



The Royal Australasian
College of Physicians

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Submission

***COAG Panel inquiry: National elective surgery targets,
the National Access Guarantee, and Emergency
Department targets***

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Executive Summary

The national health reforms recognise that Australia's health system faces long-term challenges from population ageing, a growing burden of chronic and complex disease, pressure on access to services, Indigenous health gaps and inadequate, historical payment arrangements that are inefficient and unresponsive to changing health care needs.

Our health care systems have become disjointed and inefficient through lack of coordination and clarity of roles. Too often, the burden is shifted from community based care to our hospitals and, in particular, the Emergency Departments (EDs) and the Intensive Care Unit ("ICU").

Improving the patient journey in hospitals, by ensuring early transfer or discharge to appropriate care facilities, will allow better health outcomes, reduce frustrations within the health care systems, and contain rising health care costs.

A major problem for the health care system is 'access block', which delays admissions to hospital inpatient areas from EDs.

Access block and overcrowding can be addressed through:

- Reducing both the planned and unplanned admissions
- Improved flow into and through well planned sub-acute care pathways
- Reducing avoidable or unnecessary hospital admissions
- Discharge planning and improved out-patient and community care.

These avoidable admissions to our hospitals result, in part, from a lack of acute services outside of the tertiary setting, exemplified by the shifting of elderly patients from nursing homes to the ED. There is also a paucity of specialist services outside of the hospital, especially in the primary, community settings for chronic illness diagnosis and treatment.

In order to improve the experience of patients waiting in EDs, a whole-of-system approach is required. This approach will include not only adequate funding and support but also genuine reform to the health care system to ensure that the inpatient and outpatient patient flows are incorporated through an integrated care system.

For patients with pre-existing conditions, especially in chronic illnesses such as asthma, Chronic Obstructive Pulmonary Disease (COPD), heart disease and diabetes, the

incidence of emergency admission to hospital can be reduced through better management of the disease within the community.

Continuity of care across acute, sub-acute and community services is essential to enable clients to move smoothly from one to another. (Delivering health services in a coordinated and timely manner should be a core principle of health service delivery (AHMAC, 2004). The Victorian sub-acute care model is a blueprint that could be adapted in other states and territories.

The RACP acknowledges that improved integration and coordinated health care in the primary and acute care setting outside of the hospital would dramatically improve the synergies and efficiencies of the health care system.

The national health reform process offers a once in a generation opportunity to align primary and ambulatory care, with acute and tertiary care and with sub-acute and community care. The RACP believes the current health reform process affords a unique opportunity to explore ways to develop a more coordinated and multidisciplinary approach for the entire health care system, especially to better connect care across various settings to tackle the health challenges of the future.

WA has introduced a strategy that is based on the use of clinical service redesign processes, which identify real blockages and develop relevant solutions to ensure patients move through a coordinated system to receive high quality care. “The outcome of these service improvements will impact significantly on reducing access block.”

Targets are there to drive improvements in the patient experience and reduce unnecessary morbidity and mortality. ED length of stay targets such as the ‘four hour’ target can promote improvements in work practices, hospital and system processes, and discharge planning. (R. Ferero, S. McCarthy and K. Hillman, ‘Access block and emergency department overcrowding’, Annual Update in Intensive Care and Emergency Medicine 2011).

Specific targets for EDs are just one part of the reporting system for a more integrated health care system, where all areas of a patient’s journey must have their own target. Multiple targets covering the entire system that are clinically sound are needed to support and measure sustainable change and improve patient outcomes.

The RACP recognises that the national targets are not a measure *for* improvement but a measure *of* improvement and that these improvements must be driven by the national health reforms.

The primary goal of any reform is to have a safe environment within hospitals for patients who are in the process of admission but may require more than four hours in the ED. Effectively achieving the four-hour access rule only comes with investment and some model-of-care changes. These changes are in evolution with the development of Acute Medical Units and the recognition of the importance of general physicians. However, Australia is a long way from these being provided as a universal standard of care so, until that time, the safety of patients, not a time point in the patient journey, must remain paramount.

Recommendations:

That the Council of Australian Governments:

1. Affirm support for the national health reform process to restructure the Australian healthcare system.

2. Enhance sub-acute care:

The provision of an expanded, resourced and functioning sub-acute care health service would improve services within residential aged care, mental health and other community settings, which could reduce ED presentations. [An active and functioning sub-acute care management policy all states and territories will provide the greatest gains in hospital bed management because inappropriate accommodation can be effectively managed in this sector.](#)

3. Introduce clinical guidelines for coordinated care:

Clinical guidelines for coordinating care across all the health care settings will help to reduce avoidable admissions to hospitals.

4. Enhance Specialist Care in community settings:

Community-based care should be strengthened and existing infrastructure and resources better utilised so specialist teams can provide diagnostics or treatment in primary and ambulatory settings.

5. Re-introduce generalist physicians:

General and acute care physicians can play a critical role in managing patients who present to the ED, especially those with chronic and complex co-morbidities. They also can advise of the appropriate use of interventions and co-ordinate treatment and management in the ambulatory care setting.

6. Implement and support Lead Clinicians Groups:

Lead Clinician Groups can advise on access to timely and effective ambulatory care which could reduce the number of presentations to EDs.

7. Avoid unintended consequences, such as unnecessary admission of ED patients to wards:

Avoiding unnecessary admission of ED patients to wards is important because this creates a bed blockage. Unnecessary admissions will increase inefficiencies in hospital resources.

8. Ensure care is patient centred:

Patient safety and outcomes must remain paramount under any health system. Any reforms must ensure that patient safety is not compromised and, therefore, clinical judgement takes precedence in the care of any patient. It is imperative that an ED patient receives a correct diagnosis and is engaged in making appropriate choices for their ongoing care. Patients who present with multiple complex chronic diseases often require multi-disciplinary medical team consultations and not all these teams are available 24 hours a day.

Accordingly, a necessary element in the four-hour ED access must also be to introduce categories exempt from the four-hour rule based on clinical judgement.

9. Introduce a ‘clinical judgement’ exemption:

Create mechanisms to ensure that cases that exceed the four-hour limit based on clinical judgement are recorded and exempted.

10. Ensure discharge planning and access to non-acute inpatient care is seamless:

Seamless discharge from acute care hospitals to sub-acute care and aged residential care and rehabilitation hospitals is an imperative to overcome bed blockage.

11. Ensure Adequate Primary and Ambulatory Care services:

Adequate primary and ambulatory care within population catchment areas helps reduce unnecessary presentations of patients to ED and prevent avoidable admissions. Consideration should be given to increasing the GP bulk billing rate.

12. Clearly define the role of ED:

A discussion would need to be held on the functions of EDs and Acute Medical Assessment Units (AMAU) with improved understanding of the integrated roles and

standing of each entity. A proposed model would be that the ED's role is to triage and stabilise patients and the AMAU's role is to investigate, treat and coordinate care for these patients.

13. Ensure resources are adequate:

Adequate funding and resources- including nursing and specialist medical staff (after-hours staff, salaries, diagnostic staff and equipment—will need to be adequate and appropriately distributed/redistributed. Redistribution of resources should include, where appropriate, assessment of patients by allied health staff in inpatient/outpatient/community settings. Adequate resources should include training and supporting registrars to always review diagnoses made in the ED. If resources are insufficient, access targets will only generate perverse incentives to game the system. Gaming has no benefits for patients and, indeed, is detrimental to patient outcomes as it leads to unsafe practices and an inefficient use of resources because staff must devote time to gaming practices.

14. Clearly define the four-hour target:

The four-hour rule needs to be clearly defined. Does it mean the patient must physically leave the ED within four hours by being discharged home or admitted as an inpatient within four hour? Or does the four-hour rule apply to the patient being referred for treatment within this timeframe? That is, does the four-hour rule apply only to the handover of the patient by the emergency physician to the medical/surgical/paediatric registrar? In this scenario, the patient could be deemed to have been referred for treatment, which would satisfy the four-hour target.

15. Increase supervised accommodation:

In comparison with other developed countries, Australia is well supplied with hospital beds but has few beds for supervised accommodation. These beds are for people who are too sick or difficult for the community but also too well for a hospital bed, such as mental health patients, elderly patients and those with alcohol and drug related illnesses. These patients can remain in hospital for months (sometimes longer), blocking an acute bed until an alternative arrangement for care presents.

16. Introduce an effective national approach to patients who frequently attend the ED:

Even just a few frequent frequently attending patients tend to contribute to blocks in a hospital system.

17. A combined multidisciplinary team approach to patient management:

A multidisciplinary approach is necessary to ensure the medical, social, accommodation and psychological needs of patients are assessed, and changes implemented, as required.

18. Undertake clinical trials on the four-hour rule to obtain evidence-based policy:

Whilst some hospitals already have a four-hour rule, most do have not experienced operating under these expectations. Undertaking clinical trials of the four-hour rule in all hospitals where it is introduced would provide an opportunity to identify areas for further reform, not just as it relates to meeting the targets inside the hospital, but also further areas of improvement..

Introduction

The Submission of the Royal Australasian College of Physicians (“RACP”) is in response to the specific terms of the public inquiry by the COAG Panel headed by Professor Chris Baggeley. The Panel will review the mechanisms through which elective surgery targets, the National Access Guarantee, and ED targets under National Health Reform are to be implemented and applied, having regard to clinical safety issues and practical impediments.

The focus of the RACP, therefore, is on the purpose and objective of targets and the part these play in the overall reform of Australia’s health system. The College is in a position to comment on critical concerns such as an ageing community with increased chronic illness.

While the Submission may touch on other areas such as residential care in the community and raise issues such as ‘access block’ and overcrowding in Australia’s hospitals, these are not areas of expertise for the College and other medical Colleges, such as College of Intensive Care Medicine and Australian Federation for Emergency Medicine. Colleges are better placed to comment in greater detail on systemic hospital and acute care challenges.

The College will also not be specifically commenting on the national efficiency process and the concerns raised by some that Activity Based Funding (“ABF”) skews activity towards simple elective surgery rather than managing complex medical emergencies.

The theory of the four-hour rule is good if one remembers that its aim is to reduce unnecessary delays in the ED, which compels hospitals to determine why these might be occurring, in order to provide better care for the patient and commence treatment at an early stage of arrival to hospital. The rule can also encourage better communication between primary and secondary care to come up with shared solutions to reduce acute demand.

However, the NZ situation (six hour rule) highlights that the rule can have unintended consequences, particularly when there is pressure on CEOs to meet targets. For example, in the UK patients were held in ambulances so the time clock did not start ticking. Also, in the UK as well as in NZ, patients are transferred to any ward to meet the target, regardless of bed availability in the home ward of the medical team who will have worked up the patient. Patients are then left lying unattended in ward corridors rather

than ED corridors, an equally unsafe situation even if the target is met. Admission and Planning Units can help in this regard, since nurses in these units are experienced in stabilising and monitoring patients and the impact of staff shortages are minimised by a centralised approach.

Like all clinical indicators, it is important not to lose sight of the reason for the indicator which, in this case, is to ensure patients receive the right care, at the right time, in the right location (whether this be ward, home or theatre) and by the right provider.. Indicators are not introduced simply to meet arbitrary targets.

Accordingly, it must always be kept in mind that the primary goal of any reform is to have a safe environment within hospitals for patients who are in the process of admission but may require more than four hours in the ED to complete the diagnostic algorithms and have their physiology stabilised. A four-hour access target can only be achieved with investment and some model-of-care changes. These changes are in evolution with the development of Acute Medical Units and the recognition of the importance of general physicians. However, Australia is a long way from these being provided as a universal standard of care so, until that time, the safety of patients, not a time point in the patient journey, must remain paramount. Hence, categories exempt from the four-hour rule must be developed and the criteria for each must be clear and unambiguous.

The RACP believes that national targets are not a measure *for* improvement but a measure *of* improvement and that these improvements are linked to the national health reforms.

The RACP Submission includes both acute and sub-acute inpatient and outpatient services in the definition of hospital care and refers specifically to EDs when considering the application of National elective surgery targets, the National Access Guarantee, and ED targets.

The Submission also takes into account the current national health reform process and the Council of Australian Governments (“COAG”) agreement between the commonwealth, states and territories on health care reform. It is intended to be read in conjunction with the RACP’s discussion paper on Medicare Locals and Commonwealth Submission on Lead Clinician Groups. These documents are part of the public policy development discussion and consultations on health reform and, in particular, the National Health & Hospitals Network for Australia’s Future.

The UK and Australian Experience

The objective of the systems currently implemented in the UK and in Western Australia is that no patient should spend more than four hours in an ED from arrival to admission, transfer or discharge. These targets have been criticised regarding their applicability in different jurisdictions, and outcome measures of the effectiveness of the time based targets in Western Australia are awaited.

The National Health Service (NHS)

In the context of modeling Australian applications on the experience of the NHS in the UK, it is important to note the recent article by Forero et al, states that “The UK has not actually abandoned the four-hour rule but expanded it into a suite of eight indicators that include three time-based measures, including total time in the emergency department.” (R. Ferero, Geoff. D. McDonnell, Sally. M. McCarthy, Peter. Nugus, Jeffrey Braithwaite, Kenneth. M. Hillman, Daniel. M. Fatovich, Gerard. J. Fitzgerald and Drew. B. Richardson, ‘Lessons from the four-hour rule standard in England for Australia’ MJA, Vol. 194, No. 5, 7 March 2011)

In its assessment of the NHS experience, Emergency Medicine Australia conceded there had been problems with the time-based targets, including the much publicised circumstances with the Mid Staffordshire Trust. However, overall there was no hard evidence of deliberate systemic gaming to such a level that would undermine the overall performance of the ‘four-hour rule’ in the UK.

This is not to suggest the Mid Staffordshire situation was not serious. Emergency Medicine Australia stated that, under the four hour targets, it was found the performance of that trust had “Major breaches of clinical standards and deaths had occurred.”

A 2007 BMA survey listed anecdotal comments that times were inaccurately recorded and middle managers revised figures before submitting them. Processes in some trusts were manipulated to allow the time to be ‘legitimate’ such as renaming parts of the ED as an admission unit, putting up curtains in corridors, relabeling a trolley as a bed, keeping patients in the ambulance or admitting patients to an inappropriate ward. Emergency Medicine Australia also acknowledges that gaming is not the same as the clinically unsafe practices such as deliberately admitting an unprepared patient to a ward inside the four hour benchmark.

The UK arrangements have promoted a number of practical measures to help reduce delays and improve the experience for patients, such as checklists for key areas in which delays were felt to be occurring. These include: waiting for a bed, waiting for a specialist, waiting for diagnostics and waiting for assessment.

Emergency care networks were established to involve partners in emergency care such as ambulance trusts, primary care trusts, mental health trusts, social services and the voluntary sector. Over time these developed, in some areas, into urgent care networks looking at provision of care across the whole urgent and emergency spectrum. Urgent care networks are important in facilitating integrated working for organisations involved in planning and delivering urgent and emergency care services.

Western Australia

In Western Australia, the 'Taking Pressure Off Public Hospitals 2008 – 2013' strategy identified a 'four-hour' rule program as one of the initiatives that along with a predictive capacity planning tool and improvements to pathology services, could address the major challenges facing the WA hospital system.

According to the WA Department of Health, "The aim of the Program is to improve the patient experience and quality of care provided to the patient by reducing delays in the ED, improving coordination and streamlining processes for admission and discharge across the hospital."

Importantly, the 'Taking Pressure Off Public Hospitals 2008 – 2013' strategy acknowledged that "appropriate clinical judgement will continue to be paramount and underpinned by relevant triage and other guidelines." The Department of Health states that, while the aim is to ensure that patients arriving at EDs are seen and admitted, discharged or transferred within a four-hour timeframe, the time may be longer if they are required to remain in the ED for clinical reasons.

The WA strategy is based on the use of clinical service redesign processes that identify real blockages and develop relevant solutions to ensure patients move through a coordinated system to receive high quality care.

Interestingly, the WA government was concerned that, as a result of success in reducing waiting times and ED LOS, "the public may choose to disregard alternative primary care options in lieu of convenience at public hospital sites."

The changing needs for health care

The challenges facing our health system are different to those that we have faced in the past and we need to adapt to the changes, driven primarily by an ageing population and the growing burden of chronic illness.

Chronic illnesses contribute 60% of the global burden of disease, which by the year 2020 will increase to 80%, and the increase in life expectancy and record declining death rates contribute to the ageing of Australia's population.

According to the UK Department of Health;

- Around 15 million people in England, or almost one in three of the population, have a long term condition.
- Half of people aged over 60 in England have a long term condition.
- The number of people with co-morbidities is expected to rise by a third in the next ten years.
- Those with long term conditions account for 29 percent of the population, but use 50 percent of all GP appointments and 70 percent of all inpatient bed days.
- It is estimated that the treatment and care of those with long term conditions accounts for 70 percent of the primary and acute care budget in England.
- Approximately one third of the population therefore accounts for over two thirds of the total spend.

People with long term conditions are the most frequent users of healthcare services. For many patients, the number of hospital visits for co-morbid diagnoses increases with the increasing co-morbidity burden and greater demand for specialist care and, thereby, hospitalisation.

The Australian Health Care System

We need to avoid hospital care for our patients, especially our elderly and to find more appropriate pathways for treatment. However, compared to other OECD countries Australia has one of the highest rates of hospitalisation.

Concentration of health care investment in hospital services can drive high health care costs. This concentration may restrict provision of ambulatory and community health

services that are locally accessible, responsive to chronic and complex care needs and essential to health improvement and illness prevention or the exploration of non-hospital acute care services.

With our ageing population Australia must plan for the projected increase in costs of chronic illness, and aim for cost effective care with containment of costs. Changes in chronic disease management are required to minimise acute inpatient demand, especially during winter. (Richard E Ruffin and Jan K Hooper, Responses to access block in Australia: The Queen Elizabeth Hospital Medical Division, MJA 178 (3), 2003)

The recently released annual report from the NSW Bureau of Health Information found the major weaknesses in Australia's health system were its treatment of patients with chronic conditions such as lung disease and diabetes, the rates of avoidable hospitalisations and in ensuring that services remain affordable. Rates of lower limb amputations in NSW were 17.7 per 100,000 people, and this rate was only less than the US which had 35.7 per 100,000 people. Other countries such as Canada, Norway and Britain all had fewer amputations per 100,000 than Australia.

Under the 'Head of Agreement- National Health Reform', COAG has agreed that the performance of Australia's public hospitals will improve over time. According to the Agreement, these national standards include the four-hour National Access Target to reduce ED waiting times, and the National Access Target and National Access Guarantee for elective surgery to help ensure elective surgery patients are treated within clinically recommended times.

The Agreement also states that;

"A strong primary health care system is the key to providing patients with the health care they need when and where they need it – and in doing so, to taking pressure off hospitals. Better integrated primary health care will help manage emerging challenges for the health system, including an ageing population and the increasing burden of chronic disease."

Specifically, COAG is looking to develop effective integration across Commonwealth and State funded health care services to improve coordination and integration of primary health care in local communities. This initiative is to help take pressure off hospitals and EDs, and to make it easier for patients to navigate their local health care system.

The progress measures for the COAG outcome that Australians receive high quality hospital and hospital related care that is appropriate and timely are: waiting times for services; selected adverse events in acute and sub-acute care settings; unplanned/unexpected readmissions within 28 days of selected surgical admissions; and, survival of people diagnosed with cancer (five year relative rate).

COAG's policy direction is to: reduce waiting times for elective surgery and treatment in EDs; increase the technical efficiency of public hospital services; improve safety and quality of care and make service performance information available to patients; and, provide more effective assessment and support of patients before admission and on discharge from acute care settings.

The policy reform areas identified by COAG are: move to a nationally consistent approach to activity based funding for services provided at public hospitals; implement improvements in hospital quality and safety, building on the priorities of the Australian Commission on Safety and Quality in Healthcare; increase the proportion of elective surgery patients treated within clinically recommended waiting times; improve access to rehabilitation, post-acute and transition care services; improve assessment of relative performance of public and private hospitals; improve quality of data on non-admitted patient services; and, improve levels of informed financial consent for private patients in public and private hospitals.

Specifically, COAG has identified elective surgery waiting lists through a national partnership agreement and the objectives of the COAG 'National Partnership Agreement on the Elective Surgery Waiting List Reduction Plan' are: an efficient and effective public hospital system that is able to adapt to the pressures of rising health costs and increasing demand; improved health outcomes and patient experience and satisfaction; integration between the hospital system and other health services; targeting of services; and smooth patient transitions between health settings through assessment, referral and follow up at key points throughout the healthcare system.

The outcome of this Agreement will be, by improving efficiency and capacity in public hospitals, a reduction in the number of Australians waiting longer than clinically recommended for elective surgery.

It is the last part of the agreed outcome about reductions in elective waiting times that will require improvements in efficiency and capacity in public hospitals. This is most

critical because elective surgery and planned admissions are contingent and dependent on unplanned admissions, which is at the heart of how hospitals manage inpatient demand through EDs and ICUs, through to wards and outpatient services through discharge to community and sub-acute care.

An example of an initiative that might need to be established to meet national elective surgery targets, the National Access Guarantee, and ED targets is an Interface Unit based within the Division of Medicine. The South Australian Unit, established in 1996, was developed to coordinate and facilitate early discharge from the wards. The Unit was also developed to avoid unnecessary admissions from the ED by initiating treatment/management for patients with conditions that may be managed at home but require additional support.

The nurses in the Interface Unit "broker" or organise external therapy or services (such as subcutaneous heparin for the treatment of deep venous thrombosis, or home supports for someone who is frail and would otherwise have been admitted to hospital) in association with the patient's general practitioner. (Richard E Ruffin and Jan K Hooper, Responses to access block in Australia: The Queen Elizabeth Hospital Medical Division, MJA 178 (3), 2003)

Elective targets cannot be looked at in isolation and, to take into account the total breadth of patient inflows and outflows, incorporating the primary and ambulatory, community and sub-acute care sectors, they must extend beyond the interdependency of emergency presentations.

The availability of elective beds is largely influenced by the fluctuating situation in the hospital's ED and the rate at which patients are admitted, or not, by the ED as well as the discharge rates from acute and sub-acute beds in the hospital. All of these variables need to be considered in a multi-factorial model and measurement process, that not only looks at national elective surgery targets, the National Access Guarantee, and ED targets but all the health care settings and the total health care system.

More coordination in care has the potential to not only improve the patient journey, but to remove unnecessary activities, process duplication and improve communication between the patient, their carers and clinicians involved in their patient journey. The patient journey involves the process of entering, experiencing and exiting the health care

system; it is not merely the standard of care within a setting or the formal or informal arrangements between settings or in specific locations.

Multidisciplinary teams working within the hospital and with other health care practitioners in the primary, ambulatory and sub-acute care settings can facilitate greater collaboration both within the hospital, before and admission, for discharge and for follow-up services.

Inpatient: managing access and care

Any national elective surgery targets, National Access Guarantee, and/or ED targets will first require a comprehensive reform of the Australian health care system to address the causes and drivers of people seeking acute care in our hospitals. One of the major problems facing our health system is that traditionally much of our chronic illness has been treated in hospitals. However, treatment in a hospital is costly and capacity constrained and the burden of chronic illness is growing, not only with an ageing population but also with the increasing prevalence of conditions such as diabetes in younger patients. The sum of these places a greater pressure on hospitals.

In Victoria, the Hospital Admission Risk Program (“HARP”) found that the overall number of admissions between 1999–00 and 2000–01 increased by three per cent. The percentage increase in ED presentations was highest among people aged 65 years and over (six per cent). This cohort accounted for approximately 19 per cent of total ED presentations, but contributed 35 per cent to the increase in total presentations. Thus, the over 65 years cohort contributed to the rise in the rate of ED presentations for ‘all’ patients, exceeding the cohort aged under 15 years and the cohort aged 15–64 years.

Emergency hospital admissions are expensive, difficult to coordinate and manage, and distressing for patients and families. Evidence suggests that reduced hospital time can not only lead to efficiencies and cost savings in the system but that patient outcomes might not be impacted and, in fact, they could be improved.

Reducing pressure on our hospitals and the prevention of unnecessary or avoidable Emergency admissions to better treat those patients critically requiring acute care is largely influenced by the health professionals working outside of the hospital, in primary, ambulatory and community care.

“A health care system dominated by secondary, tertiary, and emergency care will tend to be fragmented, discontinuous, uncoordinated and costly.” (Coulter, Angela., “Shifting the balance from secondary to primary care, *British Medical Journal*, Volume 311, No. 7018, 2005)

Health outcomes are significantly improved when the various health care settings are performing the right role, including having the appropriate patients at the optimum juncture in their illness or treatment. This will ensure “the right care, at the right time, in the right location, by the right provider”.

The key consideration of any national elective surgery targets, National Access Guarantee, and/or ED targets will be to better manage patient care journey and address the issue of demands on EDs.

To achieve measurable health outcomes, health settings need to be linked to ambulatory and primary health care. Coordinated care can be delivered within the hospital and across health care settings, and some acute care treatments can be delivered outside the hospital. For example, many patients with pre-existing conditions—especially in chronic illness such as asthma and diabetes and a number of emergency admissions to hospital—can be prevented through better management of the disease to prevent acute events occurring and by better management of the events once they occur.

Support needs to be given to medical specialists, within acute and sub-acute care, to improve services to residential aged care, mental health and other community health care settings. This will require significant coordination between the new Commonwealth Local Hospital Networks, and the Medicare Locals, as well as other health providers in the jurisdictions and private health sector.

The new Lead Clinician Groups can play a crucial role in the development of coordinated care through multidisciplinary teams and clearer pathways for care through the development of national clinical guidelines across all clinical settings. For example, South Australia has introduced transit bays of six beds for incoming (ED) and outgoing (discharge) patients. In addition, overcapacity beds (accepting an additional patient into a ward before a patient has been discharged) have been used, and day beds have been used for non-same-day inpatients. (Richard E Ruffin and Jan K Hooper, Responses to access block in Australia: The Queen Elizabeth Hospital Medical Division, MJA 178 (3), 2003)

The development of clinical guidelines for coordinated care would include arrangements for the management and delivery of care between the Medicare Locals and the Local Hospital Networks. Clinical guidelines for coordinating care across all the health care settings will help to reduce inappropriate, as well as avoidable, admissions to hospital.

The basis for any clinical guidelines will be to ensure that emergency admissions to hospitals are focused on unplanned admissions for acute illnesses that can only be managed in a hospital bed. Beyond the efficiency gains of coordinated care, health care

reform needs to shift the focus of care from the costly and limited resources of the hospital setting.

Preventative health will reduce the burden on acute care in hospital settings but identifying acute care in non-hospital settings is also crucial. Some research indicates that readmissions may account for up to half of all hospitalisations and 60% of hospital costs. To counter this, our health care system needs to improve access and availability of acute care outside the hospital, to better coordinate inpatient and outpatient services and to provide comprehensive and continuous care throughout the continuum of care.

The RACP supports the potential of ambulatory care to provide specialist care outside the hospital and tertiary setting as well as for ambulatory care to support acute care outside of the hospital. For example, in the United Kingdom, the NHS has attempted through a Directory of Ambulatory Emergency Care for Adults, to identify a number of conditions that could be managed outside the acute hospital setting.

This document is notable for its attempt to identify conditions that could be managed out of hospital as well as the use of the concept of ‘ambulatory emergency care.’ The NHS Directory identifies conditions such as: COPD, congestive cardiac failure, urinary tract infection, as well as potentially treatable conditions such as pulmonary embolism.

It is uncertain how applicable the NHS Directory is in an Australian health system, but conditions identified in the Directory could be treated in a similar way to those proposed in the UK. The Directory is a useful reference point and an example of how national clinical guidelines in this area could be developed through the potential outcomes of the national health reform process.

Australia’s health care system could, through a National Lead Clinician Group, identify conditions where access to timely and effective ambulatory care can either reduce the incidence of the condition or avoid substantial proportions of current hospital admissions for that condition.

Our health system needs to focus on both the onset of illnesses that could have been prevented and the admissions for those illnesses once contracted, which could have been prevented or avoided.

Reducing avoidable and/or unnecessary admissions is good for patients, through reduced costs, reduced mortality and improved function, potentially increased acute care

capacity, less impact on family and loved ones, as well as a better outcome for those managing and planning care through greater efficiencies.

Improvements in technology and advances in medical science, among other developments, have contributed to changes in the practice of medical care in the ED with more care now provided, which uses more resources. Some examples are;

- (1) an asthmatic patient who, instead of being admitted to the hospital after one hour in the ED, undergoes a prolonged six- to eight-hour treatment and observation before being discharged home;
- (2) a trauma patient who may have been readily admitted many years ago is instead discharged from the ED after undergoing extensive evaluation and investigation including radiological assessment with computed tomography (CT) imaging studies, laboratory tests, and serial evaluations;
- (3) an overdose patient who is observed for six hours and confirmed suitable for transfer to a psychiatric facility;
- (4) a patient with chest pain who has serial cardiac enzyme determinations, telemetry observation, an exercise treadmill test, and is then discharged from the ED; and
- (5) patients with certain infections such as pneumonia and pyelonephritis who receive intravenous antibiotics in the ED, are observed, and then discharged home. (Robert W. Derlet and John R. Richards, 'Overcrowding in the Nation's Emergency Departments: Complex Causes and Disturbing Effects, 35:1 Annals of Emergency Medicine, 2000).

Any measures to introduce COAG benchmarks will need to also take into account the delays in service provided by radiology, pathology, and ancillary services. As a result of advancing technology and escalating standards of care, more patients in the ED need plain radiographs, laboratory tests, or other types of specialised ancillary services such as arterial blood gas values, CT scans, magnetic resonance imaging, or nuclear scans.

A study at King's College Hospital found that 41% of new patients could be classified as presenting with primary care problems suitable for management by a general practitioner. (Jeremy Dale, Judith Green, Fiona Reid, Edward Glucksman and Roger

Higgs, Primary care in the accident and emergency department: II. comparison of general practitioners and hospital doctors, *BMJ* 311 : 427 (Published 12 August 1995)

According to Kevin Grumbach, Dennis Keane and Andrew Bindman, the massive increases in presentations to EDs can in part be attributed to the location of subspecialists in the hospital setting. (Kevin Grumbach, Dennis Keane and Andrew Bindman, Primary Care and Public Emergency Department Overcrowding, *American Journal of Public Health*, Vol. 83, No. 3, 1993).

Specialist care outside the hospital

Australia has one of the highest rates of hospitalization in the OECD and, with a rising percentage of patients being admitted to hospital through the ED, there is increasing pressure for acute and sub-acute care beds in the secondary setting.

According to the Victorian Government “The number of patients presenting to EDs on four or more occasions (within one financial year) rose by 18 per cent between 1999–00 and 2002–03. Typically, these patients have chronic and complex conditions, with many having one or more conditions frequently including COPD, chronic heart failure (CHF) and/or diabetes.” (Victorian Department of Health, Hospital Admission Risk Program).

A greater coordination of care for specific conditions, especially chronic illness, could utilise more clinic based care for cancer, diabetes and asthma. For example, a study on specialist clinics for the quality of outpatient care for patients with inflammatory bowel disease (“IBD”) found that specific IBD clinics outperformed general gastroenterology clinics in the diagnostics and treatment and provided better care.

To complement hospital service delivery and care in Australia and reduce unnecessary demand on those services, community-based care could be strengthened and better utilise existing infrastructure and resources. Strategic planning to work towards health care service models based on a continuum of care will improve the coordination of care and management of chronic illnesses, increase health promotion and health awareness and reduce stress on acute hospital services.

In the UK, outreach clinics where the hospital based specialist team provides outpatient diagnostics or treatment outside the hospital in the primary or ambulatory setting include obstetrics, orthopaedics, dermatology, ophthalmology and paediatrics. These clinics have been found to reduce travelling time, provide more convenience and reduce waiting times.

The challenges of the modern health care system are not necessarily well served by the traditional model of General Practitioner in primary care and specialist care focused in tertiary care with only limited exposure to ambulatory care.

Special consideration for National Elective Surgery Targets, the National Access Guarantee, and ED targets will need to be given for hospitals outside the metropolitan tertiary centres, and for the delivery of health care in rural and regional areas.

Outpatient: managing treatment and capacity

The principle of ensuring a person receives the appropriate health care, at the right time and in the right place implicitly recognises that the hospital might not always be the right setting. This principle also recognises that the National Elective Surgery targets, the National Access Guarantee, and ED targets will provide a truer measure of hospital performance if the EDs and other units in the hospital can comprehensively coordinate the patient flow and manage the outputs as well as inputs to acute care.

The development of co-located acute care units with appropriate resourcing and funding will require investment in infrastructure and human resources. These short stay (<72 hours) centres of care can provide management of acute medical and surgical problems, coordinate investigations and arrange follow up community based care. The advantage will be to reduce the numbers of longer stay beds and improve direct access to sub-acute care services or ambulatory and community care as appropriate.

Quality client care depends on a wide range of skilled professionals collaborating together in teams (Griffiths et al 2004). Several systematic reviews report enhanced client satisfaction, acceptance of treatment and improved health outcomes following multidisciplinary team care for complex and chronic conditions (Mickan, 2005). In a study investigating the predictors of team effectiveness, enabling conditions included a combination of team cohesion and interdisciplinary collaboration (Mickan, 2005).

Coordinated and multidisciplinary care is in practice across the Australian health care system, with current care plans for out-patients and multidisciplinary rounds in hospitals already demonstrating the benefits of these arrangements. It has been estimated that 60% of hospital inpatients require multidisciplinary assessment and intervention. Stroke care units are an example of the clinical benefits of multidisciplinary care models within the acute care settings.

Reform of the health system is required to develop a system where arrangements between the primary care responsibilities of the Commonwealth and the hospital care responsibilities of the states and territories are aligned through the new Medicare Locals and Local Hospital Networks. Coordinating service provision can be difficult across system boundaries: between general practice and hospitals or community health, and between generalist and specialist services.

Fully integrated care is required for a decrease in hospital stays to achieve a reduction in unnecessary or avoidable admissions. This care needs to involve health practitioners in the primary and ambulatory settings to allow for efficient and effective coordinated discharge procedures and treatment plans.

Health care professionals are at risk of overestimating the patients' understanding of their post-discharge treatment plan, which is an ever greater risk for the elderly and further coordination and continuity of care is needed to overcome this significant risk.

New arrangements resulting from national health reforms will provide a unique opportunity to develop clear patient pathways and seamless health care to deliver a more efficient and effective delivery of services and allocation of resources.

The Local Hospital Networks and the Medicare Locals may have the potential to support effective chronic care management programs through population based planning strategies. These strategies can deliver and support care to defined patient populations to ensure effective interventions reach all patients who need them.

A patient-centred approach to coordinated care will ensure that the required interventions are specified and delegated to members of a highly effective multidisciplinary team. Treatment plans for individual patients will assist in the effectiveness of chronic illness programs. More formal, written plans may not only help to organise the work of teams, but also help patients to navigate the complexities of multidisciplinary care and support. At a minimum, physicians and intensivists are in a strong position to facilitate improved patient centered care and support models through their ability to not only deliver care but also to coordinate a patient's health care journey.

In South Australia, home care specialist nurses have also helped prevent admissions (eg, heart failure nurses, home cancer therapy and respiratory care nurses). A "medical flying squad" was established to assess nursing home patients and was clinically effective in reducing transfers from the Regional Care Facilities (RCF) to the ED. The

Squad, however, was too costly to sustain. (Richard E Ruffin and Jan K Hooper, Responses to access block in Australia: The Queen Elizabeth Hospital Medical Division, MJA 178 (3), 2003).

Within the hospital multidisciplinary teams involving nurses, allied health workers, specialists, general practitioners, mental health workers and pharmacists, issues that can be covered include medication compliance and side effects, follow-up appointments with specialists, symptom management and pain management.

Working together, health practitioners can reduce mortality and readmission, better allocate resources, improve efficiency, promote cost savings and improve the quality of life for patients and their loved ones.

With the loss of nursing home beds from the western Adelaide region, a step-down unit was created in the hospital with a lower registered/enrolled nursing skill mix. An active multidisciplinary team facilitates placing patients in Regional Care Facilities (RCFs) or at home, with additional resources provided through brokered community services or State-based programs, such as the Adelaide Transition Alliance (which provides respite beds in RCFs) or with the Division of Surgery's "Hospital in the Home" program (which provides post-acute home nursing services from within the division's nursing resources). (Richard E Ruffin and Jan K Hooper, Responses to access block in Australia: The Queen Elizabeth Hospital Medical Division, MJA 178 (3), 2003).

Subacute Care

According to the Victorian Government's *'Planning the future of Victoria's sub-acute service system; A capability and access planning framework,'* "The separation between acute and sub-acute care, once so marked, is narrowing. Increased demand for access to acute care beds is leading to an increase in the medical acuity of patients admitted to sub-acute care."

The Victorian sub-acute care model is a blueprint that can be adapted in other states and territories.

Transferring patients from acute care to sub-acute services at the optimal time can have significant benefits for both the client and the service system (Poulos and Eager, 2007).

Sub-acute care is playing an increasingly important role in Australia's health care system, improving outcomes for patients and taking the pressure of acute care beds.

The efficient and effective flow of patients through the 'back door' of the acute hospital into rehabilitation and palliative care improves access for patients entering through EDs, or the 'front door'.

Patients who remain in acute care when their need is for rehabilitation will suffer further functional decline and iatrogenic risk, as well as a potential increase in their rehabilitation inpatient length of stay when they are transferred. The development of substitutable community-based rehabilitation programs will also improve acute care capacity (New and Poulos, 2008).

When planning elective surgical targets it is important to factor in the need for rehabilitation services at the time of admissions for these patients who might benefit. This is especially the case for elective orthopaedic surgery and some neurosurgery. While many elective surgery patients will not require rehabilitation, the timely movement of those patients who do will improve surgical ward capacity and thus throughput.

Patients can receive some of their care in a range of appropriate service settings including inpatient, home-based and centre based services (such as hydrotherapy, physiotherapy treatment programs and group-based activities such as strength training sessions) and may benefit from one or a mixture of these (Dow, 2004). For example, home-based rehabilitation has been found to increase a client's sense of empowerment as they feel more relaxed and comfortable (Von Koch et al 1998). There is increased opportunity to involve carers and other family members. It is also potentially more therapeutic for clients to practice rehabilitation tasks in the environment in which they will be ultimately required.

Sub-acute services extend and support admitted patients through treatments such as rehabilitation and geriatric care. According to the Victorian Government;

- 84 per cent of all public sub-acute care admitted admissions occur following an acute care episode.
- 80 per cent of the total transfers from acute care originated from only 10 major clinical related groups.

It is difficult to see, therefore, how national benchmarks such as national elective surgery targets, the National Access Guarantee, and ED targets cannot factor in the patient transfer to sub-acute care in the hospital, community or primary and ambulatory settings.

According to the Victorian Government's "Planning the future of Victoria's sub-acute service system; a capability and access planning framework";

"Demand for sub-acute services may be substantially influenced by initiatives that aim to increase levels of acute activity within the public hospital system, such as increased elective surgery to reduce the surgical waiting list."

The decision about whether a client receives their care at home, a centre or in a combination of both settings is determined by clinical criteria and should be subject to review as determined by the client's needs. The setting needs to be convenient for the client but also clinically appropriate for the providers and enable them to provide high-quality care.

Integration of Primary and Secondary Care

The RACP suggests, for the effective implementation of COAG targets, there will need to be measures introduced to prevent admissions or to facilitate early discharge from care in an acute hospital.

The College recognises that improved integration between primary and secondary care, through coordination of seamless care and the availability of all appropriate services in the various health care settings will reduce the pressure on hospitals and promote greater prevention and compliance with existing treatments plans.

"Increasing access to primary care services as an alternative to the ED could potentially reduce public ED overcrowding, provide indigent patients a less costly form of care for their immediate needs, and establish a regular source of care for those patients with ongoing health care needs." (Kevin Grumbach, Dennis Keane and Andrew Bindman, Primary Care and Public Emergency Department Overcrowding, American Journal of Public Health, Vol. 83, No. 3, 1993).

Hospitals will always be needed for acute care patients who, as a result of their condition, require interventions that are available only through the high technology facilities of acute hospitals.

As a result of new technologies and treatments, a large proportion of the aging population with chronic disease is surviving longer while their illness further deteriorates.

(Robert W. Derlet and John R. Richards, 'Overcrowding in the Nation's Emergency Departments: Complex Causes and Disturbing Effects, 35:1 Annals of Emergency Medicine, 2000).

It just isn't feasible to disperse these facilities and associated health practitioners throughout the community. But the first question is, what admissions could be prevented though early detection and compliance with treatment at the early stages of illness?

According to a study in the US by Katon, Von Korff, Lin and Simon, 35% of specialists reported that the severity of patients' conditions at time of referral to them was greater than it should be. It found that when detection occurred only approximately 25 to 50% of patients adequately adhered to medication and self-management activities (such as monitoring peak flow, diet change, weight loss, exercise and behavioral activation programs) in order to lower airway resistance, blood glucose, blood pressure, or depressive symptoms to recommended levels.

They stated that;

“Active follow-up to ensure adherence to treatment regimens among patients with conditions such as asthma, congestive heart failure, diabetes and depression was the exception rather than the rule.” (Wayne Katon, Michael Von Korff, Elizabeth Lin and Greg Simon, 'Rethinking practitioner roles in chronic illness: the specialist, primary care physician, and the practice nurse', General Hospital Psychiatry, Volume 23, Issue 3, 2001).

Therefore, a large percentage of patients who, diagnosed early, are not completing or correctly adhering to an already described treatment plan before hospitalisation is required. This is not substituting care from the hospital to the primary, ambulatory or community setting but rather enhancing the capability of the treatment already underway in those settings. This enhancement can prevent unnecessary or avoidable admissions for patients already undergoing treatment whose condition hasn't escalated to hospitalization.

Commenting on the success of this approach in the UK, Hensher, Fulop, Coast and Jefferys stated that;

“Prevention of emergencies is largely the responsibility of professionals working in primary care and in the community, and many strategies have emphasised better integration between these professionals, closer

involvement of and commitment from patients themselves, and the adoption of evidence based protocols agreed by all local specialists, including staff in secondary care (shared care). (Martin Hensher, Naomi Fulop, Joanna Coast, Emma Jefferys, 'Better out than in? Alternatives to acute hospital care', *BMJ Vol.* 319, 1999).

Treatments such as home dialysis have enabled patients to control their condition at home when previously they would have had to be admitted to hospital.

The length of stay in hospitals has been tackled through a variety of early discharge methods to help free up inpatient beds for faster admission from EDs but reduction length of stay for maternity patients through options such as patient hotels does not necessarily assist the ED. More generic methods such as discharge planning, nurse led inpatient care and hospital at home schemes can be applied to a wider array of illness across all wards in the hospital.

According to Katon et al, there are four levels of intensity of services in stepped care for patients with chronic medical illness:

- Level 1 care includes screening and diagnostic services for specific conditions, preventative services, outcome monitoring, and patient education regarding effective self-management. An example would be the education and lifestyle changes (increasing exercise, losing weight) for initial diagnoses of borderline hypertension or hyperglycemia in a middle-aged person.
- Level 2 involves active treatment in primary care. This may involve an allied health professional (such as a nurse) at the critical stage of diagnosis or relapse in order to provide education and support for self-management.
- Level 3 involves specialty consultation in the primary care setting for patients with persistent illness after initial (Level 2) care, or patients with complications at initial presentation.
- Level 4 involves referral to the specialty setting for highly complex cases and those with poor outcomes at Level 3. (Wayne Katon, Michael Von Korff, Elizabeth Lin and Greg Simon, 'Rethinking practitioner roles in chronic illness: the specialist, primary care physician, and the practice nurse', *General Hospital Psychiatry*, Volume 23, Issue 3, 2001).

This approach is somewhat at odds with Australia's primary/secondary care structure based on state and territory and/or commonwealth services, where there is limited specialist care in the primary and ambulatory settings.

The work of Katon et al in mental health found that specialty consultation services that provide enhanced patient education, brief treatment based on guidelines, close monitoring of outcomes and side effects and integration of specialty services into primary care have been shown to improve outcomes of major depression compared to usual primary care. On the other hand, consultation services to primary care that provided only "assessment" and recommendations for care have not improved outcomes. In addition, intensive, multidisciplinary specialty interventions in patients with severe asthma have been shown to be associated with improved pharmacotherapy, fewer emergency department visits and reduced admission rates, shortened hospital stays and lower medical costs.

A similar study in the US found more marked differences in quality of care and outcomes for patients with diabetes between endocrinologists, internists, family physicians, and general practitioners. Overall, the patients of endocrinologists had higher utilisation of glycosolated hemoglobin testing (76% vs. 32%), ophthalmologic screening (67% vs. 42%) and lipid testing (77% vs. 59%) than patients of primary care physicians. (Chin M, Zhang J, Menrel K. Specialty differences in the care of older patients with diabetes. *Med Care*, Vol. 38, 2000)..

The experience in Finland of establishing multi-specialist centres and networks in which general and specialist practitioners collaborate may provide pointers for the integration of various professions (e.g. doctors, nurses, pharmacists as well as optometrists and physiotherapists) into a single centre for health service provision. Finland's experience demonstrates how health centres can combine a variety of generalist and specialist services, contract with hospitals and run their own laboratory facilities. (European Observatory on Health Systems and Policies, World Health Organization 2006).

To measure improvements through COAG targets, we will first need to put in place the measures to deliver the required improvements and this will first require a re-organisation of the way health care is delivered in Australia. Such a reorganisation must include realignments between the Commonwealth and the states and territories on health practitioner services to achieve the desired improvements in elective surgery and emergency department waiting times.

The focus here must be on chronic illness and the specific challenges of managing co-morbidities in patients, especially for an ageing population.

The introduction of the four-hour rule across the board will provide an ideal opportunity to undertake clinical trials to obtain evidence-based policy, and to identify areas for further reform, not just as it relates to meeting the targets inside the hospital. This is important because, while some hospitals already have a four hour rule, they don't know necessarily what effect it has on other outcomes. For example, at one hospital the four-hour rule has become a catalyst to re-examine processes, to question conventional decision making pathways and to virtually eliminate bed-block to achieve waiting times in ED generally within target. In the process, the rule has reduced mean length of patient stay by one day (that is by 25%).

The role of generalists

The work of Katon et al in the United States found that care systems cannot afford to have different health practitioners managing each chronic illness for a patient, that specialist care is required in complex and advanced cases and *“Specialist supervision of the caseload of these allied health professionals may help improve outcomes”*.

The diagnosis in the ED of chronic illness becomes even more problematic when the patient also has underlying diabetes, cancer, or coronary artery disease and it may take hours to exclude a serious and occult diagnosis.

The RACP recognises the loss of general and acute care physicians has had a deleterious effect on the quality of health care delivered in the acute setting, especially in hospitals. Their reduced numbers are an impediment to health reform and, in particular, the development of integrated and coordinated care to tackle the increasing burden of chronic illness and an aging population.

Physicians and paediatricians provide care and support for complex medical conditions and continue to see the patient until these problems have resolved or stabilised. They have expertise in the diagnosis and treatment of conditions affecting different systems in the body and can therefore treat multiple illnesses in a patient, especially the difficulties faced by clinicians when confronted by the co-morbidities of complex and chronic diseases which are often undifferentiated.

Physicians have skills in holistic care and managing undifferentiated problems and conditions across specialty areas. They have an awareness of the psychosocial and the

biological aspects of illness and offer "whole person" patient care and support and can act as advocates for their patient. A broad understanding of the principles of general internal medicine can help ensure that fragmented care across different systems and medical practitioners in a multitude of settings does not result in significant co-morbidities and patient concerns unrelated to the admission being overlooked, misdiagnosed or inappropriately managed.

The focus of this submission is on the role of acute and sub-acute care physicians in the variety of acute and non-acute settings, including ambulatory, sub-acute, community and primary and ambulatory care as they relate specifically to the COAG reforms and the wider health reform agenda.

General physicians can play a critical role in managing the chronic illness caseload of the ED where, with an ageing population and increasing burden of chronic illness, there will continue to an increase in presentations from patients with co-morbidities and complex conditions.

Generalists in acute and sub-acute care can play an important coordinating role for patients with multiple problems who are exposed to the effects of polypharmacy. They also can advise of the appropriate use of invasive interventions as health practitioners grapple with the complexities of their patients' conditions requiring co-ordination and management in the ambulatory care setting.

In using the word "generalism", the RACP would like to make clear that when the term applies to the title of a type of physician, we mean a General Physician or General Paediatrician. The College has authored, in conjunction with the Internal Medicine Society of Australia and New Zealand, a detailed and referenced discussion paper entitled "Restoring the Balance", which outlines a case to better support general physician practice.

Since the introduction of incentive funding with the four hour ED rule in certain hospitals, there has been innovative use of funding received. For example, new facilities for acute short stay patients of 72 hours or less have been designed and built. These wards have been populated by acute care and general physicians, and there has been some overlap with ED physicians that have the appropriate skills base.

As a result of an ED Task force in NSW, units were commenced where the unclassifiable medical patient could be admitted and looked after until they were sorted. A lot of brave medical practitioners stepped forward to look after these units. The establishment of these units had unintended and undesirable consequences: sub-specialists were transferring responsibility of patients to other sub-specialists, which positioned ED staff to say they required authority to make the call. The units also revealed that the swing to sub specialisation in medicine had gone too far, that there was a real need for general physicians and that physicians had to get back into the ED and be called in and involved earlier.

General and acute care physicians co-operate with other colleagues (e.g. in general practice, adolescent medicine, emergency medicine, intensive care, coronary care, surgery psychiatry, and geriatric medicine) to help integrate medical care and support and provide an overview of medical management . This holistic approach makes them ideally suited to positively influence models of care and to ensure they are patient centered and reflect the social determinants of health.

Also, many physicians and paediatricians maintain procedural skills (e.g. echocardiography and endoscopy) and provide valuable investigational procedures, particularly in areas outside major metropolitan hospitals.

Ambulatory and primary care settings would benefit greatly from the broader perspective of general and acute care physicians as well as the potential for greater involvement of specialists outside of the hospital and acute setting for the prevention and treatment of chronic and complex conditions. Rural areas would also benefit greatly through the availability and access to more physicians as general and acute care specialists.

In summary, there is a significant gap in the continuum of care as the role of physicians and other specialists have not traditionally been integrated in the primary and ambulatory care settings and combined with the decline in general and acute care specialists needs to be addressed within the framework of the review .

Definitions

Physician

Physicians and paediatricians are specialists in internal medicine who have completed advanced training after their initial medical training is completed in a general internal medicine or 'a specialty' and diagnose and manage complex medical conditions in adults, children, adolescents and young people. A Paediatrician is a specialist in internal medicine focusing on the diagnosis and management of children, adolescents and young people.

Intensive Care Specialist

Intensive care medicine encompasses the assessment, resuscitation and ongoing management of critically ill patients with life-threatening single and multiple organ system failure. Work is not confined to the intensive care unit, since patients are usually admitted to the unit from the care of a primary team elsewhere within the hospital.

Acute Care

Is the treatment of a patient for a relatively short period of time in which a patient is treated for a severe episode of illness. Acute care incorporates a broad spectrum of health care, including hospital and primary health care, as well as emergency medical services.

Ambulatory Care

Ambulatory care includes community based care including diagnosis, investigation, management and treatment and rehabilitation that is provided in the community care settings.

Primary Health Care

Primary health care refers to initial or ongoing care in the community. It includes general practice, medical specialist services, allied health services and other community based health services.

Sub-acute Care

Sub-acute care includes continuing medical care in the non- acute setting and includes rehabilitation, palliative care, mental health and geriatric services, in both hospitals and the community.

Community Care

Community care can share a number of characteristics of primary care and primary health care services, as well as provide more specialised community based health services for defined target groups, for example post acute care, aged care, mental health, drug and alcohol, sexual assault.

Hospital and non-hospital Care

Hospital care is when a person has medical care in a hospital, while non hospital care is all health care not requiring an overnight stay, including primary care and community care.

Co-morbidity

A co-morbidity is a disease or condition that coexists with a primary disease but adds to the complexity of patient care.

Chronic illness

Chronic illness is of long duration and involves ongoing health care requirements.

Outpatient Care

Outpatient care is any health care service provided to a patient who is not admitted to a facility. Outpatient care may be provided in a doctor's office, clinic, the patient's home or hospital outpatient department.

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