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Response to the draft Primary Health Care 10 Year Plan 2022-2032

November 2021

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 18,863 physicians and 8,830 trainee physicians, across Australia and New Zealand. The RACP represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, infectious diseases medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

Executive summary

The *Consultation Draft - Future focused primary health care: Australia's Primary Health Care 10 Year Plan 2022-2032* (the Plan) has been developed based on recommendations made by the Primary Health Reform Steering Group. The Steering Group's recommendations followed receipt of stakeholder input which included the RACP's submission in July 2021.

Primary health care is a fundamental pillar of our health care system. We are pleased to see that many of the College recommendations have been addressed in the draft Plan.[1] There is notable consistency between actions under the "Integrated care, locally delivered" Stream 3 of the Plan and the RACP Complex care, consultant physicians and better patient outcomes model, including the need for built-in support for patient monitoring and the co-commissioning of services across LHDs and PHNs.

Under a limited consultation timeframe and constrained by the survey structure, our response to the Plan highlights three issues:

1. Actions under the three streams of the Plan should also facilitate patient access to consultant physicians and paediatricians in the community.
2. The College supports integrated health care models and related incentivising measures.
3. Genomics is a specialist referral area.

Preface to responses

The responses under each of the headings respond to the survey questions. Stakeholders were directed to address only the actions listed under the three areas of the Plan:

Stream 1 – Future focused health care
Stream 2 – Person-centred primary health care, supported by funding reform
Stream 3 - Integrated care, locally delivered.

Each question had a 300-word limit with a final comments box that allowed 1000 words. Please note our response covers select questions.

Survey responses

Stream 1 – Future focused health care

There are three action areas in this stream:
A. Support safe, quality telehealth and virtual health care.
B. Improve quality and value through data-driven insights and digital integration.
C. Harness advances in health care technologies and precision medicine.

1A. Support safe, quality telehealth and virtual health care.

We support the continuation of telehealth for specialist services (hospital to community care and private specialist to patient) and have advocated for MBS funded non-patient facing doctor to doctor communications (for example, physician to GP, and physician to other physicians, that might include GP).

The College has also proposed in the RACP Complex care, consultant physicians and better patient outcomes model (page 35) that MBS telehealth items include more than one specialist, which would

[1] The Royal Australasian College of Physicians 2021 RACP feedback on Draft recommendations from the Primary Health Reform Steering Group: discussion paper https://www.racp.edu.au/docs/default-source/advocacy-library/racp-submission-to-the-primary-health-reform-steering-group-discussion.pdf?sfvrsn=2b83c21a_4

improve direct patient access to multi-disciplinary care for multimorbid conditions (such as Cardiometabolic Syndrome).

We strongly support these actions and hope they will be achieved in well under 10 years:

- Infrastructure and services to support telehealth in primary health care will converge with virtual health infrastructure used to deliver hospital in the home and other hospital outreach services.
- Progressive changes to data and digital infrastructure, including linked data, together with clinical enablers like decision support tools will support personalisation of quality care.

1C Harness advances in health care technologies and precision medicine

Although the Plan includes actions to update the National Health Genomics Policy Framework to "address primary health care settings, including the safety, clinical utility and cost-effectiveness of genomics in primary health care" and acknowledges the need to "work with public hospital systems to establish mechanisms for specialist support to general practice on genomics and precision medicine," members expressed the view that genomics should not be considered a part of primary health care, but is a specialist referral area.

There are various challenges that need to be addressed in this context, including the level of interrelated system-wide changes required for the incorporation of genomics into routine care.[2] Clinical and laboratory genetics services are funded by the six state and two territory governments and implementing genomic medicine has been based on the state-based 'federated structure' of services under the auspices of the National Health Genomics Policy Framework.[3]

At present there is no provision for GPs to bill for genomic testing, and they must refer to a consultation physician or paediatrician. The paucity of evidence for the clinical utility of genomic testing and an overall lack of alignment of reimbursement methods to drive transformational change in healthcare remain barriers to implementation.[4]

We also recognise the complexity of this area for physicians; there is a need to train more physicians in genomics.

Stream 2 – Person-centred primary health care, supported by funding reform

There are six action areas in the Plan:

A. Incentivise person-centred care through funding reform, using VPR as a platform.
B. Boost multidisciplinary team-based care.
C. Close the Gap through a stronger community-controlled sector.
D. Improve access to primary health care in rural areas.
E. Improve access to appropriate care for people at risk of poorer outcomes.
F. Empower people to stay healthy and manage their own health care.

2A. Incentivise person-centred care through funding reform, using VPR as a platform.

It would be consistent with the principles and desired outcomes of this Plan to make provisions, including under the VPR scheme, for specialist care to be more accessible outside hospitals and to deliver services in closer partnerships with GPs. The VPR would be enhanced if paediatricians and consultant physicians were included in the VPR where appropriate to ongoing patient care in order to develop more patient-centred coordinated approaches to complex care in the community. Such a

[2] Vidgen ME, Williamson D, Cutler K, McCafferty C, Ward RL, McNeil K, Waddell N, Bunker D. Queensland Genomics: an adaptive approach for integrating genomics into a public healthcare system. NPJ Genomic Medicine. 2021 Aug 18;6(1):1-0.

[3] Stark Z, Dolman L, Manolio TA, Ozenberger B, Hill SL, Caulfied MJ, Levy Y, Glazer D, Wilson J, Lawler M, Boughtwood T. Integrating genomics into healthcare: a global responsibility. The American Journal of Human Genetics. 2019 Jan 3;104(1):13-20

[4] Stark Z, Dolman L, Manolio TA, Ozenberger B, Hill SL, Caulfied MJ, Levy Y, Glazer D, Wilson J, Lawler M, Boughtwood T. Integrating genomics into healthcare: a global responsibility. The American Journal of Human Genetics. 2019 Jan 3;104(1):13-20

provision would support the GP practices that have relationships with physicians and paediatricians who provide services to those practices.

2B. Boost multidisciplinary team-based care.
The short and medium-term actions in this stream should specify that access to inpatient, outpatient, and community-based specialist rehabilitation medicine and palliative medicine services must be enhanced. These are critical in this context, especially in the era of COVID-19.

The RACP supports coordinated GP health care. However, healthcare infrastructure must be suited to the needs of the population and better connect physician and paediatrician services to establish multidisciplinary streamlined care. Without appropriate expert complex care, delayed, uncoordinated treatment of people with multi-morbidities can lead to preventable, unplanned, reactive hospital admissions due to exacerbations of one or more of their conditions. In health system planning the value of the consultant physician has historically been overlooked and poorly supported by the public health care system, to the detriment of chronic condition management at a time when the proportion of patients with multiple chronic conditions has increased. This is a unique opportunity to relieve the heavy burden on our hospital system.

Physician specialties cover a broad spectrum of clinical practice and are commonly involved in multidisciplinary teams. Physicians have special training and expertise in the longitudinal care of patients with multiple and complex conditions. They play a critical role where there are complex health issues, psychosocial problems, and difficulties associated with effectively planning care in cases involving conflicting health priorities. In addition to organ and condition related specialties, there are generalist disciplines, such as paediatricians, geriatricians, general medicine physicians, palliative medicine and rehabilitation medicine physicians, who are critical to primary health care or ambulatory care.

2E. Improve access to appropriate care for people at risk of poorer outcomes.
The short and medium-term items under this action should specify that access to inpatient, outpatient, and community-based specialist rehabilitation medicine and palliative medicine services must be enhanced. These are important services in this context, especially as the health system and patients deal with the short- and long-term burdens of COVID-19.

2F. Empower people to stay healthy and manage their own health care.
Work has a significant impact on the health and well-being of our people, including health care workers. As part of the preventive healthcare approach the Plan promotes, the importance of work health should be recognised. Occupational and environmental medicine (OEM) physicians work as part of multi-disciplinary teams to promote the health and well-being of employees and are involved in the management and prevention of work-related injury and illness, including return-to-work issues.[5] This is an important part of “person-centred primary health care” and empowers people to manage their own care supported by the combination of skills in a multidisciplinary team.

Included actions should support and encourage GPs to continue to involve occupational and environmental medicine physicians in difficult return-to-work cases. Increasing the Medicare rebate for OEM specialty consultation would improve referral rates and back-to-work programs, because there would be less of a financial barrier for patients and doctors.

Stream 3 - Integrated care, locally delivered.

There are three action areas in the Plan:
A. Joint planning and collaborative commissioning
B. Research and evaluation to scale up what works

[5] Green-McKenzie J, Khan A, Redlich CA, Rivera A. The Future of Occupational and Environmental Medicine.

C. Cross-sectoral leadership

3A. Joint planning and collaborative commissioning
The College welcomes the support for PHNs and LHNs to develop joint regional plans and undertake collaborative commissioning approaches for "complex chronic condition pathways, including value-based care and hospital avoidance and outreach approaches".

In the longer term, where the action states "The health system in rural and remote areas is bolstered by PHN-LHN sponsored networked practices drawing on, and supporting, a robust local workforce", we suggest the action recognises the digital and technology enabled health care models as part of these practices.

Greater specificity needs to be given in the Plan to the intent to provide "greater specialist outreach to primary care settings and GP in-reach to hospital settings" to promote integrated patient-centred care. We look forward to further detail on the best ways to achieve this objective.

3C. Cross-sectoral leadership
We welcome the action to "Continue collaboration across a broad range of organisations representing different levels of government, professional and stakeholder groups in overseeing implementation of this plan".

We ask that as a key professional group that plays an important role in both community-based healthcare and in the secondary and tertiary sectors, the RACP be part of the implementation committee for this Plan in order to truly promote patient-centred, better connected health care.

Final comments (1000-word limit)

The aim of this future-focused Plan is to ensure that primary health care improves the health of populations, the cost and resource efficiency of the system, and the work life of health care providers. In our earlier submission, the RACP referred to research that indicates Australia does not have a comprehensive primary health care system.[6] It is our view that this Plan has adopted a narrow approach, where we would like to see primary health care move forward in this evolving landscape of healthcare fully prepared. In particular, we know patients are seeking: coordinated, connected healthcare that allows them to move seamlessly across levels of care according to arising needs and conditions, including complex conditions impacting the older demographic. We urge more use of the term "healthcare system" throughout and for actions to truly reflect this philosophy.

The VPR should be more focused on facilitating appropriate coordinated patient care. We view GP involvement as essential and fundamental. However, for the increasing proportion of children, young adults, adults including older persons with complex and multiple conditions, the care of physicians and paediatricians is ongoing and integral. A comprehensive care system must recognise this as a permanent factor in the care needs spectrum. New care infrastructure must support this reality to alleviate existing inefficiencies and poor patient experience to date. The Plan must drive comprehensive integrated care and be based on the fact of a health care continuum.

The College supports these actions to improve and support primary care:

- There must be more levers embedded in the Plan to facilitate patient access to physician and paediatrician care within the community (noting the resource stretched hospital system now and into the future) whether by application of the VPR to specialists where appropriate (for example to those working closely with GP practices), or by other means such as making a practical extension to the validity period for referrals from GPs to physicians and

[6] Hurley C, Baum F, Johns J, Labonte R. Comprehensive Primary Health Care in Australia: findings from a narrative review of the literature. AMJ 2010, 1, 2, 147-152, Doi 10.4066/AMJ.2010.201

paediatricians for patients with chronic/complex conditions who are ‘registered’ under such a model.

- The Plan should explicitly discuss physical disability and rehabilitation medicine services, for example in the sections “Better care for people with disability” and “Prevention and management of chronic conditions”.
- The relationship between work and health is a key factor in effective primary health care and the importance of occupational health should be noted in the Plan (for example, in sections on mental health and disability), particularly as it is closely aligned with preventive approaches to healthcare. This document refers to the working conditions of health care providers but not to those of the wider population or to the direct relationship between work and health. Australia is a signatory to the International Labour Organisation’s standards for Occupational Safety and Health and the World Health Organisation’s Health for All strategy.
- There should be specific provision for transitions of care, such as for adolescents and transitions across sectors.
- The Plan should directly address climate change and health, noting that climate change has a more deleterious impact on the health and wellbeing of certain demographic and geographic groups.
- It is important the Plan does not replicate the problematic Commonwealth /State funding divide.

We are pleased that most of the College’s previous recommendations have been acknowledged (such as including a focus on oral and dental care, supporting quality rural health care and bringing health literacy to the fore). However, we strongly believe that this Plan could go further within its 10-year timespan to ensure that the burden on the hospital system is addressed and that truly comprehensive community-based care is delivered. This Plan would have benefited from the final evaluation of the Health Care Homes trial (yet to be released), elements of which have been incorporated in the document.

The College is committed to a strong primary health care sector. For this reason, we are disappointed in the short consultation time for this nationally important and overdue initiative, especially as health care workers are struggling to respond to the crises of COVID-19.