The Royal Australasian College of Physicians

This Position Statement has been developed to provide a response to the Submission to the Health Standing Committee enquiry into Chronic Disease.

RACP Submission (2015):

Inquiry into Chronic Disease Prevention and Management in Primary Health Care

Executive Summary

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to respond to the inquiry by the House of Representatives Standing Committee on Health into Chronic Disease Prevention and Management in Primary Health Care. This submission focuses on the Committee's Terms of Reference, specifically innovative models which incentivise access, quality, and efficiency, as well as best practice examples of multidisciplinary teams.

Over the last 20 years there has been a substantial shift in the global burden of disease from communicable, maternal, neonatal, and nutritional disorders, towards non-communicable chronic diseases.[1] Of the many people with chronic conditions a rapidly increasing proportion are suffering from more than one illness.[2] This is known as multi-morbid illness.

It is estimated that 70 to 80% of healthcare costs in the United States and Europe are spent on chronic disease treatment, and more than half of all potentially preventable hospitalisations are due to chronic conditions.[3][4] The Australian context is similar, with over seven million people having at least one chronic condition.[5] In 2008-09, almost $20 billion was spent in total on the top three most expensive chronic conditions.[6]

Without doubt, the primary care sector has a key role to play in addressing multi-morbid chronic illness. However a focus on individual chronic diseases, or health sectors operating independently in their respective 'silos', is not the answer. Rather, the importance of care coordination between primary and secondary health care providers is a critical strategy to address the growing burden of chronic disease.

Improving coordination and access to our health system, and recognising and supporting multidisciplinary teams in partnership with consumers is essential to improve the health and well-being of Australians affected by chronic disease. This submission proposes three principles that may assist to deliver appropriate consumer-centred, and effective chronic disease prevention and management, namely;

- A national approach underpinned by a whole of government strategy that is supported by collaborative and sustainable models of funding.
- Increasing capacity and access to care in regions with disproportionate levels of chronic disease, and targeting populations most at risk.
- Clinical leadership from across the health sector, and support for multidisciplinary teams.

Given the fluid nature of the government's current policy priorities for primary healthcare, the College has not made specific recommendations. However, in keeping with the Inquiry's Terms of Reference, this submission highlights specific examples, including models of care and funding that illustrate best practice.The RACP suggests these should be further explored by government.

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1 Murray C et al (2013) Measuring the Global Burden of Disease N Engl J Med 2013; 369:448-457 August 1, 2
2 Jowsey T, McRae IS, Valderas J, et al. Time's up. Descriptive epidemiology of multi-morbidity and time spent on health related activity by older Australians: A time use study. PLoS ONE 2013; 8(4): e59379
3 Center for Disease Control and Prevention (2007) Chronic Disease Overview: Costs of Chronic Disease. Centers for Disease Control and Prevention Web site. Available at http://www.cdc.gov/nccdphp/overview.htm.
4 Gemmil, M (2008) Research notes on Chronic Disease Management in Europe Commission Directorate-General "Employment, Social Affairs and Equal Opportunities" Unit E1 - Social and Demographic Analysis, the London School of Economics and Political Science.
5 AIHW (2014) Australia's health 2014, p. 96
6 Dudgale, Paul (2013) Improving the response of hospitals to patients with multi-morbid chronic conditions, International Hospital Federation White Paper.

A coordinated national system and approach

There are a number of Commonwealth programs that provide the primary health care sector with the "tools" for better chronic disease management, and many elements of chronic disease best practice are present in these programs. However, the considerable overlap and complexity within and between these programs significantly detracts from their effective prevention and management of chronic disease for individual patients. Linkages between Medicare and other programs (for example, state-based programs, or community health care programs) remain fragmented, and considerable time and effort is expended trying to integrate the various separate elements of the system.

National frameworks exist for cancer, heart, stroke and vascular disease, and diabetes, as well as for other chronic diseases, and a national strategic framework for chronic conditions is currently being developed to serve as an overarching policy framework for chronic disease prevention and management in Australia.[7] The College supports the development of a national framework that draws on the current disease specific frameworks, as these frameworks embody common principles and approaches that provide an excellent blueprint for health reform. The national framework should be guided by evidence-based clinical guidelines, and developed in collaboration with clinicians that have expertise in the treatment of chronic disease.

The establishment of Primary Health Networks (PHNs) is another key component of recent health reform, and these organisations are designed to work across the full spectrum of general practice, allied health, and local hospitals, to improve integration of, and access to, care, particularly for patients with chronic diseases.[8] As Australia transitions from Medicare Locals to Primary Health Networks we need to ensure that the PHNs build collaborative partnerships with the full range of health providers.

To implement a nationally networked and coordinated strategy, chronic disease must be managed across a continuum of services and facilities. In this respect hospitals and specialists will be crucial enablers of a coordinated national approach and the future success of PHNs in their efforts to address chronic disease.

The RACP and its partners will continue to develop recommendations regarding the integration and coordination of the health system, in order to address chronic disease. In June 2015, the RACP convened an Integrated Care Working Party, and throughout 2015-16 the group will explore models of care and funding that can better address chronic disease. Models of care that address the interaction of specialists and generalist must be further explored. Some relevant examples, identified in preliminary work, are presented overleaf.

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[7] Commonwealth Department of Health http://www.health.gov.au/internet/main/publishing.nsf/Content/nsfcc
[8] Minister for Health Media Release 11 April 2015; New Primary Health Networks to deliver better local care http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2015-ley036.htm

Stepped care pathway models
The concept of stepped care has evolved over the past ten years in chronic disease treatment and management. A stepped care protocol differs from a normal protocol in that it contains explicit agreed indications for when a patient should ascend or descend the pathway of referral between primary and secondary care. For a stepped care pathway to work effectively across the spectrum of chronic disease, generalists and specialists need closer working relationships. Collaboration is required to set up the pathway, ensure that everyone enters data, and for supervision and consultation to be available from specialists.

The alliance model of care
The New Zealand (NZ) alliance model stems from practices found in the construction industry where contractors on large projects work collaboratively and share resources to complete the job. Under this model, 'everyone wins or everyone loses', and it is acknowledged that if one member is struggling, then it is in the best interests of others to help solve the problem. Alliances have been formed in all 20 NZ healthcare districts with members coming from different service areas (such as GPs, aged care, ambulance, and hospital specialties) and District Health Boards to ensure that decisions about service integration remain clinically driven.

Gold Coast Chronic Disease Wellness Program
The Chronic Disease Wellness Program (CDWP) is a part of the Gold Coast Hospital and Health Service's community services offering an integrated model of chronic disease management. The CDWP is initiated once the patients complex care needs are no longer manageable by primary care alone and when specialist multidisciplinary care is required. The aim of the program is to reduce hospital admissions and to improve patient quality of life by providing a multidisciplinary response to acute, sub-acute and primary care.

Funding quality outcomes for chronic disease treatment

Currently, the Commonwealth, states, and territories administer governance, funding, payment, regulation, and monitoring, of primary health and community care services. The sheer number of different organisations involved in care delivery across the varying levels of government contribute to fragmentation and duplication of services. Chronic disease patients who also require comprehensive care and support in the community are particularly affected by this inefficient organisation of services.

A fiscally driven policy focus on cutting the cost of health care, and cost shifting between the Commonwealth and states is not a sustainable solution and will create long term failure for Australia's primary healthcare system. Funding for chronic disease should be linked to the quality of healthcare, and based upon outcome metrics that are clinician and consumer determined.[9,10] In a recent review of a major chronic disease funding model, the Commonwealth's Diabetes Care Project, it was recommended that the federal government fund models that incorporate flexible funding for quality focused payments.[11] Performance and bundled payment models require further exploration, and funding should be considered based on both patient outcomes and adherence to good practice and quality processes.

In this respect, the RACP is supportive of the Independent Hospital Pricing Authority's recent moves to augment hospital pricing with quality and best practice pricing arrangements.[12] Similarly, as

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[9] Institute of Medicine. (2001) Crossing the Quality Chasm: A New Health System for the Twenty-first Century. Washington: National Academies Press.

[10] International Alliance of Patients' Organizations (2006) What is Patient-Centred Health Care? A Review of Definitions and Principles. Second ed. London: IAPO, 2007:1-34.

[11] McKinsey and Company (2014) evaluation Report of the Diabetes Care Project http://www.health.gov.au/internet/main/publishing.nsf/Content/eval-rep-dcp

[12] IHPA (2015) Pricing Framework 2016-17 Consultation paper https://consultation.ihpa.gov.au/

proposed in the Reform of the Federation White Paper, blended fee-for-service and risk-weighted capitation payments from joint Commonwealth/State funding should be trialled.[13]

It is anticipated that funding for chronic disease prevention and management in primary health and community care will be a central issue for the newly established Primary Health Care Advisory Group. Existing Medicare programs (e.g. Practice Incentive Program , Service Incentive Payments, Chronic Disease Management items), community health care programs (e.g. the Home and Community Care Program), and state community health programs should be brought together for this purpose. Under any proposed realignment of Medicare program arrangements, a single point of entry for chronic disease prevention and management programs should be considered.

Specialist medical services remain a significant contributing factor to health expenditure, and hospital spending remains the largest component of health spending.[14] Funding discussions regarding the management of chronic disease should not be restricted to primary care providers alone.

Research shows that if specialist incentives and behaviour are better addressed, attempts to redesign chronic disease treatment pathways are more likely to be successful.[15] Other health systems have achieved improved outcomes for patients and payers by focusing on all relevant providers of care. Examples of alternative funding models are described below, and should be further tested within an Australian setting.

Accountable Care Organisations
The basic design of an Accountable Care Organisation (ACO) is primary-care-based. However, ACOs include patient-attribution rules, which define which doctor is financially responsible for the care of a patient. The organisations often have global risk-bearing contracts, wherein providers take on financial risk for a population of patients with per-member-per-month spending targets.

Ontario Family Health Team model
Physician income in this model is derived from a blended funding model that combines capitation, and fees for services, with this reimbursement strategy providing incentives for patient-centred care. Family Health Teams have achieved improvements at the organisational and service-delivery levels. While changes in terms of patient experience and outcomes are not yet evident in all domains, there are early signs of improvement, particularly in chronic disease management. A central feature of funding is that the Canadian Government provides salaries for interdisciplinary team members, rather than relying on a fee-for-service model.

The UK Quality and Outcomes Framework (QOF)
This framework delivers financial rewards for providing an agreed level of service for a particular activity. Within the framework the General Medical Services 'Enhanced Services' provides a financial payment for providing additional service elements, for example, chronic disease treatments not routinely regarded as forming part of a primary care contract. Target or function payments, also referred to as payment for performance are used to incentivise healthcare providers to meet the quality standards as outlined in the framework.

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[13] Department of Premier and Cabinet (2015) Reform of the Federation White Paper. https://federation.dpmc.gov.au/

[14] AIHW (2014) Health expenditure in Australia 2012-13. http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129548869

[15] Australian Institute for Primary Care (2008) System reform and development for chronic disease management http://www.chpcp.org/resources/aipc_system_reform_feb08[1].pdf

Equitable access for chronic disease treatment.

The incidence of chronic disease is disproportionately high in rural and remote communities, and especially high among Aboriginal and Torres Strait Islander peoples.[16] Geographic coverage of chronic disease treatment services is variable. While it is not possible to apportion the generally poorer health outcomes outside major cities to access, environment or risk factor issues, it is likely that each of these three play a part.[17]

General physicians participating in clinical outreach teams have the potential to play a major role in early intervention and chronic disease management services to geographically isolated areas. These services are strengthened if used in conjunction with an expanded tele-health system utilising digitally integrated support services (for instance, in areas such as pathology and radiology). Combining services in this manner has the potential to greatly expand the reach of primary health services to address chronic disease.

Generalist physicians are particularly beneficial where people suffer from multi-morbid illness, as is common in the case of chronic disease. Again, this becomes even more important where access to physicians and other medical professionals is limited. Whilst no clear indication of the extent of cuts is known, planned funding cuts of up to one third[18] to the Rural Health Outreach Fund (RHOF) will have a significant impact on specialist access, and, subsequently, the prevention, management, and treatment of chronic disease.

The RACP argues that a coordinated and national chronic disease strategy must ensure equitable access to available treatments. There are examples of models of care and funding that provide effective and equitable access across geographical regions, and target populations most at risk. We suggest that these be further supported.

Checkup Outreach Services in Queensland
Checkup are the fund holders for the RHOF and the Medical Outreach Indigenous Chronic Disease Programme in Queensland. A recent review by Pricewaterhouse Coopers demonstrated that outreach visits by medical specialists to patients in regional communities remain a cost-effective alternative to in-hospital admission and treatment.

Hospital in the Home Programme
Hospital in the home (HITH) provides acute or subacute treatment in a patient's residence for chronic conditions that would normally require admission to hospital. State based programs have been running for several years, and studies shows that HITH reduces mortality, readmission rates and cost compared with in-hospital care, in a statistically and clinically significant way.

HARP Victoria
The Hospital Admission Risk program provides specialised client-centred medical care and coordination in the community/ambulatory setting through a combined response of hospital and community services. This approach aims to prevent avoidable hospital admissions by targeting the top 5% of the risk band by restricting eligibility to those who have had at least one hospital admission in the previous 12 month period.

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[16] AIHW (2011) Contribution of chronic disease to the gap in adult mortality between Aboriginal and Torres Strait Islander and other Australians

[17] AIHW (2008) The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples.

[18] Russell, Lindsay (2015) Analysis of the Federal Health Budget and Related Provisions 2015-16, Menzies Centre for Health Policy, University of Sydney.

Support for multidisciplinary teams and clinician leadership

One of the core recommendations of the National Health and Hospitals Reform Commission was the need to strengthen multidisciplinary integration of primary health care services. Support for multidisciplinary teams to treat chronic disease should be an imperative for government. Research has shown that the success of chronic disease management strategies hinges on successful integration of specialist physicians, collaboration between disciplines and organisations, strong clinical leadership; and early involvement of clinicians. [19] As such, we suggest that specialists must be part of early planning and implementation of new models if they are to be successful and sustainable.

Service development and provision should be led and informed by the health workforce, organisations, and consumers in partnership. This principle was recognised in the recent announcement concerning PHNs, with the Minister for Health acknowledging that much more can be achieved through strong leadership of the sector and in particular with input from treating clinicians.[20] Recently, the government established a Primary Health Care Advisory Group led by former Australian Medical Association President, Dr Steve Hambleton. The Advisory Group will investigate options to provide better care for people with complex and chronic illness and crucially greater connection between primary health care and hospital care.

Patients with chronic disease transition through care with multiple providers. This transition places the patients in a vulnerable position, especially when they move from hospital to community service providers.[21] Care coordination for chronic diseases depends on sharing of information between relevant service providers. However, information linkage between primary care, specialists and hospital is often inadequate, and discharge summaries frequently contain insufficient information.[22]

Addressing the complexity of chronic disease, and the exchange of information between the multiple service providers, requires more than a public health, or primary health care perspective. Rather, it will require clinicians taking a leadership role in planning effective clinical care and pathways between primary and secondary care. Two examples where the expertise of specialists has been supported and successfully lead to treatment redesign are provided below.

Waitemata District Health Board (DHB) Elective Surgery Pilot
The Waitemata DHB's joint arthroplasty pilot programme for non-urgent elective surgery began at Waitakere Hospital in 2010. This program is incentive based and clinically led, and aimed to increase productivity, reduce costs, and increase quality for patients. This clinician led, incentive based service model for hip and knee surgery was highly commended in 2013 by the Institute of Public Administration in New Zealand as an example of how clinical leadership leads to successful health systems reform.

Inala Chronic Disease Management Service
In November 2013, Inala began piloting a novel model of care for Chronic Kidney Disease, the Keeping Kidneys Service is the first of its kind in the world. The aim of the program is to screen, diagnose, and develop management plans for the increasing number of renal patients in the community by upskilling GPs under the oversight and leadership of a nephrologist. Due to the success of the service in providing accessible and culturally safe chronic disease management to Indigenous clients, funding from Queensland Health will see the program model replicated in two further sites in 2015.

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[19] Taylor D, Lahey (2008). Increasing the involvement of specialist physicians in chronic disease management. Health Services Policy. 2008 Jan; 13 Suppl 1:52-6.

[20] Minister for Health Media Release 11 April 2015; New Primary Health Networks to deliver better local care http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2015-ley036.htm

[21] Naylor J, (2006). Transitional care: a critical dimension of the home healthcare quality agenda. Healthcare Qual. 2006 Jan-Feb; 28(1):48-54.

[22] Kripalani, S. et al. (2007). Deficits in communication and information transfer between hospital-based and primary care physicians. The Journal of the American Medical Association, 297, 831-41.

As outlined throughout the submission, innovative models of integrated care and funding exist within both Australia and internationally, and these models provide future directions for the treatment of chronic disease. However, a sustained and continued focus by Government is required to support a coordinated national approach, and scale up best practice models of care as they emerge.

Funding for new models of care that integrate medical specialist care will be a critical to making further inroads to chronic disease management. As discussed, current health reform activities should explore models of care that incentivise and support secondary and primary health clinicians, working in collaborative partnerships with consumers and the community.

It is also vital that Australia continues to support equitable access to chronic disease treatments, and that chronic disease programs are targeted to the populations most as risk. Policies must acknowledge that medical specialists work successfully in various programmes to extend access to treatment in regional and remote areas, and that benefits will flow from systems that encourage general physicians to support primary health care treatment of chronic disease.

Active engagement and leadership by the medical workforce, as well as support for clinician-led models of chronic disease management, must be a key strategies for addressing the growing burden of chronic disease.

The RACP thanks the House of Representatives Standing Committee on Health for the opportunity to provide a submission on this very important issue. We would be pleased to be involved in any future discussions on improving the health and well-being of those affected by chronic disease.