximately 70%[28]. Cancer survivors are vulnerable to suffering from a second cancer and/ or comorbid chronic conditions[29]. Follow-up care is essential for patients who have completed their active cancer treatment, to:

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[18] Ibid 7.

[19] Australian Institute of Health and Welfare, “Chronic Conditions and multimorbidity” (2023).

[20] Australian Bureau of Statistics, “National Health Survey” (2022).

[21] Ibid 5.

[22] Ibid 5.

[23] Ibid 26.

[24] Claire Jackson, Jane Tsai, Cathy Brown, Deborah Askew and Anthony Russell, “GPs with special interests Impacting on complex diabetes care”, Australian Family Physician 39 (2010).

[25] Cancer Australia, “All Cancer in Australia”, (2023).

[26] Cancer Council, “National Cancer Statistics”, (2023).

[27] Michael Jefford, Doris Howell, Qiuping Li, Karolina Lisy, Jane Maher, Catherine M Alfano, Meg Rynderman and Jon Emery, “Improved models of care for cancer survivors” *The Lancet* (2022).

[28] Ibid 29.

[29] Rashidul Alam Mahumud, Khorshed Alam, Jeff Dunn and Jeff Gow, “The burden of chronic diseases among Australian cancer patients: Evidence from a longitudinal exploration, 2007-2017” PLoS One (2020).

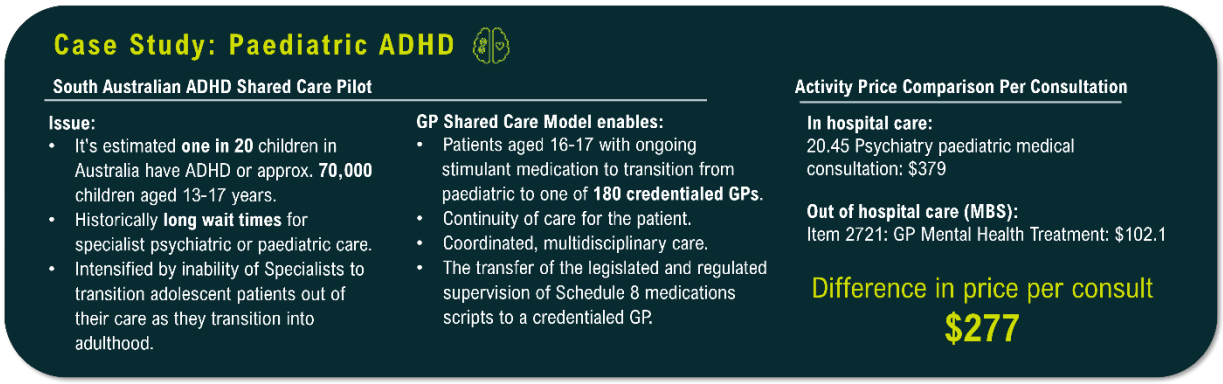
- assess whether the cancer has returned
- discuss physical and emotional health
- monitor and manage any risk factors and side effects of treatment[30].

The results from a review into the effectiveness of Shared Care in cancer survivors found that when comparing shared care and hospital-based care, patient satisfaction of shared care is higher, the effectiveness of shared care is similar, and the costs were lower[31].

Mental Health

The National Study of Mental Health and Wellbeing 2020-2022 found that 42.9% of Australian's aged 16–85 years had experienced a mental disorder at some time in their life but only 17.4% had seen a health professional for their mental health in the prior 12 months[32]. Among international researchers, there is consensus that most patients with mental health conditions should continue to be treated in general practice, but that mental health treatment should be optimised through strengthened collaboration between primary care and specialised mental healthcare services including under Share Care models[33]. Studies have shown that a holistic approach to patient care, including strong collaboration between GPs and mental health services, leads to improved patient outcomes[34]. Research has also identified Mental Health Shared Care results in:

- improved mental and physical health outcomes
- reduced unnecessary hospitalisations and associated costs
- reduced unmet need for treatment
- improved access to and engagement with specialist care, and
- improved intersectoral collaboration communication[35].



[30] Cancer Australia, "Shared cancer follow-up and survivorship care" (2024).

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[32] Australian Bureau of Statistics, "National Study of Mental Health and Wellbeing", (2020-2022).

33 Michael Marcussen, Lene Berring, Mogens Hørder, Jens Søndergaard and Birgitte Nørgaard, "Development of a model for shared care between general practice and mental healthcare: a protocol for a co-production study", BMJ Open (2022).

[34] Anton N. Isaacs and Eleanor K. L. Mitchell, "Mental health integrated care models in primary care and factors that contribute to their effective implementation: a scoping review", *International Journal of Mental Health Systems* (2024).

[35] Brian J Kelly, David A Perkins, Jeffrey D Fuller, and Sharon M Parker, "Shared care in mental illness: A rapid review to inform implementation", *International Journal of Mental Health Systems* (2011).

Barriers to Expanding Shared Care

The 2023 mid-term review of the NHRA Addendum included the finding that equitable access to primary care is constrained by available workforce, care models and service affordability, which puts demand on hospital activity, affects patient outcomes and shifts the service delivery burden to States and Territories as providers of last resort.

Despite Shared Care being accepted by patients, proven to reduce hospital admissions, emergency department presentations and able to deliver high quality health outcomes, our stakeholders have identified three key practical barriers to further development and implementation of Shared Care models:

National Funding Models don't support management and oversight of Shared Care

The existence and management of Shared Care programs varies across States and territories with some health departments opting for state-wide models and others leaving this responsibility to individual hospitals or health networks. One of the identified barriers to the consistent expansion of the Shared Care models (conditions and locations) is the lack of a class and price for the program coordination costs of overseeing shared care services.

While the costs related to the care provided to patients is met by national health funding models (either ABF or MBS), the cost of overseeing, coordinating and operationalising a Shared Care program including, developing the operating model, program promotion and information sharing as well as performance monitoring, clinical governance, GP network management, navigator services, data collection and reporting, is not covered. It is therefore left to the individual states or hospitals to fund these functions from within existing budgets – and this rarely occurs given current the pressures on the acute health system.

The clinical workforce requires specialised training to enable capacity and availability

Low levels of adequately trained primary care clinicians and lack of time within the current workforce are known barriers to the effective implementation of integrated Shared Care models[36]. Access to and delivery of training for primary care clinicians, as well as accreditation and registration processes and oversight, is needed, alongside appropriate funding mechanisms for these functions, to enhance the capability and capacity of Australia's primary care workforce.

Absence of coordination of Shared Care Programs

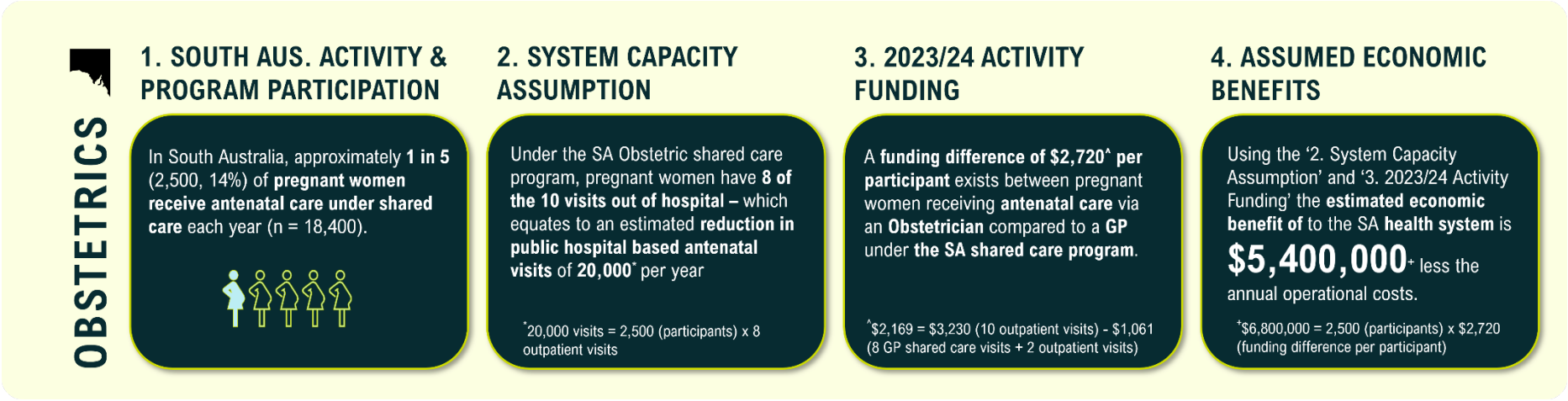
Even where a workforce with capability and capacity to provide care in the community exists, without a mechanism such as an independent program management function to systematically coordinate the shared care program, an effective integrated care will not be optimised. Independent coordination facilitates co-designed pathways, recruitment of community-based clinicians, formal connection with tertiary and primary clinicians and navigator services, leading to effective multi-disciplinary care. This barrier is intrinsically linked to a funding model for the oversight of Shared Care Programs.

[36] Ibid 7; Lisy K, Kent J, Piper A and Jefford M., "Facilitators and barriers to shared primary and specialist cancer care: A systematic review" Supportive Care in Cancer (2020).

Expanding use of Shared Care | System level impacts

Cross System Economic Value – South Australia Obstetric Shared Care Case Study

The following modelling has been undertaken to demonstrate the economic value to the South Australian health system of the operation of the SA Obstetric Shared Care program. The modelling conservatively suggests an economic benefit of **$5.4M** is generated annually through the program which is offset but the significantly lower (less than 10% of the estimated benefit) annual operational costs.



Enhancing Health System Capacity – Scaling the opportunities

The following analysis has been undertaken, using publicly available information[37], to illustrate the potential system benefits of national implementation of shared care models both in terms of releasing system capacity and potential economic value.

POTENTIAL OPPORTUNITY TO EXPAND SHARED CARE

ENDOCRINOLOGY

System Volume

As an example of chronic disease management, each year approximately **508,000 visits occur in an Endocrinology outpatient clinic** for patients with conditions such as diabetes.

Activity Price Comparison Per Consultation

In hospital care:
20.34 Endocrinology medical consultation: $303

Out of hospital care (MBS):
Item 36 20 minute consultation: $80.1
[Item 721 Chronic disease management plan development (Annual): $158.80]
[Item 732 Quarterly review of management plan: $79.3]

Difference in price per consult **$223**

CANCER CARE

System Volume

Each year, approximately **970,000 visits occur in a medical oncology outpatient clinic** including for patients requiring **Cancer follow up care**.

Activity Price Comparison Per Consultation

In hospital care:
20.42 Medical oncology medical consultation: $303

Out of hospital care (MBS):
Item 36 20 minute consultation: $80.1
[Item 871 Cancer management plan development (Annual): $158.80]
[Item 872 Cancer Care Case Conference: $41.8]

Difference in price per consult **$223**

[37] Australian Institute of Health and Welfare, "Non-Admitted patient Care 2022-23: Australian hospital statistics" (2023), National Efficient Price Determination 2023-24, Medicare Benefits Schedule.

The role that the Independent Health and Aged Care Pricing Authority could play

Alignment with the National Health Reform Agreement Agenda

The Commonwealth and the States have committed to work in partnership to improve the provision of GP and primary health care services, as well as the effective integration of health services at a local and national level to improve care coordination for people with chronic and complex needs

Despite most of Australia's health funding being directed to public hospitals, the NHRA is about much more than financing the hospital system. As detailed in the 2020–25 NHRA Addendum, the four strategic principles guiding recent attempts at health system reform are:

- Improving efficiency and ensuring financial sustainability
- Delivering safe, high-quality care in the right place at the right time
- Prioritising prevention and helping people manage their health across their lifetime
- Driving best practice and performance using data and research.

The Addendum also identifies the intention that "the long-term health reforms under the NHRA will support better coordinated care in the community, focus on prevention and keeping people out of hospital". Additionally, the 2023 mid-term review of the NHRA Addendum recommend that models of care that can identify and respond to emerging gaps, and that make the best use of scarce resources, be established with equitable and sustainable funding attached.

Enabling Shared Care Through the National Pricing Framework

The cost of overseeing and operationalising Shared Care programs is not currently covered by a national funding model. While direct funding for this type of activity has not historically fallen within the remit of IHACPA, state health departments and hospitals are effectively (indirectly) using ABF to cover the costs of overseeing Shared Care programs – albeit on an ad hoc basis.

The near universal, long-term availability of Obstetric Shared Care across Australia suggests this is a model of care that is well understood and supported, with the associated management costs willingly absorbed and balanced against the financial and capacity benefits brought by the programs. It appears however, that applying this knowledge to expand Shared Care to different condition types, where the magnitude of the benefits are yet to be demonstrated, is beyond the risk appetite of the health system in the current climate of overflowing hospitals and stretched health budgets. This represents a significant lost opportunity to make better use of scarce resources and optimise hospital utilisation for those who can't be treated in another setting.

Our stakeholders have advised that having a class and price for the program coordination costs of shared care would remove a key barrier to broader implementation of Shared Care models. Given this, and the current impetus to investigate and sustainably invest in models of care, that can identify and respond to emerging gaps, and that make the best use of scarce resources, it is our position that IHACPA should investigate the inclusion of Shared Care in the General List of In-Scope Public Hospital Services and the establishment a class and price for the program coordination costs of shared care services pathways, training, accreditation, navigation and governance and quality assurance.

Conclusion

Recent reviews have highlighted the need for models of care and multidisciplinary teams that operate at the interface between primary and tertiary care to be established to drive the effective integration of health services and to enhance care coordination for people with chronic and complex needs.

Shared Care, which is grounded in joint responsibility and collaboration for planned care between specialists, and primary care providers, and has demonstrated benefits for people with chronic and complex needs, answers this challenge but there are practical barriers to its broad implementation that need to be overcome.

Establishing a class and price for the program coordination costs of shared care services is essential to facilitating the broader implementation of Shared Care models and unlocking the potential benefits they offer to patients and the health system. It is therefore our position that this should be explored alongside the inclusion of Shared Care in the General List of In-Scope Public Hospital Services to better enable equitable access and sustainable implementation of Shared Care programs nationwide.

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