The Royal Australasian College of Physicians

Response to the Commonwealth Government's Lead Clinicians Groups Proposals

22 February 2011

The Royal Australasian College of Physicians

Lead Clinicians Groups

Purpose

The Royal Australasian College of Physicians (RACP) is committed to support the development of a more sustainable and efficient health care system into the 21st Century which will manage the increasing demands of complex and chronic illness, including preventive health and self-management, to deliver better health outcomes and improve quality of life for all Australians.

Physicians can demonstrate significant benefits to the health care system and to patient through providing a significant contribution to the proposed Lead Clinicians Groups. They provide care to patients in both hospital and community settings, and often care for patients who move between these settings in the course of their illnesses. They are thus familiar with the issues which Lead Clinicians Groups will be addressing in terms of co-ordinating the various modes of health care. Through public health, they are also familiar with matters relating to the health and care of populations generally, as well with strategies to prevent illness and disease. Physicians can also contribute, in the context of their specialisations, to the development and promotion of evidence based treatment standards and guidelines.

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 unresponsive to changing health care needs. The RACP values the achievement of health equality for all - equal health care for equal need - to ensure we achieve the best outcomes from health care services.

Delivering on this ambition however should first recognise that, relative to other OECD countries, there is a frustrating focus on hospital related health care across Australia. Concentration of health care investment in hospital services can drive high health care costs and 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.

A strengthened community care sector, given appropriate infrastructure and resources, would complement hospital service delivery and care in Australia and reduce unnecessary demand on those services. 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. The proposed Lead Clinicians Groups will enhance these developments.

Many physicians are already involved in the various state and territory structures that provide mechanisms for promoting best practice. Considerable amounts of time and effort have been invested in the existing local mechanisms, and the RACP considers that that work should be built on, rather than replaced. Local Lead Clinicians Groups would be able to utilise the coordination systems that have already been developed at local level.

The RACP supports the current health reform process which 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 ambulatory and primary care with the other care settings.

Recommendations:

- The development of pathways for the optimal 'patient journey' is the key considerations for Lead Clinician Group model.

- The Lead Clinicians Groups develop communication pathways for Local Hospital Networks and Medicare Locals based on local and regional requirements.

- That there is a single National Lead Clinicians Group, with capacity to form working groups on specified issues.

- The National Lead Clinicians Group has a clear relationships and communication pathway with the Australian Commission on Safety and Quality in Health Care, the National Health and Medical Research Council, the Australian Health Ministers' Council, the Australian Health Ministers' Advisory Council and State and Territory Governments to complement existing mechanisms for clinical input.

- Each Medicare Local and Local Hospital Network has a Local Lead Clinicians Group.

- The Local Lead Clinicians Groups act as a 'champion' that promulgates optimal care and referral pathways, and coordinates new initiatives that integrate local care solutions, including promoting these key issues to the National Lead Clinicians Group.

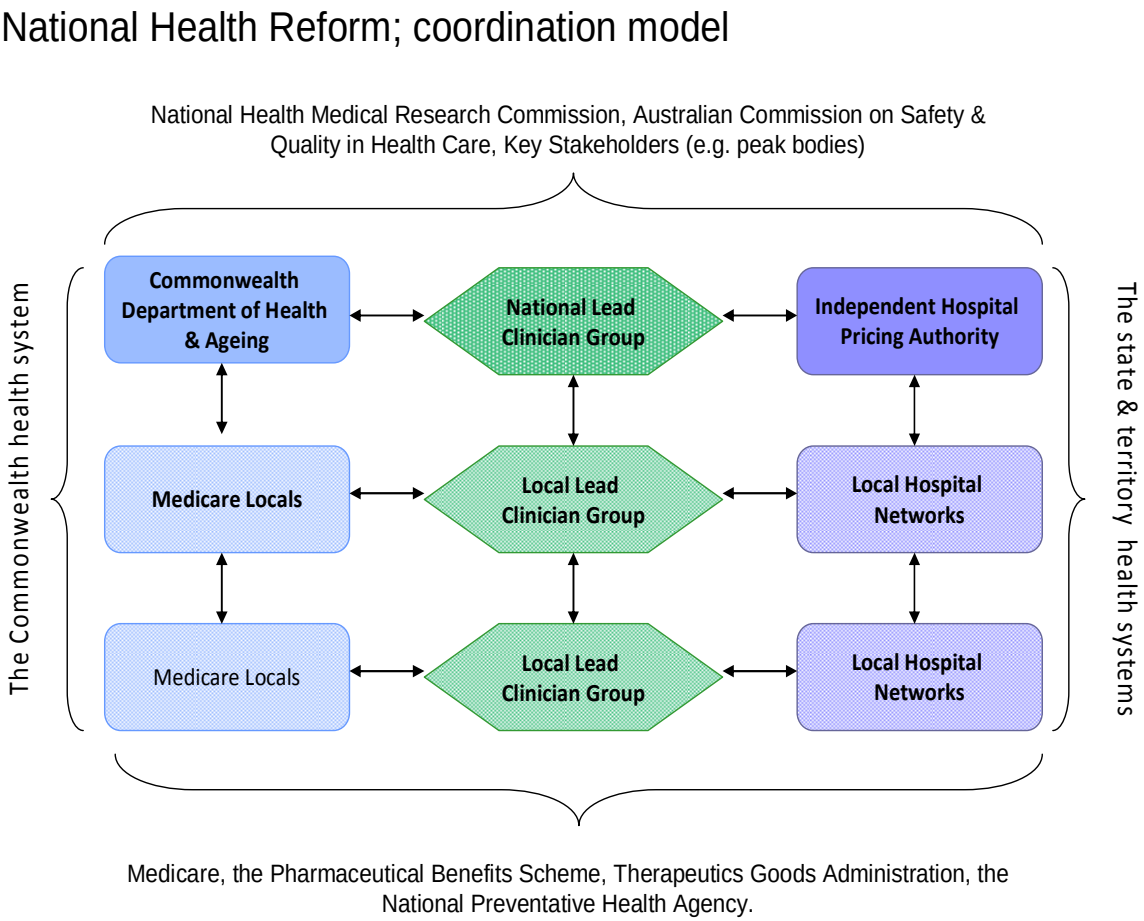
- Recommending the development and implementation of best practice clinical guidelines to achieve the goal of patient centred coordinated care in a two-way (top-down and bottom-up) relationship between National and Local Lead Clinician Groups

- The Lead Clinicians Groups are the key vehicles to facilitate the implementation of the COAG agreement objective that "Medicare Locals and Local Hospital Networks will work together to integrate services and improve the health of local communities"

- The Local Lead Clinicians Groups provide strategic oversight and direction of Local Hospital Network and Medicare Local implementation of clinical priorities and guidelines.

- The Local Lead Clinicians Groups develop and implement local clinical guidelines for services available in the area.

Diagram 1: National Health Reform; coordination model



Executive Summary

Australia's physicians can improve the overall patient care experience by improving the quality and safety of health care, and improving the coordination of treatment provided. Physicians can also contribute to the proposed Lead Clinicians Groups.

Public health physicians are familiar with matters relating to the health and wellbeing of the general population, as well as implement strategies to prevent illness and disease.

The focus of this paper is on how the Royal Australasian College of Physicians ("RACP") ("College") can facilitate the continued improvement of Australia's health care system, and contribute to the development and promotion of evidence based treatment standards and guidelines., and implementation of national health reforms such as Lead Clinicians Groups.(1)

Lead Clinicians Groups will develop the necessary strategies and processes to integrate the care provided by different services.

The strategies will facilitate the development and uptake of improved systems for communicating or sharing information between ambulatory and primary health care, specialist, and hospital based care such as e-health records, and telehealth.

Health outcomes are significantly improved when the primary and ambulatory health care system is effective.(2)

Increasingly in ambulatory and primary health care settings, medical practitioners will be faced with the management and treatment of complex and chronic conditions. However, with fragmentation of health care across multiple settings there can be an increasing inefficiency and breakdown in communication between health care providers, patients and treating institutions.

"***Australia's primary health care system is a complex mix of Commonwealth, state and territory, and privately funded and delivered services. While it performs reasonably well for many, for the growing number of people with chronic disease, and especially those with multiple and complex conditions, this is not the case.[21] These people generally have multiple complex health care needs, often provided in different settings and by different health professionals and are often at risk of experiencing an acute event. For these patients, the need to navigate their own way through the system and between multiple services and health care providers can be a daunting experience, with poor coordination leading to worsening outcomes, preventable acute events and emergency department and hospital admissions. With an ageing population, and a growing prevalence and burden of chronic disease, these issues will only become more acute."***

Towards a National Primary Health Care Strategy;
Department of Health and Ageing 2009

Timely intervention and prevention of emergencies is largely the responsibility of health professionals working in the community (3). Through the National Health Reform and COAG meeting, the College strongly believes the current health reform process affords a unique opportunity to explore the development of a more coordinated and multidisciplinary approach for the entire health care system, involving specialist physicians in the primary and ambulatory setting.

Significant coordination between the new Local Hospital Networks, and the Medicare Locals, as well as other health providers in the jurisdictions and private health sector, would be necessary to achieve better integration of services. Lead Clinicians Groups should provide this connecting and coordinating function. COAG recently recognised the need to coordinate Medicare Locals with the Local Hospital Networks in the February 2011 Heads of Agreement – National Health Reform (clause 49):

"*The parties agree that Medicare Locals and LHNs will work together to itegrate services and improve the health of local communities*" (4).

Lead Clinicians Groups will provide this role through:

- Establishing a clear relationship and communication pathway with Local Hospital Networks and Medicare Locals.
- Establishing a clear relationship with the National Lead Clinicians Group, ACSQHC , the NHMRC and existing mechanisms for clinical input
- Establishing a clear relationship with the AHMAC, AHMC, and state and territory health agencies, including existing pathways for clinical engagement.
- Acting as a 'champion' that promulgates optimal care and referral pathways, and innovative local initiatives that integrate and coordinate care solutions, including through the National Lead Clinicians Group
- Recommending best practice clinical guidelines to achieve the goal of patient centred coordinated care in a two-way (top-down and bottom-up) relationship between National and Local Lead clinician groups
- Providing strategic oversight of Local Hospital Network and Medicare Local implementation of clinical priorities and guidelines.

Jurisdictional attempts to engage clinical expertise vary in design, scope and coverage with some states and territories. Some jurisdictions have made significant developments which the Lead Clinicians Groups should expand and develop further. The introduction of Lead Clinicians Groups provides a mechanism for improving the interconnection of these services and entities, leading to their better coordination and more efficient and effective use.

Improved integration of community based care will lead to reduced hospital admissions, and improved quality of life for patients through reduced interactions with the health care system, and system wide savings over time.

The need for better managed care in the ambulatory setting is further supported by the recently released annual report from the NSW Bureau of Health Information, stating that 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. (5) The rate of lower limb amputations in New South Wales was 17.7 per 100,000 people. The United States which had 35.7 per 100,000 people. All other countries examined such as Canada (11.3), Norway (10.9) and Britain (9.0) had fewer amputations per 100,000 than New South Wales.

Working with the Lead Clinicians Groups and other health bodies, Australia's physicians can provide a key role in the development and implementation of an efficient and effective model of care.

Australia's changing demographics, such as population ageing and the increasing prevalence of chronic and complex disease), the ever increasing requirements for more people to receive complex and overlapping care (from a variety of health care providers in the continuum of care such as general practitioners and medical specialists), and linking through ambulatory care, hospital settings, sub-acute care and increasingly additional community support for patients in their own homes. This care must be well coordinated if people with complex needs are to receive continuum of care that is comprehensive, and if they are to take an active role in their own care and their future health needs.

The College will work closely with the Department on developing key measures of success for the National and Local Lead Clinicians Groups.

Background

The prevalence of chronic and complex disease increases with an ageing population. More people are receiving complex care from a variety of health care providers including medical specialists, often with episodes of hospital care, in addition to ongoing care in the community. 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.

Shifting the focus of health care and support from acute intervention to proactive management of chronic conditions and preventive interventions and along with effective health promotion will be needed to improve quality of life and contain rising health care costs.

As a result of our current federated structure there are numerous impediments to the management of care and support for people with chronic conditions.

This will require new processes for the delivery of health care and the coordination of management and support.

"Under the MBS, remuneration generally focuses on the activity involved in individual episodes of treatment. Health professionals are not supported to provide care that takes a whole-of population focus, and do not always have the capacity and tools (e.g. clinical decision support systems) to deliver evidence-based and best practice care."

Towards a National Primary Health Care Strategy;
Department of Health and Ageing 2009

The National Health and Hospitals Reform process provides an unprecedented opportunity to develop a national approach to coordination and continuity of care and support for people with multiple service needs, where care is accessed from combined funding through the appropriate funding model from existing commonwealth and state/ territory programs through the Local Hospital Networks and the Medicare Locals. The operation of a national approach, with foundations that recognise Australia's federated system, will be supported by the proposal for Lead Clinicians Groups.

Physicians commonly deal with patients with chronic conditions, which, although predominantly involving community based care, may involve periods of hospital admissions. Physicians are well aware of the hurdles to impeding optimum healthcare t and support of such patients and are thus particularly well placed to assist in developing and contributing to Lead Clinicians Groups.

Lead Clinicians Groups are also expected to have a role in the development and dissemination of effective, evidence based standards and guidelines. These should lead to better outcomes and better utilisation of resources. The establishment of a National Clinical Guidelines Group is recommended (See * Reference *UK National Clinical Guidelines Centre www, ncgc.ac.uk)

Role of physicians in coordinated care and preventative health

The Medicare Locals discussion paper on governance and functions comments:

"The Australian health care system care is currently fragmented, both within the primary health care sector and across hospitals, aged care and specialist care. This fragmentation, and the current uncoordinated proliferation of primary health care services (across program types, sectors, providers and funders) has often led to the most vulnerable patients and clinical populations missing out on the services they require, or receiving treatment in inappropriate settings."(6)

The following scenario was published in the MJA in 2005:(7)

> Mr A, a 70-year-old Maltese migrant with limited English, has diabetes and vascular compromise of his right foot. He also has a longstanding but stable mental illness, managed by his Maltese-speaking psychiatrist, Dr B, and his general practitioner, Dr C. Mr A attends the combined diabetic, surgical and foot clinic at the nearest teaching hospital. The clinic sends its reports about Mr A to Dr C, who scans them into her paperless patient record, but she has no direct access to the results of Doppler imaging or pathology tests. Dr C continues standard diabetes monitoring between Mr A's clinic attendances, sending results to the clinic.
>
> The various consultants at the hospital clinic decide that Mr A needs to have a below-knee amputation. Although Mr A tells Dr C of the planned surgery, the relevant letter does not arrive until three weeks after the operation. Only then does Dr C learn that Mr A was referred to a rehabilitation hospital.
>
> Dr C does not get a discharge summary from the rehabilitation hospital, as it goes to the referring surgical registrar from the vascular team at the hospital.
>
> Mr A spends 6 weeks in the rehabilitation hospital. The patient's family asks Dr C to intervene because Mr A is becoming depressed. Dr C contacts the rehabilitation registrar, who tells her about an impending psychiatric referral with an interpreter. The registrar is surprised to learn of the existing arrangements for Mr A's psychiatric care, as the referral from the hospital made no mention of this. As Mr A is still in the rehabilitation hospital, the decision to continue with the new, separate stream of psychiatric care stands.
>
> *Long-term effect of fragmented healthcare delivery*
>
> Because of increasing allied health costs and lengths of stay when healthcare delivery for individual patients is fragmented, the wait for hospital beds for patients with vascular conditions doubles, within the space of a year, from 3 weeks to 6 weeks.

In the above case scenario, there could have been improved outcomes with the effective integration of hospital and community services. In the above case:

- The General Practitioner (GP) could have coordinated the preoperative investigations on the patient;
- The psychiatrist could have been informed of the patient's impending admission and could have arranged to see the patient in the ward, provided ongoing psychiatric support, and coordinated his discharge and follow-up treatment on discharge ;

- Effective discharge planning with the objective of an early discharge and continuing care at home would be possible because the hospital based discharge planner would be able to organise the following community based services:
    - postoperative home-based medical care from the GP.
    - nurse visits;
    - home-visit physiotherapy;
    - community transport to the day hospital rehabilitation gym and to the psychiatrist;
    - social worker support for accessing benefits;
    - regular specialist follow-up consultations in the hospital outpatient department or the specialist's rooms; and

In the original scenario, the equivalents of the above listed services would need to be provided to the patient as an inpatient in the acute care hospital and in the rehabilitation hospital.

Care delivered with better integrated services would thus result in less time spent in hospital with associated decreased costs.

Lead Clinicians Groups will be able to enhance the provision of the necessary connections between services that could improve situations such as the one in the scenario described above. This will allow better coordination of services so that a patient's progress (or journey) through the health care service in the course of treatment or management of an illness is not interrupted by structural barriers between the services.

Multidisciplinary and Coordinated Care

Coordinating service provision can be particularly difficult across system boundaries: between general practice and hospitals or community health, and between generalist and specialist services. (8) Lead Clinicians Groups, particularly Local Lead Clinicians Groups, can encourage better coordinated care.

There are considerable difficulties working across different funding sources, and inter-professional and institutional systems. Our current system is also largely systematic and financially based on discrete episodes of care involving single diagnoses of individual patients by an assigned medical practitioner. In looking at major health reform, new funding models need to be developed which encompass patient centred care across multiple sites of care and aiming to promote independence and support in communities.

"While the importance of multidisciplinary teams in providing primary health care services is increasingly recognised, team-based models of care can be restricted by current program and funding arrangements."
Towards a National Primary Health Care Strategy;
Department of Health and Ageing 2009

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Coordinated care and support with a patient centred approach can ensure that the required interventions are specified and delegated to members of a multidisciplinary team. Treatment plans for each patient could assist in the effectiveness of chronic illness programs, and more formal, written plans would assist in organising the work of teams and would help patients to navigate the complexities of multidisciplinary care and support. Physicians are in a strong position to facilitate improved patient centred care and support models through their ability to coordinate a patient's health care journey.

Lead Clinicians Groups

At both national and local level, Lead Clinicians Groups will provide a vehicle for:

- Improving patient pathways and the optimal 'patient journey' are the key considerations for Lead Clinician Group model

- Promoting optimal standards and developing nationally consistent, evidence based guidelines that are effective;

and

- Promoting a nationally consistent approach that delivers efficient and effective communication between the Local Hospital Networks and the Medicare Locals.

In this way patients will have **the right care, at the right time and in the right location**. These new arrangements can thereby help to improve coordination, identify service delivery gaps and reshape under-performing elements within the continuum of care and to address identified service delivery gaps by appropriately directing funding through open and transparent governance to new or existing providers.

It is envisaged that the National Lead Clinicians Group would provide leadership and expertise at the national level. It would be the logical conduit for guidelines and standards, developed by Colleges in conjunction with national bodies such as the NHMRC, the ACSQHC and others including Local Lead Clinicians Groups.

At local level, Local Lead Clinicians Groups would also provide advice with respect to guidelines and standards but would predominantly be aimed at facilitating the better integration of services, in particular the Medicare Locals and Local Hospital Networks, both developing and implementing more productive service delivery.

People living along state boundaries will need special consideration due to overlapping jurisdiction and health care providers.

Membership of National Lead Clinicians Group

The RACP represents over 13,500 physicians, covering the fields of internal medicine, paediatrics, public health medicine, rehabilitation medicine, occupational and environmental medicine, child health, sexual health medicine, addiction medicine and palliative medicine and representing physicians in over 20 specialty areas.

Physicians are medical specialists who have completed advanced training after their initial medical training is completed in a particular area or 'specialty' and diagnose and manage complex medical conditions in adults, children and young people.

Specialist physicians, such as public health physicians, can also provide advice tailored to the national and the local level on preventative health.

Physicians provide care and support for complex medical conditions and continue to see the patient until these problems have resolved or stabilised. Care involves providing acute care and sub-acute care in the hospital setting, and non-acute care in the community. Care in the community may involve working with other services, including ambulatory care services. In the case of patients with chronic conditions, which may be subject to periods of exacerbation, the care will be long term and will involve coordination of treatment in all of these settings at different times.

"Not only in general practice, but in other primary health care services, the scope and extent of preventive activity is restricted. Research also suggests low rates of detection for many significant conditions with, for example, evidence that 50% of people with diabetes and 75% of people with Chronic Obstructive Pulmonary Disease (COPD) were not aware that they had the condition."
Towards a National Primary Health Care Strategy;
Department of Health and Ageing 2009

Advances in medicine have increased the complex nature of health care which requires specialist medical advice, support and coordination.

The health profile of adolescents , young people and young adults has become much more complex over the past few decades requiring very different sets of responses Greater survival from congenital conditions through to adolescence requires increasingly complex care. Their care is compounded by a higher incidence of other chronic conditions (e.g. type 1 and type 2 diabetes), and of previously uncommon conditions such as obesity, depression and anxiety, eating disorders, sexually transmitted disorders and substance abuse.

For the purposes of this paper it should be noted that 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 provides the capacity to positively influence models of care which should be patient centred and reflect the social determinants of health.

Physicians, therefore, can provide valuable input into Lead Clinicians Groups, both at national and local level, because of their insights into particular medical conditions, their expertise in public health, and because of their existing role in providing care to patients across a range of settings, services and other health care providers.

The memberships of Local Lead Clinicians Groups will be influenced by local requirements, including the precise structure and function of the bodies. As acknowledged in the discussion paper, there are pre-existing structures in the states and territories. Some of

these pre-existing structures include a diverse membership of health care professionals and health department officials.

The College looks forward to engaging with the Department to facilitate the most appropriate mechanism for specialist physicians as local 'clinical leaders',

Single versus Multiple National Lead Clinicians Groups

There are advantages in comparing each model.

A single National Lead Clinicians Group would develop a streamlined operation, serving as a focal point for interaction and leadership between the national and local bodies. It has the virtue of simplicity, which is a useful characteristic in a health care system that is already complex. Working groups could involve additional members or clinicians with relevant expertise, including existing members of Local Lead Clinicians Groups.

A single group would ensure national consistency and the latest best practice models of care. A single National Lead Clinicians Groups could apply the local learnings throughout the health care system, led by Local Lead Clinicians Groups. National guidelines would leverage opportunities, reduce risks and promote the highest standards of safety and quality.

The alternate proposal, for multiple National Lead Clinicians Groups, would require coordination to ensure information flows and clarity of reporting structures. There is a risk that these groups would start to function independently of each other reducing the potential benefits of consultation and coordination of a national health reform.

Promoting optimal standards and guidelines that are effective and evidence based

The National Health and Medical Research Council (NHMRC), Australian Commission on Safety and Quality in Health Care (ACSQHC) and other similar bodies lead the development of standards and guidelines to improve the quality and safety of health care delivery. As noted in the discussion paper, there is 'no routine and timely arrangement that enables these initiatives to be systematically disseminated within the health system for adoption locally.'

The National Lead Clinicians Group is well placed to evaluate and promulgate these standards and guidelines working with NHMRC and ACSQHC. Similarly, through their connections with Local Lead Clinicians Groups and other bodies, they will be able to consider issues that have arisen for one Local Lead Clinicians Group that has potential to affect other regions of Australia and propose areas for investigation to the NHMRC, ACSQHC and others.

At a local level, it is proposed that Local Lead Clinicians Groups will provide a similar role with respect to Local Hospital Networks and Medicare Locals.

It would be beneficial if the National Lead Clinicians Group and Local Lead Clinicians Groups of each jurisdiction routinely informed each other of actual and proposed actions (including proposed investigation of particular issues). If the action or proposed action coincides with or overlaps with something that another Lead Clinicians Group is doing or

contemplating, this will allow either a coordination of effort or a redirection of effort in order to avoid duplication. Differences of approach should be resolved by negotiation.

Coordination with Medicare Locals and Local Hospital Networks

The Lead Clinicians Groups initiative will be a key aspect of providing connections between and within Medicare Locals and Local Hospital Networks, and thus to providing better coordination of care. This will assist in designing appropriate patient pathways in order to promote the optimal 'patient journey', i.e. **the right care, at the right time, in the right location**.

A National Lead Clinicians Group, and especially Local Lead Clinicians Groups, has the potential to connect Medicare Locals with Local Hospital Networks through their key responsibilities to 'assist with service planning and efficient allocation of clinical services' and develop local solutions to local issues. At a local level, physicians are well placed to advise on the operational and systemic linkages between Medicare Locals and Local Hospital Networks because of their presence in all parts of the health care supply chain.

If the local health care providers are not appropriately coordinated then opportunities to promote best practice will be missed. Local Lead Clinicians Groups can be the 'glue' that connects local delivery of health care across the multiple providers and multiple settings. By providing this connection, Local Lead Clinicians Groups will capture opportunities and best practice that can be referred to the National Lead Clinicians Group to consider broader application.

In this process physicians, especially those in public health, can lead population based resourcing and priority setting. Involving specialist physicians leads to a more efficient and effective allocation of resources for local community health care needs.

Ensuring that a primary health care approach to population health is based on sound public health principles, including evidence based practice, needs planning and monitoring of health outcomes. Lead Clinicians Groups can coordinate and lead local population health, with a focus on health promotion and health protection and a particular emphasis on reducing socio-economic differentials in health. There are a multitude of specialist medical services that could be better coordinated and managed. The recommendations of the NHHRC and the National Preventative Taskforce should be implemented and in particular, the involvement of an agency to guide national strategic direction in public health.

Local Lead Clinicians Groups will be particularly useful in integrating care in rural and remote areas, which may involve care across more than one Medicare Local or Local Hospital Network. These areas require effective and efficient coordination of primary and ambulatory care, including specialists, with aged and community care, local acute care services, rehabilitation and palliative care services through the local hospital or Multi-Purpose Service Centres to ensure that services are provided as close to home as possible and continuity of care for patients who need to travel for more specialised treatment within the region or to specialised services in urban centres.

Local Lead Clinicians Groups have the potential through facilitating relationships between Medicare Locals and Local Hospital Networks to provide seamless care for patients in their rural and remote communities. The patient must feel confident and know where and how their care will be provided within the region.

Rural people with complex care requirements have particular needs for extended coordination and case management. Local Lead Clinicians Groups could ensure that there are tertiary referral strategies to address the time consuming and logistically difficult task of coordinating several appointments within one trip to the city or regional centre for a hospital visit. This would result in savings on time, trips and costs to both the patient, their families and the health system.

Greater coordination through multidisciplinary teams facilitated by the Medicare Locals working with the Local Hospital Networks will improve patient care.

The Lead Clinicians Groups initiative, by working together Medicare Locals and Local Hospital Networks can contribute valuable evidence on potentially preventable hospitalisations, which currently increase by remoteness for a range of chronic, acute and vaccine preventable conditions.

Existing structures

As the discussion paper acknowledges, there are already pre-existing mechanisms in the states and territories for providing advice and guidance to Local Hospital Networks. Although they may not function as Local Lead Clinicians Groups in the sense discussed, they do carry out key functions in terms of gathering information, planning resources and disseminating standards and guidelines. Many have undergone significant development in recent times in response to both local pressures (for example, the Garling report in New South Wales) and in response to the National Health Reforms.

The RACP agrees that Local Lead Clinicians Groups should take into account these pre-existing arrangements. Many people including physicians have invested considerable amounts of time and effort in the existing local mechanisms, and that work should be built on, rather than replaced. The local mechanisms have already developed, and continued to develop, a body knowledge, skills and goodwill among the people already involved. Local Lead Clinicians Groups have much to gain by working with and re-designing and extending local structures. Although the existing mechanisms are complex, their replacement may be counterproductive, in terms of disrupting useful coordination systems.

Development of systems serving a similar function to Local Lead Clinicians Groups is also ongoing. Thus for example, in Queensland, which has a number of state wide and local clinical networks, many of the questions being raised in this discussion paper are under consideration.(9) One issue under consideration is the management of patients who move across boundaries.

The UK's National Institute of Clinical Excellence, including the National Clinical Guidelines Centre (www.ncgc.ac.uk), provides a practical example of a template to consider for adaptation and implementation of the Lead Clinicians Group design and purpose within the Australian context. The College supports the NICE, including the NCGC, and made this support public in the College's Federal election statement in August 2010.

Arrangements may be different in each jurisdiction as long as communication between the Local Lead Clinicians Groups and National Lead Clinicians Group is clear and as long as the key objectives are identified and coordinated. There is significant variation in the size and population of the various Australian jurisdictions and the needs of their respective health

systems also vary. Existing structures in those jurisdictions have been designed to meet those needs.

Once the model for National Lead Clinicians Group is resolved, there could then be consultation with the jurisdictions about appropriate connections to their existing systems.

Conclusion

The College supports the ongoing health reforms which will better integrate and coordinate care, especially in the ambulatory and primary care settings. Appropriate investment and reform in primary and ambulatory health care is necessary, long-overdue and will dramatically improve not only our health care system, but the patient outcome.

Stripping away the legacy of our inherited arrangements will allow our health system to allocate care in the best setting at the most appropriate time and in the most efficient and effective way.

The College supports the current health reform process which provides a unique opportunity to explore the development of a more coordinated and multidisciplinary approach for the entire health care system, involving specialist physicians in the primary and ambulatory setting.

Through the national health reform process, there is a once-in-a-generation opportunity to coordinate the multiple care settings through the new Medicare Locals, Lead Clinician Groups, Local Hospital Networks, Health Preventative Agency, General Practitioner Super Clinics and Health Workforce Australia.

As medical specialists, physicians are already involved in the provision of health care across a range of health care settings and are well placed to advise on innovative evidence based solutions that drive coordinated care, improve the patient journey and deliver better patient outcomes.

Lead Clinicians Groups, working with Medicare Locals and Local Hospital Networks, have an opportunity to plan and resource to reduce avoidable admissions through more coordinated and patient centred care.

For example, a diabetes clinic, involving all relevant health clinicians could reduce the likelihood of an amputation through an effective care plan that promoted patient compliance with their treatment program through both the multidisciplinary support and provision of the care in a single community based location. However, more work is required to determine the detail of Lead Clinicians Groups, including their model, structure, roles and implementation.

Physicians have a vital contribution to make to this work and the College keenly anticipates further opportunities to work with the Department during coming months.

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