# Building Trust into Care and Health Systems

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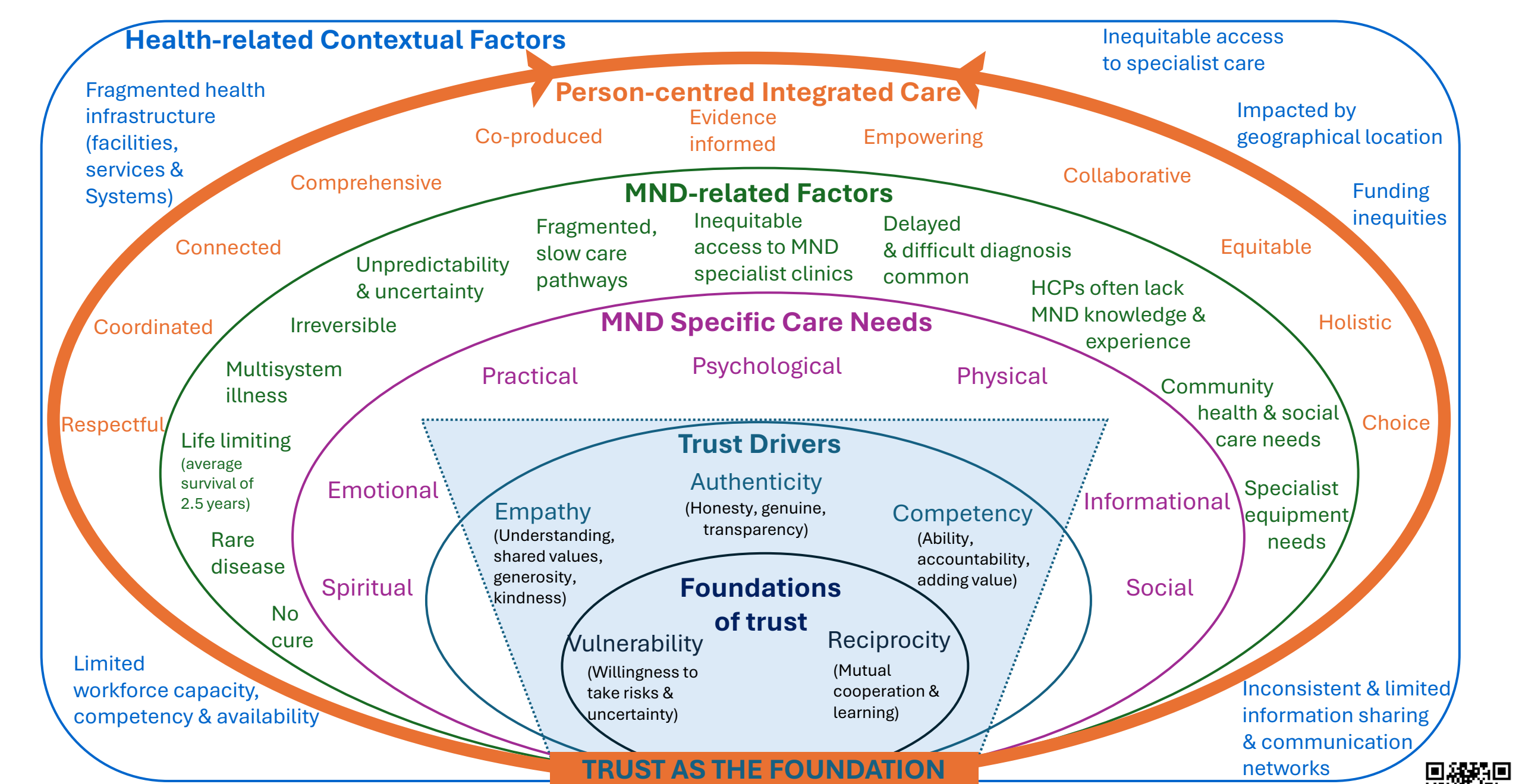
IFIC International Foundation for Integrated Care

MTU Ollscoil Teicneolaíochta na Mumhan Munster Technological University

# Overview of session

- Recap on the concept of trust
- The role of trust in practice and policy
- The role of trust in bridging health inequalities
- Trust as an enabler of integrated care models
- Practical system perspective to trust
- Trust recipe




Reference: Lisiecka, D.; Dyson, N.; Malpress, K.; Smith, A.; McNeice, E.; Shack, P.; Hutchinson, K. 'Finally, in Hands I Can Trust': Perspectives on Trust in Motor Neurone Disease Care. Healthcare **2025**, 13, 1994. https://doi.org/10.3390/healthcare13161994

# Why trust matters

*Trusted interactions make every part of a health system work better*

**1 Access & adherence**
People seek care when needed and follow treatment

**2 Teamwork**
Professionals collaborate in multidisciplinary care

**3 Safety**
Less miscommunication and fewer errors

**4 Innovation**
Staff feel safe to take calculated risks

**5 Speed**
Faster decisions, less questioning of motives

**6 Resilience**
Systems and societies cope better in crises

**177**

countries analysed in The Lancet (2022)

Higher trust in government and in each other was linked to fewer COVID-19 infections and higher vaccine uptake, and mattered more than preparedness scores or health-system capacity.

McKee, M., van Schalkwyk, M. C. I., Greenley, R., & Permanand, G. (2024). Placing trust at the heart of health policy and systems. International Journal of Health Policy and Management, 13, 8410. https://doi.org/10.34172/ijhpm.2024.8410, Bollyky T, Hulland E, Barber R et al. (2022) Pandemic preparedness and COVID-19: an exploratory analysis of infection and fatality rates, and contextual factors associated with preparedness in 177 countries, from Jan 1, 2020, to Sept 30, 2021 The Lancet; 399, 1489-1512

# Why trust is overlooked

*Discussed when things go wrong, then forgotten*

| | | |
|---|---|---|
| 1 | **Complex** | No single definition; knowledge sits in disciplinary silos; meaning varies across languages |
| 2 | **Dynamic** | Takes years to build and seconds to lose |
| 3 | **Specific** | Can apply to one relationship or competence, not the whole system |
| 4 | **Unmeasured** | Largely absent from health-system performance metrics |
| 5 | **Unequal** | Lack of trust can be rational for groups who have been marginalised or mistreated |

*"Trust arrives on a tortoise and leaves on a horse."*

Dutch proverb

McKee, M. et al. (2024). Placing trust at the heart of health policy and systems. International Journal of Health Policy and Management, 13, 8410. https://doi.org/10.34172/ijhpm.2024.8410; McKee, et al., (2025). From transaction to transformation: Building trust in health systems; A response to recent commentaries. International Journal of Health Policy and Management, 14, 9188. https://doi.org/10.34172/ijhpm.9188

# What builds trust in practice

*Actions proposed across the debate and the WHO/Observatory report*

### 1 Trust the people

Recognise public capability; support rather than blame (Reicher)

### 2 Engage and co-produce

Deliberative methods such as citizens' assemblies; co-production with patients, carers and clinicians

### 3 Track trustworthiness

Trust performance indicators collected routinely (Gille et al.)

### 4 Be trustworthy

Transparency, empathy, commitment and competence; ethical leadership (Peters)

### 5 Reach marginalised groups

Community health workers and culturally appropriate communication

### 6 Build relationships

Face-to-face contact, shadowing and time for dialogue between policy-makers, managers and clinicians

McKee, M. et al., . (2024). Placing trust at the heart of health policy and systems. International Journal of Health Policy and Management, 13, 8410. https://doi.org/10.34172/ijhpm.2024.8410; McKee, M., van Schalkwyk, M. C. I., Greenley, R., & Permanand, G. (2025). From transaction to transformation: Building trust in health systems; A response to recent commentaries. International Journal of Health Policy and Management, 14, 9188. https://doi.org/10.34172/ijhpm.9188

# What the wider evidence adds

*And where the gaps are*

## 3 of 194

studies in a 2025 scoping review of trust in public health looked at trust repair or maintenance

Kalulu, P., et al (2025). Trust, trust repair, and public health: A scoping review. *Frontiers in Public Health, 13*, 1560089. https://doi.org/10.3389/fpubh.2025.1560089

## 30

countries: low trust linked to poor health, access barriers, dissatisfaction with care and corruption

Heinz, A. (2026). Predictors of low trust in national healthcare systems in 30 countries. *BMC Health Services Research, 26*, 885. https://doi.org/10.1186/s12913-026-15026-8

## 50

years of research: main threats are errors, discrimination and profit motives

Taylor L, Nong P, Platt J. Fifty Years of Trust Research in Health Care: A Synthetic Review. Milbank Q. 2023;101(1):0120.

**Implication:** surveys can show where trust is low, but understanding why, and how it is rebuilt, needs qualitative work with patients, carers and staff, and a focus on trust as an outcome of care, not only an input.

# The role of trust in practice and policy

*Trust is both an enabler of good care and an outcome of it*

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## In practice

*Patients, clinicians and teams*

| | |
|---|---|
| **Seeking care** | People come forward early and disclose openly |
| **Engagement** | Adherence and genuine shared decision-making |
| **Team working** | Staff speak up about errors when they are not blamed |
| **Retention** | Staff stay when they trust their employer |
| **Technology** | Clinicians trust AI enough to use it, not to defer to it |

## In policy

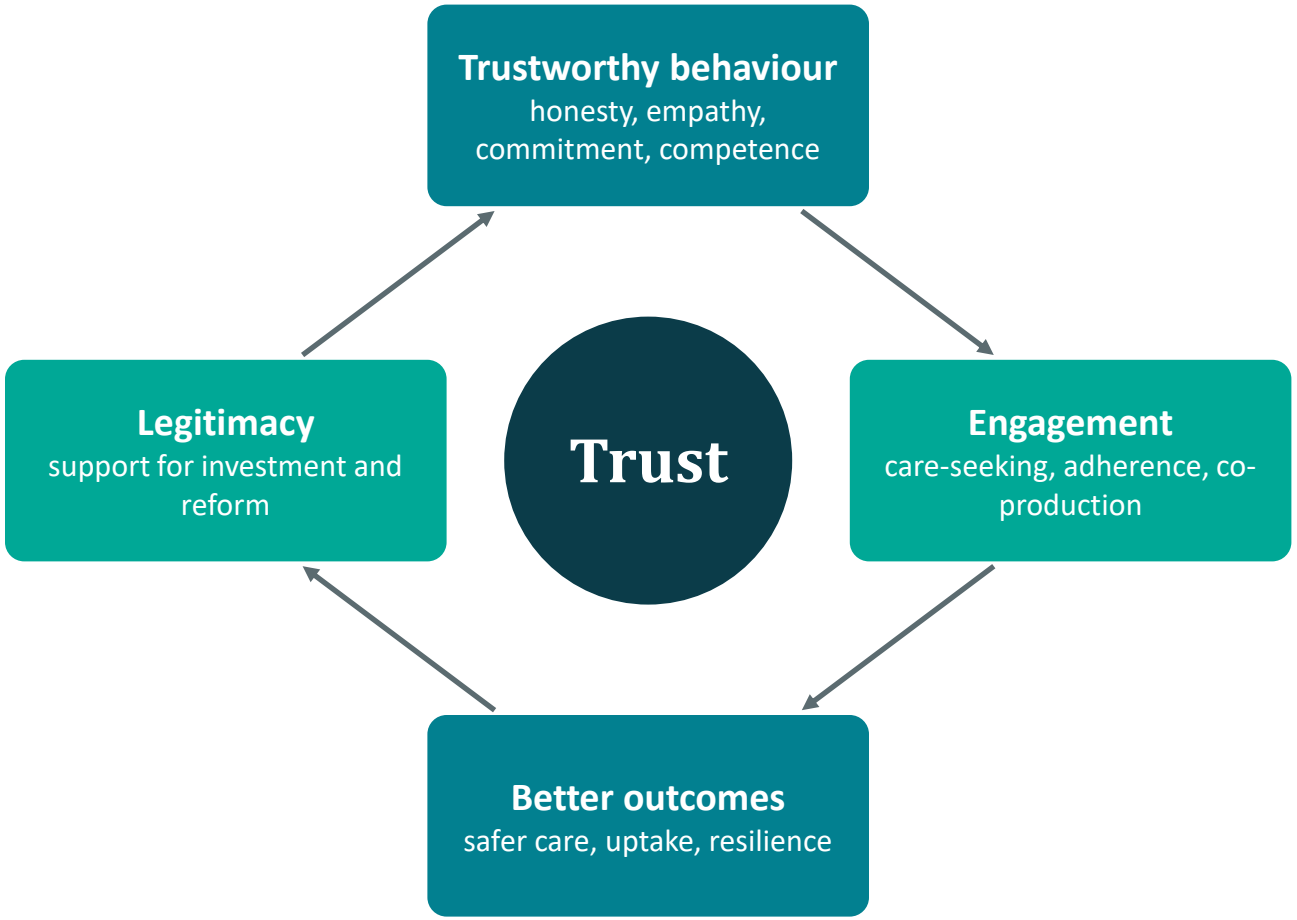
*Public, government and institutions*

| | |
|---|---|
| **Solidarity** | Public support for shared, publicly funded care |
| **Public health** | Compliance and vaccine uptake in crises |
| **Reform** | Legitimacy for change and transformation |
| **Investment** | Politicians fund systems they believe will deliver |
| **Equity** | Reaching groups whose mistrust is rooted in experience |

McKee, M., et al., (2024). Placing trust at the heart of health policy and systems. International Journal of Health Policy and Management, 13, 8410. https://doi.org/10.34172/ijhpm.2024.8410, Bollyky T, Hulland E, Barber R et al. (2022) Pandemic preparedness and COVID-19: an exploratory analysis of infection and fatality rates, and contextual factors associated with preparedness in 177 countries, from Jan 1, 2020, to Sept 30, 2021 The Lancet; 399, 1489-1512; Finegood, D. T., & Yakimov, C. (2024). Why systems thinking is needed to center trust in health policy and systems: Comment on “Placing trust at the heart of health policy and systems.” International Journal of Health Policy and Management, 13, 8706. https://doi.org/10.34172/ijhpm.8706

# Building trust: a reinforcing cycle

*Easy to lose, slow to rebuild; it has to be earned at every level*




## What practice can do

- Make time for relationships, not only transactions
- Learning culture: report and learn, don't blame
- Listen to lived experience; be open about uncertainty and error
- Acknowledge why some groups don't trust services

## What policy can do

- Involve people early: co-production and citizens' assemblies
- Be transparent; tackle conflicts of interest and corruption
- Measure trust, and use qualitative research to understand it
- Principles over rigid top-down targets

;McKee, M., et al (2024). Placing trust at the heart of health policy and systems. International Journal of Health Policy and Management, 13, 8410. https://doi.org/10.34172/ijhpm.2024.8410; Finegood, D. T., & Yakimov, C. (2024). Why systems thinking is needed to center trust in health policy and systems: Comment on "Placing trust at the heart of health policy and systems." International Journal of Health Policy and Management, 13, 8706. https://doi.org/10.34172/ijhpm.8706; WHO Europe/Observatory, Trust: the foundation of health systems, 2024

# Trust helping to bridge health equity gaps

- **Kate Frazer**

**Associate Professor, School of Nursing, Midwifery and Health Systems**


**Wednesday 30th September 2026**

# Outline of presentation

Experiences and importance of trust in marginalised/ vulnerable populations

Impact of trust on policies and practice

# What do we mean by trust

Author manuscript
*Annu Rev Public Health*. Author manuscript; available in PMC 2025 May 01.

Published in final edited form as:
*Annu Rev Public Health*. 2024 May ; 45(1): 465–484. doi:10.1146/annurev-publhealth-061022-044737.

## Conceptualizing and Measuring Trust, Mistrust, and Distrust: Implications for Health Equity and Building Trustworthiness

**Jennifer Richmond, PhD, MSPH**[1], **Andrew Anderson, PhD**[2], **Jennifer Cunningham-Erves, PhD**[3], **Sachiko Ozawa, PhD, MHS**[4], **Consuelo H. Wilkins, MD, MSCI**[5]

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# Richmond et al. 2024 .....

*'Trust is vital to public confidence in health and science, yet there is no consensus on the best way to conceptualize, define, measure, or intervene on trust and its related constructs (e.g., mistrust, distrust, and trustworthiness)'.*

Trust and its related constructs (e.g., mistrust, distrust, and trustworthiness) are inextricably linked to vulnerability (Hall et al. 2001).

In medical and public health contexts, patients are particularly vulnerable because placing trust in untrustworthy entities with power (e.g., providers who misuse their power) can have devastating health consequences.

Therefore, building trust in public health and healthcare systems has been cited as a component of health equity (Wyatt et al. 2023).

*In healthcare, patients are in a vulnerable position due to information asymmetry, where they typically have less medical knowledge than providers (Richmond et al., 2024)*

*So what do we need to consider....*

*Trust involves vulnerability: we accept dependence on another person or institution because we expect them to act appropriately.*

*Mistrust and distrust are not the absence of trust: they arise from experiences of racism and marginalisation, discrimination and institutional failure.*

*Trustworthiness belongs to the institution or clinician and not patients. The question is where the system deserves trust.....*

*For health equity, the goal is to build trustworthy systems: the patients and those with low trust are not the problem.*

# Contemporary example of trust and health equity

***Irish Travellers as a minority ethnic group*** *provide an important example of why trust cannot simply be demanded from individuals.*

*Low trust is not an inherent cultural characteristic and represents experiences of racism and discrimination.*

*Ethnic minority status in Ireland 2017*

The All-Ireland Traveller Health Study (AITHS) (2010) confirmed inequalities in health and the significant influence of the social determinants of health (SDoH).

Travellers experience markedly reduced life expectancy and increased premature mortality.

# All Ireland Traveller Health Study (AITHS)

41% of Travellers reported complete trust in health professionals, compared to 82% of the general population.

53% were worried about unfair treatment

40% worried about lack of respect and dignity

Over 40% reported discrimination when accessing services

The AITHS 2010 data provides evidence of experiences of lower quality and challenges in accessing information.

What changed from 2010 to 2026 .....

REVIEW ARTICLE OPEN ACCESS

# Irish Travellers' Cancer Awareness and Engagement With Prevention, Screening and Early Diagnosis: A Qualitative Study of Barriers and Enablers

Kate Frazer[1] | Regina Joye[1] | Patricia Fitzpatrick[2] | Reuel Jalal[1] | Mary Brigid Collins[3] | Lynsey Kavanagh[3] | Abigail Murfitt[2] | Brigid Quirke[4] | Una Kennedy[5] | Triona McCarthy[5] | Maria McEnery[5] | Aine Lyng[5] | Patricia Fox[1]

[1]School of Nursing, Midwifery and Health Systems, University College Dublin, Dublin, Ireland | [2]School of Public Health, Physiotherapy and Sports Science (SPHPSS), UCD, Dublin, Ireland | [3]Pavee Point Traveller & Roma Centre, NGO, Dublin, Ireland | [4]National Social Inclusion Office, Health Service Executive, Dublin, Ireland | [5]National Cancer Control Programme, Health Service Executive, Dublin, Ireland

**Correspondence:** Kate Frazer (Kathleen.frazer@ucd.ie)

**Received:** 3 February 2026 | **Revised:** 27 July 2026 | **Accepted:** 20 August 2026

**Funding:** National Cancer Control Programme

Four themes described the interactions between everyday structural disadvantage, culture, privacy, fear and family roles; systems-level barriers; and Traveller-led and service-level enablers.

Awareness did not always translate into an opportunity to act.

Racism and discrimination, literacy barriers, living conditions, limited service choice, inaccessible communication and inflexible appointment systems constrained engagement.

Pride in Traveller identity, trusted relationships, Traveller Community Health Workers, accessible information and culturally safe services supported engagement. (Frazer et al. 2026)

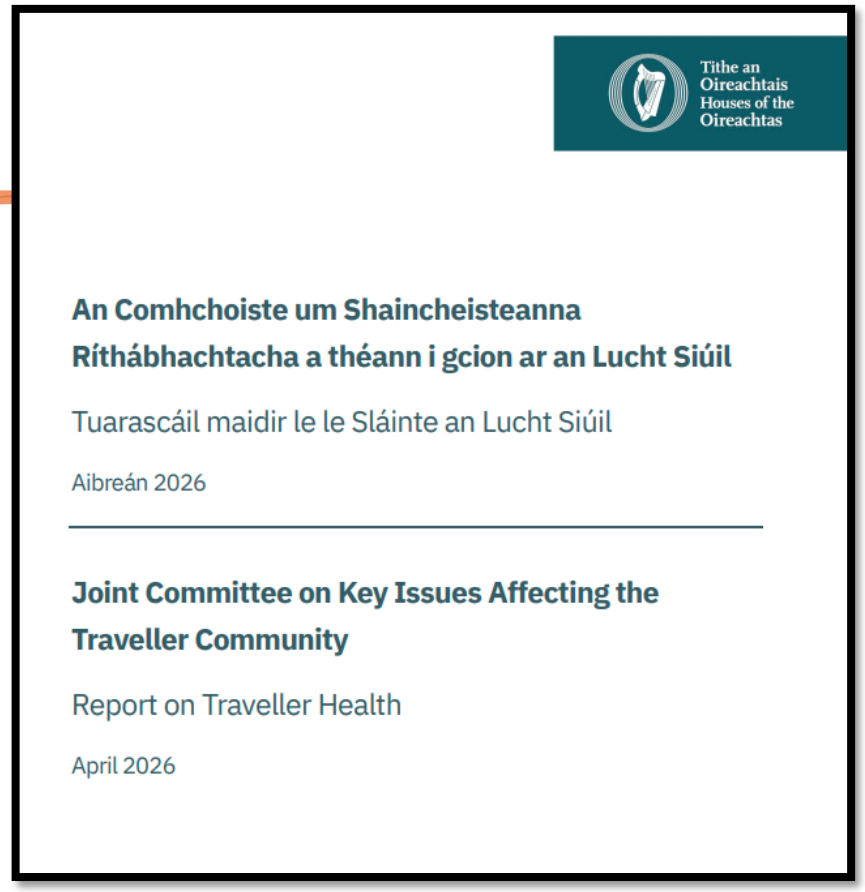
*And you might make a phone call, and you mightn't get an appointment for a week or two...It is a common problem when they go to doctors. They're coming out no wiser like. Because, like, they could go to a doctor and they come out a lot worse because they've been given all those big wordings and things. And names and things. .... So maybe some doctors wouldn't, you might have a doctor who might have a great time for a person and explain everything properly. But then you might have a doctor that just wants you out faster.....Just rush. Rush you. ..... That you're in there for maybe a minute or two and they just want you in and out fast. You tell them your symptoms, and they just can't wait to get you out. So, I think a doctor should give that Traveller person more time. Because over the lack of education, they have. And do more clearer words for them. Give them a better understanding.*

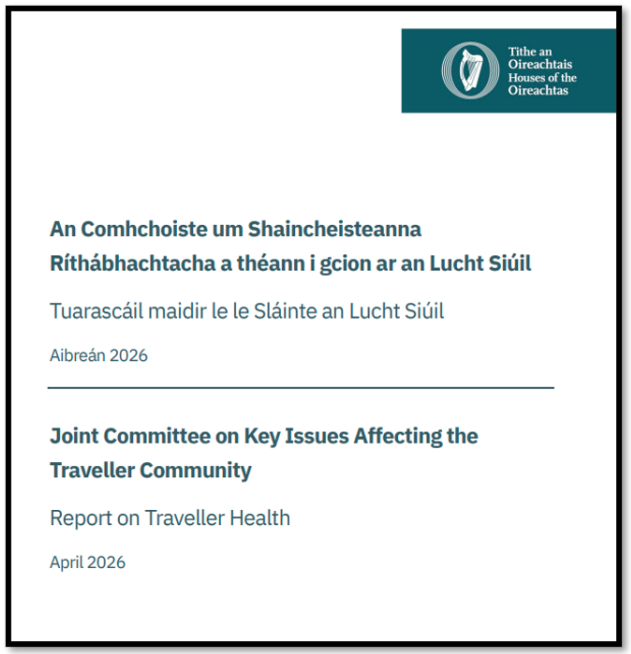
(Participants 12, 13)

Frazer et al. 2026

# Policy implications

- *I am presenting this Report on Traveller Health and Mental Health with a deep sense of responsibility and urgency.*
- ***The evidence laid before the Committee is stark, unambiguous, and profoundly troubling.***
- ***It reveals a pattern of racism, discrimination, and systemic neglect that has left an entire ethnic community feeling abandoned within its own country.***
- *The findings speak to a pervasive lack of hope among* ***Travellers - an erosion of trust that has taken root after generations of unequal treatment and unmet commitments.***
- *This report does not simply outline policy failures;* ***it exposes the human cost of those failures.***
- *The* ***disparities in health outcomes****, the disproportionate burden of mental ill health, and the lived experiences shared with the Committee all point to* ***a crisis that can no longer be met with incremental or symbolic responses.***
- *The* ***status quo has already inflicted too much harm*** *(p.5)*






## Health Care Access and Trust

### Literacy

Low literacy rates in the Traveller community present a barrier to accessing existing health care services and can be addressed through educational supports in schools, adult education programmes, and amending the means of healthcare communications.

Witnesses from UCD cited literacy as a barrier to Traveller engagement with healthcare, due to jargon-heavy communications about services and appointments which can be compounded by preexisting distrust, shame, and fatalism.

Limited literacy also impacts access to medical cards and engagement with necessary administrative tasks relating to healthcare.

Public health nurses were cited as playing an important role in helping people understand what is meant in letters about medical appointments, test results and screening programmes, as well as liaising with both Traveller Primary Health Care Project Workers and supporting Travellers themselves directly.

Low literacy rates also contribute to the marginalisation of Travellers in the democracy, politics and policymaking, and particular efforts to create inclusive approaches particularly to policy and programmes that affect Travellers should be made inn accordance with the

# What Did I learn

Trust is relational

Trust must be earned

Power and vulnerability matter

Partnership is part of the solution

# Closing Points

For me, trust is not simply an individual attitude – it's produced through relationships.

Continuity, communication and respect create conditions in which trust can develop.

For marginalised communities we should not ask why don't they trust us and we should ask – what would make our services trustworthy?

**Integrated, person-centred care depends on trust, and trustworthiness must be part of how we design, implement and evaluate care.**

# Thank you!

Kathleen.frazer@ucd.ie

https://people.ucd.ie/kathleen.frazer

# Acknowledgement of Country

# Trust as an enabler in implementing integrated models of care into practice

MACQUARIE University

AUSTRALIAN INSTITUTE OF HEALTH INNOVATION

Home > Implementation Science Communications > Article

## Trust is essential: implementing paediatric care coordination in rural Australia

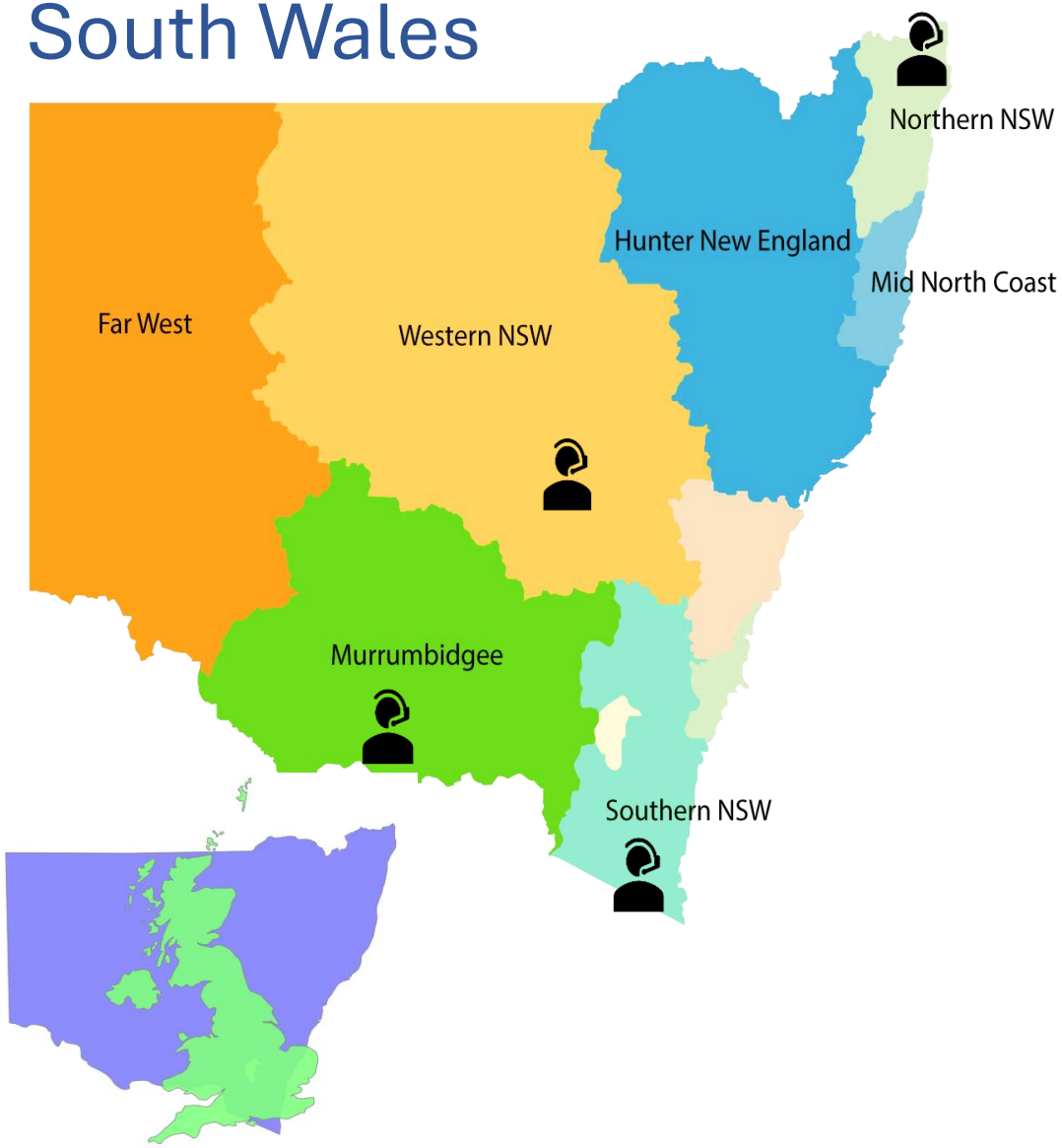
Research | Open access | Published: 17 July 2026

In press: Hutchinson, K., de Groot, A., Smithers-Sheedy, H., Lingam, R., & Zurynski, Y. Trust is essential: implementing paediatric care coordination in rural Australia. *Implement Sci Commun* (2026). https://doi.org/10.1186/s43058-026-01028-4

This study explored how trust was operationalised between families of children with medical complexity and care coordinators in the Rural Kids Guided Personalised Service (RuralKidsGPS) model, and how relational and contextual factors shaped trust-building processes.

Lingam R, Smithers-Sheedy H, Hodgson S, Hutchinson K, Meyers Morris T, Hu N, Nassar N, Schroeder E-A, Rana R, Dickins E, Bula K, Zurynski Y. Evaluation of RuralKidsGPS: A Novel Integrated Paediatric Care Coordination Model of Care in Rural Australia – a Mixed-Methods Study Protocol. *International Journal of Integrated Care,* 2023; 23(4): 10, 1–11. DOI: https://doi. org/10.5334/ijic.7008

# **WHERE** has RuralKidsGPS been implemented in New South Wales




# Complexity and sociodemographic characteristics

71 % of children needed complex care coordination across primary, secondary and tertiary care

| Characteristic | % N= 424 |
|---|---|
| **Priority Populations** | **27.5%** |
| • Aboriginal and Torres Strait Islander | 18.8% |
| • Culturally and Linguistically Diverse, refugee, Out of Home Care, parent w/disability | 8.7% |
| **Low SES (IRSAD ≤4$^{th}$ decile)** | **62%** |

Index of Relative Socioeconomic Advantage and Disadvantage (IRSAD) (Socio-Economic Index For Areas)

# What does existing evidence say?

## Relationships begin with TRUST…. '*the glue that makes partnerships work*' Hunter & Perkins (2012)

## TRUST…..

- Is a foundational element in the establishment and maintenance of effective healthcare relationships.
- Can optimise implementation efforts
- Acts as a moderator of implementation outcomes
- Aids adoption and sustainability

Hunter & Perkins (2012) DOI: 10.1258/jhsrp.2012.011127

# Contributions to the literature and understanding of trust in implementation practice

01

This study helps advance implementation science by **showing how relational competencies and local knowledge can mitigate systemic inequities and foster sustained healthcare relationships.**

02

These findings contribute to **conceptual advancement, positioning trust not just as a facilitator but as both a mechanism and an outcome in implementation processes.**

03

The creation of the **Trust in Implementation Practice (TIP) framework and its contextual expansion (TIP-C) provides a novel, theory-informed lens for operationalising trust in implementation research.**

# Parents and family carers value a paediatric care coordinator as trustworthy, dependable, responsive and supportive

# Quotes demonstrating the key trust constructs

| Constructs of trust | Illustrative quotes |
|---|---|
| **Authenticity** | '*Any service, any questions I have, I can ask PCC [name]. And **if she doesn't know, she won't give me a false answer**. There's never any false hope. What she's thinking is exactly the truth*.' (P16) |
| **Empathy** | '*I just feel like I have that person that's **sharing the load**, because that load was so heavy. And now I feel she's [PCC] there, so now I've got time to do my mental health.' (P13)*<br><br>*'There are some clients that I don't ask to be part of the research project, so I do use my clinical judgment if they've got a really sick palliative baby and **I just think that their cups are too full** [large caring load]'. (PCC2)* |
| **Competency** | '*PCC [name], trying to get things through, or just trying to get appointments and trying to get appointments followed up. Trying to get answers, all of that stuff. Just **knowing that there's someone else that I can rely on**. I've found PCC [name] to be the most reliable support that I've had so far'. (P8)* |
| **Vulnerability** | '*Last two years, my mental health had taken a massive dive. **I didn't have a choice** [but let PCC support me]'. (P17)*<br><br>*'Sometimes it's a **scary conversation** to ask them [families about what their needs are] because you're not sure. **Not sure if you're gonna [going to] have anyone/anything to offer them** either'. (PCC1)* |
| **Reciprocity** | '*We've got **all the confidence in the world in them** [PCC and local health care staff], and **it feels like they have all the confidence in the world in us**'. (Fam5)* |

# Key themes related to enabling trust building

| Paediatric care coordinators (PCCs) understand the family's circumstances | Paediatric care coordinators demonstrate competency in assisting families | Cooperative expectations within care relationships | Parental advocacy for RuralKidsGPS is driving engagement and equity | Strong relational ties with Paediatric care coordinators enable family advocacy |
|---|---|---|---|---|
| PCCs tailor support by recognising and responding to each family's unique context. | Families trust PCCs because they reliably navigate systems and solve problems | Care works best when families and PCCs engage and collaborate as partners | Parents actively champion RuralKidsGPS to overcome barriers, especially in rural areas | Trusting relationships with PCCs empower families to advocate more confidently |
| *Empathy, authenticity and vulnerability* | *Competency, empathy and authenticity* | *Empathy, authenticity and reciprocity* | *Empathy, competency and reciprocity* | *Vulnerability, empathy and reciprocity* |
| **Consolidated Framework for Implementation Research (CFIR) constructs**: Assessing Needs, Innovation Recipients, Assessing Context, Recipient-centredness | **CFIR constructs**: PCCs as Implementation Facilitators, Tailoring Strategies, Assessing Needs, PCCs as Innovation Deliverers, Capabilities | **CFIR constructs**: Relational Connections, Communications, Assessing Needs, Human-quality-centredness | **CFIR constructs**: Relational Connections, Tailoring Strategies, Communication, Human-quality-centredness | **CFIR constructs**: Recipient-Centredness, PCCs as Implementation Facilitators, PCCs as Innovation Deliverers, Motivation |

Damschroder LJ, Reardon CM, Widerquist MAO, Lowery J. The updated Consolidated Framework for Implementation Research based on user feedback. Implement Sci. 2022 Oct 29;17(1):75. doi: 10.1186/s13012-022-01245-0.

# Key themes related to undermining trust-building

## Past negative healthcare experiences

*Being repeatedly let down by the system created distrust and mistrust*

***CFIR constructs**: Local Attitudes, Local Conditions, Partnerships & Connections, Work & Information Technology Infrastructure, Communications*

## Health system fragmentation and information gaps

*Fragmented system disrupting continuity of care*

***CFIR constructs**: Local Conditions, Policies & Laws, Information Technology Infrastructure, Tension for change, Compatibility, Relative Priority*

## Unclear paediatric care coordinators' role

*Unclear role boundaries reduced confidence and limited engagement*

***CFIR constructs**: Relational Connections, Culture, Tension for Change, Relative Priority*

## Paediatric care coordinators' role complexity and constrained capacity

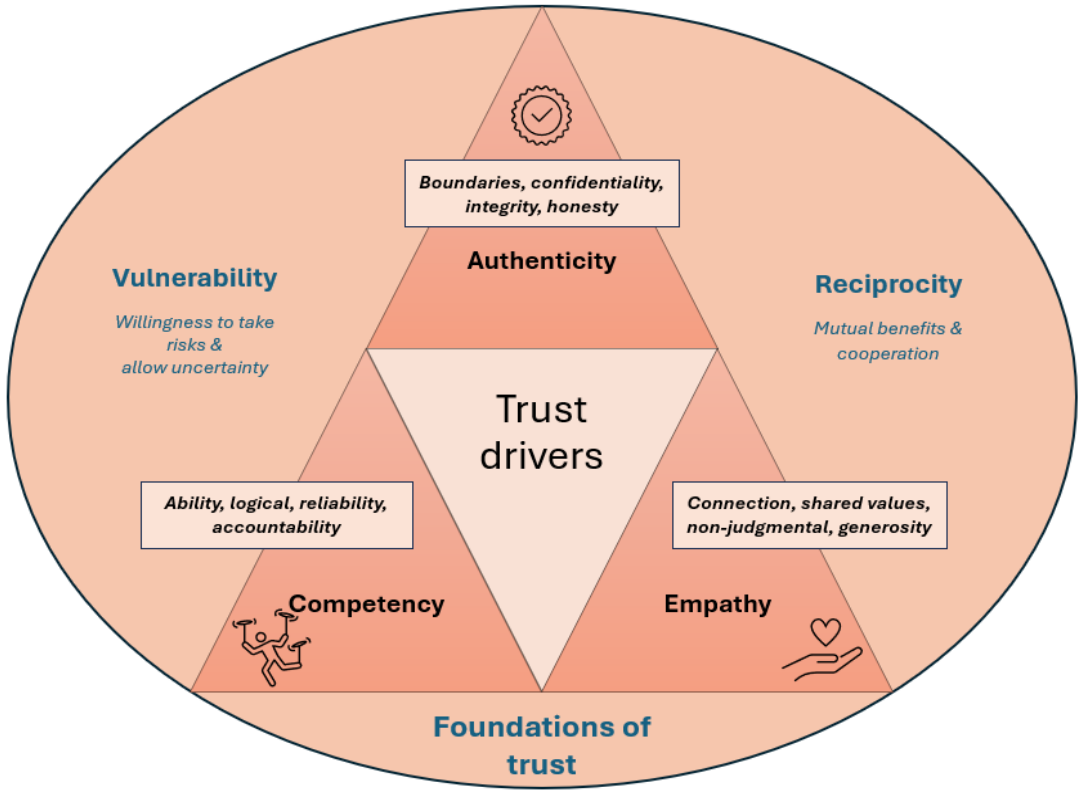
*Role complexity and limited capacity reduced PCCs' ability to provide consistent support*

***CFIR constructs**: Local Conditions, Tension for Change, Compatibility, Relative Priority, Resources*

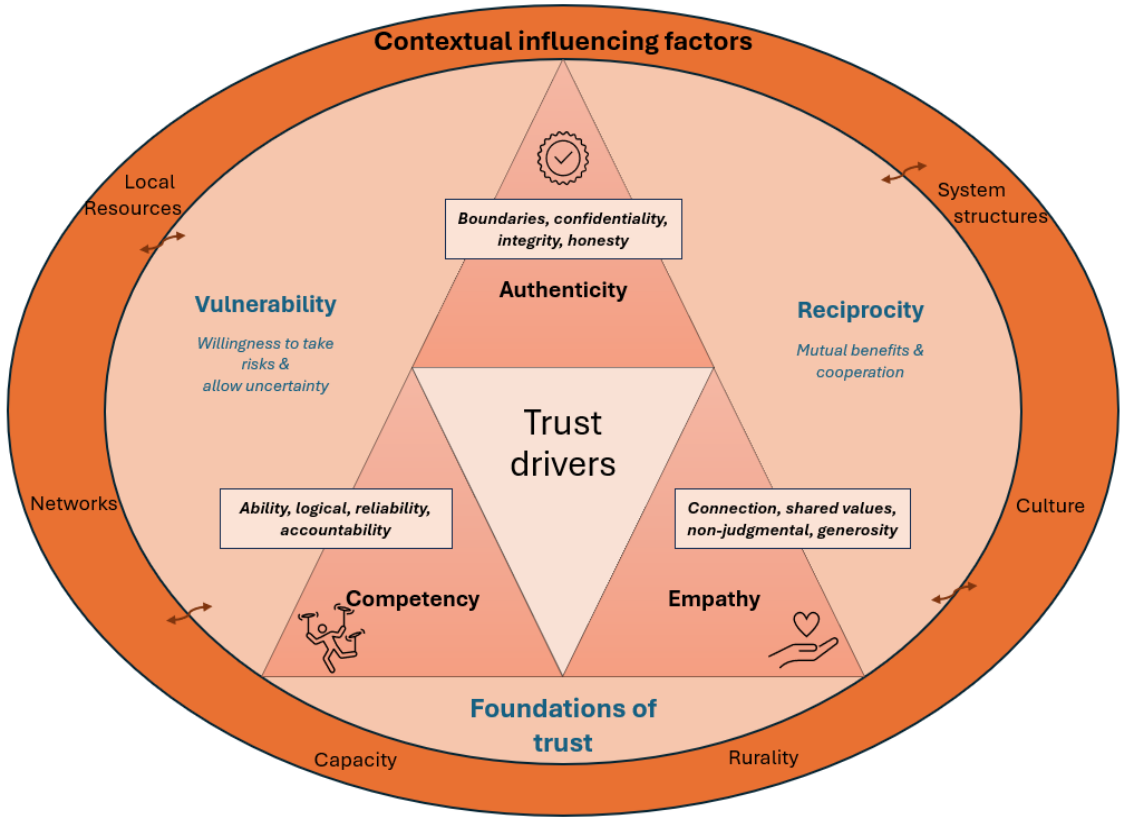
# Conceptual frameworks

Recognising trust as a deliberate implementation strategy may strengthen the success and sustainability of innovative models by supporting context-responsive care, reducing disparities, and advancing equity-driven, sustainable, integrated healthcare systems.

## Trust in Implementation Practice [TIP]




## Trust in Implementation Practice – Context [TIP-C]



# Take home message……

**Operationalising Trust** can influence implementation processes and support health service innovation and engagement to:

1. **Develop** effective therapeutic relationships,
2. **Support** the implementation efforts and advocacy for change in service delivery and sustainability,
3. **Strengthen** care integration across healthcare settings, regardless of geographic location.

*'If we didn't have [Care Coordinator], I would have zero faith in [state name] Health. She keeps all the doctors in line, she keeps all the nurses in line, she has everything organized, she's two steps ahead….. she looks at the whole picture of [Child].....She is our number one healthcare professional'* [parent of child with medical complexity]

MACQUARIE University

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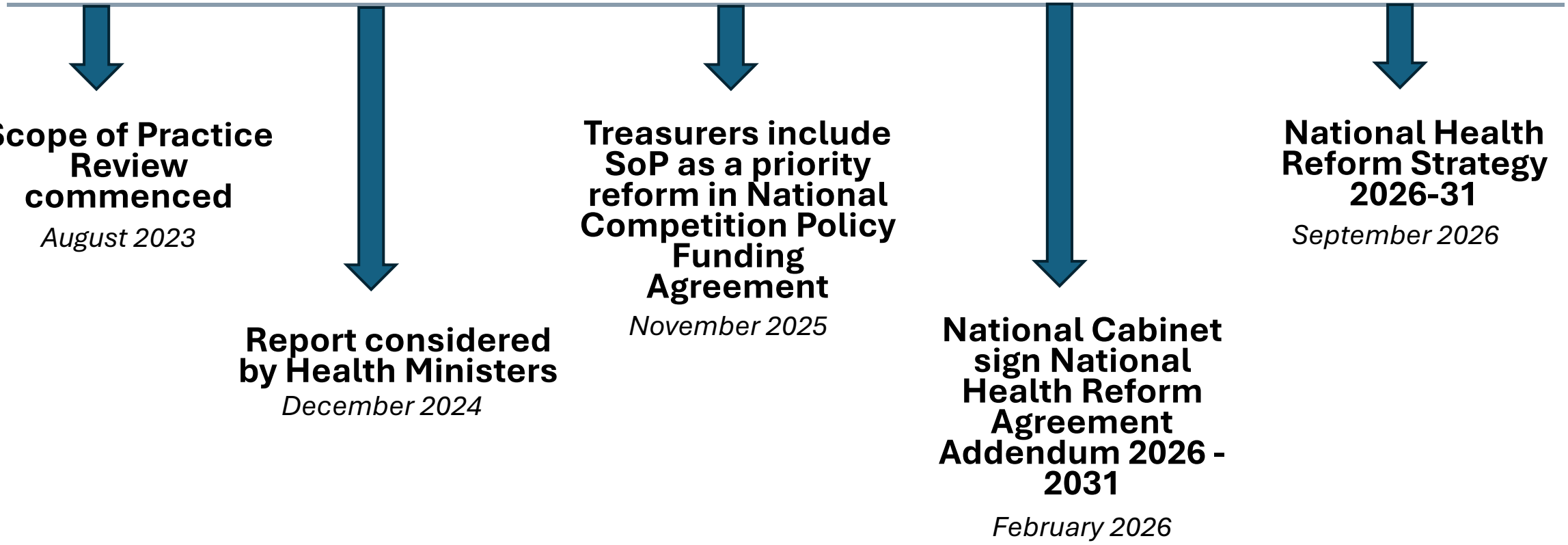
# Building trust into care & health systems

## *Workforce design, regulation and funding/payment policy settings*

Professor Mark Cormack
National Centre for Health Workforce Studies, ANU
IFIC Webinar
30 September 2026

Australian National University

# *Unleashing the Potential of our Health Workforce*
# [Scope of Practice Review]



# High level findings (1/2)

**Overall**

**Virtually all health professions working in the primary care sector, including GPs, have some restrictions or barriers to working at full SOP that are unrelated to their skills, qualifications, competence and acceptance of professional accountability for their practice**.

**Workforce design, development, education and planning**

**Awareness of health professional scope of practice is limited.** Consumers and health professionals frequently have a limited understanding of the skills, capabilities, competence and scope of practice of members of the primary care team.

**Preparation of, and support for, health professionals to practise in primary care is limited, especially when compared to the public hospital and health care sector**. Learning about primary care during pre-professional entry programs is limited for some health professions, resulting in challenges attracting the primary care workforce. Support to remain, and develop skills, in primary care are limited, resulting in challenges retaining the primary care workforce. Support for multidisciplinary teams is limited.

**Legislation and regulation**

**There are opportunities to improve health professional regulation** to further strengthen, develop and modernise the NRAS to further enable and support more health professionals to work to full scope of practice

**Other legislative & regulatory settings restrict scope of practice in primary care**. Outside the NRAS, other legislative and regulatory settings have a more significant and restrictive impact on health professionals working to their full scope of practice.

# High level findings (2/2)

**Funding and payment policy**

**Funding and payment policy settings restrict scope of practice in primary care**. Funding and payment mechanisms impede health professionals from working to full scope of practice and as part of a multidisciplinary team. Health professionals practising and remunerated via a predominately fee-for-service payment system face the most significant barriers; those practising and remunerated in a non-fee-for-service payment system face the least barriers to working to full scope of practice and as part of a multidisciplinary team.

**Enablers**

**Structures, infrastructure and mechanisms to support and enable effective clinical governance and risk management in the primary care sector are variable**, more basic, less resourced and generally voluntary when compared to that which applies in the hospital sector.

**Culture and leadership are the most critical dependencies for achieving change in primary care**. Healthcare reform requires cultural change at system, profession, organisation and individual levels.

**Rural and remote settings** often provide the greatest opportunity for more immediate and enduring positive change which support full scope of practice in a multidisciplinary context.

**Overall**

There are numerous examples of **effective, team-based, full scope of practice models and services**, including

- Aboriginal Community Controlled Health Organisations (ACCHOs)
- rural and remote multidisciplinary services
- community health services targeting higher risk, lower socioeconomic groups and
- innovative general practice models that employ, support and/or provide a range of multidisciplinary services and optimise the use of primary care and practice nurses.

# Summary of reforms & recommendations

## Theme A: Workforce design, development, education and planning

**Reform A1:** National Skills and Capability Framework and Matrix

**Rec 1** Develop a National Skills and Capability Framework and Matrix

**Reform A2:** Strengthen the capability of the primary care workforce

**Rec 2** Establish a primary care workforce development program

**Rec 3** Amend the National Law to provide a consistent authority of the HMM to give policy directions on registration and accreditation functions

**Rec 4** Develop principles for Interprofessional Education (IPE) and interprofessional capabilities for primary care, collaborative practice and First Nations health care

**Rec 5** Remove unnecessary barriers to supervision in primary care education and training

## Theme B: Legislation and regulation

**Reform B1:** Initiate a more balanced and consistent approach to regulating scope of practice

**Rec 6** Progress activity-based regulation of scope of practice to complement the status quo focus on protection of title approach

**Rec 7** Program of review and potential harmonisation of existing legislation and regulation

**Rec 8** Strengthen and standardise the regulatory model for health professions currently operating outside of the National Registration and Accreditation scheme (NRAS)

**Reform B2:** Independent, evidence-based support for health workforce innovation, access and productivity

**Rec 9** Establish an Independent Mechanism to provide evidence-based advice and recommendations in relation to significant workforce innovation, emerging health care roles, and workforce models that involve significant change to scope

## Theme C: Funding and payment policy

**Reform C1:** Funding and payment models enable and support health professionals in multidisciplinary care teams to work to full scope of practice

**Rec 10** Introduce a new blended payment to enable access to multidisciplinary health care delivered by health professionals working to their full scope of practice in primary care

**Rec 11** Introduce a bundled payment model for maternity care

**Reform C2:** Direct referral pathways supported by technology

**Rec 12** Implement new direct referral pathways for consumer access to specified non-General Practitioner (GP) specialist MBS items

## Theme D: Enablers and other key considerations

**Rec 13** Program governance and reform structure to oversight reforms

**Rec 14** Develop a new capacity building and implementation support program for the 31 Primary Health Networks (PHNs)

**Rec 15** Develop and implement communications and training strategies

**Rec 16** Commit to a shared definition of cultural safety across primary care

**Rec 17** Mandate participation by primary care providers in an approved accreditation program

**Rec 18** Prioritise implementation of reforms in rural, remote and underserviced areas

# BAKING A

**What is most needed by this person, at this time?**

**What do the organisation and wider system need to do to support this?**

## SCENARIO

A new staff member raises a concern about a patient's care. Will they feel safe to speak up—and will the organisation respond?

## YOUR ACTIVITY

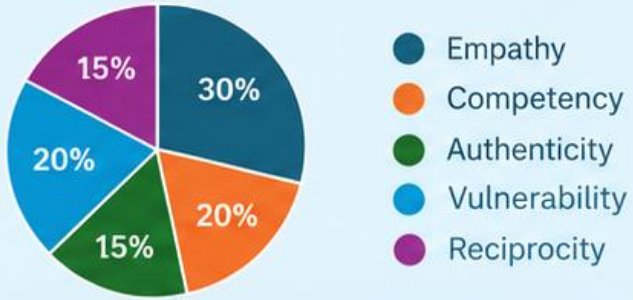
You have 100 points. How would you divide them across the five ingredients?

## REFLECT

1. Which ingredient is strongest?
2. Which is missing or weakest?
3. What is hardest to achieve?
4. Does the pie change across individual, organisation and policy?

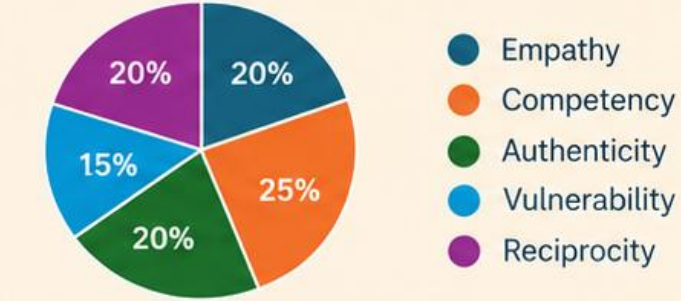
## INDIVIDUAL

Day-to-day interactions between people.



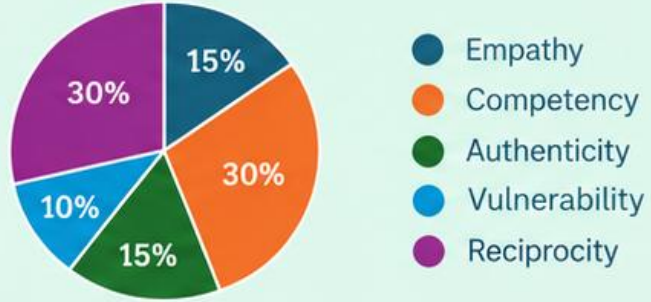

## ORGANISATION

Culture, leadership and ways of working.




## POLICY / SYSTEM

Rules, resources and the enabling environment.




**Trust is built through relationships— and enabled or constrained by systems.**

# What can we do better?

We don’t just work in the health system: we have a role and responsibility to improve **how** it works.

Every healthcare professional leaves a footprint on the system. The question is whether it simply reflects the system as it is or helps create the system it needs to become.

Recognise, reflect on and value the points of interaction where trust is built, maintained or undermined, and use these insights to guide change both at the policy and practice level

# Key takeaways

1. Trust is a core of health systems, not a soft extra
2. It is complex and dynamic: hard to build but easy to lose, important to measure and understand
3. Move from transactional to relational care, and from blame to reflection and learning
4. Policy and the wider system should set the standards and conditions for trustworthy care
5. Treat trust as an ongoing process and a shared responsibility, built through relationships across individuals, systems and policies