The Royal Australasian College of Physicians

This submission has been developed to provide a response to the RACGP Vision for sustainable health care discussion paper.

The Royal Australasian
College of Physicians

RACP Submission (2015)

RACGP consultation paper
Vision for a sustainable health system

Executive Summary

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to respond to the Royal Australian College of General Practitioners' (RACGP) consultation paper '*Vision for a sustainable health system'*. Whilst Australia is internationally recognised as delivering high quality care within an affordable system, both these aspects are increasingly coming under pressure.

The RACP supports policies that focus on patient outcomes, patient care and patient safety. We need action to reorientate the health system to ensure we are able to continue to provide high quality care and meet existing and future patient needs. Improving the integration of care and having a more patient-centred system must be central to any reform.

The RACP congratulates the RACGP on the development of this consultation paper, incorporating a broad range of General Practitioner expertise. However we believe that reforms such as those proposed in this paper need to be considered in a broader context. Physicians deal first hand with the impact fragmented care has upon patients and they see as clearly as general practitioners the detrimental effect on their patients' health and wellbeing. The intent of many of the reforms proposed cannot be realised by general practice in isolation. The roles and responsibilities of the broader multi-disciplinary team need to be recognised.

In 2011-12 it was estimated that there were 635,000 Australian hospital admissions considered to be potentially preventable. This figure equates to 7 per cent of all hospital admissions, and is an issue that must be addressed.

The medical home of a patient is not specific to general practice. For example residents in aged care facilities and people with advanced chronic or complex conditions may often find that for a period of time their primary health provider is another health care professional such as a geriatrician or palliative care physician who is working as part of a multi-disciplinary team.

Research has shown that effective governance under a medical home model occurs when it is led jointly by primary care clinicians, hospitals, and relevant specialists.[1] More recently a position paper by the American College of Physicians describes specialists as integral to primary health care led models of care.[2]

In addition, the significant and valuable role provided by the Aboriginal Community Controlled Health sector must be recognised. These service providers deliver culturally appropriate, accessible and comprehensive primary health care, and are a vital, and often preferred, medical home for Aboriginal and Torres Strait Islander people. The relationship of general practice within this setting should be further considered in consultation with the National Aboriginal Community Controlled Organisation (NACCHO).

It is imperative that we develop and implement new models of care that cut across the traditional health sectors, focus on patient needs and quality of care, support the better coordination of services across the different providers of care and the different care settings, and are funded by appropriate mechanisms that promote a new integrated and multidisciplinary way of working.

[1] Fisher, E.S (2008) Building a medical neighborhood for the medical home. N Engl J Med. 2008;359(12):1202–5.
[2] American College of Physicians, (2010) The patient centred medical home neighbour, the interface of the medical home with specialist and subspecialist practices. American College of Physicians Position Paper, accessed https://www.acponline.org/advocacy/current_policy_papers/assets/pcmh_neighbors.pdf

Identification of barriers, or challenges facing the health system

At present the health system is skewed towards rewarding discrete, acute interventions rather than fostering and developing stronger multidisciplinary healthcare teamwork. Funding systems need to promote and reinforce effective approaches to healthcare to better manage long-term conditions, including a greater focus on effective, targeted preventive health care.

There is increasing focus globally on integrated care as a means of driving both quality of care and improved efficiencies. Despite this trend, the current funding mechanisms ignore many of the aspects crucial to integrated care; including the time taken for coordination, communication and collaboration.

Much of the outpatient care currently provided within the hospital setting would be more effective and efficient if it was more community-based. Models of care, therefore, need to be developed that enable specialist care to be provided in community-based settings, including within general practice.

There are significant cultural barriers to overcome. The culture of the health system often encourages clinicians to act in silos rather than coordinate with each other. This starts early in clinicians careers, with separate training pathways for different medical specialties, including the general practice specialty. This is a core reason for the strong support of the RACP for the Specialist Training Program, which supports specialist training positions in community-based settings, enabling trainees to develop skills in multidisciplinary teamwork at the start of their career.

A well-balanced and well planned health workforce is critical. This includes utilizing the full capacity of nursing, allied health staff, community and Aboriginal and Torres Strait Islander Health Workers, as well as specialists and general practitioners.

Other broader challenges to an effective and efficient health system must also be acknowledged, including an increased investment in preventive health measures, addressing the social determinants of health, and the growing environmental challenges that affect the distribution of health and wellbeing across the population.

The RACP has recently established an Integrated Care Working Party with RACGP and consumer representation. This Working Party will explore models of care, funding mechanisms and other strategies that provide better coordinated and integrated multidisciplinary health care delivery. We look forward to working with the RACGP on this matter and to sharing the outcomes of this more broadly across the health sector.

Initiatives proposed in the RACGP consultation paper

4.1. Acute Care - Fee for Service arrangements

Funding systems are needed that encourage and reward healthcare professionals and service providers for working together. Whilst the fee for service (FFS) model is a very effective model to deal with acute instances of care, additional approaches are also needed that better address the complex and ongoing needs of an increasing number of patients. It is well recognised that FFS can lead to perverse incentives to focus on volumes of care services, and it does little to promote or support coordinated, long-term and complex care. The RACP calls for new models of care, and work must be undertaken to develop and trial new funding mechanisms.

Consideration should be given to models that blend the current fee for service model (whether at the practitioner or hospital level) with alternative approaches such as capitation payments and bundled payments. Within a medical home model, there is evidence that bundled payments to multiple providers has been shown to reduce costs and improve patient outcomes.[3] [4]

4.2. Patient enrolment through General Practice

The RACP supports the use of effective models of care, and is of the view that patient enrolment is a model that warrants consideration. Should an incentive payment be provided to support this model, it is vital that comprehensive electronic health records be a mandatory aspect of the model and tied to this incentive payment.

The RACP supports further discussion as to how all health service providers will contribute to and provide stewardship of patient information, as well as appropriate and timely communication of relevant information.

4.3. Complexity Loading

Evidence suggests that the cost and utilization of health services within a medical home model is concentrated amongst high-risk and high-cost patients.[5] [6] Therefore recognition of the additional work load that complex patients impose is necessary and the provision of a complexity loading element has merit.

Serious consideration should be given to this, however, caution needs to be taken to ensure no perverse incentives are inadvertently introduced that encourage 'cherry picking' patients to the disadvantage of the vulnerable and those in the most need.

4.4. Comprehensiveness payments

Funding mechanisms that provide for more holistic patient care are likely to improve efficiency and effectiveness by reducing transitions between service providers. However further detail is required to provide any sort of assessment of the proposal outlined in this consultation paper.

There is emerging evidence that comprehensiveness payments to both specialist and primary health clinicians can lead to better use of health resources and potentially shared savings across health services. Partial capitation and global payments incentives are two such comprehensiveness payment measures that are shown to provide for shared accountability, better patient care, and lower costs. [7] [8]

---

[3] Paying for the Medical Home: payment models to support Patient Centred Medical Home Transformation (2009) http://www.co.fresno.ca.us/viewdocument.aspx?id=47520

[4] McCarthy D, Mueller K, Wrenn J (2009) Geisinger Health System: achieving the potential of system integration through innovation, leadership, measurement, and incentives. The Commonwealth Fund.

[5] Paulus RA, Davis K, Steele GD (2008) Continuous Innovation in Health Care: Implications of the Geisinger Experience," Health Affairs, Vol. 27, No. 5, September/October 2008, pp. 1235–1245.

[6] Higgins et al (2014) Medical Homes and Cost and Utilization Among High-Risk Patients 2014;20(3):e61-e71http://www.ajmc.com/journals/issue/2014/2014-vol20-n3

[7] John Kautter et al (2007) Medicare Physician Group Practice Demonstration Design: Quality and Efficiency Pay-for-Performance Health Care Finance Review. Fall; 29(1): 15–29. PMCID: PMC4195009

[8] W. Carl Cooley et al. (2009) Improved Outcomes Associated With Medical Home Implementation in Paediatric Primary Care; Paediatrics Vol. 124 No. 1 July 2009, pp. 358-364 (doi:10.1542/peds.2008-2600)

4.5. Integration

In order for clinicians to change behaviours and practice norms, the health system must provide adequate support for improving integration through shared care. The Independent Pricing Hospital Authority (IPHA) notes that interdisciplinary care is a form of intervention with vast amount of literature supporting its validity.[9]

The consultation paper highlights that greater integration of care can lead to reduced hospital bed days, readmission rates and facilitate early discharge. However to realise these potential benefits the scope of this paper and the reforms it is proposing must be broadened beyond general practice.

The reforms need to address the multiple instances of care provided by different healthcare professionals in different settings. These models must promote patient-centred care, encourage a multidisciplinary health team approach, and allow care to be provided at the most appropriate location in the most appropriate way by the most appropriate health professional. One clear aspect that has not seemingly been considered is strategies to increase the provision of specialist care in community-based settings, including in general practice and aged care facilities.

4.6. Research

Practice payments that require evidence of research may be a difficult to demonstrate. It is also unclear how this proposal will link with relevant state and federal strategic directions already occurring, or planned in the area of health and medical research. Alternative arrangements should be compared with this proposal which could also include the provision of grants that specifically provide for general practice research.

The RACP agrees that inadequate support for sustaining and improving health and medical research is a barrier, and that this research needs to be clinician-led. Specialists self-report that coordination, facilitation and management of research are major issues and a hindrance to research activities.[10]

The improved uptake and use of electronic health records has the potential to significantly improve the capacity of clinicians to undertake health and medical research.

4.7. Practice Nursing

A key aspect of proactive chronic disease management is allowing all clinicians to work at the top of their scope of practice. Efforts that promote consideration of the role of practice nurses as fundamental part of the primary care team are therefore supported. Not enough information of what is being proposed is available for a full evaluation of this however the outcomes of incentivising practice nursing will depend on role delineation, training and competency requirements. It is unclear what specific changes are being suggested that may differ to the current Practice Nurse Incentive Payments (PNIP).

4.8. Teaching

The RACP recognises that there are costs associated with providing high quality training, and supports the need for practices to be able to invest in and support the training of the future general practice workforce.

---

[9] Independent Hospital Pricing Authority, the Pricing Framework for Australian Public Hospital Services 2014-15 http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/content/CA25794400122452CA257C1B0001F452/$File/Pricing-Framework-Aust-PublicHospitalServices-2014-15.pdf

[10] Hiscock et al (2014) Clinical Research potential in Victorian Hospitals: The Victorian Clinical research needs analysis survey. Internal Medicine Journal doi: 10.1111/imj. 12396

As highlighted earlier in our comments about the Specialist Training Program, we support moves to increase the provision of training positions in community-based settings and to further reorientate early training experiences to recognise and experience a multidisciplinary healthcare team approach.

4.9. IT and infrastructure

It is essential that the health system makes provision for long-term, effective strategies to drive the use of electronic health record systems, and communications between these systems, as a priority.

The RACP strongly encourages greater engagement across the sector in the development of eHealth technologies. These information systems should ensure clinicians have the right information at the right time, reduce the incidence of unnecessarily repeated tests and diagnostics, enable the better coordination of services, reduce the potential for unsafe interactions or interventions, and support the involvement of patients, carers and families in the decision making process.

Greater engagement is necessary with physicians in the development and uptake of electronic health record systems. To date, the design, planning and implementation of the approach has involved very limited engagement with the physician workforce and this must be rectified. The overwhelming majority of RACP members surveyed – more than 92 per cent, indicate that they had experienced little to no engagement concerning the implementation of the current system.[11]

One of the expected benefits of a coordinated electronic health record is the quick and efficient sharing of patient information between general practitioners and specialists[12], however this benefit cannot be achieved without the effective engagement and support of physicians.

In addition, technology must be better utilised to improve access to healthcare. System reforms should also be calling for funding for telehealth and video case conferencing to be extended beyond the rural and remote sectors of the community. The benefits offered by telehealth are clear, and it is equally valuable for people living in urban areas, especially for older people, patients who require an escort, or people living with chronic illness or disability.

Conclusion

The RACP sees this consultation paper as a good opportunity to engage a wide range of stakeholders on policies that will drive future reforms to deliver the health system Australia needs.

We appreciate the opportunity provided by the RACGP with this consultation paper to make comment, however it is vital that reform of general practice is not considered in isolation. In depth consideration is needed regarding the broader context of the provision of patient care services, including by specialists and allied health, and the locations of patient care within hospital, palliative, and community settings.

The RACP looks forward to ongoing engagement with the RACGP and other key stakeholders in the development of forward-looking policies to bring about effective system change.

---

[11] RACP Submission into the Personally Controlled Electronic Health Records Program Review (2013) accessed at https://www.racp.edu.au/page/policy-and-advocacy/e-health

[12] Review of the personally controlled electronic health record, the National Electronic Health Transition Authority (NEHTA), December 2013.